

**MEDICAL STAFF BYLAWS
RULES & REGULATIONS**

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Bylaws of the Medical Staff of Lawrence + Memorial Hospital

PREAMBLE

The Lawrence and Memorial Hospital (hereinafter referred to as "the Hospital") is a non-profit community hospital organized under the laws of the State of Connecticut the purpose of which is to serve as a general hospital providing patient care, education, and research. The Medical Staff is responsible for the quality of medical care in the Hospital and the cooperative efforts of the Medical Staff, the President/CEO and the Board are necessary to fulfill the Hospital's obligations to its patients.

The physicians, dentists, podiatrists and Affiliated Health Care Practitioners practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. **"Board"** means the Board of Directors of the Hospital, also referred to as "The Board," or, by The Joint Commission, as the "Governing Body."
2. **"Bylaws"** means these Bylaws of the Medical Staff and, when used as a generic description, also shall include the Rules and Regulations of the Medical Staff, and Medical Staff Policies.
3. **"Clinical Privileges" or "privileges"** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, or surgical services.
4. **"CMO"** means the Chief Medical Officer appointed by the Board to act on its behalf in Medical Staff affairs in cooperation with the President of the Medical Staff.
5. **"Ex-officio"** means service as a member of a body by virtue of an office or position and, unless otherwise expressly provided, means without voting rights.
6. **"Ongoing Professional Practice Evaluation" or "OPPE"** means the professional practice evaluation of applicants for membership and of Members of the Medical Staff, and may include chart review, monitoring clinical practice pattern, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of patients (e.g., consulting physicians, assistants at surgery, nursing or administration personnel).
7. **"Affiliated Health Care Professional"** means, and is limited to: Physician Assistants, Certified Nurse Anesthetists, Certified Nurse Midwives, Advanced Practice Registered Nurses and Clinical Psychologists. These Affiliated Health Care Professionals shall be individuals other than licensed physicians, dentists, and podiatrists whose patient care activities require that their authority to perform specified patient care activities be under the direct supervision of a Physician or Chief of Service to which they are assigned. Specific privileges and obligations with regard to each category of Affiliated Health Care Professionals shall be delineated by the Department to whom the Affiliated Health Care Professional is assigned.
8. **"Hospital-based physician"** means a Member of the Medical Staff who is in any one of the following categories: (1) the Member is considered by the Hospital to be a full-time employee of the Hospital in accordance with its usual and customary personnel policies; or (2) during any calendar year, the Member is regularly employed by the Hospital for 20 hours a week or more, or (3) the Member spends 50% or more of the Member's professional working time as a paid employee of the Hospital, or (4) the Member is employed by an entity which has an exclusive services agreement with the Hospital.
9. **"Medical Executive Committee" or "MEC"** means the Medical Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Board.

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10. **"Medical Staff"** means the formal organization of all physicians, dentists, and podiatrists who are privileged to attend patients in the Hospital, duly licensed in the State of Connecticut for their appropriate practice.
11. **"Medical Staff Year"** means the period from October 1 through September 30.
12. **"Patient Contact"** means any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital.
13. **"Practitioner"** means an appropriately licensed medical physician, dentist, or podiatrist applying for or exercising clinical privileges in this Hospital.
14. **"President/CEO"** means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.
15. **"Professional Liability Insurance" or "Malpractice Insurance"** means a policy of insurance, issued by a carrier licensed or authorized to do business in Connecticut, which meets the coverage limits and other terms specified by the Board from time to time.
16. **"Special Notice"** means written notification sent by certified mail, return receipt requested.
17. **"Yale New Haven Health System Affiliated Hospital"** shall include Yale New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, Westerly Hospital and any other hospital that affiliates with Yale New Haven Health.

INTERPRETATION

Whenever the Bylaws do not specifically address a topic or cover a matter, or there is a need for interpretation, the MEC may issue an interpretation. In arriving at an interpretation, the MEC may take into account the usual and customary policies and practices of the Medical Staff, whether written or unwritten, and in its discretion may also bring to bear the expert medical knowledge of its members. MEC interpretations shall be maintained with the minutes of the MEC.

In the event that any law or regulation or mandatory Joint Commission or other applicable mandatory accreditation requirement clearly requires the Hospital or the Medical Staff to take particular action in connection with credentialing or any other matter covered by these Bylaws, such law, regulation, or accreditation requirement, unless specifically provided otherwise in the Bylaws, shall be complied with pending review by the Bylaws Committee, and to the extent possible, shall be construed as being consistent with the provisions of these Bylaws. Once the Medical Staff becomes aware of the law, regulation, or requirement, the Bylaws Committee shall meet as soon as practical to review the law, regulation, or requirement at issue, seek input from legal counsel or other appropriate individual as the Bylaws Committee see fit, and consider whether or not a revision to the Bylaws, based upon the law, regulation, or requirement is appropriate. If the Committee determines that an amendment to the Bylaws is appropriate, the Committee shall consider the appropriate amendment following the procedures set forth herein.

These Bylaws are not intended to create rights in any third parties; there are no third-party beneficiaries to these Bylaws.

NON-DISCRIMINATION

In accordance with Hospital and Medical Staff policy, all provisions of the Bylaws shall be interpreted and applied so that no person, Member, applicant for Membership, Hospital employee, patient, or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under

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any program or activity of the Hospital and its Medical Staff. Any reference to males or females, or use of the masculine or feminine gender shall be interpreted whenever possible as including both sexes.

NATIONAL PRACTITIONER DATA BANK AND CONNECTICUT DEPARTMENT OF PUBLIC HEALTH REPORTING REQUIREMENTS

Except as otherwise required by law, the Hospital's authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as a final action by the Board and only using the description/information set forth in the final action as adopted by the Board following completion of the hearing process. Where no hearing was requested or granted, and the Member remains on the Medical Staff, the Member shall be granted the opportunity to meet with the President and the CMO to review and discuss the proposed Data Bank report before it is filed. The Hospital shall report all revisions of an adverse action as required by law.

The Hospital's authorized representative shall only report credentialing actions to the Connecticut Department of Public Health when reporting is required pursuant to the provisions of Chapter 370 of the Connecticut General Statutes as amended from time to time.

Nothing in this provision shall preclude the Hospital's authorized representative from properly and fully disclosing information about a Member to another Hospital or healthcare provider when authorized by the Practitioner.

NOTICE BY CERTIFIED MAIL, RETURN RECEIPT

In any case in which the Bylaws requires notice by Certified Mail, Return Receipt, it shall be acceptable to utilize other methods that can be tracked in order to document delivery and which require a signature upon delivery, such as Express Mail, FEDEX, and Messenger Hand Delivery.

ARTICLE I: NAME

The name of this organization shall be the "Medical Staff of the Lawrence and Memorial Hospital".

Section 1. AUTHORITY

These Bylaws, Rules and Regulations of the Medical Staff of the Lawrence and Memorial Hospital are created under the authority of the Hospital Bylaws, Article VII, which is made a part hereof by reference and appears in full as Appendix A herewith, said hospital Bylaws being those adopted by the Board of Trustees on December 12, 1953, and as amended thereafter.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

Section 1. OVERVIEW AND PURPOSES

OVERVIEW

The Medical Staff provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the Medical Staff process. The Medical Staff is also responsible for the ongoing evaluation of the competency of the practitioners who are privileged,

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delineating the scope of privileges that will be granted to practitioners and providing leadership in performance improvement activities throughout the Hospital.

The purposes of the Medical Staff are:

- a. To promote the goal that all patients admitted to or treated in any of the facilities, Departments, or services of the Hospital shall receive high quality of care;
- b. To promote a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges that each practitioner may exercise in the hospital and through review and evaluation of each practitioner's performance in the hospital;
- c. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- d. To initiate and maintain, in cooperation with the Board, rules and regulations for self-government of the Medical Staff; and
- e. To provide means, such as the Medical Executive Committee, and Representatives to the Board of Directors, whereby, the Medical Staff shall be consulted in the Hospital's policy making and planning process.

Section 2. RESPONSIBILITIES

The responsibilities of the Medical Staff in cooperation with the Board are:

- 2.1 To assume responsibility for the quality and appropriateness of patient care rendered by all practitioners authorized to practice in the Hospital through the following measures:
 - a. A credentials program, which includes a mechanism to confirm eligibility for membership and privileges, for appointment and reappointment and for the granting of clinical privileges.
 - b. A continuing medical education program, fashioned at least in part on the needs demonstrated through patient care audit and other quality maintenance programs;
 - c. A concurrent utilization review program to allocate inpatient medical and health services based upon patient-specific determinations of individual medical needs;
 - d. A program of assessing and improving the quality of care throughout the organization;
 - e. A consistent process for the completion of Medical Records as outlined in the Rules and Regulations.
 - f. Agree to abide by the Medical Staff Code of Conduct.
- 2.2 To recommend to the Board action with respect to:
 - a. Appointments, reappointments, staff category, Departmental assignments, and clinical privileges;
 - b. Specified services for Affiliated Health Care Professionals; and
 - c. Corrective action.

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- 2.3 To communicate to the Board regarding the quality and efficiency of medical care rendered to patients in the hospital through regular reports and recommendations concerning the implementation, operation, and results of patient care audits and other quality maintenance activities.
- 2.4 To initiate and pursue corrective action with respect to practitioners, when warranted.
- 2.5 To develop, administer, and seek compliance with these Medical Bylaws.
- 2.6 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
- 2.7 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1. GENERAL STATEMENTS REGARDING MEDICAL STAFF MEMBERSHIP

- 1.1 Membership as a Privilege
Membership on the Medical Staff of Lawrence and Memorial Hospital is a privilege that shall be extended only to professionally competent physicians, dentists, or podiatrists who continuously meet the eligibility requirements, qualifications and standards, set forth in these Bylaws. Appointment to and membership on the Staff shall confer only such clinical privileges as have been granted by the Board in accordance with these Bylaws. Gender, race, creed and national origin are not used in making decisions regarding Medical Staff membership and the granting or denying of clinical privileges.
- 1.2 No Automatic Right to Membership
No physician, dentist, or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that such individual is duly licensed to practice medicine or dentistry or podiatry in this or any other state, or that the individual is a member of any professional organization, or because such individual is certified by any clinical board, or that the individual had in the past, or presently has such privileges at another health care facility or in another practice setting.
- 1.3 Facility/Resource Limitations
The Medical Executive Committee or the Board may determine that the appointment and/or privileging process cannot be completed, in whole or in part, based upon limitations in terms of the availability of Hospital resources or facility to accommodate the applicant's practice.

This determination may be based upon either:

- a. The Hospital's present inability as supported by documented evidence satisfactory to the Board or to the Medical Executive Committee to provide adequate facilities or support services for the applicant and the applicant's patients, or
- b. The Hospital's written plan of development or plan of patient care, including the types of patient care services to be provided or currently implemented.

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Any such decision that an application cannot be completed, in whole or in part, based upon the hospital's inability to accommodate the applicant shall not be deemed adverse, shall not be considered a denial of privileges or membership, and shall not entitle the applicant to the rights and provisions of the Fair Hearing Plan (Article XVIII).

Section 2. ELIGIBILITY REQUIREMENTS

Individuals who satisfy the requirements outlined below will be considered eligible for appointment or reappointment to the Medical Staff and clinical privileges, as applicable. These requirements apply during and after the time of any appointment, reappointment, or granting of clinical privileges.

2.1 Bylaws, Rules, Regulations and Policies

Applicants and current Medical Staff must agree to abide by Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff Policies and Procedures

2.2 Identity Verification

At the time of initial application, all applicants must provide identity verification in the form of a notarized U.S. passport or driver's license in accordance with Medical Staff Administration policy;

2.3 Licensure

In order to be eligible for appointment, Medical Staff and Affiliated Medical Staff in all categories are required to have and maintain appropriate current licensure in the State of Connecticut in their profession as outlined herein.

Applicants for Initial Appointment

Applicants for initial appointment must hold a current, unrestricted license to practice in the State of Connecticut. Individuals whose State of Connecticut license or license in any other State or country is currently restricted for any reason are not eligible. Restriction includes, but is not limited to probation, practice monitoring/oversight or a requirement for completion of additional training or education.

Applicants who have ever had a license in any state or country permanently revoked for any reason are not eligible for appointment.

Applicants with a history of a licensure action(s) in any state which have been resolved with no residual restrictions may be eligible for appointment. Consideration shall be given as to the concerns that gave rise to the licensure action, assessment of impact on privileges requested, time that has elapsed since resolution of the matter and patient safety. Such applicants are not eligible for temporary privileges.

Absent any other concerns regarding eligibility, applicants who are subject to a civil penalty, reprimand or censure with requirements limited solely to payment of a monetary fine or submission of administrative fees may be considered for appointment once verification has been obtained directly from the relevant state licensing board confirming that all obligations have been fulfilled with no residual licensure restrictions. Such applicants are not eligible for temporary privileges.

No hearing rights shall be afforded for failure to meet eligibility requirements related to licensure.

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Current Members

Members of the Medical or Affiliated Health Care Professional Staff are required to notify the Chief Medical Officer and Medical Staff Administration immediately upon the occurrence of licensure action of any kind in the State of Connecticut or any other state or country. This includes, but is not limited to, revocation, suspension, surrender, voluntary agreement not to exercise as well as entrance into a consent order for any purpose including, but not limited to, fine, censure, reprimand, probation, or restriction.

ARTICLE VII, Section 4 outlines the consequences of various licensure actions.

2.4 Federal and State Drug Control Registration

When required in order to exercise clinical privileges, Medical Staff members must have and maintain a current, unrestricted, DEA registration in the State of Connecticut as well as a State of Connecticut Controlled Substance Certificate at all times.

Individuals applying for initial appointment may have a pending certificate or certificates. If either or both is pending, the applicant must complete the appropriate Federal DEA/State Controlled Substance Certificate Waiver Form in which they agree not to prescribe controlled substances at the Hospital until appropriate prescribing authority has been granted.

Applicants for initial appointment shall immediately become ineligible for appointment and clinical privileges if either or both Federal or State certificate are not able to be obtained or, once obtained, is restricted and no hearing rights shall be afforded.

Medical Staff members who do not renew their DEA certificates before expiration shall be required to complete a Federal DEA/State Controlled Substance Certificate Waiver Form in which they agree not to prescribe controlled substances at the Hospital until such certificate has been renewed.

ARTICLE VII, Section 4 outlines the consequences of actions taken against a Medical Staff member's Federal or State authority to prescribe controlled substances.

2.5 Education

Physicians:

Physicians must be graduates of an allopathic or osteopathic medical school accredited for the duration of their attendance by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association, the American Osteopathic Association its successor agency.

Certification by the Education Commission for Foreign Medical Graduates (ECFMG) or evidence of having successfully completed a "Fifth Pathway" are acceptable alternative means of fulfilling this requirement.

Dentists:

Dentists must be graduates of a dental school accredited for the duration of their attendance by Commission on Dental Accreditation of the American Dental Association or its successor agency.

Podiatrists:

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Podiatrists must be graduates of a podiatric school accredited for the duration of their attendance by the Council on Podiatric Medical Education of the American Podiatric Medical Association its successor agency.

CRNAs:

Certified Registered Nurse Anesthetists must be graduates of a state approved basic nursing education program and graduates of an education program accredited by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education Programs.

Nurse Practitioners:

Nurse Practitioners must be graduates of a state approved basic nursing education program, and graduates of a Board of Nurse Registration and Nursing Education approved course of study for nurse practitioners conducted within an accredited academic institution. The course of study for nurse practitioners must include both a didactic component as well as supervised clinical experience.

Physician Assistants:

Physician Assistants must be graduates of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistants which is recognized by the Council for Higher Education Accreditation.

Other Affiliated Health Care Professionals:

Must be graduates of appropriately accredited educational programs relevant to their practice area.

2.6 Training

Physicians must have evidence of having successfully completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post graduate training program.

Dentists and Oral & Maxillofacial Surgeons, except for those engaged in the practice of general dentistry, must have evidence of having successfully completed at least one year of a residency program accredited by the Commission on Dental Accreditation (CODA).

Podiatrists must have evidence of having successfully completed a residency program accredited by the Council on Podiatric Medical Education.

An “accredited” postgraduate training program is one which is fully accredited, as applicable, throughout the time of the applicant's training by:

- the Accreditation Council for Graduate Medical Education; or
- the American Osteopathic Association; or
- the Commission on Dental Accreditation; or
- the Council on Podiatric Medical Education; or
- a successor agency to any of the foregoing

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2.7 Competence

Applicants for Initial Appointment

In order to be eligible for appointment and privileges, applicants for initial appointment must provide, or cause to be provided, evidence of current professional competency to exercise the clinical privileges requested with reasonable skill and safety and sufficient to demonstrate to the Medical Staff and Board of Trustees that any patient treated will receive high quality medical care.

In order to be eligible for appointment and privileges, applicants for initial appointment may not have any of the following:

- a. a history of adverse professional review actions regarding medical staff membership or clinical privileges for reasons related to clinical competence or professional conduct including, but not limited to, denial, revocation or suspension (excluding precautionary suspension) of membership or clinical privileges; or
- b. any formal investigations or for cause Focused Professional Practice Evaluation (FPPE) pending resolution or completion at another institution; or
- c. previously resigned appointment or relinquished clinical privileges during a Medical Staff investigation or in exchange for not conducting such an investigation

Initial applicants with any of the above are not eligible for appointment. If such information is identified and verified during the application process, the applicant shall be notified accordingly and the application considered voluntarily withdrawn.

Current Members

Upon reappointment, current members of the Medical Staff must provide, or cause to be provided, evidence of the following:

1. Have admitted or cared for a sufficient number of patients in the Hospital inpatient and/or outpatient settings to allow evaluation of continuing competence by the Chief of the relevant Department. This requirement is considered not applicable for individuals seeking appointment to the Active Referring or Referring Affiliated Health Care Professionals categories.
2. Absent a sufficient volume of patient care activity at the Hospital, verification of competence and activity from another Hospital and/or from appropriate peers, acceptable to the Chair and Credentials Committee must be supplied in the form of references. References must be submitted consistent with the process and forms required by Medical Staff Administration. This requirement is considered not applicable for individuals seeking appointment to the Active Referring or Referring Affiliated Health Care Professionals categories.

Members must also fulfill any applicable Departmental or Sectional specific criteria for reappointment.

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2.8 Health Status

In order to be eligible for initial or reappointment, applicants must attest to a satisfactory physical and mental health status and the ability to perform the requested privileges with reasonable skill and safety.

New Applicants and current medical staff must disclose any limitations with their current physical or mental health that affects, or has the potential to affect, their ability to safely exercise the requested privileges and may be required to undergo specific testing.

Additionally, new applicants and current medical staff members must provide sufficient documentation to evidence fulfillment of requirements for mandatory vaccinations and any other standard health testing consistent with medical staff policies in order to be or remain eligible for membership and privileges.

Applicants and current members who fail to comply will be considered ineligible until all requirements are fulfilled.

Current members who do not comply will be automatically terminated.

ARTICLE VII, Section 4 outlines the consequences for failure to comply with health status requirements.

2.9 Federal or State Health Care Programs

To be eligible for initial or continued appointment, practitioners must not currently be debarred, excluded or precluded by agreement or on an involuntarily basis from participation in Medicare, Medicaid or any other federal or state governmental health programs.

Databases made available by governmental agencies regarding debarment, exclusion, and preclusion due, but not limited to, fraud, program abuse or other sanctions or actions are queried at the time of initial appointment and reappointment to the Medical Staff as well as on a monthly basis.

These databases include, but are not limited to, the following: Office of the Inspector General (OIG), General Services Administration (GSA), Office of Foreign Asset Control (OFAC), Centers for Medicare and Medicaid Services (CMS), and the State of Connecticut Department of Social Services (DSS).

Processing of applications for practitioners who are identified and verified with the source organization as debarred, excluded or precluded during the course of initial appointment will cease and be automatically deemed voluntarily withdrawn. No hearing rights will be afforded.

ARTICLE VII, Section 4 outlines the consequences of actions taken against current Medical Staff members relative to participation in federal or state governmental health care programs.

2.10 Insurance Coverage

Medical Staff members must continuously maintain valid and sufficient malpractice insurance that will cover their practice at the Hospital in not less than the minimum amounts as from time to time may be recommended by the President and Chief Medical Officer following review by the Medical Executive Committee and approval by the Board of Trustees, or provide other proof

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of financial responsibility in such manner as the Board of Trustees may from time to time establish.

In the event of a lapse of a policy or a change in carrier, Members are obligated to obtain tail insurance, or the new policy must be fully retroactive in terms of coverage, so that the individual remains fully insured at all times.

Members are responsible for immediately notifying the Medical Staff Administration department, in writing, of any lapse in coverage (including any uninsured tail coverage period), reduction in coverage below Hospital required amounts and/or change in carrier.

Evidence of appropriate coverage must be immediately available or made immediately available upon request at all times and a complete claims history must be provided at the time of initial and reappointment.

ARTICLE VII, Section 4 outlines the consequences of failure to maintain malpractice insurance coverage.

2.11 Response Time

Medical Staff members must be located close enough to the Hospital to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their hospitalized patients. This includes making arrangements to ensure that other current members of the medical staff with appropriate privileges have agreed to provide coverage in relevant hospital location(s) when the Medical Staff member is not available. Such coverage arrangements must be identified at the time of initial and reappointment.

Consistent with the responsibilities of the Department/Section Chair for oversight and management of all clinical department functions, individual clinical leaders may establish specific response times within which members of the Department or Section must be available to be considered timely.

Based upon the requirements of the medical staff category to which they are appointed, some medical staff members may be required to fulfill responsibilities regarding emergency call and to provide other services as may be determined by the applicable Department or Section.

2.12 Continuing Education / Medical Staff Education

All members of the medical staff are required to participate in continuing medical education related to their area of practice to fulfill the continuing medical education expectations associated with maintenance of their license to practice in their profession.

At the time of reappointment, all members must attest to having, and being able to produce, if requested, evidence of continuing educational credits earned, as specified by current requirements of the individual's licensing body of the State of Connecticut, Department of Public Health.

Successful completion of any Medical Staff Education training required at the time of initial and reappointment must be done for an application for initial or reappointment to be deemed complete. The appointment and privileges of Medical Staff who fail to complete Medical Staff Education training before their current appointment lapses will be automatically terminated.

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Under these circumstances, the Medical Staff member will be eligible for reinstatement once there is evidence that training has been successfully completed.

