

**BRIDGEPORT HOSPITAL**  
**MEDICAL STAFF BYLAWS**  
**Rules & Regulations**

Approved: December 5<sup>th</sup>, 2024

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## **PREAMBLE**

Recognizing that the Medical Staff is responsible for the quality of patient care, treatment and services in Bridgeport Hospital, and must accept and assume this responsibility subject to the ultimate authority of the Bridgeport Hospital Board of Trustees, and recognizing that the best interests of the patients are protected by the cooperative efforts of the Medical Staff and the Bridgeport Hospital Board of Trustees acting in accordance with applicable law and required accreditation standards, the Medical Staff of Bridgeport Hospital is hereby organized in conformity with these Bylaws, Rules and Regulations hereinafter stated.

# ARTICLE I

## NAME AND DEFINITIONS AND RULES OF CONSTRUCTION

### 1.1. NAME

The name of this organization shall be the “Medical Staff of Bridgeport Hospital.”

### 1.2. DEFINITIONS

“**Board of Trustees**” means the Bridgeport Hospital Board of Trustees.

“**Community-Based Physician**” means a member of the Active Medical Staff who (1) primarily practices in a private community-based practice in the Greater Bridgeport Area; and (2) is not an employee of Bridgeport Hospital, Yale-New Haven Hospital, Yale New Haven Health System, Yale University, or Bridgeport Hospital & Healthcare Services, Inc.; and (3) is not an employee or member of Northeast Medical Group, Inc. (“NEMG”) or Yale Medicine (YM) nor of any successor medical group.

“**Dentist**” means a person who holds the degree of Doctor of Medical Dentistry or Doctor of Dental Surgery who is licensed to practice dentistry.

“**Hospital**” means Bridgeport Hospital in Bridgeport, Connecticut.

“**Licensed Independent Practitioner**” means an individual permitted by law and by the Hospital to provide care, treatment and services.

“**Medical Review**” means the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals and such other functions considered to be “peer review” within the meaning of such term as set forth in Section 19a-17b(s) of the Connecticut General Statutes, as amended from time to time. Medical review includes, but is not limited to, credentialing and privileging decisions made pursuant to Article III of these Bylaws, collegial and other informal efforts to improve practitioner performance, and any formal proceedings initiated under Articles IX and X of these Bylaws. Medical review activities shall be kept in strictest confidence.

“**Medical Review Committee**” means any committee or subcommittee referred to in or authorized under these Bylaws or those of the Hospital when they are conducting peer review functions within the meaning of such term as set forth in Section 19a-17b(2) of the Connecticut General Statutes, as amended from time to time, including but not limited to:

- The Clinical Risk/Mortality Review Committee;
- The Credentials Committee;
- The Medical Staff Evaluation Committee;
- The Nutrition, Pharmaceutical and Therapeutics Committee;
- The Patient Care Review Committee;
- Ethics Committee;
- Infection Control Committee;

- Other committees engaged in Medical Review referred to in or authorized under the provisions of Article VIII of these Bylaws or the Hospital bylaws;
- Department and Section committees;
- Hearing and appellate review committees;
- Subcommittees or liaison committees;
- The Joint Commission (TJC) (which while performing accreditation services for the Hospital, shall be acting as a Medical Review Committee engaged in peer review, as an agent of the Hospital, and shall be bound to protect the confidentiality of information of the Patient Care Review Committee when engaged in peer review functions, pursuant to state law and the contract between TJC and the Hospital); and
- Meetings as a committee of the whole of any Department or Section or any other committee or entity established hereunder or under the Charter and Bylaws of the Hospital.

Any individual gathering information or providing services for or acting on behalf of, and at the direction of, any such Medical Review Committee, including but not limited to the Senior Vice President-Chief Medical Officer, Department Chairs and Associate Chairs, Section Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, and experts or consultants retained to perform peer review functions, is considered to be engaged in peer review on behalf of the Hospital.

**“Medical School”** means a medical, osteopathic, dental, or podiatric school which meets the requirements of accreditation by the American Osteopathic Association, the Liaison Committee on Medical Education, the American Podiatric Medical Association, or the American Dental Association. Graduates of medical schools not accredited by the above entities must be certified by the Educational Commission for Foreign Medical School Graduates.

**“Medical Staff”** means all Physicians, Dentists, and Advanced Practice Providers who are privileged to attend and/or provide treatment for patients in Bridgeport Hospital, as well as Honorary Medical Staff members.

**“Physician”** means a person who holds the degree of: (a) Doctor of Medicine or Doctor of Osteopathy and is licensed to practice medicine; or (b) Doctor of Podiatric Medicine and is licensed to practice podiatry.

**“Advanced Practice Providers”** means a person who is licensed to practice as a: Physician Assistant-Certified, Advanced Practice Registered Nurse, Certified Nurse Midwife, Certified Registered Nurse Anesthetist or Clinical Psychologist.

**“Writing”** for purposes of this document any reference to “writing” of orders or other patient documentation will be understood to include entering orders or documentation using the Hospital’s Electronic Medical Record system. Specific instructions related to the format of written orders apply only to downtime when orders will be entered/transcribed on paper forms.

### 1.3. RULES OF CONSTRUCTION

When construing these Bylaws or the Rules and Regulations, the following principles shall apply:

- 1.3.1 **Gender.** Wherever in these Bylaws and Rules and Regulations a masculine noun or pronoun is used, it shall refer equally to the feminine noun or pronoun.
- 1.3.2 **Severability.** If any provision of these Bylaws or Rules and Regulations is determined by a court or administrative agency with competent jurisdiction to be invalid or in violation of any law or regulation, such provision shall be deemed to be severed from these Bylaws or Rules and Regulations and the remainder shall be given effect as if such invalid provision never had been included.
- 1.3.3 **Consistency.** To the extent possible, these Bylaws, the Rules and Regulations, the Hospital's Bylaws, policies of Departments and Sections, and agreements between the Hospital and members of the Medical Staff, shall be construed as being consistent with one another. If consistent construction is not possible, then provisions that specifically provide that they supersede inconsistent provisions shall be given effect unless unlawful.
- 1.3.4 **Conflict.** It is the intention of the Hospital and its Medical Staff that their respective Bylaws be construed as being consistent. If an inconsistency appears, every effort should be made to implement the provisions of these Bylaws, which have been adopted by the Medical Staff and by the Board of Trustees of Bridgeport Hospital, as written. In the event of an irreconcilable conflict, members of the Medical Staff Executive Committee and the Board of Trustees shall consult and attempt to identify which of the two provisions is most current and best reflects the intention of the Medical Staff and the Board of Trustees.

The provisions of this section are not intended to alter or supersede other provisions of these Bylaws that specify how these Bylaws are to be interpreted, construed, or applied.

- 1.3.5 **Captions and Titles.** All captions and titles are used for convenience only and shall not limit or otherwise affect in any way the scope or manner of interpretation of any provisions of these Bylaws or the Rules and Regulations.
- 1.3.6 **Parliamentary Procedure.** All matters of parliamentary procedure not otherwise specified by the Medical Staff Bylaws shall be governed by the most current revision of Robert's Rules of Order.



## **ARTICLE II PURPOSES**

### **2.1. PURPOSES**

The purposes of the Bridgeport Hospital Medical Staff shall be:

To initiate and maintain rules and regulations for the governance of the Medical Staff;

To provide a mechanism through which individual Physicians, Dentists, Podiatrists, Advanced Practice Providers, Resident Staff and Clinical Fellows may obtain clinical privileges at the Hospital;

To provide mechanisms through which the Medical Staff, the Board of Trustees and the Chief Executive Officer of the Hospital may discuss matters of mutual concern including medical-administrative problems, and coordinate medical activities of the Hospital in a manner that promotes quality and efficient patient care, teaching and research activities and fulfills the Medical Staff's accountability to the Board of Trustees;

To ensure that all patients admitted to the Hospital or treated in the Hospital's outpatient department(s) receive quality care, and to provide for continuous performance improvement.

To provide medical education experiences and opportunities for the Medical Staff, students, residents, fellows and others in order to maintain professional standards and advance professional knowledge and skill.