ARTICLE VII, Section 4 outlines the consequences for failure to comply with the requirements related to continuing medical education or completion of medical staff education training.

2.13 Medical Staff Dues.

The Medical Executive Committee shall establish the amount of medical staff dues to be collected and the categories of Medical Staff subject to payment of dues as well as the manner of expenditure of such funds.

Current members of the Medical Staff who are required, by virtue of appointment to certain categories, to pay medical staff dues are defined in Article IV.

Dues are collected annually at the end of each calendar year. Payment is due the first Monday in January and invoices shall be sent a minimum of thirty (30) days before payment is due. Medical Staff who are required to pay dues are notified by Medical Staff Administration. Medical Staff dues are not prorated for any reason. A second notice is distributed to those who have not paid by the first Monday in January and the relevant Department Chair shall be informed of any members of their Department who are delinquent in making payment.

Medical Staff members subject to dues payment are appropriately informed of the required response time and consequences for failure to pay dues in a timely manner as outlined in ARTICLE VII, Section 4.

2.14 Contracted and Exclusively Contracted Services

In clinical services in which the Hospital contracts exclusively with a group for the provision of certain Hospital-based professional services and other contracted professional services, appointment to the Medical Staff and access to Hospital resources is restricted to physicians and any other practitioners, as applicable, who are members of the group under contract or who are designated by the Chair as an extension of the group so as to enable the service to fulfill its obligations to the Hospital for patient care, education and research.

Where such exclusive contracts for professional services exist, continued appointment to the Medical Staff and clinical privileges are contingent upon the Member maintaining group membership with the contracted organization. In the event that group membership no longer exists, the Member shall be deemed to have automatically and voluntarily resigned from the Medical Staff.

Practitioners who are deemed ineligible to apply for appointment because they are not subject to an exclusive contract arrangement as described above or those who have been terminated because they are no longer appropriately associated are not entitled to a hearing under these Bylaws.

Other Contractual Arrangements

Notwithstanding any other provision of the Bylaws, or of the Rules & Regulations, the Hospital may require that membership and clinical privileges be contingent upon, and expire simultaneously with, other agreements or understandings or contractual relationships that are not exclusive. In the event that an agreement has such a provision or there is such an

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understanding, the provisions of these Bylaws, Rules & Regulations and policies of the Medical Staff with respect to a hearing shall not apply.

The application of an individual whose specialty area of practice is one in which the Hospital has an exclusive or other contractual arrangement with a specific group and the individual is not a member of said group will not be processed and the applicant will be notified accordingly. This shall in no way be construed to be an action of the Medical Staff or be subject to Fair Hearing, appeal or appellate review under these Bylaws.

2.15 Ethics and Professional Behavior

All applicants and current Members of the Medical Staff are expected to demonstrate that they are able to work cooperatively and collegially with others to provide quality patient care. This includes adherence to the ethics of their profession, to the Yale New Haven Health System Standards of Professional Behavior and the Medical Staff Code of Conduct.

Since the date of initial licensure to practice his/her profession, applicants and current members must have never been convicted of any felony or misdemeanor relevant to Medical Staff responsibilities.

2.16 Board Certification

Board Eligibility / Certification Requirements for Physicians, Dentists and Podiatrists

Prospective Members of the Medical Staff must either (a) be currently certified by one of the U.S. specialty certifying boards as applicable to his/her practice and identified below or (b) have completed all of the relevant U.S. specialty board certification training requirements and, at the time the application is considered complete, consistent with these Bylaws, be considered by the relevant board as “eligible” to take the required examination(s) leading to Board Certification, or as eligible to do so after obtaining any Board required practice experience.

Current Members must remain board eligible by one of the U.S. specialty certifying boards identified below in order to remain eligible to be a member of the medical staff. This requirement is applicable to Members of all medical staff categories.

Members who are not certified at the time of appointment have five (5) years from the date of appointment to the Medical Staff by the Board of Trustees to achieve initial certification by the U.S. specialty certifying board applicable to his/her practice in order to remain eligible for membership and privileges. No hearing rights will be afforded for failure to meet board certification requirements.

If an applicant for initial appointment previously held certification from a U.S. specialty certifying board that has lapsed, but he/she remains eligible for recertification, he/she shall have three (3) years from the date of appointment to the Medical Staff by the Board of Trustees to achieve certification. If U.S. Board Certification is not achieved within such period, the member shall no longer be eligible for membership and privileges. No hearing rights will be afforded.

Board Re-Certification Requirements for Physicians, Dentists and Podiatrists

Members whose U.S. board certification bears an expiration date shall successfully complete recertification no later than three (3) years following such date in order to maintain appointment.

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Members who were appointed prior to October 1, 2020 shall have five (5) years following expiration to achieve recertification in order to maintain appointment.

Exceptions to Board Certification Requirements

Under special circumstances at the discretion of the relevant Department Chief and Chief Medical Officer, an exception to the requirements for initial certification and recertification as described above may be requested. Such requests shall be made in writing and submitted to the Credentials Committee for consideration.

Exceptions may be recommended based upon: (1) board certification granted in another country that is determined to be equivalent to U.S. certification; (2) special clinical expertise held by the applicant and desired to support patient care or (3) unique educational contribution.

The Credentials Committee shall consider all exceptions and make its recommendation to the Medical Executive Committee (MEC). The Medical Executive Committee shall, in turn, consider the recommendation of the Credentials Committee and forward its own recommendation to the Patient Safety and Clinical Quality Committee of the Board of Trustees (PSCQ).

Foreign trained practitioners who are approved under any exception will be required to obtain certification by the appropriate U.S. board as identified below whenever the relevant board offers a pathway for them to become certified and, if applicable, under these circumstances, certification from the applicable U.S. board will be required within five (5) years of eligibility.

Physicians

American Board of Medical Specialties (ABMS) certifying board
American Osteopathic Board

Dentists

American Board of Oral & Maxillofacial Surgery
American Board of Pediatric Dentistry
American Board of Orthodontics
American Board of Prosthodontics
American Board of Periodontology
American Board of Endodontics
American Board of Oral & Maxillofacial Pathology

Note: Dentists in the practice of general dentistry are exempt from requirements for board certification.

Podiatrists

American Board of Foot and Ankle Surgery (ABFAS) (formerly known as the American Board of Podiatric Surgery (ABPS)
American Board of Podiatric Medicine (ABPM)

ARTICLE XII, Section 4 outlines the consequences for failure to meet requirements for board certification.

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Section 3. ADDITIONAL REQUIREMENTS

3.1 Practice History

At the time of application for appointment, each applicant shall answer “Practice History Information” questions contained in the application, which include whether or not the applicant:

1. has been convicted of or charged with or pled guilty or nolo contendere to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent thereof;
2. has been denied any license, certification, narcotics permit, hospital appointment or privilege;
3. has had any license, certification, narcotics permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily;
4. has been the subject of disciplinary action including allegations related to any forms of impairment, disruptive behavior or unprofessional conduct;
5. has any condition that would compromise his/her ability to practice with reasonable skill and safety; and
6. is currently engaged in illegal drug use or dependent upon any controlled substance of alcohol.

Information provided by applicants in conformance with this requirement shall be treated as confidential.

If any such actions were ever taken with respect to (1) through (6) above, details will be required as part of the initial appointment or reappointment process. Applicants must also provide information regarding any pending challenges, complaints, investigations, or other proceedings that might lead to any of the actions cited in this section. This information will be shared with the relevant Department Chair and the Credentials Committee.

Section 4. BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

- a. Provide patients with care of the generally professionally recognized level of quality and efficiency;
- b. Provide patients with care of the generally professionally recognized level of quality and efficiency;
- c. Discharge such staff, Department, service, committee and hospital functions for which the Member is responsible by appointment, election or otherwise;
- d. Prepare and complete in timely manner the medical and other required records for all patients under the Member’s supervision; and
- e. Document an appropriate medical history and physical examination consistent with Hospital policy. Specifically, a history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or

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registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours of admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition shall be completed. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission and prior to any surgical procedure or procedure requiring anesthesia services.

Section 5. DURATION OF APPOINTMENT

5.1 Duration and Renewal of Initial and Modified Appointments

All initial appointments, and modifications of appointments pursuant to Article VI, Section 6 and 7, shall be for a period of not more than three years. Initial appointments for less than three years may be appealed by the physician through the Fair Hearing Plan.

5.2 Appointments by the Board

Initial appointments and modifications of appointments shall be made by the Board which shall act only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws; provided that in the event of unwarranted delay by the Medical Executive Committee which delay is defined as a period of 100 days after receipt of the completed application, the Board may act without such recommendation provided that the Board bases its action on the same kind of information as is usually considered by the Medical Executive Committee.

5.3 Reappointments

Reappointments by the Governing Body to any category of the Medical Staff shall be for a period of not more than three years.

Section 6. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

6.1 Initial Appointments

Practitioners granted clinical privileges at initial appointment are subject to Focused Professional Practice Evaluation (FPPE). Performance shall be evaluated by the Chair of the Department or the Chair's designee for purposes of FPPE.

6.2 Modification in Staff Category and Clinical Privileges

The Medical Executive Committee may recommend to the Board a change in Staff category of a current Staff member or the granting of additional privileges to a current Staff member pursuant to Article VI, Section 8. All new privileges for current Staff members shall be subject to Focused Professional Practice Evaluation (FPPE).

Section 7. LEAVE OF ABSENCE

A leave of absence from the Medical Staff may be either: (1) requested by a Member or (2) activated by the Chief Medical Officer.

A leave of absence is defined as a period of time during which the member's membership and clinical privileges are temporarily inactive. During the period of a leave, the member may not exercise clinical

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privileges at any Hospital inpatient or outpatient setting, provide care via telemedicine link or hold office or other positions. All other membership rights, duties and obligations shall also be inactive.

7.1 Leaves of Absence Requested by Members

Members typically request leaves of absence for, but not limited to, the following reasons: personal health or mental health concerns or health concerns of the medical staff member's family; maternity/paternity leave; practice relocation, or military duty.

The request for a leave must include the reason for the leave, the start date and anticipated return date. The period of time for a leave of absence may not initially exceed one year. A leave of absence may be renewable upon written request by the Medical Staff member, up to a maximum of two years.

If a Member's current Medical Staff appointment is due to expire during a leave of absence, the Medical Staff Member must, during the leave, apply for and meet the requirements for reappointment or else membership and clinical privileges shall lapse and the member deemed to have voluntarily resigned at the end of the current appointment period. If the member subsequently wishes to rejoin the Medical Staff, he/she shall be required to reapply in accordance with the process specified in ARTICLE III for application for initial appointment.

7.2 Return from Leave of Absence

In order to request a leave of absence, the Medical Staff member must personally submit a written or email notice to the Department Chair and Chief Medical Officer, copied to Medical Staff Administration. Medical Staff members are expected to request a leave any time they are away from Medical Staff or patient care responsibilities for longer than thirty [30] days due to circumstances which affect, or have the potential to affect, their ability to care for patients safely and competently.

7.3 Leave of Absence Activated by the Chief Medical Officer

At any point after becoming aware that a Member of the Medical Staff is away from patient care responsibilities or due to circumstances which affect, or have the potential to affect, the ability to care for patients safely and competently, the Chief Medical Officer may automatically place a member on leave of absence. The Chief Medical Officer may consult with the Department Chair and other medical staff leaders or the Medical Staff Health Committee as deemed necessary.

7.4 Approval of Leave of Absence

The Chief Medical Officer or his/her designee approves all leaves of absence and their duration. As a matter of routine, approved leaves of absence are reported along with other routine medical staff changes to the Credentials Committee, Medical Executive Committee and Board of Trustees or Patient Safety and Clinical Quality Committee of the Board of Trustees.

7.5 Notification

All Medical Staff members placed on leave will be informed in writing or via email of the granting of a leave of absence including the approved duration and any specific requirements regarding the process for return.

7.6 Return from a Leave of Absence

In order to return from leave of absence, a Member must request to do so personally in writing via a letter or email to the Department Chair and Chief Medical Officer, copied to Medical Staff

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Administration. All applicable eligibility requirements as identified in Article III must be fulfilled in order to return from leave of absence.

The Department Chair and Chief Medical Officer approve returns from leave of absence. Based upon circumstances, the Chief Medical Officer may invoke review by the medical staff health committee or other medical staff committees before approving return from a leave of absence in order to assess whether the Member is able to exercise the required privileges with reasonable skill and safety.

If the leave of absence was for personal physical (except for maternity leave) or mental health or other health conditions, the request for reinstatement must be accompanied by a report from the individual's physician or, as applicable, treatment facility or program, indicating that the individual is capable of resuming a hospital practice and there are no conditions which have or have the potential to affect the member's ability to care for patients safely and competently. The member must execute any release(s) requested by the relevant medical staff leaders to facilitate communications with the individual's physician (or, if applicable, treatment facility or program) to adequately assess his or her ability to resume safe practice.

Practitioners who are on leave of absence for reasons not related to their own personal physical or mental health conditions may be required to provide a statement regarding the activities in which they were engaged while on leave of absence if deemed appropriate by the Department Chair, Chief Medical Officer or his/her designee.

Applicable State licensure, DEA and state controlled substance registration and professional liability insurance coverage must be current and any reappointment application materials must be received in order for the Member to return from a leave.

Appropriate references may be required in order for Members who practiced medicine in any capacity during a leave of absence. When required, such references must be submitted and deemed satisfactory before the Member's leave is terminated.

7.7 Failure to Request Renewal of Leave or Reinstatement/Return from Leave of Absence

Failure to request renewal of a leave at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

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.

7.8 Systemwide Notification

For members who hold Medical Staff appointments at more than one Yale New Haven Health System Affiliated Hospital, information concerning leaves of absence will be shared among the relevant Hospitals.

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Section 8. CONFLICT OF INTEREST POLICY

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

- a. The Chairs of all committees, including ad hoc task forces, are encouraged to consider and discuss potential conflicts of interest. Standing committees shall use the guidelines of disclosure as follows:
- b. Committee members shall disclose the existence of:
 1. Ownership by a member or their immediate family of material financial interests in any company that furnishes goods or services to the hospital or is seeking to provide good or services to the hospital;
 2. Any honoraria, speaker's fees, research grants or funding, or consulting fees (for example, from a pharmaceutical company or a managed care organization);
 3. Personal compensation from the hospital especially if pertinent to discussion of certain programs or proposals;
 4. Participation on other organizations with potential conflicts of interest (e.g. other hospitals, HMO's, competing private healthcare businesses);
 5. Other personal relationships, activities, or interests which may inappropriately influence a member's decisions or actions; and/or
 6. Gifts, including goods and services or honoraria, from vendors who sell to the hospital. (Note: An "honorarium" or a payment for consulting services is a gift in whole or part unless it can be demonstrated that the recipient provided services of an equivalent value.)
- c. Members of the following standing committees shall make an annual disclosure by questionnaire to the chairs and will make disclosures as appropriate during meetings: Medical Executive Committee, Pharmacy and Therapeutics Committee, Operating Room Committee, and Credentials Committee. Ad hoc committees and other standing committees shall decide at the first meeting and annually thereafter if an annual disclosure by questionnaire will be required.
- d. A general requirement that committee members with any potential conflicts of interest be excused from discussion of an issue may diminish the ability of the committee to have full, informed debate. If a member's ability to render a fair and independent decision is jeopardized by the conflict of interest, the member should ask to be excused from discussion and/or vote. If a member does make such a request, and the majority of the other committee members believe that the Member should be excused from discussion or vote, the chair shall require the member to do so.
- e. If a member discloses a potential conflict of interest and seeks a deliberation as to whether abstention from participation in discussion or vote is warranted, he/she should

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leave the room while the remaining members determine whether a conflict of interest exists.

- f. If a committee member has reasonable cause to believe that another member has failed to disclose a potential conflict of interest, such member shall inform the chair who shall provide an opportunity for the member in question to address the committee about the expressed concerns. The committee shall then deliberate as above. Any member who is required to request to be excused from participation in deliberations will be given an opportunity to appeal to the committee in person.
- g. The minutes of the meeting shall include the names of persons excused for conflicts of interest and whether any discussion of potential conflicts of interest occurred. The nature of the conflict shall also be identified in the minutes.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. CATEGORIES

The Medical Staff shall be divided into Active Attending, Active Referring, Courtesy, Consulting, Telemedicine and Honorary categories.

Section 2. THE ACTIVE ATTENDING MEDICAL STAFF

Active Attending is an Active Staff category which shall consist of selected physicians, dentists, and podiatrists who demonstrate substantial commitment to the welfare and programs of the Hospital as well as its purposes, objectives and mission.

The obligations of members of the Active Attending Staff shall include the following:

- a. utilization of the Hospital as a principal site of hospital practice by actively participating in caring for patients at the Hospital (a physician, dentist or podiatrist may also be deemed to have utilized the Hospital as a principal site of practice during any period in which the practitioner has made a reasonable, good faith effort to do so);
- b. maintain an office or practice close enough to the Hospital to provide continuing care to patients and to assure availability within a reasonable time frame when a patient's condition requires prompt attention; each Department or Section shall determine specific timeframes required;
- c. eligible for admitting, consulting and any other privileges for which they are qualified;
- d. demonstration of a willingness to participate in teaching programs;
- e. demonstration of a willingness to serve on committees, boards, or in administrative positions;
- f. must assume responsibility for call and/or consultation or to provide other services as requested by the relevant Department or Section Chair consistent with applicable Medical Staff Policies and Rules & Regulations;
- g. demonstration of a willingness to contribute to medical staff activities such as, but not limited to, quality review programs, teaching conferences, risk management and utilization management as requested by the relevant Department or Section Chair;

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- h. demonstration of a willingness to have patients participate as part of teaching;
- i. demonstration of a willingness, with the concurrence of both the patient and the physician, to participate in research efforts,
- j. participation in Departmental and Sectional meetings including quality review programs and teaching conferences; and
- k. pay medical staff dues

The rights of members of the Active Attending Staff shall include the following:

- a. may vote in Medical Staff elections, on adoption or amendment of the Bylaws and associated Rules & Regulations and on issues presented at any meetings of the Medical Staff, or Department, Section or Medical Staff Committees of which he or she is a member consistent with the requirements of these Bylaws;
- b. eligible for election to serve as a Medical Staff Officers consistent with the requirements of Article X;
- c. eligible to serve in departmental and sectional leadership roles as further defined in these Bylaws;
- d. eligible to serve as Members of the Medical Executive Committee as applicable and further defined in Article XI, Section 2;
- e. eligible to be a voting member or Chair of any medical staff committee
- f. may, after serving for a period of time designated by each Department, request exemption from certain departmental responsibilities consistent with any relevant Departmental or Medical Staff Policy including, but not limited to, taking call, by making such request to the relevant Department Chair and upon approval by the MEC;
- g. will be granted priority access to resources of the Hospital including, but not limited to, procedure rooms, operating rooms and beds when access becomes restricted due to high census or utilization

Section 3. ACTIVE REFERRING STAFF

Active Referring is a membership-only, Active Staff category that shall consist of selected physicians, dentists and podiatrists who are not clinically active in the Hospital inpatient or outpatient setting and will not serve as the responsible Attending physician for hospitalized patients. Members of this category are expected to maintain a commitment to the clinical, educational and/or community service mission of the Hospital and typically include primary and ambulatory care practitioners and others who will access Hospital services and facilities for their patients by referral for admission and care.

Practitioners qualify for Active Referring status by:

- a. maintaining an active ambulatory practice and utilizing the Hospital facilities for their patients;
- b. maintaining a strong relationship with the Hospital through participation in formal Hospital Committees or administrative functions that support patient care when asked to participate

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- c. demonstrating a willingness, as appropriate, based on practice capacity and payor participation, to accept the referral of patients who do not have a relationship with a primary care or other relevant outpatient provider for outpatient care upon their discharge from the hospital or emergency department

Members of this category must meet the basic qualifications outlined in these Bylaws with the exception of any requirements related to hospital patient care activity.

Members of the Active Referring category:

- a. do not hold clinical privileges and may not provide any clinical care to patients in any Hospital inpatient or outpatient setting but may, by ordering such studies in the Hospital's electronic medical record, refer patients to a Hospital facility for outpatient laboratory, radiologic or other outpatient studies or services as permitted by Hospital policy;
- b. may not write/enter orders or progress notes or give verbal or telephone orders to direct the care of hospitalized patients (except as noted in a. above);
- c. are encouraged to follow their patients when hospitalized under the care of another physician and to participate in that care by offering any pertinent information via the electronic medical record or personal communication with the responsible practitioner to support the care while the patient is hospitalized and/or post-discharge;
- d. may visit their hospitalized patients socially and view their medical records;
- e. must have appropriate training on the electronic medical record in order to use it to communicate via "Staff Messaging" with the practitioners responsible for the patient while hospitalized;
- f. may attend and participate in Departmental and other Hospital meetings including educational meetings such as Grand Rounds and other CME activities;
- g. are eligible to vote in medical staff elections, on adoption or amendment of Medical Staff Bylaws, Rules and on issues presented at Medical Staff or Departmental Committee meetings;
- h. are eligible for election to serve as a Medical Staff Officer;
- i. are eligible to serve on any Medical Staff Committee;
- j. are required to pay Medical Staff dues; and
- k. are exempt from Ongoing Professional Practice (OPPE) and Focused Professional Practice Evaluation (FPPE)

Members of the Active Referring category who wish to resume or begin Hospital-based practice or care for patients at any Hospital inpatient or outpatient location are eligible to apply for clinical privileges. Consistent with applicable Medical Staff Rules and Policies, if approved for privileges, training on the Hospital's electronic medical record system appropriate to the area of practice must be completed before participating in patient care at any Hospital facility.

Requests for clinical privileges will be reviewed individually relative to evidence of current competence and consistent with the relevant sections of these Bylaws. Proctoring may be required.

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Section 4. CONSULTING STAFF

The Consulting Staff shall consist of selected physicians, dentists and podiatrists with specialized clinical expertise that is deemed desirable for patient care and/or student and trainee education at the Hospital.

Consulting Staff members do not meet the requirements for Active Attending staff appointment relative to utilizing the Hospital as a principal site of hospital based practice and do not have to meet the requirements geographic or any other office location requirements.

Members of the Consulting Staff:

- a. have an active staff appointment and privileges at other hospital/s;
- b. may or may not have an established practice within the Hospital community;
- c. are eligible for privileges for which they are qualified;
- d. if granted surgical privileges, serve as the responsible attending in surgical cases and responsible for providing or arranging appropriate patient coverage;
- e. may attend meetings of the Medical Staff and their department;
- f. are not eligible to vote at any meetings or serve as medical staff officers except with permission by the CMO and under unique circumstances involving practitioners with special expertise; and
- g. do not pay Medical Staff dues

Section 5. TELEMEDICINE STAFF

The Telemedicine Staff shall consist of physicians, dentists and podiatrists whose relationship with the Hospital is strictly limited to providing service via telemedicine and, therefore, never physically provide service to patients at any Hospital site.

Telemedicine is defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications for the purpose of providing patient care, treatment and services.

Teleradiology is a specific subset of telemedicine which refers to the practice of providing either official or preliminary readings of images solely through a telecommunications link.

In order to be eligible for appointment to the Telemedicine Staff category, a Member must eligibility requirements as stated in these Bylaws with the exception of those related to office location.

Members of the Telemedicine staff:

- a. may exercise such clinical privileges as granted but will never have primary responsibility for any patient;
- b. as possible, may attend meetings of the Department to which he/she is appointed but may not vote;
- c. may not serve as a Medical Staff officer, Department or Section Chair, or Chair or member of any committee; and may not vote in Medical Staff matters;

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- d. except as relevant to fulfill obligations in providing telemedicine services, are exempt from all responsibilities of emergency service care (call), consultation assignments, and clinic duties; and
- e. pay applicable Medical Staff dues

Section 6. HONORARY STAFF

The Honorary Staff shall consist of physicians, dentists and podiatrists who are retired from practice and are not active in the Hospital. Members of this category do not hold clinical privileges, are not required to undergo reappointment and are not required to maintain malpractice insurance.

Members of the Honorary Staff:

- a. are appointed for life and may be removed only for cause by the Medical Executive Committee;
- b. are not eligible to vote in any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;
- c. may not serve as medical staff officers, Department or Section Chairs or Chairs of any committees;
- d. may not serve on Hospital committees except with permission by the CMO under unique circumstances involving special expertise;
- e. may attend Medical Staff and Departmental meetings of an educational nature;
- f. may participate in Medical Staff social events; and
- g. do not pay Medical Staff dues

Section 7. ROTATING RESIDENTS AND CLINICAL FELLOWS

1. Rotating Residents and Rotating Clinical Fellows are in training under a program that is not sponsored by the Hospital. These trainees spend a period of time at the Hospital and function under supervision as defined under a Program Letter of Agreement between the sponsoring program and the Hospital. Rotating Residents and Rotating Clinical Fellows function as trainees.
2. Rotating Residents and Rotating Clinical Fellows do not have Clinical Privileges.
3. Rotating Residents and Rotating Clinical Fellows must meet the basic eligibility requirements as applicable and stated in Article III.
4. Rotating Residents and Clinical Fellows appointed at another Health System Affiliated Hospital are not required to complete any application in order to rotate at the Hospital.
5. Rotating Residents and Rotating Clinical Fellows from sponsoring institutions or organizations that are not part of a Health System Affiliated Hospital who seek to participate in a rotation at the Hospital under a Program Letter of Agreement must complete an appropriate application.
6. Rotating Residents and Rotating Clinical Fellows may be required to take call in their capacity as trainees as determined by their sponsoring institution or organization. They may attend meetings of their applicable Department or Section, as applicable, but have no voting rights. They may now serve on any Medical Staff Committees as defines in these Bylaws or serve as a Medical Staff Officer, Department Chair or Section Chief. They are not required to pay Medical Staff Dues.

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7. Rotating Residents and Rotating Clinical Fellows who, following completing of their training, as qualified for and seek Medical Staff Membership and Clinical Privileges must, as applicable, apply for and be granted such in accordance with these Bylaws.
8. Rotating Residents and Clinical Fellow appointments to the Medical Staff are co-terminus with the training appointment as defined in the Program Letter of Agreement.
9. The various provisions of these Bylaws shall apply to members of the Rotating Residents and Clinical Fellows only as specifically provided. Provisions relating to appeals, hearing and appellate review shall not apply to the Rotating Residents and Rotating Clinical Fellows.

ARTICLE V: AFFILIATED HEALTH CARE PROFESSIONALS

Affiliated Health Care Professionals shall include the following: nurse anesthetists, licensed nurse midwives, nurse practitioners, physician assistants, and psychologists. Based upon the needs of the Hospital, other types of practitioners may be credentialed and privileged to this category upon recommendation of the Credentials Committee to the Medical Executive Committee and with approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.

Individuals appointed in this category do not share in the rights of Medical Staff Members except as specifically outlined in these Bylaws. They are, however, subject to the same responsibilities and the same terms relative to provision of care and compliance with the Bylaws, Rules and Regulations and any applicable policies of the Medical Staff or Hospital.

Provisions relating to hearings, appeals and appellate review shall apply to Affiliated Health Care Professionals.

Supervision

Nurse anesthetists, licensed nurse midwives, nurse practitioners and physician assistants shall practice under the supervision, control, responsibility and direction of a physician member of the Medical Staff and required to have a supervising (or collaborating) physician who is a member of the Medical Staff.

Affiliated Staff in these professions may not exercise any clinical privileges without a supervising or collaborating physician and may only exercise privileges at the location(s) at which his/her supervising (or collaborating) physician is privileged to practice. In the event that a member of this staff who is required to have a supervising or collaborating physician is no longer sponsored by that physician, the member must immediately notify the Medical Staff Administration department, provide the name of the new supervising or collaborating physician or be deemed to have voluntarily resigned.

In the event that the supervising or collaborating physician becomes unexpectedly unavailable to do an emergency or another unforeseen circumstance for an extended period of time, one of or the alternative supervising or collaborating physician as identified in the written agreement shall assume responsibility until a permanent replacement can be confirmed.

A written supervising/collaboration agreement between a physician member of the Medical Staff and all nurse anesthetists, licensed nurse midwives, nurse practitioners and physician assistants is required. The agreements between a physician assistant and the supervising physician must be reviewed and renewed on an annual basis.

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Supervision/collaboration shall be defined as the oversight of, or the participation in, the work of the member of Affiliated Health Care Professional including availability of direct communication either in person or by telephone. The written supervising agreement shall define how alternate supervision by another appropriately privileged physician member of the Medical Staff shall be provided when the primary supervisor is unavailable.

Appointment and Privileging

Wherever applicable, Affiliated Health Care Professionals are subject to all of the eligibility requirements and shall be appointed and privileged consistent with the processes for Medical Staff as identified in these Bylaws. Except for those who do not hold clinical privileges, individuals in this category shall be subject to the policies, procedures and requirements for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

Members in this category must have graduated from an accredited institution applicable to their profession and have and maintain certification and/or licensure by an appropriate body and, as applicable, in accordance with State of Connecticut statutes.

Affiliated Health Care Professionals shall be appointed in at least one of the Departments of the Medical Staff. Each Affiliated Health Care Professional shall be appointed in the same Department and, as applicable, Section as his or her supervising or collaborating physician.

Certain members of the Affiliated Health Care Professionals Staff are authorized to conduct medical screening examinations as defined under federal law. These include physician assistants and nurse practitioners. Licensed nurse midwives are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms.

Affiliated Health Care Professionals:

- a. may not serve as Medical Staff Officers or in any Medical Staff leadership roles as defined in these Bylaws;
- b. may not vote in Medical Staff elections or on changes to the Medical Staff Bylaws, Rules or Regulations, medical staff policies or other Medical Staff matters;
- c. may serve on Departmental and Hospital committees if requested and attend meetings of the appropriate section or service if requested; and
- d. do not pay Medical Staff dues.

Referring Affiliated Health Care Professionals

Affiliated Health Care Professionals who practice in an outpatient setting only and wish to apply for membership only (no clinical privileges) as Affiliated Health Care Professionals must be under the supervision, as required, of a member of the Medical Staff. Individuals in this category typically seek this status for membership strictly for clinical support reasons (e.g. including, but not limited to, access to Hospital electronic medical records, conferences and meetings) and may be appointed to the Referring Affiliated Health Care Professionals category.

Members of this category, by definition, do not hold clinical privileges, and shall be exempt from Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) requirements.

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Section 1. FAIR HEARING POLICY FOR AFFILIATED HEALTH CARE PROFESSIONALS

The Fair Hearing and Appellate Review Mechanism for Health Professional Affiliates shall be as follows:

- a. Adverse decisions with respect to the denial of appointment or reappointment, the denial or removal of clinical privileges, or corrective action may be appealed by the practitioner to the Medical Executive Committee (MEC).
- b. If a decision is appealed, the Department Chair, or the Chair of the committee making the adverse decision, and the practitioner shall file written statements with the Medical Executive Committee.
- c. The Medical Executive Committee (or an ad hoc subcommittee of the Medical Executive Committee authorized by the Medical Executive Committee or its Chair to hear and decide the matter) may request to meet with the Chair and the practitioner. In the absence of such a request by the Medical Executive Committee or its authorized subcommittee, the practitioner shall have the right to such a meeting at the practitioner's request.
- d. The decision of the Medical Executive Committee or its subcommittee shall be in writing and shall set forth the reasons for the decision. In the case of a subcommittee of the MEC, the report shall be presented to MEC for approval, modification, or rejection.
- e. The Chair or the practitioner may appeal the decision of the Medical Executive Committee to an ad hoc committee of the Board of Directors appointed by the Chair of the Board.
- f. In its sole discretion, the ad hoc committee of the Board of Directors shall establish a procedure to review the decision of the Medical Executive Committee, but at a minimum shall permit the Chair of the MEC and the practitioner to file written statements. The decision of the ad hoc committee of the Board of Directors shall be in writing and shall be final.
- g. The Medical Executive Committee and the ad hoc committee of the Board of Directors may establish reasonable time limits to implement the provisions of this section.
- h. No person with a conflict of interest shall serve as a member of a reviewing body under this sub-section.

ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

Section 1. GENERAL PROCEDURE

The Medical Staff through its designated Departments, committees, and officers shall evaluate and consider every application for appointment or reappointment of physicians, dentists, podiatrists and Affiliated Health Care Professionals and each request for modification of membership status and shall transmit recommendations thereon to the Board. Practitioners appointed at other YNHHS with full clinical privileges may be appointed to the Telemedicine category by proxy in accordance with the YNHHS Telemedicine Policy.

Each recommendation concerning the appointment or reappointment of a member of the Medical or Affiliated Health Care Professional Staff and the clinical privileges to be granted shall be based upon whether the applicant meets the eligibility requirements as outlined in ARTICLE III, Section 2 along with any and all other requirements as outlined in these Bylaws.

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Section 2. REQUIREMENTS FOR APPLICANTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

- a. Individuals seeking initial appointment or reappointment to the Hospital Medical Staff must meet the eligibility requirements as outlined in ARTICLE III, Section 2.
- b. Those who are eligible shall complete and submit an appropriate application and provide any relevant supporting documentation as required for a complete application.
- c. Acknowledgment and Agreement: Applicants acknowledge receipt of and that they have read the Bylaws, Rules and Regulations of the Medical Staff and agree to be bound by the terms thereof. Additionally, if the applicant is granted membership and/or clinical privileges, he/she agrees to provide for continuous care for his/her patients.
- d. Qualifications: The applicant shall provide, or cause to be provided, sufficient information evidencing that he or she meets the qualifications as stated in these Bylaws for the particular Staff category to which the applicant requests appointment.
- e. The relevant Department Chair, Credentials Committee or its Sub-Committee, Medical Executive Committee, Board, or any individual designated on behalf of these persons or committees may also require additional information to appropriately assess the education, training and clinical competence for privileges requested, and/or qualifications for initial or continued membership. When such information can only be obtained from organizations or individuals that are not part of the Hospital, it shall be the responsibility of the applicant to provide or make available such information consistent with Section 4. Failure on the part of the applicant to provide, or cause to be provided, such information shall constitute a failure to complete an application for initial appointment or reappointment.
- f. Authorization to Obtain Information; Immunity. Applicants acknowledge and agree that the Hospital and Medical Staff may seek, obtain, and use all information that it deems necessary to carry out their obligations under these Bylaws and Rules and Regulations and, with respect to employed Medical or Affiliated Health Care Professional Staff, for purposes of employment.

Section 3. EFFECT OF APPLICATION FOR INITIAL APPOINTMENT OR REAPPOINTMENT

By applying for initial appointment or reappointment to the Medical Staff, the applicant:

- a. Signifies the applicant's willingness to appear for interviews in regard to the application and to furnish such additional information as may be requested.
- b. Authorizes hospital representatives to consult with others who have been associated with the applicant or who may have information bearing on the applicant's competence and qualifications.
- c. Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of the applicant's professional qualifications and ability to carry out the clinical privileges the applicant requests as well as of the applicant's professional ethical qualifications for membership.
- d. Releases from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and the applicant's credentials.

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- e. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for appointment and clinical privileges.
- f. For purposes of this Section the term "hospital representative" includes the Board, its directors and committees; the President/CEO; Chief Medical Officer, all Medical and Affiliated Health Care Professional Staff members, Departments and committees, and employees and agents, which have responsibility for collection or evaluating the applicant's credentials or acting upon the applicant's application; and any authorized representative of any of the foregoing.
- g. Agrees to execute additional authorizations/releases required to implement the provisions of this section.

Section 4. COMPLETION OF THE APPLICATION / RESPONSIBILITY OF APPLICANTS

All applicants, Members and Affiliated Health Care Professional Members of the Medical Staff are responsible for providing information deemed adequate for an appropriate evaluation of education, training, experience, current competence, ethics, personal qualities and qualifications to serve as an exemplary model for trainees and for resolving any doubts that arise regarding their qualifications during the initial appointment or reappointment process.

Applications will be considered complete when all questions on the required forms have been thoroughly answered, all supporting documentation (including full responses from reference writers) has been supplied and all information has successfully been verified through primary sources consistent with regulatory requirements and the requirements as outlined herein. A complete application may become incomplete if, during the credentialing process, it is determined that new, additional or clarifying information is required to confirm qualifications.

If an applicant for initial appointment or re-appointment fails to provide, or cause to be provided, any requested information, the application shall be deemed "incomplete" and processing will cease. If this occurs during a re-appointment and the applicant's appointment lapses, he/she shall be considered to have voluntarily resigned from the Medical or Affiliated Health Care Professional Staff as applicable until/unless required documentation can be provided and the application approved in accordance with ARTICLE VI, Section 5.

Any application for initial appointment or re-appointment that continues to be incomplete sixty (60) days after the applicant has been notified of additional information required will be deemed to have been voluntarily withdrawn.

Applicants for initial appointment and re-appointment attest that all statements, answers and information contained in their application and supporting documents are true, correct and complete to the best of their knowledge. Any misstatement or omission from the application is grounds to cease processing the application. The applicant will be informed of the misstatement or omission and permitted to provide a written response. If, upon review, a misstatement or omission is determined to be immaterial and/or unintentional, processing will resume.

Applicants for initial appointment and re-appointment attest that they understand that falsification, misrepresentation or omission of any material fact(s) will be sufficient cause for ceasing processing of an

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initial application or automatic relinquishment of appointment and privileges without the right to request a hearing or appeal.

Section 5. APPLICATION PROCESS FOR INITIAL APPOINTMENT

5.1 Additional information required for initial appointment:

The following shall be required for initial appointment in addition to the material outlined in Sections 2 and 3 above:

- a. References: Except as noted below for applicants who are presently appointed at another Yale New Haven Health System Affiliated Hospital, a minimum of three (3) references is required for all applicants. References must be from individuals in leadership (e.g. chief, section chief, medical director, supervising/collaborating physician) roles who have firsthand and direct information concerning the applicant's practice and character and can provide an objective assessment as to the applicant's performance in the six (6) areas of ACGME competency.

Specific guidelines as to requirements for references depending upon education and training as well as length of time in practice are incorporated into the application for initial appointment.

Based on information gathered in the application and in the course of the credentialing process, additional references may be requested and, if requested, shall be required in order for an application to be deemed complete. References will be requested via the process and form developed by Medical Staff Administration. References must be returned directly to Medical Staff Administration.

Requirements for references for applicants who currently hold a medical staff appointment at a minimum of one other Yale New Haven Health System Affiliated Hospital are modified as outlined in the Policy entitled "Requirements for References for Crossover Practitioners."

- b. Professional Liability Insurance and Experience: Based on the information provided or obtained during the credentialing process, additional information pertaining to professional liability insurance and experience may be requested and shall be required for the application to be deemed complete.

Section 6. PROCESSING THE INITIAL APPOINTMENT APPLICATION

6.1 Verification of Information

Applications for initial appointment shall be submitted to Medical Staff Administration, which shall, in timely fashion, solicit appropriate references and perform primary source and other verification of licensure and other qualifications as required by The Joint Commission. All verifications shall be through a primary source whenever possible or through a source approved by The Joint Commission as satisfying the requirement for primary source verification. Medical Staff Administration shall promptly notify the applicant about any difficulty in collecting and/or verifying required information.

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6.2 Transmission of Information

Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chair for review.

6.3 Department Action

Upon receipt, the Chair of each Department in which the applicant seeks privileges shall review the application and supporting documentation, whenever possible, conduct a personal interview with the applicant, and then transmit his or her recommendation regarding appointment, staff category, Department and section assignment and clinical privileges to the Credentials Committee. Any special conditions, as applicable, will also be communicated. Generally speaking, special conditions shall be incorporated into the Focused Professional Practice Evaluation (FPPE).

The Departmental action shall include, when appropriate, a review and recommendation regarding appointment and clinical privileges requested by the appropriate Section Chief(s) prior to the Chair's final recommendation.

A Department Chair or Section Chief may request additional information as he/she deems appropriate to assist in his/her evaluation of the candidate in order to make his/her recommendation. Under these circumstances, the application shall become incomplete consistent with Section 4 and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

The recommendation of the Department Chair shall be forwarded to the Credentials Committee or, as applicable, its Sub-Committee.

The Department Chair shall have twenty (20) business days to make a recommendation. In the event that the Department Chair fails to provide his or her recommendation within twenty (20) business days of receiving a completed application or withholds a recommendation, the application will be forwarded to the Credentials Committee for action.

6.4 Credentials Committee Action

The Credentials Committee, or its Sub-Committee shall review the application, the supporting documentation, review the Department Chair's recommendation, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. In addition, the Credentials Committee may determine that more information is needed in order to make its recommendation. In this case, an application becomes incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this Article. Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendations as to appointment, staff category, Department and Section, clinical privileges to be granted and any special conditions associated with the appointment to the Medical Executive Committee.

The Credentials Committee may recommend an appointment of less than two (2) years to the Medical Executive Committee. Typically, this will occur if information obtained in the credentialing process suggests that there may be concerns about the practitioner's performance

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or qualifications that are not of significant magnitude to deem the applicant ineligible for appointment and privileges but warrant a period of initial monitoring. In such cases, the requirements and expectations shall be articulated as part of routine FPPE and the applicant notified accordingly of such expectations and consequences of not fulfilling them in the manner or timeframe outlined.

6.5 Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendations, the Medical Executive Committee shall consider the recommendations of the Credentials Committee. In addition, the Medical Executive Committee may request additional information from the applicant that the Committee deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this Article. The Medical Executive Committee shall then forward its recommendations to the Board including staff category, Department and Section, clinical privileges recommended to be granted and any special conditions to be attached to the appointment.

- a. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the Committee shall promptly forward it to the Board.
- b. Unfavorable Recommendation: When the recommendation of the Medical Executive Committee is unfavorable in whole or in part, the unfavorable recommendation will be considered an adverse action. In such cases, the applicant shall be entitled to the Fair Hearing Process as set forth in Article XVIII.

6.6 Appointments of Less than Three Years:

The Medical Executive Committee may recommend an appointment of less than three (3) years to the Board under the circumstances described in Section 6.4 above. The recommendation for an appointment of less than three (3) years is not considered adverse.

6.7 Board Action

- a. On Favorable Medical Executive Committee Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. The applicant shall be promptly informed of the Board's action by a mechanism that will allow for confirmation of receipt to be secured. If the Board rejects a favorable recommendation of the Medical Executive Committee, this shall be deemed an adverse action and entitle the applicant to a Fair Hearing pursuant to Article XVIII of these Bylaws.
- b. In addition, the Board may request additional information from the applicant that the Board deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this Article.

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c. EXPEDITED APPROVAL

In the sole discretion of the Medical Staff, expedited board approval may be requested for the following medical staff actions:

- Initial appointment to the Medical or Affiliated Health Care Professional Staff
- Reappointment to the Medical or Affiliated Health Care Professional Staff
- Granting of additional privileges to Medical or Affiliated Health Care Professional Staff

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

- The applicant meets all eligibility requirements as stated in ARTICLE III, Section 2;
- The application for initial appointment, reappointment or granting of additional privileges has been deemed complete in accordance with Section 4;
- The Credentials Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges; and
- The Medical Executive Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges.

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

- The application is incomplete; or
- The Medical Executive Committee makes a final recommendation that is adverse or has limitations.

Consistent with ARTICLE III, Section 2, any applicant with a current challenge to his or her license in any state or whose membership at another hospital or health care facility has been subject to involuntary termination or privileges at another hospital or health care facility are subject to involuntary limitation, reduction, restriction, denial or loss are not eligible for appointment.

Other situations in which expedited approval shall be evaluated on a case-by-case basis include, but are not limited to the following:

- There is a previously successful challenge to licensure or registration in any state; or
- The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant; or
- The Hospital Department Chair makes a recommendation not to approve or refuses to make a recommendation; or
- The applicant has prior arrests or convictions.

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6.8 Notice of Final Decision

The applicant shall be notified of the Board's decision by way of a letter copied to the relevant Department Chair which includes the following: (1) the staff category to which the applicant is appointed; (2) the Department and, when appropriate, the clinical section to which the applicant is assigned; (3) the clinical privileges the applicant may exercise; (4) obligations and expectations concerning the Focused Professional Practice Evaluation (FPPE) process for new privileges and (5) any special conditions associated with the appointment.

6.9 Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical or Affiliated Health Care Professional Staff until he/she is able to provide sufficient documentation evidencing that the concerns which led to the initial adverse decision have been addressed. A new application will be required and it shall be processed as an initial application.

6.10 Time Periods for Processing

Applications for appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause or as otherwise provided for in these Bylaws, shall be processed within the time periods specified in this Section. Medical Staff Administration shall initiate the recommendation and approval process of applications by transmitting the application to the Department Chair upon confirming that the applicant has submitted all required information allowing the application to be deemed complete consistent with Section 4.