## **ARTICLE III MEDICAL STAFF MEMBERSHIP**

### **3.1. GENERAL STATEMENTS REGARDING MEDICAL STAFF MEMBERSHIP & CLINICAL PRIVILEGES**

- 3.1.1 Membership a Privilege.** Membership on the Medical Staff of Bridgeport Hospital is a privilege that shall be extended only to those competent persons who continuously meet all of the qualifications, standards, and requirements set forth in these Bylaws and Rules and Regulations.
- 3.1.2 Board of Trustees Authority to Grant.** As specified in the Charter and Bylaws of Bridgeport Hospital, the Board of Trustees has the sole authority to grant or deny initial and continuing membership on the Medical Staff of Bridgeport Hospital. The Board of Trustees shall act on initial appointments and reappointments to, or revocation of, Medical Staff membership only after there has been a recommendation by the Medical Staff Executive Committee to the Professional and Quality Review Committee of the Board of Trustees.
- 3.1.3 No Automatic Right to Membership.** No person shall be entitled to membership on the Medical Staff merely because he holds a certain degree, is licensed to practice in this or any other state, is a member of any professional organization, is certified by any clinical board, or had or presently has medical staff membership or privileges at another hospital or health care facility.
- 3.1.4 Coterminous Membership.** Notwithstanding any other provision of these Bylaws or of the Rules and Regulations, the Hospital may provide, by agreement, that membership on the Medical Staff and clinical privileges are contingent on, and shall expire simultaneously with, such agreement. In the event that an agreement contains such a statement, the provisions of these Bylaws, Rules and Regulations and policies of the Medical Staff with respect to hearings, appeals and appellate reviews etc., shall not apply.
- 3.1.5 Facilities Issues.** The ability of the Hospital to provide adequate facilities and supportive services for an applicant to the Medical Staff and his patients shall be included in the criteria used to evaluate applications for membership on the Medical Staff.
- 3.1.6 Unlawful Discrimination.** No aspect of Medical Staff membership or the exercise of particular clinical privileges shall be denied on the basis of unlawful discrimination.

### **3.2. BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

Except for the Honorary Medical Staff, the ongoing basic responsibilities of each member of the Medical Staff include, but are not limited to:

- 3.2.1 Professional Standard of Care.** Providing patients with the quality of care meeting the professional standards of the Medical Staff of the Hospital. This shall include at least a daily assessment of all patients (excepting those who are only at a custodial or rehabilitative level of care) and documentation of that assessment in the medical record by a Medical Staff member.
- 3.2.2 Bylaws, Rules and Regulations and Medical Staff Policies.** Abiding by the Medical Staff Bylaws and Rules and Regulations, and the applicable Department and Medical Staff policies.
- 3.2.3 Assignments.** Discharging in a cooperative manner reasonable responsibilities and assignments including committee assignments imposed upon the Medical Staff member by a Department Chair, Section Chief or the President of the Medical Staff.
- 3.2.4 Medical Records and History and Physical Examination.** Preparing, and completing in timely fashion, medical records and operative dictation for all the patients to whom the Medical Staff member provides care in the Hospital, as defined in the Medical Staff Bylaws and Rules and Regulations.

Performing (or arranging for the performance of) a medical history and physical examination (“H&P”) on each patient no more than thirty (30) days before or 24 hours after an admission and documenting such H&P in each patient’s chart. When the H&P has been conducted within thirty (30) days prior to admission, an updated H&P must be performed and documented in the patient’s record within 24 hours after admission. In all cases except for emergencies, the H&P must be performed prior to any surgery or anesthesia service. The physical examination and medical history must be performed by a Physician, an oromaxillofacial surgeon (for patients admitted only for oromaxillofacial surgery) who has been granted such privileges pursuant to these Bylaws, or other qualified licensed individual in accordance with State law and Hospital policy. All H&P examinations must be conducted in accordance with the Rules and Regulations and Medical Staff policies.

- 3.2.5 Code of Ethics.** Abiding by the lawful codes of ethics adopted by applicable professional organizations (to the extent such codes are not inconsistent with the code of ethics adopted by the American Medical Association); and refusing to engage in improper patient referral and consultation practices.
- 3.2.6 Cooperation.** Working cooperatively with members of the nursing and administrative staff, other Medical Staff members, and others in the Hospital, so as to enhance patient care.
- 3.2.7 Continuous Coverage.** Making appropriate arrangements for continuous coverage of his patients, and making proper provision for his patients' care in his absence consistent with the requirements of section 3.3.11 of these Bylaws.
- 3.2.8 Continuing Education.** Participating in continuing education programs as required by the Medical Staff or its Departments or Sections and consistent with Section 3.3.12.

- 3.2.9 Emergency Department Coverage.** Participating in such Emergency Department coverage as may be deemed necessary by the applicable Departments and Sections.
- 3.2.10 Adequate Evaluation.** Having sufficient clinical activity so as to permit evaluation of continuing clinical competence by Section Chiefs and Department Chairs except for Membership without Clinical Privileges members.
- 3.2.11 Privilege Actions.** Notifying the Senior Vice President-Chief Medical Officer, and the applicable Department Chair and Section Chief of any limitation or withdrawal of his privileges at another hospital or health care facility within twenty-four (24) hours of such a change.
- 3.2.12 Malpractice Actions.** Notifying the Senior Vice President-Chief Medical Officer of any legal action brought against the Medical Staff member in relation to the care of any of his patients within ten (10) calendar days of being served with notice of such action.
- 3.2.13 Licensure Actions.** Notifying the Senior Vice President-Chief Medical Officer, the applicable Department Chair, and Section Chief within twenty-four (24) hours of the initiation of any adverse action regarding any state or federal license or registration by any regulatory body; or the Medical Staff member's voluntary relinquishment of any such license or registration.
- 3.2.14 Federal Health Care Programs.** Notifying the Senior Vice President-Chief Medical Officer within twenty-four (24) hours of exclusion from participation in any federal health care programs, provided that this responsibility shall not require notice of termination of participation from any health care program (including Medicare or Medicaid, traditional or advantage) unrelated to misconduct or a program-related crime.
- 3.2.15 Other Responsibilities.** Discharging such other Medical Staff obligations as may be established from time-to-time by Section Chiefs, Department Chairs, or the Medical Staff.

### **3.3. 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.

- 3.3.1 Bylaws, Rules, Regulations and Policies.** Agrees to abide by the Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff Policies and Procedures;

### 3.3.2 License.

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

#### 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

#### 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 IX, Section 9.4 outlines the consequences of various licensure actions.

### **3.3.3 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. 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 IX, Section 9.4 outlines the consequences of actions taken against a Medical Staff member's Federal or State authority to prescribe controlled substances.

### **3.3.4. 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:

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.

**3.3.5 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

**3.3.6 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

New 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:

- a) 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 Chair 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.
- b) 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.



**3.3.7 Board Certification.** Must be currently board certified or board eligible in the appropriate specialty and meet requirements as further defined in Section 3.6.4

**3.3.8 Health Status.**

In order to be eligible for initial or reappointment, applicants must attest to a satisfactory physical and mental health status and their 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 IX, Section 9.4 outlines the consequences for failure to comply with health status requirements.

**3.3.9 Federal 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 under these circumstances.

ARTICLE IX, Section 9.4 outlines the consequences of actions taken against a current Medical Staff member relative to participation in federal or state governmental health care programs.

**3.3.10 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 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.

**3.3.11 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/Chief 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.

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

ARTICLE IX, Section 9.4 outlines the consequences for failure to comply with the requirements related to continuing medical education or completion of medical staff education training.

### **3.3.13 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.

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 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.

ARTICLE IX, Section 9.4 outlines the consequences for failure to pay Medical Staff dues in a timely manner.

### **3.3.14 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, 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 for patient care, education to the Hospital.

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 the membership and clinical privileges of a physician, dentist or podiatrist 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 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.

### **3.3.15 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 to the Medical Staff Policy on Professionalism and Behavior.

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.

### **3.4. QUALIFICATIONS FOR MEMBERSHIP FOR RESIDENT STAFF AND CLINICAL FELLOWS**

In lieu of the qualifications set forth in Section 3.2, and 3.3 an applicant for membership on the Medical Staff in the Resident Staff or Clinical Fellows Staff categories shall satisfy the following qualifications:

- (a) documents graduation from a Medical School or certification by the Educational Commission for Foreign Medical Graduates;
- (b) is recommended to the Medical Staff Executive Committee by their Department Chair who has verified that the applicant meets the above criteria; and
- (c) states in writing whether or not he has (1) been arrested for any offense other than minor traffic violations, (2) been denied any license, certification, narcotics permit, hospital appointment or privilege, (3) had any license, certification, narcotics permit, hospital appointment or privileges withdrawn, cancelled, challenged, reduced, limited or not renewed, (4) had any voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital.

Information provided by the applicant in compliance with this requirement shall be treated as confidential.

### **3.5. INITIAL APPLICATION AND APPOINTMENT**

No person (including persons engaged by the Hospital in administrative positions), shall exercise clinical privileges in the Hospital unless and until he applies for and receives appointment to the Medical Staff with appropriate clinical privileges, or is granted temporary privileges or disaster privileges in accordance with these Bylaws.

**3.5.1 Implications of the Application Process.** By applying for membership on the Medical Staff each applicant must:

- (a) Fulfill the eligibility requirements outlined in Section 3.3.
- (b) Acknowledge responsibility to review these Bylaws and Rules and Regulations, Department policies and any other written policies relating to clinical practice in the Hospital as they apply to him, and agree that throughout the period of his Medical Staff membership he will comply with all of the above as they may be modified from time to time. Such agreement shall be documented in a statement signed by the applicant.
- (c) Understand that initial appointment to the Medical Staff is provisional for a period of time as provided in Section 3.6.

- (d) Signify his willingness to appear for interviews, and undergo a physical or psychological examination, if requested by the Credentials Committee or the Medical Staff Executive Committee. The examining physician will be chosen by the Credentials Committee at the applicant's expense, and any costs associated with such an examination will be borne by the applicant.
- (e) Release from any liability, to the fullest extent permitted by law, all persons, committees and entities for acts or omissions in connection with the investigation and evaluation of the applicant.
- (f) Consent to inspection of records and documents by the Hospital and its designees, appropriate background checks and the querying of appropriate data banks for information concerning the applicant that may be material to the evaluation of his qualifications and competence to carry out the clinical privileges he is requesting, authorize all individuals and organizations in custody of such records and documents to permit such inspection and copying by the Hospital and its designees and agree to execute special consents where required by particular individuals and organizations in order to permit the inspection and copying of such records and documents by the Hospital or its designees.
- (g) Authorize the Hospital and its designees to consult with others who have been associated with the applicant and who may have information bearing on his competence, qualifications and performance, and also authorize such individuals and organizations to candidly provide all such information to the Hospital and its designees.
- (h) Release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including but not limited to otherwise confidential information regarding his moral and ethical qualifications for Medical Staff membership.
- (i) Consent to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding his professional or ethical standing that the Hospital or Medical Staff may have, and release the Hospital and Medical Staff and their designees from liability for so doing to the fullest extent permitted by law.
- (j) Understand that in connection with his application for membership, the applicant shall have the obligation to produce sufficient information for an adequate evaluation by the Hospital of his qualifications and suitability for the clinical privileges and staff category requested, and the applicant must resolve to the satisfaction of the Hospital any reasonable concerns of the Hospital about those matters. The applicant's failure to fulfill this obligation shall be grounds for denial of his application.

- (k) Provide information about any past or present challenges to, or voluntary relinquishment of, any state or federal license or registration.
- (l) Provide information about voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.
- (m) Understand that his application will be considered incomplete and will not be processed until all the information in his application has been verified to the satisfaction of the Hospital.

**3.5.2 Initial Application Process.** Each application for initial appointment to the Medical Staff shall be submitted to the Chief Executive Officer of the Hospital (or his designee, the Senior Vice President-Chief Medical Officer) either electronically or on the form provided, with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. He shall be provided an opportunity to review the Medical Staff Bylaws, Rules and Regulations, Department and Medical Staff policies and any other written policies relating to clinical practice in the Hospital applicable to the applicant. Except as otherwise provide in the YNHHS Policy Regarding “Crossover Practitioners,” a minimum of three (3) references shall be required to be submitted from impartial Physicians, Dentists or Podiatrists, as appropriate who are familiar with the applicant's qualifications and who meet the requirements of the Credentials Committee. References shall be identified based upon the “YNHHS Guidelines for Identification of Reference Writers.”

**3.5.3 Submission of Application – Verification of Information.** Upon receiving the application form and accompanying information, the Senior Vice President-Chief Medical Officer or his designee (Medical Staff Administration Department staff) shall expeditiously seek to verify the references, licensure status and other evidence submitted in support of the application and shall submit a query or enrollment on the applicant to the National Practitioner Data Bank, Office of the Inspector General List of Excluded Individuals/Entities, the General Services Administration List of Parties Excluded from Procurement and other relevant databases, and review the responses thereto. The applicant shall be notified of any difficulties encountered by the Hospital in the verification process, and it shall be his obligation to assist the Hospital in obtaining the required information. The applicant shall be notified immediately if any information obtained during the verification process renders him or her ineligible for membership consistent with the eligibility requirements as stated in Section 3.3.

**3.5.4 Department Action.** Once all information in the application has been verified, and eligibility confirmed, the Department Chair, in consultation with the appropriate Section Chief as applicable, shall review the application, interview the applicant as necessary or appropriate and investigate the information concerning the applicant's ability to exercise the privileges requested. Within thirty (30) calendar days of receiving the completed application from Medical Staff Administration, the Department Chair shall formulate a written report to the Credentials Committee recommending whether to appoint the applicant and if appointment is

recommended, the type of appointment and the delineation of clinical privileges that should be granted to the applicant, including any limitation of clinical privileges or special conditions placed upon the exercise of such privileges

### **3.5.5 Credentials Committee Action.**

- (a) In lieu of reviewing all applications, the Credentials Committee may appoint a Sub-Committee to review and make recommendations regarding applications that are complete and defined, in accordance with Medical Staff Policy, as “clean.” Only clean applications will be eligible for Sub-Committee review and all others will require presentation to the full Credentials Committee.
- (b) Complete/Incomplete Application. An application will be deemed complete when all questions on the application have been answered, all supporting documentation has been supplied, all information has been verified and a recommendation has been submitted by the Department Chair. In the event that the Department Chair fails to provide his or her recommendation within thirty (30) days of receiving a completed application, the application will be forwarded to the Credentials Committee for action.

An application will be deemed incomplete if the need arises for new, additional or clarifying information at any time during the application review. Any application that continues to be incomplete sixty (60) calendar days after the applicant has been notified of the additional information required shall be deemed to be withdrawn, unless additional time is granted by the Senior Vice President-Chief Medical Officer for good cause shown. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

- (c) Upon receiving the completed application, the Credentials Committee or its Sub-Committee shall investigate the character, qualifications and standing of the applicant and may require the applicant to meet with the Credentials Committee to discuss any aspect of the applicant’s application, qualifications or clinical privileges requested. A physical or psychological examination of the applicant may be required by the Credentials Committee, to be conducted by a physician or physicians chosen by the Committee, with the costs borne by the applicant. The Credentials Committee shall make its recommendations to the Medical Staff Executive Committee as soon as practicable, and in all cases within three months of submission of a complete application to the Credentials Committee. In the event an application is deferred to a future meeting due to insufficient information, the Credentials Committee must make a recommendation whether to accept or reject the application within sixty (60) calendar days of such deferral.