Applications eligible for temporary privileges consistent with Section 7 may be reviewed by the Credentials Committee Sub-Committee. All others shall be reviewed at the next regularly scheduled Credentials Committee meeting.

The Medical Executive Committee shall review the application and make its recommendation to the Board at the committee's next regularly scheduled meeting following the Credentials Committee.

The Board or, under circumstances involving Expedited Approval as outlined in Section 6.7.c the appropriate committee thereof, shall then take final action on the application at its next regular meeting.

This time frame may be delayed if any of the committees or individuals responsible for reviewing an application pursuant to these Bylaws, and acting in good faith, deem that additional information is required to complete the application as provided for in this Article, or if circumstances beyond their reasonable control cause a delay.

6.11 Staff Applicant Interviews

Applicants for initial appointment shall be interviewed by the Chair of the Department(s) in which appointment is sought whenever possible, and at the sole discretion of the Credentials Committee, may be interviewed by the Credentials Committee, and by any other persons recommended by the Credentials Committee. At the sole discretion of the Committee or individual responsible to conduct an interview, such interviews may be performed by phone to accommodate special needs of the individual conducting the interview, the Committee or the applicant.

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Section 7. REAPPOINTMENT APPLICATION PROCESS

The following shall be required for re-appointment in addition to the material outlined in Sections 2 and 3 above:

7.1 Satisfaction of eligibility requirements as outlined in ARTICLE III, Section 2.

7.2 Completion of a Reappointment Application

At least one hundred and twenty (120) days prior to the expiration date of the present appointment of each Medical and Affiliated Health Care Professional Staff member, each member shall be provided with an application for reappointment.

Except for good cause, the application shall be completed and submitted to Medical Staff Administration at least ninety (90) days prior to the expiration date of the current appointment along with the items as outlined in Sections 2 and 3 above.

Failure to return the application, with all required information provided in sufficient time to allow processing and approval, shall be considered a voluntary resignation from the Medical or Affiliated Health Care Professional Staff at the expiration of the individual's current appointment.

In the event of a voluntary resignation due to failure to submit a complete application for re-appointment, as long as the reappointment application is returned with updated information within one (1) year of the resignation date, it will be accepted and processed. The applicant will be required to document activities that occurred during the period of the lapse in membership and privileges. Such documentation of activities may require verification and, depending upon the reason for the delinquency of the return, additional information may be required including, but not limited to references.

Members who fail to return a reappointment application within one (1) year of voluntary resignation will be required to complete an application for initial appointment.

7.3 Content of Reappointment Application

The reappointment application shall contain information necessary to maintain as current for the Medical or Affiliated Health Care Professional Staff member including, but not limited to, the following:

- a. Any additional training, education and experience that qualify the applicant for the privileges requested;
- b. Information about other hospital, health care organization or practice setting where the applicant provided clinical services during the preceding two (2) years;
- c. An update regarding professional liability experience, including proof of appropriate insurance coverage and limits of liability;

7.4 Transmission of Information

Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chair for review.

7.5 Department Action

The Department Chair shall review, among other things, the reappointment application as well as information about the applicant's activity at the Hospital including any available information from

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routine Ongoing or Focused Professional Practice Evaluation, Focused Professional Practice Evaluation conducted for cause and the applicant's peer review file as relevant. Information and references from external organizations as applicable shall also be considered.

All information pertinent to the physician's clinical competence to perform the privileges requested shall be considered in the recommendation of the Chair as well as the applicant's attendance and participation at relevant Departmental and Staff meetings; assigned committee meetings and continuing education meetings.

The Department Chair may also request additional information as deemed necessary to appropriately assess qualifications for appointment and privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing consistent with Section 4. The Chair shall transmit his/her recommendation to the Credentials Committee as to whether the appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

The Department Chair shall have twenty (20) business days to make a recommendation. In the event that the Department Chair fails to provide his or her recommendation within twenty (20) business days of receiving a completed application or withholds a recommendation, the application will be forwarded to the Credentials Committee for action.

7.5 Credentials Committee Action

The Credentials Committee shall review the application for reappointment, the supporting documentation, the Department Chair's recommendations, and such other information available to it that may be relevant to consideration of the reappointment of the applicant with the privileges that have been requested. The Committee may also request additional information as it deems necessary to appropriately assess qualifications for appointment and requested privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this Article.

Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendation as to reappointment, and if reappointment is recommended, category, Department and Section, clinical privileges to be granted and any special conditions associated with the reappointment to the Medical Executive Committee.

The Credentials Committee may recommend a reappointment of less than two (2) years to the Medical Executive Committee. Typically, this will occur if information obtained in the reappointment process identifies concerns not previously identified through Ongoing or Focused Professional Practice Evaluation or if re-appointment is concurrent with a for-cause Focused Professional Practice Evaluation. In such cases the practitioner will be notified and given an opportunity to meet with the Credentials Committee before its recommendation is forwarded to the Medical Executive Committee.

7.6 Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendation, the Medical Executive Committee shall consider the recommendations of the Credentials Committee.

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In addition, the Medical Executive committee may request information from the applicant that it deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the responsibility of the applicant to provide, or cause to be provided, any information necessary for completion consistent with Section 4.0.

The Medical Executive Committee shall forward its recommendation to the Board as to whether appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

In the event that the recommendation of the Medical Executive Committee is adverse, in whole or in part, the final adverse recommendation shall not be made or forwarded to the Board for action until the applicant has been informed and offered the opportunity to request a Fair Hearing pursuant to Article XVIII of these Bylaws. The Board shall be apprised of these actions.

The Medical Executive Committee may also defer action for further discussion or consideration. The Committee may also request additional information as noted above in order to fully assess the applicant's qualifications.

7.7 Conditional Re-Appointment

In the event that the Credentials Committee or Medical Executive Committee requires additional time to consider an application for reappointment or an investigation or hearing is pending, a short-term conditional re-appointment may be recommended, pending the conclusion of the process. Conditional re-appointments are subject to the same requirements and are approved through the same process as all other re-appointments as outlined herein.

In such cases, the applicant will be notified and given an opportunity to meet with the relevant Committee. Any plan for monitoring or other criteria for regaining a two (2) year appointment will be discussed with the practitioner. This action is not considered adverse.

7.8 Board Action

Thereafter, the procedure provided in Sections 6.7 through 6.12 shall be followed as closely as possible.

7.9 Time Periods for Processing

Transmittal of the reappointment application and its return shall be carried out in accordance with Section 7.1 of this Article. Thereafter, and except for good cause, each person, Department, and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all recommendations concerning the reappointment shall have been transmitted to the Credentials Committee for its consideration and action pursuant to Article VI, Section 7.5, to the Medical Executive Committee for its consideration and action pursuant to Article VI, Section 7.6 and to the Board for its action pursuant to Article VI, Section 7.7, all prior to the expiration date of the membership of the individual being considered for reappointment.

Section 8. REQUESTS FOR MODIFICATION OF STAFF CATEGORY OR CLINICAL PRIVILEGES

A Member of the Medical or Affiliated Health Care Professional Staff, as applicable, may, either in connection with reappointment or at any other time, request modification of his/her staff category, Departmental assignment or clinical privileges by submitting the request in writing or via email to Medical

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Staff Administration. Requests shall be processed in substantially the same manner as provided in Article VI, Section 7 for reappointment.

Article VII: DETERMINATION OF CLINICAL PRIVILEGES

POLICY IN REGARD TO FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION (FPPE AND OPPE)

It is the Policy of the Hospital to establish and provide a systematic, consistent process to assure that there is sufficient information available to confirm the current competency of Medical and Affiliated Health Care Professional Staff in the granting of new privileges at the time of initial appointment, reappointment or between reappointment cycles and to address issues concerning the ability of these individuals to provide safe care. FPPE and OPPE provide the basis for obtaining Hospital-specific information of the current competency of all individuals holding delineated clinical privileges.

Section 1. EXERCISE OF PRIVILEGES

Every physician, dentist, podiatrist or other professional who provides direct clinical services at this hospital by virtue of Medical or Affiliated Health Care Professional membership shall, in connection with such practice and except as provided in Sections 5 and 6 of this Article, be authorized to exercise only those clinical privileges or specified services specifically granted by the Board. No individual shall be required to perform an act which is in violation of his/her ethical, moral, or professional principles, standards, or good medical judgment.

Section 2. DELINEATION OF PRIVILEGES IN GENERAL

2.1 Requests

Each application for appointment and reappointment to the Medical or Affiliated Health Care Professional Staff must contain a request for the specific clinical privileges desired by the applicant. A request for modification of privileges pursuant to Article VI, Section 8 must be supported by documentation of training and/or demonstrated clinical competence.

2.2 Basis for Determination of Clinical Privileges

Requests for clinical privileges shall be evaluated on the basis of the applicant's documented education, training, demonstrated clinical competence, and demonstrated ability and judgment. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, patient contacts, and the documented results of the patient care audit and other quality maintenance activities required by these and the hospital corporate Bylaws to be conducted at the hospital. Clinical privileges granted or modified on initial appointment, reappointment, or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for Medical and Affiliated Health Care Professional Staff. It shall be the applicant's responsibility to make such information available pursuant to Article VI, Sections 4.

2.3 Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI.

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Section 3. LIMITATIONS OF PROFESSIONAL PRIVILEGES

All Members and Affiliated Health Care Professional Members of the Medical Staff shall function within the scope of their approved delineated clinical privileges, with the understanding that it may not be safe or clinically appropriate to exercise all privileges in all Hospital sites or locations.

Notwithstanding this general rule, in an emergency, a Medical Staff or Affiliated Health Care Professional member of the Medical Staff may perform any medical or surgical procedure permitted by his or her respective training and experience and Connecticut license.

Section 4. PRIVILEGES FOR NEW PROCEDURES

Requests for additions to the current privilege delineation form(s) to include new procedures and associated criteria with respect to qualifications for education, training or experience necessary to be eligible for the new procedure shall be made by or transmitted to the Medical Staff Administration Department.

Modifications to privilege delineation forms must be reviewed and recommended by the relevant Department Chair and, as applicable, Section Chief.

Requests to add or modify a privilege or procedure that will be available in more than one specialty will be reviewed and recommended by all of the relevant Department Chairs and, as applicable, Section Chiefs.

Recommended modifications received by Medical Staff Administration will be forwarded to the Credentials Committee, Medical Executive Committee and Board of Trustees for approval.

Requests by medical staff members for privileges to perform new procedures will not be processed until: (1) a determination has been made that a new procedure can and will be offered by the Hospital and (2) criteria to be eligible to request the privilege has been recommended by the Department Chair and, as applicable, Section Chief and approved through the appropriate medical staff committees as noted above.

A member of the Medical Staff seeking privileges for a new procedure must apply for that privilege on the appropriate approved privilege delineation form and must be credentialed through the process as outlined in Article VI, Section 8.

Any additional privileges granted shall be subject to a period of Focused Professional Practice Evaluation (FPPE) in accordance with these Bylaws and applicable Medical Staff Policy.

Section 5. CHANGES TO PRIVILEGE DELINEATION FORMS

Requests for changes or additions to current privilege delineation form(s) for modifications with respect to qualifications or education, training or experience necessary to be eligible for existing privileges shall be recommended by the relevant Department Chair, and, as applicable, Section Chief and transmitted to the Medical Staff Administration Department. Recommendations to any privilege delineation form will be forwarded by Medical Staff Administration to the Credentials Committee, Medical Executive Committee and Board of Trustees for approval.

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Section 6. SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges for dentists shall be processed, evaluated, and granted in the manner specified in Section 2.5 of this Article. Surgical procedures performed by dentists shall be provided in accordance with the relevant provisions of the Rules and Regulations of the Department of Surgery. Members of the dental section may admit patients directly. Such patients must have an admission history and physical examination. This examination on patients with no medical or other surgical problems may be performed by oral surgeons provided such a privilege has been previously approved by the Credentials Committee; otherwise, an admission history and physical examination must be rendered by a consultant physician with the dentist being responsible for the portion of the H&P relating to dentistry. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical sections.

Section 7. SPECIAL CONDITIONS FOR PODIATRY PRIVILEGES

Requests for clinical privileges for podiatrists shall be processed, evaluated, and granted in the manner specified in Section 2.5 of this Article. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. Members of the podiatry section may admit patients directly. Procedures on patients with an ASA Classification of III or higher require that the history and physical examination be performed by a consulting physician, with the podiatrist responsible for the portion related to podiatry. All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

Section 8. TEMPORARY PRIVILEGES

Temporary privileges may be granted to a qualified candidate for Medical or Affiliated Health Care Professional Affiliate Staff membership by the Chief Executive Officer or his designee under two circumstances as described below:

1. Complete, clean application pending approval; or
2. Urgent patient care need

Generally speaking, applicants with any of the following shall not be considered “clean” applicants and, therefore, ineligible for temporary privileges:

- Failure to meet eligibility requirements as stated in Article III, Section 2
- Previously successful challenges to licensure or registration in any state;
- Hospital Department Chair recommendation is not to approve or refuses to make a recommendation; or
- Pending or prior arrests or convictions for any reason

Consistent with ARTICLE III, Section 2, any applicant with a current challenge to his or her license in any state or whose membership at another hospital or health care facility has been subject to involuntary termination or privileges at another hospital or health care facility are subject to involuntary limitation, reduction, restriction, denial or loss are not eligible for appointment.

On the occurrence of any event of a professional or personal nature which casts doubt on the candidate's qualifications or ability to exercise the temporary privileges granted, the Chief Medical Officer, in consultation with the appropriate Department Chair may suspend or terminate temporary privileges.

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A candidate shall have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges or termination of such privileges.

In the event of any such termination, the individual's patients then in the hospital shall be assigned to another practitioner by the Department Chair responsible for supervision. When feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

In exercising temporary privileges, the applicant shall act under the supervision of the Chair of the Department to which the applicant is assigned. Temporary privileges shall not exceed 120 days and shall normally not extend past the date of the earliest Board meeting at which the applicant's request for privileges can be acted upon.

Complete, clean application pending approval:

A candidate shall not be considered qualified for temporary privileges until the application for privileges is complete consistent with ARTICLE VI, Section 4 and a recommendation of the Department Chair has been received. Temporary privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less. The Credentials Committee will be informed of all temporary privileges granted by its Sub-Committee at its next regularly scheduled meeting.

Urgent Patient Care Need

This is defined as circumstances in which the condition of a Hospital patient requires urgent or emergent care from a physician with special clinical expertise or training. Temporary privileges for urgent patient care need may not be invoked to accommodate scheduling conflicts or issues.

In cases of bona fide urgent patient care need, the Chief Medical Officer on the recommendation of the Department Chair and Credentials Chair, or their respective designees, may grant temporary privileges for a specified period of time. Such temporary privileges will be time limited specifically to the dates of the specific services the physician is asked to provide and, as applicable, the specific patient/s.

Individuals who are granted temporary privileges for an urgent patient care need may be licensed in another U.S state consistent with Connecticut State Statutes. Minimum requirements for eligibility are listed below.

1. Evidence demonstrating that the applicant meets eligibility requirements as outlined in ARTICLE III, Section 2
2. Verification of license
3. Verification of malpractice insurance to cover services provided at the Hospital;
4. Complete application to the Medical Staff specifying the privileges requested, dates and, as possible, specific patients;
5. Verification of appointment and relevant clinical privileges at a Joint Commission (or equivalent) accredited hospital;
6. Verification of completion of education and appropriate training;
7. Evidence of current competence and ability to perform the requested privileged with reasonable skill and safety as confirmed via the usual reference request form, written statement or a documented phone call from, at minimum, the Department Chair or section chief or the individual in a position with direct knowledge of the applicant's performance at the applicant's primary hospital;

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Section 9. DISASTER PRIVILEGES DURING ACTIVATION OF THE EMERGENCY PREPAREDNESS PLAN

Disaster privileges may be granted when the Emergency Preparedness Plan has been activated and the organization is unable to handle the immediate patient needs. The granting of such privileges shall be consistent with Joint Commission standards and pursuant to the Medical Staff policy for “Disaster Privileges During Activation of the Emergency Preparedness Plan.”

Individuals granted emergency privileges under this provision are not considered to be Members of the Medical staff or applicants for membership.

ARTICLE VIII: COLLEGIAL INTERVENTION, CORRECTIVE ACTION/FORMAL INVESTIGATION, NOTIFICATION REQUIREMENTS, AUTOMATIC RELINQUISHMENT, TERMINATION OR SUMMARY SUSPENSION; MEDICAL STAFF HEALTH; CODE OF CONDUCT AND MEDICAL STAFF PROFESSIONALISM CONCERNS

The purpose of this Article is to provide appropriate, effective, and flexible ways for Medical Staff to address issues relating to an individual practitioner’s clinical practice, behavior that is disruptive to the Medical Staff or Hospital operations, or any other conduct by a Member of the Medical Staff that requires action to comply with the provisions of these Bylaws (or with federal or state law). Regular peer review or quality committee/risk management activities, evaluations performed by Department Chairs or the Credentials Committee at the time of re-appointment, and matters brought to the attention of the Medical Executive Committee, may lead to collegial interventions or corrective actions. Whenever possible, collegial intervention should be considered prior to resorting to other disciplinary provisions of this Article.

Section 1. COLLEGIAL INTERVENTION

1.1 The Goal of Collegial Intervention

Collegial Intervention is intended to encourage collegial and educational efforts by Medical Staff leaders to address questions relating to a practitioner’s clinical practice and professional conduct. The goal of these efforts is to attempt to arrive at voluntary, responsive actions by the practitioner to resolve questions that have been raised.

Unprofessional behavior, as defined in Section 7 will be addressed in accordance with the YNHHS Medical Staff Professionalism Policy

1.2 Definition of Collegial Intervention

Collegial intervention efforts may include, but are not limited to, feedback, mentoring, counseling, sharing of comparative data, monitoring, and additional training or education. The Chair of a Department, the MEC, the CEO, the Credentials Committee, the Professional Practice Evaluation Committee (PPEC), the Medical Staff Professionalism (MSPC) or the Chief Medical Officer (“CMO”) may identify Medical Staff members who may benefit from collegial intervention.

1.3 Informal Counseling or Assistance

Nothing in this Section is intended to preclude informal efforts by any Member of the Medical Staff to counsel or assist another Member, provided that such efforts are not in violation of the provisions of these Bylaws.

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1.4 Documentation

Documentation of collegial interventions should be shared with the applicable medical staff committee as necessary and maintained in the practitioner's peer review file.

1.5 Relationship to Corrective Action, Summary Suspension, etc.

In the event that collegial intervention is not successful in achieving a desired outcome, a formal investigation and corrective action may be pursued consistent with the provisions of these Bylaws.

Section 2. CORRECTIVE ACTION / REVIEW/FORMAL INVESTIGATION

When concerns are raised regarding the clinical practice of a Medical or Affiliated Health Care Professional, if he/she demonstrates behavior that is inconsistent with the Medical Staff Code of Conduct or if he/she violates acceptable ethical standards or Medical Staff or Hospital Bylaws, policies or Rules & Regulations, a review of the matter and circumstances may be indicated. These issues are generally evaluated by the Chief Medical Officer, Department Chair, Section Chief or others as delegated by the Professional Practice Evaluation Committee (PPEC) or the Medical Staff Professionalism Committee (MSPC) and addressed with the individual. All efforts are made to address and resolve these issues at one of these levels through collegial intervention as outlined in Section 1.

In some instances, following inquiry into the matter, referral is made to the PPEC or MSPC for review. A Focused Professional Practice Evaluation (FPPE) may also be undertaken and coordinated with the appropriate medical staff leader consistent with the Medical Staff FPPE Policy.

Following unsuccessful documented attempts at collegial intervention at this level or in the event that there are concerns about a practitioner that are of a very serious nature, further inquiry may be initiated. After sufficient inquiry and validation that the issues identified are credible, the Chief Medical Officer, the PPEC, MSPC, the Medical Executive Committee or the Patient Safety & Clinical Quality Committee of the Board of Trustees may recommend a formal investigation to the Credentials Committee, Medical Executive Committee or Patient Safety & Clinical Quality Committee of the Board of Trustees.

In addition, a Department Chair may also request that the Chief Medical Officer, PPEC, MSPC, Medical Executive Committee or the Patient Safety & Clinical Quality Committee of the Board of Trustees review a matter regarding a member of his/her Department for consideration of an investigation.

The Credentials Committee, Patient Safety & Clinical Quality Committee of the Board of Trustees or Medical Executive Committee considers the recommendation and, if they agree, formally commences an investigation by making a resolution to do so. Resolutions must be approved by a majority of those present and voting. A resolution to initiate an investigation made by the Credentials Committee will be forwarded to the Medical Executive Committee for approval.

The body identified to conduct the investigation shall be deemed to be the Investigation Committee.

The Committee that resolved to initiate the investigation may choose to serve as the Investigation Committee, may request that another Committee serve as the Investigation Committee or may appoint or request another Committee to appoint an Investigation Committee. The Investigation Committee may establish a sub-committee for the purpose of "fact-finding" in the investigation. The sub-committee reports its findings to the Investigation Committee.

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None of the above shall be construed to limit the ability of the individuals authorized in these Bylaws to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff whenever such action must be taken immediately in the best interest of patient care. In such instances, the process identified in Section 5 shall be followed.

The practitioner in question is notified in writing of the investigation, the steps that will be taken during the investigation, his/her responsibilities, rights and options and that he/she will have an opportunity to participate in the process before any final determinations are made.

The Investigation Committee shall not include partners, associates or relatives of the individual being investigated and shall have the authority to review relevant documents and interview individuals with information pertinent to the matter at hand as well as the authority to use outside consultants, if needed. It may also require physical and mental examinations/evaluations of the individual under investigation.

The individual under investigation shall have the right to meet with the Investigation Committee, be informed of the allegations against him/her that form the basis of the investigation and discuss, explain or refute the evidence presented.

The investigative process of this committee is not considered a hearing and, as such, the individual under investigation shall not have the right to be represented by legal counsel during the proceedings.

At the conclusion of this process, the Investigation Committee shall submit its recommendation(s) to the Medical Executive Committee or Credentials Committee if the Investigation Committee is not the Credentials Committee. The individual under investigation is informed of the recommendation of the Medical Executive Committee.

If the recommendation is adverse and the Medical Executive Committee concurs in whole, in part or modifies a recommendation that remains ultimately adverse, the individual under investigation shall be entitled to a Fair Hearing as described in Article XVIII.

Section 3. NOTIFICATION REQUIREMENT

3.1 Medical Staff Members Obligation to Report

All members of the Medical or Affiliated Health Care Professional Staff are required to advise the Chief Medical Officer via Medical Staff Administration in writing immediately upon the occurrence any of the following:

- a. any change in malpractice insurance coverage;
- b. loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation and/or fine) taken regarding a professional license in Connecticut or any other state;
- c. loss (other than for routine non-renewal), suspension, consent order or any other action whether voluntary or involuntary that is taken with regard to state or federal authority to prescribe controlled substances;
- d. loss (other than routine non-renewal or resignation of unused clinical privileges), suspension, reduction, resignation, relinquishment, limitation (or any other action arising out of concerns related to competence or professional deportment of membership or clinical privileges) at any other health care facility;

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- e. initiation of formal investigation at any other health care facility;
- f. filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and
- g. any arrest or the filing of any criminal charge by local, state or federal authorities.

These reporting requirements are in addition to the information that is collected at the time of initial appointment and reappointment.

The circumstances surrounding any of the above occurrences, or failure to comply with the requirement to report them, will be evaluated individually in terms of pursuing disciplinary or other action. Fair hearing or appellate review rights are not applicable under circumstances in which practitioners fail to meet eligibility requirements as outlined in ARTICLE III, Section 2.

3.2 Adverse Professional Review Actions, Investigations or For Cause FPPE

Medical staff members are required to report any adverse professional review actions, investigations or for cause FPPEs taken at other facilities. Continuation of medical staff membership and privileges for current members of the medical staff who become subject to any such actions at another hospital or health care facility shall be addressed as described below:

- 1. an adverse professional review action regarding appointment or clinical privileges for reasons related to clinical competence or professional conduct including, but not limited to, denial, revocation or suspension (excluding precautionary suspension) of membership or clinical privileges; or
- 2. any formal investigations or for cause Focused Professional Practice Evaluation (FPPE) pending resolution or completion at another institution; or
- 3. resigned appointment or relinquished clinical privileges during a Medical Staff investigation or in exchange for not conducting such an investigation at another institution.

For any of the above actions taken at another Yale New Haven Health System Affiliated Hospital, the action taken by one Health System Affiliated Hospital shall be immediately and automatically applicable at any other Health System Affiliated Hospital as relevant to the practitioner's membership status and clinical privileges at that hospital.

For actions taken by a hospital that is not affiliated with Yale New Haven Health, the matter shall be immediately brought to the attention of the Chief Medical Officer and relevant department Chair for evaluation and determination as to the relevance to the practitioner's membership status and clinical privileges.

If currently privileged in the area of practice related to the action taken at the other hospital, related privileges shall be automatically relinquished pending review and recommendation by Credentials Committee, Medical Executive Committee and approval by the Board.

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Section 4. AUTOMATIC RELINQUISHMENT, TERMINATION OR SUSPENSION

4.1 Automatic Suspensions and Terminations

The following outlines situations upon which Medical Staff membership and clinical privileges of a Medical Staff member are subject to automatic relinquishment, termination or suspension.

a. Licensure

The following licensure actions shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:

1. Revocation, voluntary relinquishment or voluntary surrender or suspension of a license in any state;
2. Agreement with a governmental entity not to exercise a license to practice;
3. Permanent licensure restriction;
4. Lapse of a license to practice in Connecticut due to failure to renew.

In the event that privileges are automatically relinquished, the Member shall be notified in writing and alternate care coverage shall be provided for the Member's patients who remain in the Hospital. The desires of the patient should be considered. The relevant Department Chair shall be responsible for ensuring that such coverage is provided.

All other licensure actions, including, but not limited to, civil penalty, reprimand or censure, practice monitoring, proctoring or temporary licensure restrictions shall immediately be brought to the attention of the relevant Chair and Chief Medical Officer. In accordance with these Bylaws and relevant medical staff policies, the matter shall be forwarded to the Credentials Committee or Professional Practice Evaluation Committee for review and recommendation.

No hearing rights shall be afforded under circumstances leading to automatic relinquishment of membership and privileges related to licensure actions.

b. Federal and State Drug Control Registration

The following shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:

1. Agreement with a Federal or State governmental agency not to exercise a permit to prescribe controlled substances related to investigation by the agency; or
2. Surrender, revocation, suspension or limitation of a Federal DEA or State Controlled Substance certificate.

No hearing rights shall apply under these circumstances.

Automatic relinquishment does not apply to the lapse or surrender of a Federal DEA or State of Connecticut Controlled Substance certificate under circumstances in which the member no longer requires the certificate to exercise clinical privileges and the member had not entered into an agreement not to prescribe related to an investigation.

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c. Federal or State Health Care Programs

In the event that a current member of the Medical Staff is identified and verified with the source organization as debarred, excluded or precluded from participation in any federal or state health care program, the Chief Medical Officer and relevant medical staff leader will be immediately notified and the appointment and privileges of the Medical Staff member will be automatically terminated.

Practitioners who have been debarred, excluded or precluded from participation in a federal or state health care program for reasons having to do with the provision of health care services or care of patients such as, but not limited to, billing or other financial fraud, patient abuse or felonies will be permanently ineligible for appointment to the Medical Staff.

Practitioners debarred, excluded or precluded for other reasons may be eligible for reinstatement if fully reinstated with the relevant governmental entity subject to review and consideration of the circumstances surrounding the debarment, exclusion or preclusion by the Credentials Committee, Medical Executive Committee and Patient Safety and Clinical Quality Committee of the Board of Trustees.

Practitioners whose membership and privileges are automatically terminated related to debarment, exclusion or preclusion from federal health care program participation are not afforded hearing rights.

d. Health Status

Failure to comply with any health status requirements as outlined in ARTICLE III, Section 2 will result in automatic termination from the Medical Staff. Individuals who are automatically terminated for failure to comply with health status requirements are not afforded hearing rights.

e. Continuing Education / Medical Staff Education

Failure to attest to or provide evidence when requested of compliance with State of Connecticut requirements for continuing medical education or failure to complete any required Medical Staff Education Training at the time of initial or reappointment will result in automatic termination of medical staff appointment and privileges. Hearing rights are not afforded under these circumstances.

f. Medical Staff Dues

The membership and privileges of members who fail to pay Medical Staff dues within thirty (30) days of the second notice shall be considered automatically suspended. Membership may be immediately restored if payment is received within an additional thirty (30) days assuming that reappointment applications or any other required documentation has been submitted by the member. All others will be required to reapply in accordance with ARTICLE III of these Bylaws.

Medical Staff membership and privileges will be automatically terminated if dues payment has not been made thirty-one (31) days following automatic suspension.

Members who are automatically terminated for failure to pay medical staff dues in a timely manner are not afforded hearing rights.

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Members who have been approved for a Leave of Absence in accordance with Article III, Section 7 of these Bylaws may pay medical staff dues upon receipt of notice or upon return from Leave of Absence.

In addition to leave of absence, under extenuating circumstances acknowledged by the Medical Staff President, the Medical Executive Committee may consider and grant requests for extension of the deadline to pay dues.

g. Leave of Absence

Failure to request renewal of a leave of absence at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments. Hearing rights are not afforded under these circumstances.

h. Insurance Coverage

Failure of a Medical Staff member to maintain professional liability insurance to the extent required by the Board of Trustees shall result in automatic suspension of the member's clinical privileges. If the Medical Staff member does not provide evidence of required professional liability insurance within thirty (30) calendar days after written warning of the delinquency from Medical Staff Administration, his Medical Staff membership shall be automatically terminated.

i. Board Certification

Failure of a Medical Staff member to obtain or maintain board certification consistent with the requirements, as applicable, as outlined in ARTICLE III, Section 2 shall result in automatic termination. Hearing rights are not afforded under these circumstances.

j. Cooperation with Peer Review Activities

As a matter of routine proceedings, the Professional Practice Evaluation Committee (PPEC) or the Credentials Committee may request that a member of the Medical Staff participate in a review of his/her own Hospital cases, aspects of Hospital based practice, or matters involving professional behavior. Clinical privileges and medical staff membership may be considered automatically relinquished for refusal to cooperate with such reviews when requested until the necessary input has been provided.

Under these circumstances, hearing rights are not afforded.

4.2 Notice

Once it has been determined that a condition or circumstance exists warranting automatic suspension, the practitioner shall be notified of the automatic suspension. Such notification shall include the reason for the automatic suspension, the effective date of the automatic suspension, and the conditions under which such suspension shall be lifted.

Except for administrative suspension for failure to complete medical records, such notification shall be signed by the President or Vice President of the Medical Staff. If the President or Vice President of the Medical Staff is unavailable, the CEO or the CMO may issue the notification.

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Except for the case of automatic suspension for Medical Records, the MEC shall be apprised of the automatic suspension at its next regularly scheduled meeting. In the case of suspension for medical records, the Health Information Management Department may develop a process for the notification of practitioners, which process shall be approved by the MEC.

4.3 Termination of Automatic Suspension

Unless otherwise provided for in this article and in the absence of any corrective action taken in association with an automatic suspension, the automatic suspension shall be terminated at such time as it is confirmed by the President of the Medical Staff, Vice President of the Medical Staff, the CEO, or the CMO that the circumstances causing the suspension no longer exist. In the case of automatic suspension for Medical Records, this determination may be made by the Department of Health Information Management.

4.4 Continuous suspension of a medical staff member for three (3) months pursuant to this section, shall be considered a voluntary resignation from the Medical Staff and the member's Medical Staff membership shall be terminated.

Section 5. SUMMARY SUSPENSION

5.1 Criteria and Initiation

Summary suspension only may be imposed under extraordinary circumstances. Whenever it appears highly likely that a practitioner's conduct or situation requires that immediate action be taken to prevent imminent danger to the health or safety of any patient, Staff member, or other person in the Hospital, the chair of the clinical Department, or the President of the Medical Staff, or in their absence the Chief Executive Officer of the Hospital shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Such summary shall become effective immediately upon imposition, and subsequently the President/CEO shall, on behalf of the imposer of such suspension, promptly give notice of the suspension to the practitioner.

5.2 Medical Executive Committee Action

Within seven business days after such summary suspension, a special meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation, or termination of the terms of the summary suspension.

5.3 Duration of the Summary Suspension

The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall, if so determined by the MEC, remain in effect pending final resolution.

Section 6. MEDICAL STAFF HEALTH

An impaired physician or practitioner is defined by the AMA as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol." Observed inappropriate behaviors of an impaired physician or practitioner during the exercise of their professional duties may include, but are not restricted to, perceived problems with judgment, interactions, speech, alcohol odor, physical illness or loss of motor skill, depression, illness, or observed substance abuse.

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Concerns regarding impairment or medical staff health will be managed as outlined in the YNHHS Medical Staff Health Policy / Practitioner Health Issues

6.1 Refusal to Accept a Referral to a Program

If, after referral to the Medical Staff Health Committee, a medical staff member declines to cooperate with the Committee, or declines to accept a referral to, or cooperate with a program recommended by the Committee, or if the recommended treatment program reports that the physician is not cooperating with the recommended treatment program, in the interests of patient safety, this will be escalated via other applicable provisions of these Bylaws.

6.2 In the Course of Reviewing a Collegial Intervention or a Corrective Action

In the course of a Collegial Intervention, a Corrective Action as provided in these Bylaws, or as required by law, the MEC or the Department Chair, or the Medical Staff Health Committee may recommend that a medical staff member who displays behavior which may be indicative of impairment be referred to the Health Assistance Intervention Education Network (HAVEN) Program. At the discretion of the referring Medical Staff leader or committee, the Collegial Intervention or Corrective Action may either continue simultaneously or be temporarily delayed while the HAVEN program intake and interventions proceed.

6.3 Records and Documentation

All reports, documents, and records of meetings and communication related to actions taken in accordance with this Section shall be maintained in a secure and confidential manner in the Medical Staff Administration Department under the supervision of the CMO.

6.4 Employed Physicians

Except as otherwise provided in their agreements with the Hospital, physicians who are employees of the Hospital shall have the same rights, privileges, and responsibilities of other Members of the Medical Staff. Nothing in these Bylaws, Rules and Regulations, and Policies, however, is intended to supersede any provision of such agreements or the Human Resources policies and procedures of the Hospital.

Section 7. CODE OF CONDUCT and MEDICAL STAFF PROFESSIONALISM CONCERNS

7.1 It is the policy of the Hospital that all persons within its facilities be treated with courtesy, respect, and dignity. To that end, the Medical Staff requires that all members of the Medical Staff conduct themselves in a professional and cooperative manner in the Hospital.

If a member fails to conduct himself or herself appropriately, consistent with the Code of Conduct or YNHHS Standards of Professional Behavior, the matter shall be addressed as outlined in the YNHHS Medical Staff Professionalism Policy.

7.2 The objective of the Code of Conduct is to encourage optimum patient care by promoting a safe, cooperative, respectful and professional health care environment and to eliminate any behaviors that disrupt Hospital operations, adversely affect the ability of others to competently perform their jobs or have a negative impact on the confidence of patients and families in the Hospital's ability to provide quality care.

For purposes of this section, this Code of Conduct applies to the interactions of Medical and Affiliated Medical Staff with other Medical and Affiliated Medical Staff, House Staff, employees, patients and visitors.

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The behavior of members of and applicants for membership on the Medical and Allied Health Professional Staffs constitutes an essential component of professional activity and personal relationships within the Hospital. Civil department fosters an environment conducive to patient safety and quality and the teaching of students. Consistent with the Code of Conduct, in addition to the qualifications set forth above, a member of the Medical Staff or of the Affiliated Health Care Staff at all times shall demonstrate an ability to interact on a professional and respectful basis with each other, hospital staff, patients, visitors and others.

The Code of Conduct is not in any way intended to interfere with a Staff member's right: (1) to express opinions freely and to support positions whether or not they are in disagreement with those of other Medical or hospital staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development; (3) to engage in good faith criticism of others; or (4) to voice objection or concern about hospital policies and procedures. It is, however, expected that all differences in opinion will be expressed in an appropriate forum and manner.

Examples of inappropriate conduct include, but are not limited to, the following:

- use of threatening, abusive or hostile language, comments or behaviors that belittle, berate, degrade, intimidate, demean and/or are threatening to another individual;
- inappropriate physical contact or threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- use of loud, profane, or similarly offensive language;
- derogatory comments or criticisms about the quality of care provided by the Hospital, another Medical Staff member, or any other individual made outside of an appropriate forum;
- impertinent or inappropriate comments (or illustrations) made in medical records or other official documents concerning the quality of care provided by the Hospital or another individual
- willful disregard of Medical Staff and Hospital requirements, Policies and Procedures, failure to cooperate on assigned responsibilities or an unwillingness to work collaboratively with others
- written or oral statements which constitute the intentional expression of falsehoods, or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others
- retaliation against any person who addresses or reports violations of the Code of Conduct

Examples of serious violations of the Code of Conduct include, but are not limited to:

- deliberate destruction of any hospital property
- possession of any unauthorized firearm or weapon
- gross immoral, fraudulent or indecent conduct
- Harassment: the Hospital prohibits all forms of unlawful and unacceptable harassment, including harassment due to race, religion, sex, national origin, age, marital status, sexual orientation and disability.

Sexual harassment is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subject to it or who witness it and is considered a serious violation of the Code of Conduct. Examples include, but are not limited to, the following:

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- verbal: innuendoes, epithets, derogatory slurs, jokes, propositions, graphic commentaries, threats and/or suggestive or insulting sounds;
- visual: derogatory posters, cartoons or drawings; suggestive objects or pictures; leering and/or obscene gestures;
- physical: unwelcome physical contact including touching, interference with an individual's movement and/or assault;
- other: making or threatening retaliation as a result of an individual's negative response to harassing conduct

Violations of the Code of Conduct shall be referred to and reviewed by the Medical Staff Professionalism Committee (MSPC) and referred to the Credentials Committee as deemed appropriate.

ARTICLE IX: STAFF DEPARTMENTS AND CLINICAL SERVICES

Section 1. ORGANIZATION OF STAFF DEPARTMENTS AND CLINICAL SERVICES

Each Department shall be organized as a separate part of the Medical Staff and shall have a Chair who is selected and has the authority, duties, and responsibilities as specified in Article XI. Each clinical service shall be organized as a specialty service within a Department, shall be directly responsible to the Department within which it functions and shall have a chief of service who is selected and has the authority, duties, and responsibilities as specified in Article X Section 5.

Section 2. DESIGNATION

2.1 Current Departments and Services or Sections

- a. The current Departments are: Anesthesia, Emergency Medicine, Medicine, Obstetrics/Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, Rehabilitation Medicine and Surgery.
- b. The current services or sections are:

	<u>Responsible Department</u>
Allergy & Immunology	Medicine
Cardiology Service	Medicine
Dermatology Service	Medicine
Endocrinology Service	Medicine
Family Medicine Service	Medicine
Gastroenterology Service	Medicine
Hospitalist Service	Medicine
Infectious Disease Service	Medicine
Internal Medicine Service	Medicine
Interventional Cardiology	Medicine
Medical Oncology/Hematology Service	Medicine
Nephrology Service	Medicine
Neurology Service	Medicine
Pulmonary Service	Medicine
Radiation Oncology Service	Medicine
Rheumatology Service	Medicine
Obstetrics & Gynecology Section	OB/GYN
Gynecology Section	OB/GYN

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Neonatology Service	Pediatrics
Outpatient Pediatrics	Pediatrics
Pediatric Hospitalists	Pediatrics
Diagnostic Radiology	Radiology
Teleradiology	Radiology
General Surgery Section	Surgery
Neurosurgery Section	Surgery
Ophthalmology Section	Surgery
Orthopedics Section	Surgery
Otolaryngology Section	Surgery
Plastic/Hand Section	Surgery
Podiatry Section	Surgery
Thoracic Surgery Section	Surgery
Urology Section	Surgery
Vascular Surgery Section	Surgery
Dental Section	Surgery

2.2 Future Departments and Services

When deemed appropriate, the Medical Executive Committee and the Board, by their joint action, may create a new, eliminate, subdivide, further subdivide or combine Departments or services.

Section 3. ASSIGNMENT TO DEPARTMENTS AND CLINICAL SERVICES

Each member of the Staff shall be assigned membership in at least one Department, but may be granted membership and/or clinical privileges in one or more of the other Departments and services. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of that Department and the authority of the Department Chair.

Section 4. RESPONSIBILITY, FUNCTIONS, AND ORGANIZATION OF DEPARTMENTS

The primary responsibility delegated to each Department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Department shall:

- a. In collaboration with the Quality Assurance and Utilization Review Committees, conduct retrospective patient care audits for the purpose of analyzing, reviewing, and evaluating the quality of care within the Department. The number of such audits to be conducted during the year shall be as determined by the Medical Executive Committee, but shall not be less than the number required by the Joint Commission on Accreditation of Hospitals, or if higher, the number required by law. Each Department shall review all clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that Department. Family practitioners shall be subject to review by each Department in which they exercise clinical privileges and shall be subject to such review as the services of family practice may conduct.
- b. Establish guidelines for the granting of clinical privileges within the Department and submit the recommendations required under Articles VI and VII regarding the specific privileges each Staff member or applicant may exercise and the specified services that each Affiliated Health Care Professional may provide.

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- c. Conduct or participate in, and make recommendations regarding the need for, continuing medical education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.
- d. Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; (4) fire and other regulations designed to promote patient safety.
- e. Coordinate the patient care provided by Department's members with nursing and other non-physician patient care services and with administrative support services.
- f. Foster an atmosphere of professional decorum within the Department appropriate to the healing arts.
- g. Meet at least nine times a year for the purpose of receiving, reviewing, and considering patient care audit findings and the results of the Department's other review, evaluation and education activities and of performing or receiving reports on other Department and staff functions.
- h. Establish such committees, services, or special care units, or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

Section 5. FUNCTIONS OF CLINICAL SERVICES

Each service shall, upon the approval of the Medical Executive Committee and the Board, perform the functions assigned to it by the Departmental Chair to which it is assigned. Such functions may include, without limitation, the continuous monitoring of patient care practices, retrospective patient care audit, continuing education programs and credentials review and privileges delineation. The service shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

ARTICLE X: OFFICERS

Section 1. OFFICERS OF THE STAFF

1.1 Identification

The elected officers of the Staff shall be:

- a. President
- b. Vice-President
- c. Immediate Past President
- d. Secretary-Treasurer

1.2 Qualifications

Members of the Active Staff (Active Attending or Active Referring) who have fulfilled the requirements for initial FPPE are eligible for nomination.

1.3 Nominations

- a. By Nominating Committee: The Nominating Committee shall be appointed by the President of the Medical Staff from members of the Active Staff. The Nominating Committee shall convene and shall submit to the Secretary of the Staff one or more

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qualified nominees for each office. The names of such nominees shall be prominently posted on the Medical Staff Bulletin Board at least two weeks prior to the annual meeting.

- b. By petition: Nominations may also be made from the floor at the time of the annual meeting.

1.4 Election

Officers shall be elected at the annual meeting of the Staff. Only Staff members accorded the prerogative to vote for general Staff officers under Article IV shall be eligible to vote. Voting shall be by written ballot on the day of the annual meeting and during the subsequent three business days, and voting by proxy shall NOT be permitted. A signed ballot sent directly to Medical Staff Administration via email or fax and verified, shall be considered acceptable. Secret balloting is available only at the annual meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

1.5 Term of Elected Office

Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following the officer's election. Each officer shall serve until the end of the officer's term and until a successor is elected. Re-election for two consecutive terms is not permissible. Future re-election is permissible.

1.6 Vacancies in Elected Office

Vacancies in offices, other than that of President, shall be filled by the Medical Staff by a special election. If there is a vacancy in the office of President, the Vice-President shall serve out the remaining term.

1.7 Duties of Officers

a. President

The President shall serve as the chief administrative officer of the Medical Staff to:

1. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
2. Serve as Chair of the Medical Executive Committee.
3. Be an ex-officio member, with vote, of all committees except the nominating committee.
4. Serve as a member of the Hospital's Board of Directors with full vote. Represent the views, policies, needs and grievances of the Medical Staff to the Medical Executive Committee, to the Board, and to the President/CEO.
5. Be a spokesperson for the Medical Staff in its external professional and public relations, and participate in public relation activities of the Hospital.
6. Appoint special ad hoc committees.

b. Vice President

In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall be a member of the Medical Executive Committee and serve as a member of the Hospital's Board of Directors with full

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vote. The Vice President shall automatically succeed the President when the latter fails to serve for any reasons.

c. Immediate Past President

The Immediate Past President will be a member of the Medical Executive Committee and a member of the Hospital's Board of Directors with full vote.

d. Secretary-Treasurer

The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to this office. The Secretary shall also be a member of the Medical Executive Committee.