**3.5.6 Medical Staff Executive Committee Action.** Upon receipt of the report and recommendation of the Credentials Committee, the Medical Staff Executive Committee shall consider the application at its next regularly scheduled meeting. The Medical Staff Executive Committee may vote on the application, request additional information, return the latter to the Credentials Committee for further investigation, or elect to interview the applicant. When the recommendation of the Medical Staff Executive Committee is favorable to the applicant, it shall promptly forward a report together with supporting documentation to the Professional and Quality Review Committee of the Board of Trustees with special comment on the category of membership, Department affiliation, clinical privileges to be granted and any special conditions to be attached to the appointment. When the recommendation of the Medical Staff Executive Committee is adverse to the applicant, the applicant shall be notified by the applicable Department Chair or Senior Vice President-Chief Medical Officer. If the applicant, having been notified still wishes to pursue Medical Staff Membership, the Professional and Quality Review Committee of the Board of Trustees shall be promptly informed by written notice, and given a statement of the reason for the adverse recommendation.

**3.5.7 Professional and Quality Review Committee/Board of Trustees Actions.** The Board of Trustees may delegate the authority to render decisions regarding initial appointment as well as reappointment to the Medical Staff and renewal or modification of clinical privileges to the Professional and Quality Review Committee of the Board of Trustees. Such delegation of this authority shall not be applicable in the following situations:

- (a) The Medical Staff Executive Committee recommendation is adverse to the applicant or with limitations;
- (b) There is a current challenge or previously successful challenge to the applicant's licensure or registration;
- (c) The applicant has received an involuntary termination of medical staff membership at another organization;
- (d) The applicant has received an involuntary limitation, reduction, denial or loss of clinical privileges; or
- (e) There has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

Upon receipt of the report and recommendation of the Medical Staff Executive Committee, the Professional and Quality Review Committee of the Board of Trustees shall review and vote on the application at its next regularly scheduled meeting and forward its recommendation to the Board of Trustees for final action.

In those cases where the Board of Trustees delegates authority to the Professional and Quality Review Committee, the Board of Trustees shall ratify the decisions of the Professional and Quality Review Committee at the next regularly scheduled

meeting of the Board of Trustees. In those cases where the Board of Trustees has not delegated authority to the Professional and Quality Review Committee, the Board of Trustees as a whole shall review the recommendations of the Medical Staff Executive Committee and the Professional and Quality Review Committee and vote on the application at its next regularly scheduled meeting.

When final action on the application has been taken by the Professional and Quality Review Committee or the Board of Trustees, the Chief Executive Officer of the Hospital (or his designee, the Senior Vice President-Chief Medical Officer) shall transmit the decision to the applicant and, if he is to be accepted for Medical Staff membership, secure the applicant's signed agreement to be governed by these Bylaws, Rules and Regulations and Department and Medical Staff policies. The applicant shall receive such orientation as is prescribed by the Medical Staff Executive Committee.

In cases where the Professional and Quality Review Committee or, when applicable, the Board of Trustees does not concur with a Medical Staff Executive Committee's recommendation relative to the applicant's appointment to the Medical Staff, the matter shall be reviewed by an ad hoc committee composed of three (3) members of the Board of Trustees and three (3) members of the Medical Staff Executive Committee. The members will be appointed by the Chairs of the respective bodies. The ad hoc committee will review the application and make a recommendation to the Professional and Quality Review Committee of the Board of Trustees. The Professional and Quality Review Committee shall make a recommendation to the Board of Trustees whose decision shall be final.

**3.5.8 Reapplication After Adverse Appointment Decision.** An applicant whose application for Medical Staff membership is denied by the Board of Trustees shall not be eligible to reapply to the Medical Staff for a period of two (2) years unless there is a significant change in the status of his application. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required.

### **3.6. APPOINTMENT TO THE MEDICAL STAFF**

**3.6.1 Observation of New Medical Staff Members.** Each new member of the Medical Staff shall undergo observation and evaluation by the Department Chair and/or his designee(s) via Focused Professional Practice Evaluation (FPPE) and all new clinical privileges shall be subject to FPPE. FPPE shall be according to whatever format each Department deems appropriate, as set out in Department and the Medical Staff policies in order to adequately evaluate the new Medical Staff member. FPPE shall be based upon a number of criteria which may include, but is not limited to, the following (not all of which may be applicable in the evaluation of every provisional Medical Staff member):

- (a) the results of quality assessment and improvement activities related to the provisional member's performance;

- (b) utilization of the Hospital's resources;
- (c) participation in Department and Medical Staff activities;
- (d) ethical conduct;
- (e) demonstrated compliance with these Bylaws, Rules and Regulations and Department and Section policies;
- (f) Continuing professional education;
- (g) involvement in any professional liability actions;
- (h) current competence and evidence of ability to perform clinical privileges requested;
- (i) proctoring reports, if any;
- (j) previously successful or currently pending challenges to any professional licensure or registration, or the voluntary relinquishment of such licensure or registration;
- (k) voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital;
- (l) professional performance, judgment, and clinical or technical skills;
- (m) peer recommendations; and
- (n) behavior and interaction with other physicians, patients and their families, and staff.

This information shall be reviewed by the Department Chair and be considered in the recommendation to terminate provisional status.

**3.6.2 Clinical Privileges and Rights of New Medical Staff Members.** New members of the Medical Staff shall be entitled to exercise those clinical privileges granted by the Board of Trustees and to attend and vote at meetings of the Medical Staff.

Until the period of Focused Professional Practice Evaluation is complete, new Medical Staff members shall not hold office in the Medical Staff organization, but may serve on committees.

**3.6.3 Action Upon Completion of FPPE.**

- (a) Upon completion of FPPE, the appropriate Department Chair (or in the case of a Department Chair, a Senior Attending Medical Staff member of the Department) shall advise the Credentials Committee which shall make its report and recommendation to the Medical Staff Executive

Committee which, in turn, shall make its recommendation to the Board of Trustees regarding the clinical privileges and Medical Staff status of the new Medical Staff member.

- (b) If the new Medical Staff member has satisfactorily demonstrated his ability to exercise the clinical privileges initially granted, meets the appropriate Department and Medical Staff standards and otherwise appears qualified for continued Medical Staff membership, the period of FPPE shall be deemed complete.
- (c) If the new Medical Staff member fails to meet appropriate Department and Medical Staff standards, the Department Chair may recommend to the Credentials Committee at any time any of the following: (i) that the Medical Staff member be terminated from the Medical Staff; (ii) that the Medical Staff member not be reappointed to the Medical Staff; (iii) that the Medical Staff member's clinical privileges be modified; or (iv) that the period of FPPE continue for a stipulated amount of time not to exceed two additional years except as noted in Section 3.6.6.
- (d) After review of the recommendation of the Department Chair and the new Medical Staff member's clinical performance, the Credentials Committee will make a recommendation to the Medical Staff Executive Committee which, in turn, shall make its recommendation to the Board of Trustees regarding a modification or termination of clinical privileges or termination of Medical Staff membership.

#### **3.6.4 Board Certification Requirements.**

##### 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.

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.

#### 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.

#### Exceptions to Board Certification Requirements

Under special circumstances at the discretion of the relevant Department Chair 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; or (2) special clinical expertise held by the applicant and desired to support patient care.

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)

Medical Staff members appointed prior to January 1, 2019 will remain subject to the initial Board Certification requirements in effect prior to January 1, 2019.

### **3.7. REAPPOINTMENT TO THE MEDICAL STAFF**

The term of initial appointment to the Medical Staff shall not exceed a period of three (3) years. Each reappointment, if granted by the Board of Trustees, shall be for a period of not more than three (3) years.

All terms, conditions and procedures relating to initial appointment to the Medical Staff shall apply to continued appointment and clinical privileges and to reappointment.

#### **3.7.1 Reappointment Application.**

(a) At least ninety (90) calendar days in advance of when the current appointments would expire, Medical Staff Administration will define the list of Medical Staff members who will need to be reappointed and send each Medical Staff member to be reappointed a package containing a description of the reappointment process, a reappointment application form, questionnaire, list of clinical privileges to be reviewed, and requests for other documents required for the reappointment process. Medical Staff Administration shall have the discretion to determine the timelines for the reappointment process, and to stagger Medical Staff appointments in a manner that promotes efficiency in such process.