1.8 Removal of Officers

The Medical Executive Committee, by a two-thirds vote, may recommend the removal of any Medical Staff Officer for conduct detrimental to the interests of the Medical Staff or if the Officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office; provided that notice of the meeting at which such action shall be taken is given in writing to such Officer at least ten (10) days prior to the date of the meeting. The Officer shall be afforded the opportunity to speak at the meeting at which the decision is to be taken and prior to the taking of any vote on such removal. The removal shall be effective when approved by the majority of the Medical Executive Committee and Board.

Section 2. OTHER OFFICERS OF THE STAFF

2.1 Departmental Chair

a. Qualifications

Each Chair shall be a member of the Active Staff. Additionally, each Chair shall be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process and shall be willing and able to faithfully discharge the functions of the office.

b. Identification

Candidates who fulfill the qualifications as stated above and are appropriate and interested in performing the duties of the Chair as described in these Bylaws will be recommended by the relevant Department in consultation with the Chief Medical Officer.

c. Term of Office

The Department Chair will be appointed to a 3-year term which may be renewable subject to the process outlined herein and so long as the Chair is effectively carrying out the duties and responsibilities outlined in these Bylaws to the satisfaction of the members of their department, of the Medical Executive Committee, and the Board.

d. Selection

In the event of a vacancy or creation of a new Chair position, the selection of the Department Chair will be made by a simple majority of the members of the respective Department who are eligible to vote based upon their medical staff category and who participate in the vote followed by a simple majority of voting members of the Medical Executive Committee. The Medical Executive Committee shall forward its recommendation for Chair to the Board for final approval.

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The continued appointment of individuals currently serving as Chairs will be re-evaluated at the time of reappointment to the Medical Staff.

e. Removal of a Department Chair

Removal of a Department Chair from office may be initiated by the Board acting upon its own recommendation, or upon the recommendation of the Medical Executive Committee or a two-thirds majority vote of the Department members eligible to vote. Removal from office shall be accomplished pursuant to Article X, Section 1.8 of these Bylaws.

f. Duties: Each Chair

1. Account to the Medical Executive Committee for all professional and administrative activities within the Chair's Department, and particularly for the quality of patient care rendered by members of the Chair's Department and for the effective conduct of the patient care audit and other quality maintenance functions delegated to the Chair's Department.
2. Render regular reports on each member at least at the time of reappointment.
3. Develop and implement Departmental programs in cooperation with the President of the Medical Staff and with input from the CMO, and consistent with the provision of Article X and Article XII, for credentials review and privileges delineation, continuing medical education, utilization review, concurrent monitoring of practice and retrospective patient care audit.
4. Be a member of the Medical Executive Committee, give guidance on the overall medical policies of the hospital and make specific recommendations and suggestions regarding the Chair's own Department.
5. Maintain continuing review of the professional performance of all practitioners within clinical privileges and all others with specified services in the Chair's Department and report regularly thereon to the Medical Executive Committee.
6. Transmit to the appropriate authorities, as required by Articles VI through VIII, recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners in the Chair's Department.
7. Appoint such committees as are necessary to conduct the functions of the Department specified in Article X and designate a Chair and secretary for each.
8. Enforce the Hospital and Medical Staff Bylaws, rules, policies and regulations within the Chair's Department including initiating corrective action and investigation of clinical performance and ordering required consultations, when necessary.
9. Implement within the Chair's Department action taken by the Medical Executive Committee.
10. Participate in every phase of administration of the Chair's Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.
11. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Chair's Department as may be required by the Medical Executive Committee, the President/CEO, or the Board.

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12. Perform such other duties commensurate with the office of Chair as may from time to time be reasonably requested of the Chair by the President of the Medical Staff, the Medical Executive Committee, or the Board.
13. Appoint Chief of Services assigned to the Department with the concurrence of the Medical Executive Committee and the Board.
14. Make service roster assignments for the Department.
15. Prepare a description of the qualifications of the respective Chiefs of Service, and their duties as Chiefs of Service.

Section 3. ADDITIONAL OFFICERS

The Board may, after considering the advice and recommendations of the Medical Staff, appoint additional practitioners to administrative positions within the Hospital to perform such duties as prescribed by the Medical Executive Committee and the Board, or as defined by amendment to these Bylaws. Such a practitioner must become and remain a member of the Staff. In all events, such practitioner is subject to these Bylaws and to the other policies of the Hospital.

ARTICLE XI: COMMITTEES AND FUNCTIONS

Section 1. 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 Medical Executive Committee pursuant to Article XII, Section 7 of these Bylaws,
- 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, 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, the CMO, and experts or consultants retained to perform peer review.

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 are set forth in the Connecticut General Statutes.

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Section 2. MEDICAL EXECUTIVE COMMITTEE

The MEC is accountable to the Medical Staff for its performance of all of these duties.

a. Composition

All members of this committee shall be voting members of the Medical Staff. The President/CEO, or designated representative, shall be required to attend meetings and to provide a recording secretary. The President/CEO shall attend ex-officio without vote. The Chief Medical Officer and the Vice President for Patient Care Services will attend ex-officio without vote. Full voting members shall consist of the President of the Medical Staff as Chair, the Vice-President, Secretary-Treasurer, and immediate Past President of the Medical Staff, the Chairs of all Departments, the Chief of the Family Practice Service, the Medical Director of the Hospitalist Service, and three at-large members elected from and by the Medical Staff. The elected members shall be elected at the annual meeting, may serve for two consecutive 2-year terms, may be re-elected for another cycle after a two-year hiatus.

b. Duties

Receiving and acting upon the reports and recommendations from medical staff committees, Departments, services and assigned activity groups; implementing the approved policies of the medical staff; recommending to the Board all matters relating to appointments, reappointments, staff categorization, Department/ service assignments, clinical privileges, and corrective action; acting as an oversight committee to each Departments' actions taken to improve quality/performance and effectiveness fulfilling the medical staff's accountability to the Board for the quality of overall medical care rendered to patients in the hospital; initiating and pursuing corrective action when warranted, in accordance with these bylaws; and informing the medical staff of Joint Commission accreditation programs and the accreditation status of the hospital. In addition, the Medical Executive Committee may act on behalf of the organized medical staff between Medical Staff meetings subject to such limitations as may be imposed by these bylaws.

c. Meetings

The Medical Executive Committee shall meet at least ten times a year and maintain a permanent record of its proceedings and actions. A report of the proceedings and actions of the Medical Executive Committee shall be made by the senior elected Medical Staff representative serving on the Medical Executive Committee at the regularly scheduled Medical Staff meeting. A copy of the minutes of committee meetings shall be kept in the office of the President/CEO and shall be available for inspection by any member of the Active Medical Staff. In the event of special meetings, Members may participate by telephone or by other remote means of accessing the meeting; this shall be noted in the minutes.

d. Removal of Medical Executive Committee members

Medical Executive Committee members may be removed for the same reasons and in the same manner as the removal of Officers (Article XI, Section 1.8).

Section 3. CREDENTIALS COMMITTEE

a. Composition

The Credentials Committee shall consist of practitioners who are members of the Active Attending, Active Referring or Consulting Staff selected by the Medical Executive Committee on an annual basis that will ensure representation of the major clinical specialties, the hospital-based specialties, and the Medical Staff at-large. This committee shall have the right and authority to enlist ad hoc participation of any member of the Medical Staff for the purpose of interviewing a new Staff applicant, or reviewing the application of a prospective Staff member, or interviewing and/or reviewing a change in Staff status or clinical privileges of a current Staff member. The

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Credentials Committee may opt to appoint a Sub-Committee to act on its behalf with respect to clean applicants for appointment that are eligible for temporary privileges consistent with these Bylaws and relevant Medical Staff Policies.

b. Duties

The duties of the Credentials Committee shall be:

1. To review the credentials of all applicants and to make recommendation for membership and delineation of clinical privileges in compliance with Articles IV, V, VI, and VII of these Bylaws.
2. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendation from the Departments in which such applicant requests privileges.
3. To review and establish guidelines and policies in the area of clinical privileges when requested to do so by the Medical Executive Committee.

With approval from the Medical Executive Committee, some of the responsibilities of the Credentials Committee may be assumed by a Centralized Credentials Committee that includes representatives from each of the participating YNHHS Affiliated Hospital Medical Staffs. Representatives from the Lawrence + Memorial Hospital Medical Staff shall include the Chief Medical Officer or individuals selected by the Chief Medical Officer.

Any recommendations made by the Centralized Credentials Committee shall be forwarded directly to the Medical Executive Committee for action.

Section 4. OBSTETRICS AND GYNECOLOGY

- a. Any physician planning to perform a therapeutic abortion shall document the medical contraindication to pregnancy which constitutes a risk of grave and permanent impairment of physical health to the woman involved. Severe fetal malformations may also be documented as a reason for the procedure.
- b. Elective abortions, interruption of pregnancy before viability at the request of the woman but not for reasons of impaired maternal health (as defined above) or fetal disease (as defined above), are not performed at this Hospital.
- c. The attending physician and two other members of the OB-Gyn Department, selected by the Chair of the OB-Gyn Department or his/her designee, will review the documentation before each such procedure. All three must agree that the above criteria have been met before the above-mentioned procedure is performed.

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Section 5. BYLAWS COMMITTEE

a. Composition

This committee shall consist of at least five members of the Active Medical Staff, to be selected annually by the Medical Executive Committee. The CMO and President of the Medical Staff shall be ex-officio members with vote.

b. Duties

The duties of the Bylaws Committee shall be:

1. To conduct reviews of the Medical Staff Bylaws and Rules and Regulations and to recommend to the Medical Executive Committee any necessary modifications to reflect current Medical Staff practices or new laws and regulations.
2. To review and deliberate on proposals for Bylaws changes submitted by the Medical Executive Committee or Medical Staff and make recommendations on any proposed amendments.

e. Meetings

The committee shall meet on an as needed basis.

Section 6. PROFESSIONAL PRACTICE EVALUATION COMMITTEE (PPEC)

a. Composition

The Chair will be appointed by the Medical Executive Committee, Chief Medical Officer or representative of Chief Medical Officer's Office, representatives of the Medical Staff from each major clinical department and supported by a Legal & Risk Services representative. Additional members may be added at the discretion of the Medical Executive Committee.

b. Meetings

Monthly

Section 7. MEDICAL STAFF PROFESSIONALISM COMMITTEE (MSPC)

a. Charge

1. review alleged violations of the Medical Staff Code of Conduct referred by the Chief Medical Officer or Department Chairs;
2. designate the Chief Medical Officer to act between meetings to address issues of immediate concern having to do with compliance with the Medical Staff Code of Conduct;
3. facilitate mechanisms for correction of problems identified including, but not limited to, referral of practitioners to external programs or counseling as appropriate;
4. assist the Hospital in maintaining compliance with the requirements of The Joint Commission;
5. report to the Medical Executive Committee and the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding institutional concerns related to practitioner behavior;
6. refer issues, as applicable, having to do with alleged violations of the Code of Conduct or health/fitness to work to the Credentials Committee or, as appropriate, Medical Staff Health Committee, for deliberation;

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7. communicates accordingly with and involves individuals whose practice or aspects of practice are under review as well as the applicable Chair or Section Chief. Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence. Reports as needed to the Medical Executive Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees.
- b. Composition
The MSPC membership shall be the same as the PPEC.
- c. Meetings
At least annually.

Section 8. MEDICAL STAFF HEALTH COMMITTEE

- a. Charge
To establish and maintain a mechanism for educating Medical Staff and trainees to recognize the signs and symptoms of potential or actual health impairment among colleagues; to assist in identifying such potential or actual health impairment; to implement Medical Staff policy when incidents of actual or potential health impairment require evaluation; make recommendations to the Medical Executive Committee regarding Medical Staff Health policy changes and report as needed.
- b. Composition
The Chair shall be appointed by the Medical Executive Committee; membership includes representatives from the Medical and Affiliated Medical Staffs, Chief Medical Officer or his/her designee. Other Hospital staff may participate ex officio as appropriate.
- c. Meetings
Meets as needed

Section 9. BLOOD BANK & TRANSFUSION COMMITTEE

- a. Charge
Ensure the safety and appropriate usage of blood and blood products in accordance with state and national standards by setting standards and procedures for the appropriate use of blood and blood products, monitor the use of blood and blood products, review adverse reactions to blood and blood components and educate the Medical Staff on the use of blood and blood products.
- b. Composition
Medical Staff members, including representatives of the NICU, Oncology and Medicine, Blood Bank leadership including the Director and Supervisor, pertinent department leadership from IV Therapy, Cancer Center and the Chief Medical Officer or their representative.
- c. Meetings
Quarterly

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Section 10. CRITICAL CARE COMMITTEE

- a. Charge
Review hospital-wide critical care policies and adult cardiopulmonary resuscitation policies and practices; to define critical care guidelines/standards that will provide for highly skilled critical care; and to provide leadership, monitoring and support for activities related to critical care.
- b. Composition
The Chair will be appointed by the Medical Executive Committee, membership includes Chief of Cardiology or designee, Medical Director of the Intensive Care Unit, Medical Director of Emergency Medicine, representatives of the Medical and Affiliated Medical Staffs from the departments of Anesthesia and Surgery and the Chief Medical Officer or their designee. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Bi-monthly

Section 11. INFECTION PREVENTION COMMITTEE

- a. Charge
To oversee the program or plan of action designed to identify infections that occur in patients and staff that have the potential for disease transmission, identify opportunities, for reduction of risk for disease transmission, and recommend risk reduction practices by integrating principles of infection prevention into all direct and indirect standards of practice.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes representatives of the Medical and Affiliated Medical Staffs from each major clinical department and the Chief Medical Officer or their designee. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Monthly

Section 12. MEDICAL RECORDS COMMITTEE

- a. Charge
To ensure that all medical records meet high standards of patient care, usefulness and of historical validity.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes a minimum of two (2) representatives of the Medical and Affiliated Medical Staffs and the Chief Medical Officer or their designee. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Quarterly

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Section 13. MEDICAL STAFF EDUCATION/LIBRARY COMMITTEE

- a. Charge
Ensure the high quality of healthcare through the presentation and approval of educational programs.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes representatives of the Medical and Affiliated Medical Staffs. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Meets as needed

Section 14. ONCOLOGY COMMITTEE

- a. Charge
To provide multidisciplinary oversight of all aspects of cancer patient care, from curative to palliative, assuring access to consultative services in all major disciplines, with the utmost concern for patient and family well-being.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes representatives of the Medical and Affiliated Medical Staffs from general and specialty surgery, medical oncology, diagnostic radiology and radiation oncology. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Quarterly

Section 15. PHARMACY & THERAPEUTICS COMMITTEE

- a. Charge
To objectively appraise, evaluate and select medications to be used by the institution be administering the formulary system, which includes developing and maintaining the formulary and establishing and implementing policies on the use of drug products.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes representatives of the Medical and Affiliated Medical Staffs and the Chief Medical Officer or their designee. Other hospital staff may participate ex-officio as appropriate.
- c. Meetings
Monthly

Section 16. RADIATION SAFETY COMMITTEE

- a. Charge
To ensure the safe use of radioactive material and ionizing radiation in accordance with state and NRC regulation and the hospital license.
- b. Composition
The Chair will be appointed by the Medical Executive Committee; membership includes representatives of the Medical and Affiliated Medical Staffs, including the Radiology Medical Director and the Chief Medical Officer or their designee. Other hospital staff may participate ex-officio as appropriate.

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Section 17. OTHER COMMITTEES

Medical Staff, through the action of the Medical Executive Committee, shall establish additional appropriate committees to monitor and review clinical services and Medical Staff functions on a regular basis. Such committees may also function as "Medical Review Committees" or committees conducting studies of morbidity or mortality as defined above. Any proposed changes to such committee descriptions must be reviewed by the Medical Executive Committee and approved in accordance with Article XVI. Adoption and Amendment of Medical Staff Policies.

ARTICLE XII: MEDICAL STAFF MEETINGS

Section 1. REGULAR MEETINGS

Regular Staff meetings shall be held as needed and requested by the Medical Staff President. It is recommended that Active Attending and Active Referring Staff members attend all Medical Staff meetings. An annual Staff meeting shall be held within 90 days of the end of the fiscal year. The agenda of such meeting shall include reports, or review and evaluation of the work done in the clinical Departments and the performance of the required Medical Staff functions, election of officers and representatives to the Executive Committee.

Section 2. SPECIAL MEETINGS

- a. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within 15 days after receipt of a written request stating the purpose of such meeting and signed by not less than twenty-five Members of the Active Staff. The President of the Medical Staff shall designate the time and place of any special meeting.
- b. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail or E-mail, to each member of the Active Staff not less than 10 days before the date of such meeting, by or at the direction of the President (or other persons authorized to call the meeting).

If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at the Member's address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such a meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. QUORUM

A quorum for Medical Staff meeting will be defined as ten (10) members with voting privileges at any regular or special meeting of the Medical Staff.

Section 4. REFERENDUM VOTE

Any votes of the Medical Staff will be posted within seven (7) days. If within thirty (30) days of any vote twenty (20) members of the Medical Staff (eligible to vote) sign a request for a reconsideration of the vote, the issue will be presented again at the next regular meeting or a special meeting of the Medical

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Staff. A ballot will thereafter be sent to all voting members of the Medical Staff with information about the issues, both for and against, to be returned to the Medical Staff Office within thirty (30) days. A Bylaws amendment will require two-thirds majority of those voting to pass (see also Article XIX). Other votes may pass by a simple majority of those voting.

Section 5. ATTENDANCE REQUIREMENTS

Medical Staff Meetings are a responsibility of membership and attendance is strongly encouraged.

Section 6. AGENDA

- a. The agenda at any regular Medical Staff meeting shall be:
 1. Call to order
 2. Consideration of the minutes of the last regular and of all special meetings
 3. Introductions and announcements
 4. Communications
 5. Report from the President/CEO of the hospital
 6. Reports of committees
 7. New business (including elections, where appropriate)
 8. Adjournment
- b. The agenda at special meetings shall be:
 1. Reading of the notice calling the meeting
 2. Transaction of business for which the meeting was called
 3. Adjournment
- c. The procedure to be followed at all Staff meetings shall be in accordance with Robert's Rules of Order.

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings, without notice other than such resolution. Departments shall hold regular meetings at least nine times yearly, unless canceled by the Chair of the Department, to review and evaluate the clinical work of practitioners with privileges in the Department.

Section 2. SPECIAL MEETINGS

A special meeting of any committee or Department may be called by or at the request of the Chair or chief thereof, by the President of the Medical Staff, or by one-third of the group's then members, but not less than two members. In the event of special meetings, Members may participate by telephone or by other remote means of accessing the meeting; this shall be noted in the minutes.

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Section 3. NOTICE OF MEETINGS

Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or Department not less than five days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at the Member's address as it appears on the records of the hospital with postage prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. QUORUM

Thirty percent of the Active Medical Staff members of a committee or Department, but not fewer than two members, shall constitute a quorum at any meeting.

Section 5. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or Department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

Section 6. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members will serve without vote unless otherwise specified; they shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

Section 7. MINUTES

Minutes of each regular and special meeting of a committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the Executive Committee. Each committee and Department shall maintain a permanent file of the minutes of each meeting.

Section 8. ATTENDANCE REQUIREMENTS

- a. Attendance at Department Meetings is encouraged. Participation on Medical Staff Committees is expected of all members of the Active Staff. Members assigned to committees are expected to attend at least 50% of the committee meetings. Physician attendance at Committee meetings will be considered at the time of Committee reappointments.
- b. A practitioner whose patient's clinical course is scheduled for discussion at a regular Departmental meeting, shall be so notified and shall be expected to attend such meeting. On request by a Medical Staff Committee reviewing the clinical course of a practitioner's patient, the practitioner shall be required to attend the committee meeting. The Chair of the respective meeting, shall give the practitioner at least five days advance written notice of the time and place of the meeting.

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- c. Failure by a practitioner to attend any meeting with respect to which the practitioner was given notice that the Member's attendance was mandatory, unless excused by the appropriate Departmental Chair or committee Chair, for showing a good cause, shall result in an automatic suspension of all or such portion of practitioner's clinical privileges in compliance with corrective action as stated in Article VIII, Section 1.4 and Section 3.3 of the Medical Staff Bylaws.

ARTICLE XIV: RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws. See Appendix B.

ARTICLE XV: ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES

The Medical Staff shall adopt a Medical Staff Policy Manual that will contain policies to implement more specifically the general principles found within the Bylaws and Rules and Regulations. These shall include policies that relate to the proper conduct of the Medical Staff organizational activities as well as to the level of practice required of each Medical or Health Professional Affiliate staff member in the hospital. Such Medical Staff policies will be appended to the Bylaws. The method for introduction and implementation of new policies or the amendment or deletion of existing policies in this manual shall be delineated in the Bylaws of the Medical Staff. All such policies shall be considered to be implemented pursuant to written Bylaws.

1. New Medical Staff policies, or proposed changes to Medical Staff policies, may be introduced by any member of the Medical Staff or through the appropriate Medical Staff committee, Department, or service. Such proposals shall be submitted to the Medical Staff President.
2. These proposals shall be submitted to the Medical Executive Committee.
3. The Medical Executive Committee will discuss and act on the proposal. The sponsor of the policy may come to the Medical Executive Committee meeting and participate in the discussion. Medical Executive Committee action may include:
 - a. Adopting or rejecting the proposal;
 - b. Forwarding the proposal to a Department, service, or committee for discussion and comment prior to formal action;
 - c. Table proposal for further discussion and future action at the next Medical Executive Committee meeting.
4. Before formal action by the Medical Executive Committee, the Medical Staff will be notified of the subject matter of the policy proposal.
5. Adoption of a proposed Medical Staff policy, or amendment or removal of an existing policy, by the Medical Executive Committee shall require a two-thirds majority vote of Medical Executive Committee members present and voting, excluding abstentions.

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6. The Medical Staff will be notified within seven (7) days of the meeting. The policy will be implemented 21 days following such notice except as described in #7 below.
7. A letter signed by 20 members of the Active Staff prior to the end of the 21 day notice, shall be cause to bring the policy change before the entire Medical Staff at a regular or special Medical Staff meeting. In such a case, implementation of the policy shall be deferred until action of the Medical Staff.

When a policy is brought before the Medical Staff pursuant to this section:

- a. There must be at least two (2) weeks notice to the Medical Staff that the proposed policy will be discussed and acted upon.
 - b. Discussion and vote on the policy may be taken at the meeting following sufficient notice.
 - c. In the case of such policies, action at the full Medical Staff meeting shall require only a simple majority.
8. No Medical Staff policy may be passed or implemented in the manner described in this section if it contradicts, is inconsistent with, or is intended to replace any portion of the Bylaws of the Medical Staff. Prior to acting upon such a policy, the Bylaws must first be appropriately amended through the mechanism delineated in the Bylaws of the Medical Staff. **See Appendix C.**

ARTICLE XVI: INDEMNIFICATION

All Medical Staff officers, Department Chairs, section chiefs, committee chairs, committee members, and individual Staff members who act for and on behalf of the Hospital in performing functions pursuant to these Bylaws, shall be indemnified by the Hospital when acting in good faith in those capacities.

ARTICLE XVII: PHYSICIAN EMPLOYMENT AND EXCLUSIVE SERVICES AGREEMENTS

Whenever the Hospital intends to terminate any exclusive agreement with a group of hospital-based physicians for the providing of services to patients (such as agreements with anesthesiologists, pathologists, or radiologists), and whenever the Hospital intends to terminate an employment relationship with any other Member of the Medical Staff, the Hospital first shall provide reasonable advance notice to and consult fully with the Medical Executive Committee provided that the group or individual in question requests such consultation with the Medical Executive Committee. In the event that the Medical Executive Committee is of the view that a termination is not appropriate and so advises the Hospital, but the Hospital continues to intend to terminate the agreement, the Medical Executive Committee's view on the matter and the view of Hospital Administration shall be presented to the Board of Directors for resolution.

The Medical Staff Membership and clinical privileges of physicians who are Hospital employees shall be governed by these Bylaws. These Bylaws shall not be interpreted to govern or control the employment relationship. Except for the consultation requirement set forth in this provision, employment matters shall be governed exclusively by the physician's employment agreement with the Hospital (if any), and/or the Hospital's applicable employment and personnel policies.

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ARTICLE XVIII: FAIR HEARING PLAN

INITIATION OF HEARING

Section 1. PREAMBLE

This Article sets forth the process and standards for the right to a hearing, scheduling a hearing, and an appeal to the Board of Directors.

Section 2. RECOMMENDATIONS OR ACTIONS

The following recommendations or actions shall, if deemed adverse pursuant to Section 3 of this Article, entitle a practitioner (Physician, Dentist, or Podiatrist) affected thereby to a hearing:

- a. Denial of appointment
- b. Denial of reappointment
- c. Suspension of Medical Staff membership other than an Automatic Suspension
- d. Suspension of Clinical Privileges including reduction or revocation other than minor administrative suspensions (e.g., failure to complete medical records)
- e. Mandatory Concurring Consultation Requirement Prior to Performing

No other recommendations or actions shall entitle a practitioner to a hearing or appellate review. For example, none of the following, or analogous actions, create any right to a hearing or appeal.

1. Issuance of a letter of guidance, warning, or reprimand
2. Imposition of conditions, monitoring, or a general consultation requirement (*i.e.*, the practitioner must obtain a consult but need not obtain prior approval for performing the procedure.
3. Termination of temporary privileges
4. Automatic relinquishment of appointment or clinical privileges
5. Voluntary relinquishment of appointment or clinical privileges
6. Denial of a request for a leave of absence, or extension of a leave of absence
7. Determination that an application is incomplete
8. Determination that an application will not be processed due to a practitioner's misstatement or omission
9. Appointment or reappointment for less than three years.

Section 3. WHEN DEEMED ADVERSE

A recommendation or action listed in Section 2 of this Article shall be deemed an adverse action only when it has been:

- a. Recommended by the Medical Executive Committee; or
- b. Taken by the Board of Directors contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing previously existed; or

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- c. Taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

Section 4. NOTICE TO PRACTITIONERS AND REQUESTS FROM PRACTITIONERS FOR HEARINGS/APPEALS

Whenever a practitioner is entitled to a hearing or appeal to the Board, the President/CEO shall give 10 business days written notice to the practitioner of such right. When relevant, the practitioner shall be advised by such notice of the practitioner's Medical Staff status pending further action. Such notice shall provide that a professional review action has been proposed to be taken against the practitioner, contain a concise statement of the reasons for the proposed action, explain that the practitioner has a right to request a hearing, and provide an explanation of the time limits set forth below. The notice also shall contain a summary of the practitioner's hearing rights under this Fair Hearing Plan.

Any practitioner who has received notice of the practitioner's right to a hearing or Board appeal may request such hearing or appeal to the Board by giving written notice addressed to the President/CEO. Such request shall be made within 15 business days of the sending of the notice of such right; if not so made, the right to such hearing shall be deemed to have been permanently waived. Hearings should be scheduled as soon as possible subsequent to the receipt of the request by the practitioner, but in no event less than 30 days from the date of receipt of the practitioner's request. However, the practitioner shall be given at least ten (10) business days written notice of the date, time and place of said hearing or appeal to the Board. When the first notice is given, the practitioner shall be provided with a copy of these Bylaws.

Section 5. APPOINTMENT OF HEARING COMMITTEE

Hearings shall be conducted by a Hearing Committee composed of at least three (3) members of the Medical Staff: (a) appointed by the CEO and the President of the Medical Staff, (b) none of whom are in direct economic competition with, professionally associated with, related to, or have any significant referral relationship with the practitioner, and (c) shall not have participated in the formal investigation that led to the action, provided that knowledge of the matter involved shall not preclude any individual from serving as a Member of the Committee;. Whenever possible, at least one Member shall be of the same service as the practitioner. One of the members so appointed shall be designated by the President and CEO as the Chair. The President/CEO, Chief Medical Officer, and a member of the Board of Directors shall have a right to attend the Hearing, but not to participate or be part of the deliberations of the Committee.

In lieu of a Hearing Committee Chair, the CEO, in consultation with the President of the Medical Staff, may appoint a Presiding Officer, who may be an attorney. The Presiding Officer shall not act as an advocate for either side. The Presiding Officer may participate in the private deliberations of the Committee but shall not be entitled to vote.

Any objection to the appointment of any Member of the Hearing Committee for cause, or to the appointment of the Presiding Officer, shall be made in writing to the CEO and the President of the Medical Staff within 10 business days of notice of the composition of the Committee, with a full written explanation of the basis for the objection. The CEO and the President shall have the discretion to accept or reject the objection. If the objection is accepted, an alternate shall be appointed in the same manner as the appointment of the rejected individual.

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Section 6. NOTICE OF HEARING AND STATEMENT OF REASONS

The CEO shall schedule the hearing and provide, by special notice, the following:

- The time, place, and date of the hearing;
- The names of the Hearing Committee Members and Chair (or and Presiding Officer) if known.

A statement of the reasons for the recommendation, including a list of patient records (If applicable), and information supporting the recommendation.

The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing.

Section 7. WITNESS LIST

The practitioner and the body making the adverse recommendation are referred to in this Article from time to time as the “parties.”

At least 10 business days before the pre-hearing conference, both parties shall provide a written list of the names of proposed witnesses to the other party and to the Chair or Presiding Officer. The witness list shall include a brief summary of the anticipated testimony of the witnesses.

The witness list of either party may, in the discretion of the Chair or 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, and that there is a complete written explanation as to why the name did not previously appear on the witness list.

Section 8. RIGHT TO RELEVANT EVIDENCE

- a. The practitioner requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained by the practitioner and the practitioner’s representatives as confidential and not be disclosed for any purpose outside of the hearing:
 1. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons for the hearing, at the practitioner’s expense;
 2. written reports of experts relied upon by the Medical Staff;
 3. redacted copies of relevant minutes; and
 4. copies of any other written documents relied upon by the Medical Staff.

The providing of this information is not intended to waive any privilege under the CT Peer Review Act or the Connecticut statute protecting the proceedings of studies of morbidity and mortality.

- b. No information shall be provided regarding the practices of other individual practitioners.
- c. Prior to the pre-hearing conference, on dates set by the Chair/Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. Objections must be based on consideration of lack of relevancy. The Chair or Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause for not previously making the objection.

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- d. Evidence unrelated to the reasons for the recommendation or to the practitioner's qualifications for appointment or the relevant clinical privileges (such as evidence relating to the practices of other individual practitioners) shall be excluded.
- e. Neither the practitioner, nor the practitioner's attorney, nor any other person acting on behalf of the practitioner shall contact Hospital employees appearing on the Medical Staff or Board's witness list concerning the subject matter of the hearing, unless specifically agreed upon by the parties' respective legal counsel.

Section 9. PRE-HEARING CONFERENCE; SIDE BAR CONFERENCES

The Chair or Presiding Officer shall require representatives of the parties (who may be legal counsel) to participate in a pre-hearing conference. At the pre-hearing conference, the Chair or Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

If a procedural question could have been presented at the pre-hearing conference, the Chair or Presiding Officer may refuse to subsequently consider the matter.

Each party may prepare a pre-hearing statement, which shall be provided to the other party and to the Committee and Chair or Presiding Officer prior to the hearing.

At the discretion of the Hearing Committee, the Chair or Presiding Officer may entertain argument by legal counsel on procedural matters outside the presence of the Hearing Committee.

The Chair or Presiding Officer, the Medical Staff, and the Board, may be advised by legal counsel to the Hospital throughout the proceeding.

Section 10. RECORD OF HEARING

An accurate record of the hearing shall be kept. The Hearing Committee may select the method to be used, such as court reporter, electronic recording unit, or detailed minutes of the proceedings. A practitioner may, no later than 10 days prior to the pre-hearing conference, elect an alternate method from among the foregoing methods and a practitioner electing such alternate method shall bear the cost. Nothing herein shall preclude a hearing record by more than one method at the discretion of the Hearing Committee.

Section 11. HEARING PROCEDURE

The Hearing Committee, in its discretion, may postpone or adjourn a hearing. The Medical Executive Committee or the Board of Directors, whichever made the decision being heard, shall designate a representative or representatives (who may include consultants or attorneys) to present information in support of the adverse decision.

Failure by a practitioner, without good cause shown to the Hearing Committee, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

At the hearing, each party shall have the right:

- 1. to call and examine witnesses,
- 2. to introduce exhibits;

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3. to cross-examine any witness;
4. to have representation by legal counsel who may call, examine, and cross-examine witnesses and present the case; and
5. to submit a written statement at the close of the hearing

The Hearing Committee may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

Section 12. PERSONS TO BE PRESENT; NO "GUESTS"

The hearing shall be restricted to those individuals directly involved in the proceeding. "Guests," including the media, family members, and Medical Staff Members who are not formally representing the practitioner, are not permitted to attend hearing or appeal sessions.

Section 13. QUORUM AND VOTING

Attendance by all Members of the Hearing Committee shall be mandatory and constitute a quorum. Recommendations to the MEC/Board shall be by a majority of the Committee.

Section 14. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

Order of Presentation:

The Executive Committee/Board shall first present evidence in support of its recommendation. Thereafter, the practitioner who requested the hearing will present their response.

Basis of Hearing Committee's Recommendation:

The Hearing Committee shall uphold the adverse recommendation if it finds by a preponderance of the evidence that:

- The action was taken in the reasonable belief that it was in the furtherance of quality health care;
- It was taken after a reasonable effort to obtain the facts of the matter;
- Adequate notice was provided to the practitioner and the procedures were fair; and
- the action was taken in the reasonable belief that the action was warranted by the facts known

In arriving at this determination, the Hearing Committee shall consider the evidence presented to it, provided that members of the Committee may take into account and refer to their own professional expertise, experience, and knowledge.

Deliberations and Recommendation of the Hearing Committee:

Within 20 business days after final adjournment of the hearing (which may be designated as the time the Hearing Committee receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Committee shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Committee shall render a recommendation, accompanied by a written report, which shall contain a concise statement of the basis for its recommendation.

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Section 15. NOTICE OF THE REPORT OF THE HEARING COMMITTEE AND EFFECT OF RESULT

The President/CEO shall within 7 days send a copy of the report of the Hearing Committee, to: (a) the practitioner, (b) the President of the Medical Staff, and (c) the Chief Medical Officer.

The President/CEO shall within 7 days sent a copy of the final decision of the MEC to the practitioner, the President of the Medical Staff, the Chief Medical Officer and the Board of Directors.

Section 16. ACTION ON THE REPORT OF THE HEARING COMMITTEE

Within 15 business days after receipt of the report of the Hearing Committee, or, at its discretion, at its next regularly scheduled meeting, the Medical Executive Committee shall consider the same and confirm, modify or reverse its recommendation in the matter. It shall then promptly transmit its decision together with the hearing record and the report of the Hearing Committee and all other documentation considered, to the President/CEO for prompt consideration by the Board of Directors.

16.1 Effect of Favorable Result

- a. Adopted by the Board: If the Board's decision is favorable to the practitioner, such result shall become the final decision of the Board, and the matter shall be considered finally closed.
- b. The final action of the Medical Executive Committee shall promptly be forwarded to the Board by the CEO together with all supporting documentation, for final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's decision in whole or in part, or by referring the matter back to the Medical Executive Committee for it to consider the same again. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President/CEO shall promptly give the practitioner written notice informing the practitioner of each action taken pursuant to this Section. Favorable action by the Board shall become the final decision of the Board, and the matter shall be considered finally closed.

Section 17. EFFECT OF ADVERSE RESULT

If the decision of the Board continues to be adverse to the practitioner in any of the respects listed in Section 2 of this Article, the President/CEO shall give written notice to the practitioner of the practitioner's right to request an appeal to the Board by requesting it in writing within 10 business days of receipt of said notice.

Section 18. APPEAL TO THE BOARD OF DIRECTORS

Within 40 days of its receipt of a request by written notice for appeal to the Board, the Board shall convene to reconsider the matter. The practitioner may appear on the practitioner's own behalf and/or be represented by the practitioner's Medical Staff or Medical Society representative or the practitioner's attorney, who shall be entitled to present written and/or oral arguments. This appearance shall be analogous to an appellate court hearing and no new evidence may be presented. In its sole discretion, the Board may specify the amount of time for oral argument by the practitioner and by the spokesman for the adverse decision. The Board of Directors shall render a final decision no later than its next regularly scheduled meeting. Written notice of such decision shall be given by the President/CEO to the practitioner within seven business days of such decision. Notice of the same shall also be given to the President of the

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Medical Staff. Such decision by the Board following the appeal to the Board shall be deemed final for purposes of these Bylaws.

Grounds for an appeal to the Board are limited to the following:

- The assertion that there was a substantial failure to comply with the Bylaws during the hearing, so as to deny a fair hearing; and/or
- The assertion that the recommendation of the Hearing Committee was made arbitrarily or capriciously or was not supported by evidence.

Section 19. WRITTEN NOTICE

Written notice in all instances under this Article shall be given by mailing the same by certified mail, return receipt requested, or by using a recognized courier service, such as Federal Express; provided, however, that the requirement of written notice also may be satisfied by actual notice acknowledged in writing by the intended recipient or witnessed by a Member of the Medical Staff or a Hospital employee or agent.

Section 20. RIGHT TO ONE HEARING AND ONE APPEAL ONLY; NO FURTHER ACTION

No practitioner shall be entitled to more than one hearing and one appellate review on any matter.

If a hearing or appeal is pending at the time of re-appointment, the re-appointment shall be conditional and subject to the outcome of the hearing or appeal. The fact of such limited re-appointment shall not entitle the practitioner to more than one hearing or appellate review, or a new hearing and appellate review in regard to all matters being decided by the Board in its final decision.

The Final Action of the Board of Directors may not be the subject of any further administrative in-house proceeding.

ARTICLE XIX: AMENDMENTS

Section 1. PROPOSING AMENDMENTS

Proposed amendments to the Medical Staff Bylaws and Rules & Regulations are referred to the Medical Executive Committee or Bylaws Committee of the Medical Executive Committee.

If 10% of the voting members of the Medical Staff sign a petition to do so, they may propose amendments to the Bylaws or Rules & Regulations by submitting their proposals in writing to the Bylaws Committee of the Medical Executive Committee. A representative(s) from the petitioning group will be invited to participate in the Bylaws Committee.

Section 2. MEDICAL EXECUTIVE COMMITTEE ACTION

All proposed amendments, regardless of source, shall ultimately be presented to the Medical Executive Committee. Proposals for Bylaws and Rules and Regulations changes or amendments shall be distributed to members of the Medical Executive Committee at least seven (7) days in advance of the meeting at which they will be considered.

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A simple majority of those present and voting at the Medical Executive Committee may recommend approval, disapproval, approve recommendations with modifications or refer proposed amendments in whole or in part to the Bylaws Committee for initial review or re-evaluation.

Section 3. VOTING BY THE MEDICAL STAFF

All amendments approved by the Medical Executive Committee shall be submitted to the voting members of the Medical Staff. Voting members shall be allowed a minimum of fourteen (14) calendar days to consider the proposed amendments. Notifications shall be sent electronically. The notification shall include a date, time and location of a Medical Staff Meeting at which the amendments will be discussed.

In the event that 10% or more of voting members signify disagreement with any of the proposed amendments, either via expression at the Medical Staff Meeting or in discussion with an elected medical staff officer, these concerns will be transmitted to the Bylaws Committee of the Medical Executive Committee for review and consideration. One or more representative from the dissenting group will be invited to participate in the Bylaws Committee.

If fewer than 10% of voting members voice objection, the amendments shall be recommended for approval and forwarded for action to the Governance Committee of the Board.

Section 4. GOVERNANCE COMMITTEE OF THE BOARD OF TRUSTEES

Amendments approved by the Medical Executive Committee and the voting members of the Medical Staff shall be forwarded to the Governance Committee of the Board.

If the Governance Committee of the Board recommends the amendments, they shall be forwarded to the Board for final approval.

In the event that the Governance Committee of the Board or the Board modifies or disapproves any amendments proposed by the Medical Executive Committee and the voting members of the Medical Staff, such modifications shall be returned to the Medical Executive Committee which may accept or reject the modifications.

If the Medical Executive Committee accepts the modifications, they shall be submitted once again to the voting members of the Medical Staff as outlined in Section 3. above.

If the Medical Executive Committee rejects the modifications, the amendment and arguments against the modifications shall be resubmitted to the Governance Committee of the Board or the Board.

If that group approves the amendment, the approval process will proceed.

If the group is the Governance Committee of the Board, the disagreement between it and the Medical Executive Committee shall be referred to the Board. The matter will be referred to the Governance Committee of the Board if the Board was the body that recommended the modifications that were not approved by the Medical Executive Committee.

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Section 5. APPROVAL REQUIREMENTS

The Bylaws, which include the accompanying Rules and Regulations and, to the extent required by regulatory requirements, medical staff policies, may be changed or amended as described in Sections 1 through 4 above.

In addition, the Governance Committee of the Board or the Board itself may initiate such changes.

Section 6. EFFECTIVE DATE

Amendments shall be considered effective as of the date approved by the Board.

Section 7. NON-SUBSTANTIVE EDITS

Notwithstanding any of the above, the Medical Executive Committee is authorized to make non-substantive changes to the Bylaws, Rules & Regulations and medical staff policies relating to the organization of these documents including renumbering, grammar, spelling, typographical errors and similar technical revisions without approval of the voting members of the Medical Staff.

ARTICLE XX: CONFLICT RESOLUTION

The Medical Staff and the Board of Directors will make best efforts to address and resolve all conflicts in the best interests of patients, L&M Hospital and the Medical Staff.

When the MEC, the Medical Staff, or the Board of Directors acts, or considers acting in a manner contrary to a recommendation made by the MEC, the Medical Staff, or the Board, the Medical Staff officers shall meet as soon as possible with the Board, or a designated committee of the Board and Administration, to seek to resolve the conflict through informal discussions.

If these formal discussions fail to resolve the conflict, the Medical Staff President, a majority of the voting members of the Medical Staff, the President of the Hospital, or the Chair of the Board may request initiation of a formal conflict resolution process.

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

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

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

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ARTICLE XXI: SUCCESSOR IN 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 of its assets to another corporation, or in the event that it contemplates coming under the control of another entity or corporation, then (1) the Medical Staff leadership will be notified of any situation where such a transaction is likely; (2) there will be full consultation with the Medical Staff before any contemplated transaction is finalized, and (3) at least one Member of the Board of Directors of the Hospital, who also is a Medical Staff Member, will be involved in the committee or group that finalizes the transaction.”

In the event that the Hospital merges with, or is consolidated into, any other corporation(s), or in the event that it sells or transfers substantially all of its assets to another corporation, or in the event that it comes under the control of another entity or corporation, the terms of these Bylaws shall inure to the benefit of the Members of the Medical Staff at the time of such event, and these Bylaws shall be assumed insofar as possible by the corporation or entity (1) resulting from such merger or consolidation, or (2) to which the Hospital’s assets are sold or transferred, or (3) which assumes control of the business of the Hospital.

ARTICLE XXII: BYLAWS ADOPTION

These Bylaws, together with the appended Rules & Regulations, shall replace any previous Bylaws, Rules & Regulations and shall become effective once approved by the Board consistent with the process described in Article XIX.

ADOPTED by the Active Medical Staff on May 28, 1978.

original on file
William J. Murray, M.D.
President of the Staff

original on file
Daniel E. Moalli, M.D.
Secretary of the Staff

APPROVED by the Board on June 26, 1978

original on file
William M. Miner
Secretary of the Board

Bylaws of the Medical Staff of Lawrence + Memorial Hospital

Rules and Regulations of the Medical Staff of Lawrence + Memorial Hospital

APPENDIX B

RULES & REGULATIONS

1. INTRODUCTION

It shall be implicit in the acceptance of Staff appointment that all hospital policies, rules and regulations shall be followed, whether or not printed herein. All members are expected to have a copy of these Bylaws, Rules and Regulations and to keep it up to date, and it shall be the member's responsibility to be familiar with them. The President/CEO shall advise all members of all changes.

2. ADMISSION DIAGNOSIS AND INFORMATION

An admission diagnosis must be provided, if possible, by the referring physician. In case of emergency, a provisional diagnosis shall be stated as soon as possible after admission.

3.a. ADMISSION EXAMINATION; HISTORY AND PHYSICAL

General Rule

A medical history and physical examination be completed no more than 30 days before or 24 hours after admission for each patient, excluding outpatient procedures not requiring monitored anesthesia care. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition shall be completed. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission and prior to any surgical procedure requiring monitored anesthesia care or general anesthesia.