(b) The completed forms and required documents must be returned by the Medical Staff members to Medical Staff Administration in a timely fashion, at which point completion will be verified by Medical Staff Administration. The Medical Staff Administration staff shall submit a query on the Medical Staff member to, the Office of the Inspector General List of Excluded Individuals/Entities, the General Services Administration List of Parties Excluded from Procurement and other relevant databases and review the responses thereto.

**3.7.2 Department Chair Review.** The completed reappointment application and forms will be sent to the Department Chair. The Department Chair will enlist the assistance of the Section Chiefs as appropriate in reviewing the assignment of clinical privileges, and compliance with any other Department requirements for reappointment, as specified in the Department policies. Reappointment

applications shall be assessed according to a number of standards (not all of which will be applicable to every reappointment application) including, but not limited to:

- (a) Physical and mental health status;
- (b) Proof of continuing medical licensure, and controlled substances registration if applicable;
- (c) An assessment of appropriate use of Hospital resources;
- (d) A review of any malpractice activity that has taken place in the previous two (2) years;
- (e) Information concerning previously successful or currently pending challenges to any license or registration or the voluntary relinquishment of such license or registration
- (f) Information concerning voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital.
- (g) Documentation of continuing malpractice coverage at the level required by the Board of Trustees or external regulatory agencies at the time of reappointment;
- (h) Evidence of continuing conformity with the basic responsibilities of Medical Staff membership, Bylaws, Rules and Regulations and Department and Section policies.
- (i) Evidence of continuing clinical competence, clinical judgment in the treatment of patients, technical skill and ability to perform the clinical privileges requested as defined in Department policies.
- (j) Information obtained on the Medical Staff member to from the Office of the Inspector General List of Excluded Individuals/Entities, the General Services Administration List of Parties Excluded from Procurement and other relevant databases.
- (k) A review of the Medical Staff member's ability to work cooperatively with others to provide high quality patient care.
- (l) Results of performance reviews obtained through the Hospital's quality review and assessment activities including Ongoing Professional Practice Evaluation (OPPE) results.
- (m) Information provided by peers.
- (n) Satisfactory completion of such continuing medical education requirements as may be imposed by law, the Hospital or accreditation agencies.

- (o) Satisfaction of board certification requirements and maintenance of certification (MOC) requirements.

Utilizing appropriate forms, the Department Chair will provide a written recommendation to the Credentials Committee regarding the reappointment of a Medical Staff member.

If the recommendation of the Department Chair includes any reduction of status or clinical privileges of any Medical Staff member on the reappointment list or a recommendation not to reappoint, the Department Chair must notify the affected Medical Staff member concurrently with formulating the recommendation, and provide the reason(s) for the recommendation. If there is any disagreement between himself and the Section Chief on the recommendation, such disagreement shall also be documented.

### **3.7.3 Credentials Committee Action.**

- (a) The Credentials Committee, after receiving the written recommendations from each Department Chair, shall review all pertinent information available for the purpose of determining its recommendations for Medical Staff reappointment, appropriate staff category, and for the granting of clinical privileges for the ensuing appointment period.
- (b) The Credentials Committee may require a Medical Staff member seeking reappointment to undergo a physical and/or psychological examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or at any time during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of a Medical Staff member seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
- (c) The Credentials Committee shall have the right to require the Medical Staff member seeking reappointment to meet with the committee to discuss any aspect of the reappointment application, qualifications, or clinical privileges requested.
- (d) The Credentials Committee may use the expertise of the Department Chair, or any member of the Department, or an outside consultant, if additional information is required regarding the Medical Staff member's qualifications for reappointment.



- (e) If, after considering the report of the Department Chair, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by a probationary or other condition or restriction, as deemed appropriate by the Credentials Committee.
- (f) The Credentials Committee shall forward written findings and recommendations, including the report of the Department Chair, to the Medical Staff Executive Committee at least ten (10) calendar days before the meeting at which reappointment will be addressed. The completed application and all supporting documentation shall be available to the Medical Staff Executive Committee. If the recommendation is a denial of reappointment, or change in clinical privileges, the reason for such recommendation shall be stated.

**3.7.4 Medical Staff Executive Committee Action.** After receipt of the written findings and recommendations of the Credentials Committee, the Medical Staff Executive Committee shall review and vote on the applications for Medical Staff reappointment, staff category and clinical privileges and shall forward its recommendations to the Professional and Quality Review Committee of the Board of Trustees.

**3.7.5 Professional and Quality Review Committee Action.** Upon receipt of the report and recommendations of the Medical Staff Executive Committee, the Professional and Quality Review Committee of the Board of Trustees shall review and vote on the applications for Medical Staff reappointment, staff category and clinical privileges and shall forward its recommendations to the Board of Trustees for ratification or final action as necessary.

**3.7.6 Board of Trustees Action.**

- (a) In the event that the Professional and Quality Review Committee of the Board of Trustees does not concur with the Medical Staff Executive Committee's recommendations relative to reappointment, staff category and/or clinical privilege designation of a Medical Staff member, the matter shall be reviewed by an ad hoc committee composed of three (3) members of the Professional and Quality Review Committee of the Board of Trustees and three (3) members of the Medical Staff Executive Committee. The ad hoc committee members will be appointed by the Chairs of the respective bodies. The ad hoc committee will review the matter and make a recommendation to the Professional and Quality Review Committee of the Board of Trustees. The Professional and Quality Review Committee shall make a recommendation to the Board of Trustees whose decision shall be final.
- (b) Any adverse decisions on reappointment applications may be subject to the fair hearing and appeals process and shall be forwarded to the Chief Executive Officer of the Hospital who shall promptly notify the affected

Medical Staff member in accordance with the requirements of these Bylaws.

### **3.8. LEAVES 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 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.

#### 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.

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.

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.

#### 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.

### 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 Patient Safety and Clinical Quality Committee of the Board of Trustees.

### 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.

### 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 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.

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.

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.

**3.9. MEDICAL STAFF MEMBER FILES**

**3.9.1 Single Medical Staff Member File.** Medical Staff Administration shall maintain a confidential file for each Medical Staff member.

**3.9.2 Review of File.** Medical Staff members are entitled to view the content of their files consistent with the Medical Staff Policy on Applicant/Members Access to Files & Correction of Information.

**3.9.3 Content of File.**

- (a) In addition to basic demographic data, the information in a Medical Staff member's file should be accurate, objective, verifiable and should serve a meaningful purpose.
- (b) The Medical Staff member's file may include Performance Management data, information from Medical Staff monitoring committees (standing and departmental) and confirmed citations from external agencies (such as the Connecticut Department of Public Health and the Centers for Medicare and Medicaid Services).
- (c) Responsibility for including information in the files shall rest with the Senior Vice President-Chief Medical Officer, Department Chairs and the Medical Staff member himself.

Medical Staff members' files are confidential and may only be used and accessed for purposes of credentialing, patient care, peer review, risk management and other proper Hospital and Medical Staff functions.

- (d) Access to Medical Staff files other than the member shall be limited to the following: Medical Staff Administration staff, Accrediting Agencies or bodies under supervision of Medical Staff Administration staff, Chief Medical Officer, Chair of the Department of the individual physician, Chief of the Section of the individual physician, Hospital President, Medical Staff Credentials Committee Member(s), Medical Staff Executive Committee Member(s), and the Professional and Quality Review Committee and the Board of Trustees.

## **ARTICLE IV CATEGORIES OF THE MEDICAL STAFF**

The Medical Staff and Affiliated Health Care Professional Staff shall fulfill its purpose, as stated in Article II, in accordance with a table of organization by means of which patient requirements, the skills of the Medical Staff and Affiliated Health Care Professional Staff, and a practical chain of professional authority can be coordinated. Members of all categories of the Medical Staff shall meet the Board Certification requirements as set forth in Section 3.6.6.

### **4.1. CATEGORIES**

**4.1.1 Medical Staff Categories.** The Medical Staff shall include the following categories: Active Attending, Active Referring, Courtesy, Consulting, Telemedicine, Honorary, Affiliated Health Care Professionals, Referring Affiliated Health Care Professionals and Resident Staff/Clinical Fellows. At the time of initial appointment and each subsequent reappointment, the Medical Staff member's staff category shall be determined.

**4.1.2 Department Policies, Procedures and Protocols.** Department policies, procedures and protocols that define "significant clinical activity", "limited number of cases" and "minimum and maximum level of clinical activity" and that set "priority of access" standards between Active Attending and Courtesy Medical Staff members shall be reviewed by the Medical Staff Executive Committee which shall submit its recommendations to the Board of Trustees for approval.

### **4.2. ACTIVE MEDICAL STAFF**

The Active Attending and Active Referring categories shall comprise the Active Medical Staff and include Physicians, Dentists and Podiatrists.

**4.2.1 Active Attending.** The Active Attending Staff 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) utilize Bridgeport 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) demonstrate a willingness to participate in teaching programs;
- (e) demonstrate a willingness to serve on committees, boards, or in administrative positions;
- (f) assume responsibility for call and/or consultation, and to provide other services as requested by the relevant Department Chair or Section Chief consistent with applicable Medical Staff Policies and Rules & Regulations;
- (g) demonstrate 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 Chair or Section Chief;
- (h) demonstrate a willingness to have patients participate as part of teaching;
- (i) demonstrate a willingness, with the concurrence of both the patient and the physician, to participate in research efforts;
- (j) participate 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, Department, Section or Medical Staff Committees of which he or she is a member;
- (b) eligible for election to serve as a Medical Staff Officers consistent with the requirements of Article VII;
- (c) eligible to serve in departmental and sectional leadership roles as further defined in Article VI;
- (d) eligible to serve as Members of the Medical Executive Committee as applicable and further defined in Article VIII;
- (e) eligible to be a voting member or Chair medical staff committees consistent with the requirements as stated in Article VIII;

- (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
- (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

#### **4.2.2 Active Referring**

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.

Physicians, Dentists and Podiatrists 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; and
- (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 Article III 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 item #1 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 eligible for election to serve as a Medical Staff Officer;
- (h) eligible to serve on any Medical Staff Committee;
- (i) are required to pay Medical Staff dues; and
- (j) 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, 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 Article III. Proctoring may be required.

#### **4.3. COURTESY MEDICAL STAFF**

The Courtesy Medical Staff shall consist of those Physicians, Dentists and Podiatrists eligible for Medical Staff membership whose hospital based practice is primarily at another Connecticut hospital.

Members of this category:

- (a) have a practice located in the Bridgeport Hospital community;
- (b) are eligible for admitting, consulting and any other privileges for which they are qualified;
- (c) may attend meetings of the Medical Staff and their Department or Section;
- (d) are not eligible to vote at any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;
- (e) cannot serve as Medical Staff officers or as a members of the Medical Executive Committee, Credentials Committee or Bylaws Committee;
- (f) are required to have a minimum level of clinical activity at Bridgeport Hospital as determined by the relevant Department Chair or Section Chief in order to remain in this category and allow assessment of performance;
- (g) in the event that activity at Bridgeport Hospital reaches a level that is consistent with other practitioners in the same Department or Section who are members of the Active Attending staff, the member will be automatically reassigned to the Active Attending staff and expected to fulfill any and all requirements associated with that status;
- (h) when the resources of the Hospital including, but not limited to, procedure rooms, operating rooms and beds becomes restricted due to high census or utilization, members of this category shall have lower priority access to these areas; and
- (i) are required to pay medical staff dues

#### **4.4 CONSULTING MEDICAL STAFF**

The Consulting Medical Staff shall consist of those Physicians, Dentists and Podiatrists who:

- (a) have specialized clinical expertise that is deemed desirable for patient care and/or student and trainee education at Bridgeport Hospital;
- (b) May or may not have an established practice within the Bridgeport Hospital community;

- (c) Do not meet the requirements for Active Attending staff appointment relative to utilizing Bridgeport Hospital as the primary site of hospital based practice or any geographic office or other location requirements;
- (d) Have an active staff appointment and privileges at another hospital or hospitals;
- (e) Are granted clinical privileges;
- (f) May attend meetings of the Medical Staff and their Department or Section;
- (g) Are not eligible to vote at any meetings;
- (h) Cannot serve as Medical Staff officers; and
- (i) Do not pay medical staff dues

#### **4.5 TELEMEDICINE MEDICAL STAFF**

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 will be appointed to the Telemedicine category.

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 meet all eligibility requirements as stated in Article III of the 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 or Section to which he/she is appointed but may not vote;
- (c) may not serve as a Medical Staff officer, Department Chair or Section Chief, or Chair or member of any committee; and may not vote in Medical Staff matters;

- (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) are required to pay Medical Staff dues

#### **4.6 HONORARY MEDICAL STAFF**

The Honorary Medical Staff shall consist of Physicians, Dentists and Podiatrists who are retired from practice and are not active in the Hospital.

Members of the Honorary staff:

- (a) do not have clinical privileges;
- (b) are not required to undergo reappointment;
- (c) are not required to have malpractice insurance;
- (d) are not eligible to vote;
- (e) cannot serve as medical staff officers;
- (f) cannot serve on Hospital committees except with permission of the Chief Medical Officer and under unique circumstances involving special expertise;
- (g) may attend Medical Staff and Departmental and Section meetings of an educational nature;
- (h) may participate in Medical Staff social events;
- (i) are appointed for life and may be removed only for cause by the Medical Executive Committee; and
- (j) do not pay medical staff dues

#### **4.7 AFFILIATED HEALTH CARE PROFESSIONAL STAFF**

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 Professional and Quality Review 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. The supervising or collaborating physician must have the training and experience relevant to the responsibilities of the Affiliated Health Care Professional.

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 due to 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 assistants and the supervising physician must be reviewed and renewed on an annual basis.

Supervision 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 Article III. 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 and licensed nurse midwives, who 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 Articles VI and VII;
- (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) are not required to pay medical staff dues; and
- (d) may be appointed to Committees by the Department Chief or the President of the Medical Staff and may vote at such meetings except the Medical Executive Committee

**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.

**4.7.1 Medical Staff Bylaws, Rules and Regulations, Medical Ethics.** Affiliated Health Care Professional Staff will be governed in all respects by the Medical Staff Bylaws, Rules and Regulations and Medical Staff and Department policies, with the exception that an Affiliated Health Care Professional Staff member's right to a hearing and appellate review shall be governed in accordance with Section 10.10.

Affiliated Health Care Professional Staff will, at all times, abide by the principles of medical ethics of the American Medical Association, in so far as they are applicable to their duties and responsibilities.

#### **4.8 RESIDENT STAFF AND CLINICAL FELLOWS**

The Resident Staff and Clinical Fellows shall consist of Physicians in training who are appointed to this category of Medical Staff membership upon recommendation by the Department Chairs. The provisions of these Bylaws shall apply to members of the Resident Staff and Clinical Fellows only as specifically provided in these Bylaws. Members of the Resident Staff and Clinical Fellows may be appointed to committees without vote. The provisions of these Bylaws relating to hearings and appellate review shall not apply to Resident Staff and Clinical Fellows. A hearing and appellate review mechanism for grievances and corrective actions involving members of the Resident Staff and Clinical Fellows will be administered according to the policies of the Bridgeport Hospital Department of Medical Education.

#### **4.9 CHANGE OF MEDICAL STAFF CATEGORY**

Any Medical Staff member (except for Honorary Medical Staff members, Affiliated Health Care Professional Staff and Resident Staff and Clinical Fellows) who desires to be assigned to another category of the Medical Staff (e.g., a member of the Courtesy Medical Staff who wishes to transfer to Active Attending Medical Staff status, or vice-versa) and who meets the minimum criteria for such other category shall submit a written request to the appropriate Department Chair. The Department Chair will review the request and make a recommendation, and then forward the request and recommendation to the Credentials Committee. Determination of change in staff category shall be based on the criteria outlined in Section 3.7.2 and other criteria specific to the Department.