Inpatient Surgery

An H& P for a surgical patient meets the above requirements that an H & P be "performed no more than 30 days prior to admission or within 24 hours after admission," if the following four conditions are met:

- a. The H & P was performed within 30 days prior to the hospital admission; AND
- b. an appropriate assessment is performed, which must include a physical assessment of the patient to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed, was completed within 24 hours after admission, but prior to surgery, confirming that the necessity for the procedure or care is still present and the H& P is still current. The physician uses clinical judgment based on the physician's assessment of the patient's condition, and any co-morbidities, in relation to the reason the patient was admitted or to the surgery to be performed, when deciding what depth of assessment needs to be performed and what information needs to be included in the update note; AND
- c. The physician or other individual qualified to perform the H & P writes an update note addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status within 24 hours

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after admission, but prior to surgery. The update note must be on or attached to the H & P, AND

- d. The H & P, including all updates and assessments, must be included within 24 hours after admission, but prior to surgery (except in emergency situations), in the patient's medical record for this admission.

Outpatient Surgery

(Excludes outpatient procedures not requiring monitored anesthesia care)

An H & P meets the requirements if the following four conditions are met:

- a. The H & P was performed within 30 days prior to the outpatient surgery; AND
- b. An appropriate assessment performed by the MD/DO, which should include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed, was completed prior to outpatient surgery confirming that the necessity for the procedure is still present and that the H & P is still current. The physician uses clinical judgment based on the physician's assessment of the patient's condition, and any co-morbidities, in relation to the surgery to be performed, when deciding what depth of assessment needs to be performed and what information needs to be included in the update note; AND
- c. The physician or other individual qualified to perform the H & P writes an update note addressing the patient's current status and/or changes in the patient's status, regardless of whether there were any changes in the patient's status, after admission and prior to the outpatient surgery. The update note must be on or attached to the H & P; AND
- d. The H & P, including all updates and assessment, must be included in the patient's medical record, except in emergency situations, prior to surgery.
 - The history, at minimum, shall include: present illness; medications and allergies; relevant past, social and family histories; review of systems.
 - The physical exam, at minimum, shall include heart, lung, abdomen, and affected part. The impression and treatment plan shall be documented.

3.b. ASSESSMENT OF PATIENTS FOR OPERATIVE AND OTHER INVASIVE PROCEDURES

- A history and physical exam which identifies important risk factors;
- Documentation on the appropriateness of the procedure;
- All patients receiving anesthesia (general, regional or local with standby) will have the following:
 - a. Laboratory:
 - 1. Hgb/Hct (with autologous donation and/or anticipated blood loss).
 - 2. Serum potassium – for patients on diuretic therapy.
 - 3. FBS or Accu-Check – for known diabetic patients.
 - b. EKG within six months on patients 50 years of age or older, and all patients with a history of heart disease.
- Preoperative chest x-ray will be done on a case-by-case basis.

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- Other requirements may be documented in the policies of the specific treatment areas.

3.c. ASSESSMENT OF PATIENTS FOR OUTPATIENT INVASIVE PROCEDURES

All outpatient *invasive procedures require a history and physical as outlined above.

****Endoscopy, interventional cardiology/radiology, and other surgical cases requiring monitored anesthesia care.***

3.d OUTPATIENT PROCEDURES NOT REQUIRING MONITORED ANESTHESIA CARE

Visit expected to involve only administration of medication/infusions excluding general anesthetic and conscious sedation (e.g., local anesthetic) or a change in medication prescription (e.g., post-operative pain medication),

These medications/infusions may include, but are not limited to, the following: blood transfusion, chemotherapy, apheresis, remicade, biphosphanates and other therapeutic infusions. A medication and allergy list must be documented but a H&P is not required.

4. ANESTHESIOLOGIST

In handling of patients, the physician anesthesiologist is charged with the responsibility of anesthesia and his judgment in this regard shall prevail if a difference of opinion arises between him and the operating surgeon. The anesthesiologist shall obtain informed consent of the patient for the anesthesia.

5. ATTENDING PHYSICIAN

- a. All patients shall be attended by their own private physicians or Hospitalists. A patient who is to be admitted and who has no preference for an attending physician shall be assigned to the member of the Attending Staff on duty in the service to which the patient's condition indicates assignment.
- b. Every member of the medical staff agrees to provide continuum of care to his patients.

6. CARE OF FAMILY MEMBERS

Members of the Medical Staff may not serve as the Attending Practitioner for any member of their own family. Similarly, Medical Staff and Affiliated Medical Staff members may not schedule or perform operations or procedures on members of their own families in the operating rooms, procedure rooms or laboratories except in extreme emergencies when no other qualified member of the Medical Staff is available or with explicit approval by the Department Chair or Chief Medical Officer.

7. MEDICAL STAFF CONSULTATION

Clinical consultation is indicated when:

- The diagnosis remains in doubt after the results of initial diagnostic evaluation has been completed.
- The care of the patient requires a provider with clinical privileges not possessed by the attending physician.

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- The outcome of treatment is not what was expected, or the patient develops unexpected complications and management requires expertise or privileges not possessed by the attending physician.
- The patient or the patient's authorized representative has requested it.

Procedure for Requesting Clinical Consultation:

- The physician will specify by name the consultant with whom he/she wishes to consult unless it is clear that a specific group is responsible for performing the consultation and that the group will determine the consultant available and responsible. If the requested consultant is not available, the physician covering the consultant's practice shall be responsible unless otherwise specified by the referring physician.
- The request for consultation shall be written as an order. The order should, at a minimum, include the reason for the consultation as well as the requested level of involvement (e.g. consult only, consult and follow, consult and manage), as noted in "Patient Management" below.
- The referring provider shall contact the consultant to discuss the case and the reason for consultation. It is the expectation that the consultant will be readily available for such contact or will make arrangements to respond as soon as possible. During the hours of 8AM to 5PM, it is expected that the provider-to-provider communication occur via telephone or other real-time method. During the other hours, unless an emergency consultation is needed, communication may occur via available less direct electronic means including, but not limited to, text messaging, voice mail, preferred e-mail, or an intranet messaging site. Receipt of such communication needs to be confirmed by the recipient by 9AM on the following day. If communication is not acknowledged, it is the responsibility of the requesting physician to follow up with a second request.

Timing of Consultations:

- Clinical consultations, unless otherwise specified, must be performed within 24 hours of the request.
- Emergency inpatient consultations should be seen in a timely fashion consistent with the patient's clinical condition and the urgency of the situation. It is the referring physician's responsibility to communicate directly with the consultant in the case of all emergency consultations and in any instance in which the referring physician is requesting the consultant to see the patient in less than the 24hr guideline in (a) above.
- The response of consultants who are on-call for the Emergency Department who are called to the Emergency Department for Emergency Department patients shall meet the requirements of the Medical Staff Policy: "Medical Staff On-Call Policy".

Report of Consultation:

- A preliminary report of findings should be noted in a brief consultation note on the patient's chart. A complete consultation shall be dictated or handwritten. Handwritten notes must be legible. If a complete note is handwritten immediately upon completion of the consultation, no additional dictated note is required.

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- The consultant shall contact the referring physician to communicate any information necessary for the immediate management of the patient, particularly when immediate changes in management are recommended.

Patient Management:

- The referring physician shall be responsible in communicating to the consultant to what extent the consultant's involvement should be limited in regard to the direct, daily management of the patient including the writing of orders for treatment or diagnostic studies, and the need for the consultant to follow up on the patient and the frequency of such follow up. In the absence of such specified limitations, the consultant may use his/her discretion in this regard. In all cases, a consultant is permitted and expected to write orders and initiate management that is required in any emergent situation in which timely communication with the primary attending is not possible.

6. AUTOPSIES

Every member shall attempt to obtain permission for autopsies. All autopsies shall be performed upon written or telephone contact of the person legally entitled to give such consent and according to the statutes of the State of Connecticut.

Autopsy Guidelines, Inpatients

Under the following circumstances an autopsy should be requested and evidence that the request was made should be documented in the progress notes of the medical record:

1. All unexpected or unexplained deaths.
2. Deaths when the cause is sufficiently obscured as to delay completion of the death certificate.
3. Deaths in which the patients sustained or apparently suffered an injury while hospitalized.
4. Fetal deaths over 20 week's gestation.
5. Deaths known or suspected to have resulted from environmental or occupational hazards.
6. Deaths of patients who have participated in clinical trials (protocols) approved by the institutional review board.
7. Medical-legal Cases: Indications for Medical Examiner input include, but are not limited to:
 - Toxic
 - Sudden or unexpected death
 - Death due to disease which might constitute a threat to the public health
 - Death at or related to the workplace
 - Death occurring under suspicious circumstances (e.g., child abuse)
8. Cases of educational interest.

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7. BLOOD

Physicians must obtain and document informed consent prior to elective transfusion of blood components in order to ensure that the patient or authorized representative understands the risks, benefits, and alternatives. Documentation shall be performed by completion of a blood consent form.

8. COMMITTEE SERVICE

All members of the Staff are obliged to serve as members of the various committees of the Staff when appointed or elected.

9. COVERAGE

All physicians must provide coverage of their medical practice at all times.

10. DEPARTMENTAL RULES AND REGULATIONS

Each department shall have the authority to develop its own rules and regulations, and policies consistent with the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies. In cases of conflict, the Medical Staff Bylaws, Rules and Regulations, and the Medical Staff Policies will prevail.

11. DISMISSAL OF PATIENTS

Doctors are requested to give advance notice of pending dismissal. Except in extenuating circumstances the patient shall be discharged only on order of the responsible physician.

12. CONTINUING MEDICAL EDUCATION

Practitioners who are credentialed by the Medical Staff and who are permitted to practice in the Hospital must participate in a continuing program of medical education. A requirement for reappointment shall be the documentation by a signed attestation statement of at least 50 CME credit (AMA Category I) hours per biannual reappointment cycle.

13. MALPRACTICE INSURANCE

A Member must maintain professional liability insurance in the form and amount specified from time to time by the Board. If a policy lapses the Member is automatically suspended. If the Member changes carriers, the new policy must provide retroactive coverage for a period of at least three years or three months or for the period that the Member has been a Member of the Medical Staff, whichever period is longer. If such retroactive coverage is not obtained, the Member must purchase tail coverage from the prior carrier that provides coverage for the period of time specified in this section. Failure to obtain retroactive or tail coverage shall result in automatic suspension of Medical Staff privileges.

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14. MEDICAL RECORDS

- a. All medical records are the property of the Hospital and shall not be removed from the hospital except in accordance with established Hospital policies and procedures and federal and state statutes.
- b. Upon admission, an admission note and orders of the attending or admitting physician shall be added to the medical record. The medical record of every patient shall contain a complete history and physical examination.
- c. All previous medical records shall be available for use of the attending staff member or consultant for each readmitted patient and will be provided upon physician request.
- d.
 1. The attending physician shall be responsible for the preparation of a complete inpatient (IP), observation (OBV), one day surgery (SDS), emergency department (ED), and outpatient (OP) medical record. For purposes of these Rules and Regulations, a completed medical record shall contain those items outlined in the most recent edition of The Joint Commission Accreditation Standards for Hospitals, and updated from time-to-time to comply with local, state and other regulatory agency requirements.
 2. A dictated Discharge Summary is required for all patient stays that include an inpatient or observation admission to the hospital. Such Discharge Summary must include the following required elements of a discharge summary:
 - The reason for hospitalization
 - The procedures performed
 - The care, treatment and services provided
 - The patient's condition and disposition at discharge
 - Information/Instructions provided to the patient and family
 - Any provisions for follow-up care
 - Final diagnosis

The following circumstances and conditions shall be the only exceptions for the requirement of a dictated discharge summary:

- a. For inpatient or observation stays of less than 48 hours, except in the case of Death or Transfer, the final progress note may serve as the discharge summary only if it contains the following required elements: the outcome of the hospitalization, the case disposition, provisions for follow up care, and the final diagnosis. Alternatively, a standardized form approved by the Hospital and the appropriate clinical department(s) may also be used for these admissions that are less than 48 hours if the required elements are documented on the form. (Note that for any and all admissions under 48 hours that involve death or transfer, a dictated discharge summary is required).
 - b. A cardiac catheterization report is acceptable as a summary if it contains the required elements for a summary as listed above.
3. All medical records will be completed within twenty-one (21) days of patient discharge.
 4. Chart entries must be legible to the average reader.

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5. Anyone who provides care or assists in providing care may make entries in the medical record as long as they date and authenticate clearly their entry and record their credential accordingly (i.e. MSW, RD, etc.).
- e. Any member who has records that are delinquent may be subject to an administrative intervention as defined in the Medical Staff Policies, up to and including suspension of privileges. Any member of the Medical Staff who remains continuously suspended for a period of three months for failure to complete his or her medical records will have their medical staff appointment terminated. Records are considered delinquent if not completed within the time frames as follows:
 1. A clinical resume must be dictated within seven (7) days of the chart being made available to the physician unless awaiting reports or studies. In this instance, a partial clinical resume must be completed within seven (7) days indicating that an addendum will follow when the designated reports/studies are received.
 2. All other items as outlined by The Joint Commission as required to designate a record complete including authentication of those physician designated documents within twenty-one (21) days of patient discharge.
- f. Except as noted in g.3), no medical record shall be filed until it is completed.
- g. The following circumstances shall defer the administrative action:
 1. The medical record is required for patient care/studies, or
 2. Illness, vacation, or a prolonged absence of the physician (LOA) in which case the records are to be completed within forty-eight hours of return, or
 3. Staff members become unavailable to complete the record in which case the Medical Record Committee may authorize the medical record department to file the record as incomplete.
- h. Initial notification of medical record delinquency will be given by the Director, Health Information Management; or her designee, to the affected physician, the Chair of the physician's department, and to the Chair of the Medical Records Committee. The Credentials Committee will receive a report for each physician at the time of reappointment.
- i. Copies of medical records may be obtained upon proper authorization signed by the patient or his representative or in accordance with established hospital policies on release of information.
- j. The obligation to complete Medical Records survives any expiration or termination of the Physician's appointment to the Medical Staff. Failure to complete records will result in a statement to that effect being placed in the practitioner's permanent professional record; and, at the discretion of the Chairman of the member's department, this negative information may be transmitted in subsequent letters of recommendation or requests for information.

15. OPERATIONS

- a. No operation shall be undertaken until all pertinent rules have been complied with, and all preoperative consultation requests have been honored in writing and the reports have been made a part of the patient's chart.
- b. If history and physical examination has been dictated but not transcribed, chart must show that dictation has been done, e.g. "History & Physical dictation (date)". In addition, the chart must contain sufficient History and Physical Examination data (on Progress Notes) to:

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1. Show the necessity for operation.
2. Clearly indicate the procedure contemplated.
3. Provide all information that can be of significance in the administration of anesthesia,
- c. The anesthesiologist will be responsible for checking the chart.
- d. A preoperative diagnosis must be recorded before operation.
- e. Informed Consent

1. Except in the event of a documented emergency, no operation or invasive procedure, during which the patient receives analgesia/sedation and there is potential loss of airway protective reflexes, shall be undertaken on any patient without the informed consent of the patient, if the patient is in a mental and physical condition capable of giving or refusing consent. Otherwise informed consent shall be secured, if possible, from a personal representative of the patient or a court-appointed conservator.

The physician responsible for the patient's care is responsible for obtaining informed consent. The physician shall discuss the contemplated procedure with the patient. Such discussion must include an explanation of any alternative procedures or treatments that might be available, and the reasonably foreseeable risks and benefits of the procedure or treatment or the risks of not having the procedure performed. The discussion should be in terms that the patient understands, but must be sufficiently informative and detailed so as to enable the patient to make an informed decision. The physician's conversation with the patient should occur before any sedation, pre-anesthesia, anesthesia, or other agents are administered to the patient.

Except in the event of a documented emergency when it is impossible to obtain consent and the life or health of the patient is in jeopardy, the physician responsible for the patient's care should obtain the patient's signature on the appropriate informed consent form following the physician's discussion of the contemplated procedure with the patient. In those instances when it is not possible to do so, the physician's office nurse or a nurse on the Hospital staff may obtain the patient's signature if requested to do so by the physician, provided, however, that the physician has previously spoken to the patient and obtained the patient's informed consent.

The procedure to be performed should be specified in the space provided on the form. If the patient has any questions regarding the specified procedure, the individual obtaining the patient's signature should arrange for the patient to discuss the procedure with the responsible physician before the consent form is signed.

2. In an emergency, if consent cannot be obtained and there is time, two physicians shall sign the chart, attesting the necessity of operation; one of these must be a member of the department of the Attending Staff relevant to the patient's illness.
3. Written consent for **MINORS** shall be given by their parents or legal guardians.
4. In addition to specific informed consent, patients have the right to be informed about the plan of care and anticipated outcomes of care. Further, they should be informed about outcomes of care, including unanticipated outcomes. Following Hospital policy, physicians are expected to inform their patients and, when appropriate their families about clinically significant deviations from expected outcomes.
5. Surgical consent and surgical consent forms shall comply with Medical Staff policy.

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- f. The physician in charge of the patient is responsible for seeing that all appropriate tissue and any other material removed at operation is delivered to the hospital pathologist who shall examine and report on same.
- g. Surgeons are expected to be prompt in starting operations.
- h. A brief operative report must be entered electronically into the medical record immediately following surgery. The brief note must contain the following elements:
 - The name(s) of the surgeon/assistant(s);
 - The pre-operative diagnosis;
 - The name of the procedure performed;
 - Findings of the procedure;
 - Estimated blood loss;
 - Any specimen(s) removed;
 - The postoperative diagnosis

In addition, a full operative report shall be documented within one (1) day of surgery and include the same elements with the detail of the surgical technique employed during the procedure. In the event that the full operative report is documented immediately following surgery and prior to the patient's transition to the next level of care (without a transcription delay), a brief operative note is not required.

Practitioners who fail to complete documentation requirements for surgical procedures within ten (10) days of the procedure shall be automatically suspended from scheduling additional elective procedures until the required documentation is complete.

- i. A post-operative anesthesia evaluation must be performed and documented on inpatients within 48 hours after a procedure requiring anesthesia services.

16. ORDERS

- a. All orders shall be legible, dated, timed and authenticated.
- b. Admitting physicians and associates, consulting physicians, or covering physicians may write orders, as may Radiologists and Anesthesiologists while the patient is under their direct care. The physician of record may change throughout the patient's stay and said physician may write orders as well.
- c. Verbal and telephone orders may be accepted and executed by the following within their scope of practice as defined by their State of CT licensure:
 - Registered nursing staff
 - Licensed practical nurses
 - Registered pharmacists
 - Respiratory care practitioners
 - Registered physical therapists
 - Registered occupational therapists
 - Licensed speech-language pathologists

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- Licensed audiologists
- Radiologic technologists
- Registered Sonographers
- Registered Nuclear Medicine Technologists
- Registered Dieticians

Verbal orders shall be authenticated as required by State and Federal law and regulations. These regulations shall be summarized and appended to these Rules and Regulations and updated as necessitated by changes made to these regulations.

A patient's attending physician may, at their discretion, authenticate (sign) verbal orders given by one of the physicians in the attending physician's coverage group or a consultant under the following conditions:

- The patient and the patient's condition are well known to the attending physician.
 - The physician giving the verbal order was the on-call physician for the attending physician or a consultant requested by the attending physician and acting in that capacity.
 - The attending physician agrees with the verbal order and, in the case of a consultant's verbal order, the attending physician has discussed the case with the consultant.
- d. No controlled substances shall be dispensed or administered except upon written order signed or initialed by the prescribing practitioner or upon an oral order of a prescribing practitioner which shall be confirmed by a written order which shall be signed or initialed by such prescribing practitioner within twenty-four hours after the giving of such oral order for schedule II controlled substances and within seventy-two hours after the giving of such oral order for other controlled substances.

Original and continuing orders for schedule II controlled substances shall be limited to a period not exceeding seven days from the time the order is entered, but may be extended for additional periods of seven days each by the signing or initialing of the order by a prescribing practitioner.

Original and continuing orders for schedule III, IV or V controlled substances shall be limited in duration as designated in the written order of the prescribing practitioner, but in no case shall such order be effective for more than thirty days.

An original or continuing medication order for a controlled substance may include a range of doses that may be administered by a licensed physician assistant, a licensed nurse or a licensed advanced practice registered nurse. The Hospital shall establish a written protocol that identifies the specific drugs that may be prescribed in ranges and that lists critical assessment parameters and guidelines to be considered in implementing such orders.

A physician may not order a drug that is not FDA-approved. Any contemplated exception to this rule must be requested in writing and reviewed and approved by the Department Chair, the CMO, and Hospital legal counsel.

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- e. A telephone DNR (Do Not Resuscitate) order may be written in situations when the attending physician or designee is not immediately available, pursuant to the DNR policy.
- f. The anesthesiologist will write preoperative orders, except in emergency. In any individual case, the surgeon may write his own orders after consultation with the anesthesiologist. In an emergency, the surgeon may write his own orders.

17. RADIOLOGISTS - RADIOLOGICAL SERVICE

- a. In handling of patients, the physician radiologists are charged with the responsibility of all phases of radiological service, essentially in the capacity of consultants, and their judgment shall prevail if a difference of opinion arises between them and the attending physician, particularly with the regard to whether or not a patient should be subjected to the requested examination or procedure.
- b. All requisitions for the radiological examinations must contain a reason for the requisition in compliance with standards of the Joint Commission on Accreditation of Hospitals.
- c. It is the responsibility of the radiologist to obtain informed consent to radiological tests or procedures requiring consent.

18. POST ANESTHESIA CARE UNIT (PACU)

By the nature of the situation, it is necessary that the surgeon and the anesthesiologist be jointly responsible for the care of patients recovering from surgery. In case of emergency, if the surgeon is not immediately accessible, it is understood that the physician anesthesiologist, after examining the patient, is authorized to institute such treatment as is deemed necessary to preserve the life of the patient. The surgeon and the attending physician shall be notified of such emergency treatment at the earliest possible moment.

19. TEACHING PROGRAM

It is the responsibility of the Staff members to participate wholeheartedly in the teaching programs of the Hospital and to serve in whatever capacity they are assigned.

20. VENTILATOR PRIVILEGES

The privilege to write ventilator orders may be granted by the Board to those individuals recommended by the Credentials Committee on advice of the Chairman of the Department of Anesthesia and the Chief of Pulmonary Services.