The Credentials Committee shall consider the request and shall report favorable recommendations to the Professional and Quality Review Committee of the Board of Trustees. When the recommendation of the Credentials Committee is against the requested change of Medical Staff category and the Medical Staff member, having been notified of this adverse recommendation, still wishes to pursue the change in Medical Staff category, the Professional and Quality Review Committee of the Board of Trustees shall be promptly informed by written notice, and given a statement of the reason for the adverse recommendation.

## **ARTICLE V DELINEATION OF CLINICAL PRIVILEGES**

### **5.1. GENERAL STATEMENTS RE CLINICAL PRIVILEGES**

**5.1.1 Membership Distinguished from Clinical Privileges.** Membership on the Medical Staff by itself does not confer clinical privileges to admit and treat patients. Members of the Medical Staff may only practice within the defined clinical privileges granted to them by the Board of Trustees. Such clinical privileges may include the right to admit patients, provide specific categories of patient care or perform specific procedures on patients.

**5.1.2 Clinical Privileges.** Clinical Privileges refers to the particular diagnostic and/or treatment modalities that a member of the Medical Staff is individually authorized to use in the care of patients in the Hospital.

**5.1.3 Admitting Privileges.** Admitting Privileges means that a Medical Staff member may admit patients to the inpatient or outpatient facilities at the Hospital. Membership on the Medical Staff does not automatically confer admitting privileges, which must be delineated in the list of the Medical Staff member's clinical privileges.

### **5.2. CLINICAL PRIVILEGE DELINEATION PROCESS**

**5.2.1 Application.** Each application for appointment and reappointment to the Medical Staff must be accompanied by a request for specific clinical privileges using a privilege delineation form approved by the Department Chair. Members of the Medical Staff may request modifications to or termination of clinical privileges at any time in accordance with the procedures set forth in this Article V.

#### **5.2.2 Review and Recommendation.**

- (a) The Department Chair, with recommendation by the respective Section Chiefs as applicable, shall review the request for specific clinical privileges and make his recommendations to the Medical Staff Executive Committee.
- (b) The following criteria shall be used in the review and delineation of clinical privileges:
- (c) The scope of services permitted by Connecticut State law and regulations, and by the Board of Trustees;
- (d) Education and training relative to privileges requested;
- (e) Current documented competence, professional performance, judgment, clinical or technical skills, documented experience in categories of treatment areas or procedures, and results of treatment;



- (f) Ability to perform privileges requested;
- (g) Current medical malpractice liability insurance coverage in the specialty for which privileges are requested in amounts of coverage as may be required from time to time by the Board of Trustees;
- (h) Information provided by peers and peer recommendations;
- (i) Continuing medical education related to the performance of requested clinical privileges;
- (j) Information from quality review and performance improvement activities and morbidity and mortality data if available;
- (k) Department-specific criteria developed by the Department Chair with input from appropriate Section Chiefs for specific privileges;
- (l) Ability of the Hospital to provide the necessary resources;
- (m) Involvement in professional liability actions including final judgments and settlements;
- (n) Previous or currently pending challenges to any professional licensing or registration, or the voluntary or involuntary relinquishment of any license or registration;
- (o) Voluntary or involuntary termination of Medical Staff membership or the voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; and
- (p) Health status adequate to perform the requested and granted clinical privileges.
- (q) The Medical Staff Executive Committee shall review the recommendations of the Department Chair and make its recommendation on the delineation of clinical privileges to the Professional and Quality Review Committee of the Board of Trustees.
- (r) The Board of Trustees shall have final approval of the delineation of clinical privileges.

### **5.3. PROVISION OF CARE IN EMERGENCY SITUATIONS**

Regardless of the specific clinical privileges granted to him, a member of the Medical Staff finding himself in the presence of a patient in a sudden life threatening emergency is expected to do all that he can do to save the patient's life within the scope of his professional license.

#### **5.4. TEMPORARY ADMITTING & CLINICAL PRIVILEGES**

Temporary admitting and clinical privileges may be granted for up to 120 calendar days by the Chief Executive Officer of the Hospital or his designee, upon the written recommendation of the respective Department Chair or Chief Medical Officer. Such temporary privileges may be granted: (i) when an application for Medical Staff membership is deemed complete and the applicant has received a favorable recommendation from the Medical Staff Credentials Committee or its Sub-Committee; or (ii) in unusual circumstances documented by the Department Chair and in the interest of patient care. To qualify for temporary privileges under 5.4 ii the applicant must have submitted: (a) a completed application for Medical Staff membership that is on file in Medical Staff Administration; (b) verification of current professional license and narcotic permits if applicable; (c) verification of graduation from an appropriate medical school and, where appropriate, residency training; and (d) professional liability insurance in the form of an insurance certificate and in the amount then currently required for Medical Staff members of Bridgeport Hospital. In addition, Medical Staff Administration shall, for each applicant for temporary privileges, submit a query to or enrollment in the National Practitioner Data Bank and review the response thereto, confirm that the applicant has no current or previous successful challenge to licensure or registration, no involuntary termination of medical staff membership at another hospital and no involuntary limitation, reduction, denial or loss of clinical privileges at another hospital. The Department Chair shall delineate clinical privileges for each practitioner holding temporary privileges and verify clinical competence and ability to perform the privileges requested. The Department Chair or Section Chief, or their designees, shall supervise a practitioner holding temporary privileges.

In addition, at the request of the Department Chair or his designee, the Chief Executive Officer of the Hospital shall have the authority to grant temporary privileges for the care of a specific patient to a Physician, Dentist or Podiatrist who is not a member of the Medical Staff of Bridgeport Hospital but who can be verified to be a member in good standing at another appropriately accredited hospital. Such applicants shall: (a) have a current professional license to practice; (b) be clinically competent; and (c) have professional liability insurance in the amount then currently required for Medical Staff members of Bridgeport Hospital. The Department Chair shall delineate clinical privileges for such Physician, Dentist or Podiatrist and verify clinical competence. The temporary privileges shall be limited to the duration of that patient's hospitalization at Bridgeport Hospital. In the exercise of such privileges the Physician, Dentist or Podiatrist shall be supervised by the Department Chair or his designee.

#### **5.5. DISASTER PRIVILEGES**

When an external disaster (Code D) has been declared, and the hospital Emergency Management Plan has been activated, and there is a need for additional Physicians or other Advanced Practice Providers (APPs) who are not members of the Medical Staff of Bridgeport Hospital, the Chief Executive Officer of the Hospital (CEO), or his designee, may grant Disaster Temporary Privileges to Physicians and other APPs. Such Disaster Privileges shall be granted consistent with the Disaster Privileges Policy.

## **ARTICLE VI CLINICAL DEPARTMENTS**

### **6.1. RESPONSIBILITY FOR PATIENT CARE**

**6.1.1 Responsible Physician and Informed Consent.** The management and coordination of each patient's care, treatment and services in the Hospital is the responsibility and privilege of a responsible Physician in the appropriate Section or Department with appropriate privileges.

Except in those emergency situations when it is physically impossible, the responsible Physician shall obtain proper informed consent on a form signed by the patient, parent, guardian, spouse, or other authorized representative as a prerequisite for any procedure or treatment requiring informed consent, as specified in the administrative policy of Bridgeport Hospital under "Patient Consent to Medical and Surgical Procedures and Anesthetics".

**6.1.2 Section Chief and Department Chair.** Oversight of the professional practice of the Medical Staff and Affiliated Health Care Professional Staff in each Section shall be the responsibility of the Section Chief and the Department Chair. In each instance, the Department Chair is the final departmental authority.

The Department Chair shall coordinate the professional practice of all the Sections.

**6.1.3 Medical Staff Executive Committee.** The coordination of the work of all the Departments and providing general oversight of the quality of care provided by them, shall be the responsibility of the Medical Staff Executive Committee.

**6.1.4 Board of Trustees.** The Medical Staff Executive Committee is responsible to the Board of Trustees for the quality of clinical care, treatment and services provided to patients in the Hospital and for ensuring quality patient care, treatment and services.

### **6.2. GENERAL STRUCTURE OF THE MEDICAL STAFF**

The Medical Staff structure is divided into Departments and Sections. The clinical activities of the Medical Staff shall be performed within the specific Departments and Sections. The designation of any Section does not imply that appointments to this Section must be made. The Medical Staff Executive Committee may add, modify or eliminate Sections to any Department as the need arises.

The Departments and Sections of the Medical Staff are as follows:

#### **Department of Anesthesiology**

- a) Section of Acute and Chronic Pain Management
- b) Section of Ambulatory Anesthesia
- c) Section of Cardiovascular Anesthesia
- d) Section of Critical Care Medicine

- e) Section of Neuroanesthesia
- f) Section of Obstetric Anesthesia
- g) Section of Pediatric Anesthesia

**Department of Emergency Medicine**

- a) Section of Emergency Care
- b) Section of Ambulatory Emergency Care
- c) Section of Occupational and Industrial Medicine
- d) Section of Pediatric Emergency Medicine

**Department of Medicine**

- a) Section of Allergy
- b) Section of Ambulatory Care
- c) Section of Cardiovascular Diseases
- d) Section of Dermatology
- e) Section of Endocrinology
- f) Section of Family Medicine
- g) Section of Gastroenterology
- h) Section of Geriatrics
- i) Section of Hematology
- j) Section of Hospital Medicine
- k) Section of Infectious Diseases
- l) Section of Nephrology
- m) Section of Neurology
- n) Section of Oncology
- o) Section Of Palliative Care
- p) Section of Physical Medicine and Rehabilitation
- q) Section of Primary Care
- r) Section of Pulmonary, Critical Care & Sleep Medicine
- s) Section of Radiation Medicine
- t) Section of Rheumatology

**Department of Obstetrics and Gynecology**

- a) Section of Ambulatory Gynecologic Surgery
- b) Section of Ambulatory Obstetrics and Gynecology
- c) Section of Gynecology
- d) Section of Gynecologic Oncology
- e) Section of Maternal-Fetal Medicine
- f) Section of Obstetrics
- g) Section of Reproductive Endocrinology/Infertility

**Department of Pathology and Laboratory Medicine**

- a) Section of Clinical Chemistry
- b) Section of Clinical Hematology and Microscopy
- c) Section of Cytology
- d) Section of Histology
- e) Section of Microbiology and Immunology

- f) Section of Pathology
- g) Section of Transfusion Medicine

**Department of Pediatrics**

- a) Section of Adolescent Medicine
- b) Section of Allergy and Immunology
- c) Section of Ambulatory Medicine
- d) Section of Cardiology
- e) Section of Developmental Pediatrics
- f) Section of Gastroenterology
- g) Section of Hematology/Oncology
- h) Section of Hospitalist Medicine
- i) Section of Neonatology
- j) Section of Nephrology
- k) Section of Pediatric Neurology
- l) Section of Pulmonology

**Department of Psychiatry**

- a) Section of Child Psychiatry
- b) Section of Geriatric Psychiatry

**Department of Radiology**

- a) Section of Body Computed Tomography
- b) Section of Interventional Radiology
- c) Section of Neuroradiology
- d) Section of Nuclear Radiology
- e) Section of Ultrasound

**Department of Surgery**

- a) Section of Cardio-Thoracic Surgery
- b) Section of General Surgery
- c) Section of Neurosurgery
- d) Section of Ophthalmology
- e) Section of Dentistry
- f) Section of Orthopedics
- g) Section of Otolaryngology and Head and Neck
- h) Section of Plastic and Reconstructive Surgery
- i) Section of Podiatry
- j) Section of Trauma, Burns and Surgical Critical Care
- k) Section of Urology
- l) Section of Vascular Surgery

**6.3. DEPARTMENT CHAIRS**

There shall be a Department Chair or Interim Department Chair responsible for each clinical Department. Each Department also may have a Vice or an Associate Department Chair responsible for assisting the Department Chair.

**6.3.1 Qualifications of Department Chairs.** The Chair of each Department shall be a Senior Attending Medical Staff member who is board certified by the appropriate American Board of Medical Specialties or other equivalent certifying board, and who specializes in the work of that Department.

**6.3.2 Appointment of Department Chair.** The process described below shall be followed to assist the Hospital and its Medical Staff in appointing a Department Chair.

- (a) When possible, a Department Chair should indicate his intention to resign his position at least twelve (12) months prior to the effective date of that resignation.
- (b) Upon acceptance of such resignation, or in the event of a vacancy, a Selection Committee shall be appointed by the President of the Medical Staff. The Selection Committee shall consist of three (3) existing Department Chairs, the President of the Medical Staff, the Senior Vice President-Chief Medical Officer, a Physician member of the Department for which the Chair is being sought, as well as one other Community-Based Physician on the Medical Staff. For the Departments which have a residency program with a Yale School of Medicine (YSM) affiliation or integration arrangement, the Chair of the YSM department will be asked to recommend an individual for appointment to the Selection Committee. A member of the Resident Staff from the involved Department may also be requested by the President of the Medical Staff to serve on the Selection Committee.
- (c) The Selection Committee shall elect its Chair from among its members.
- (d) The functions of the Selection Committee shall be to review the current job description of the Department Chair position and recommend appropriate modifications and to recommend to the Medical Staff Executive Committee candidates to fill any vacancies in the position of Department Chair.
- (e) In those departments composed of a single independent medical group practice or professional corporation providing the medical services in the Department by contract with the Hospital, the Department members will be given the opportunity to nominate a candidate for Department Chair from amongst their members. The nominee shall be reviewed by the Selection Committee and may be recommended by majority for appointment. If the candidate recommended is unacceptable to the Selection Committee, the Department shall be notified through its Department Chair or Acting Department Chair and the Department members will be given the opportunity to propose other candidates. If no candidate nominated by the Department members is acceptable to the Selection Committee, the Selection Committee will indicate an alternative selection process.

- (f) In departments other than those specified in Section 6.3.2(e) above, the Selection Committee will indicate the process they deem appropriate for the selection of a new Chair in the particular Department.
- (g) The Selection Committee shall report its choice of candidate through its Chair to the Medical Staff Executive Committee. The Medical Staff Executive Committee will review the recommendation and will forward its recommendation to the Professional and Quality Review Committee, which in turn will forward its recommendation to the Board of Trustees for final approval.

**6.3.3 Duties and Responsibilities of Department Chair.** The Department Chair shall be responsible for:

- (a) continuous surveillance of the professional performance of all Medical Staff, Affiliated Health Care Professional Staff, Resident Staff and Clinical Fellows in his Department who have delineated clinical privileges;
- (b) all clinical activities of the Department and any Section of the Department;
- (c) administrative activities of the Department unless otherwise provided by the Hospital;
- (d) organizing his Department and integrating the Department into the primary functions of the Hospital, coordinating the Department's sections and integrating services within the Department and with other Departments in the Hospital, to be in compliance with these Bylaws and Rules and Regulations in the best interests of patients and the Hospital;
- (e) developing and implementing policies and procedures that guide and support the provision of care, treatment and professional services in the Department, ensuring that Department policies and procedures are in accordance with these Bylaws, Rules and Regulations of the Medical Staff;
- (f) submitting an annual report of the Department's professional activities to the Medical Staff Executive Committee;
- (g) implementing an ongoing and periodic evaluation of each member of the Department, to be utilized in accordance with these Bylaws which method for evaluating Medical Staff performance, including the type of evaluation report, shall be determined by the Department Chair and approved by the Medical Staff Executive Committee in accordance with applicable legal and other requirements;
- (h) recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

- (i) maintaining the Department's component of the Medical Staff members' file in his office, in accordance with Article III, 9.1;
- (j) recommending to the Medical Staff Executive Committee and Board of Trustees membership on the Medical Staff and delineation of clinical privileges for each member of his Department in consultation with the appropriate Section Chief where applicable;
- (k) recommending to the Hospital a sufficient number of qualified and competent persons to provide care, treatment and services in the Department;
- (l) determining the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care, treatment and services in the Department;
- (m) presiding at meetings of the Department;
- (n) maintaining high standards of professional practice by all members of the Department and quality control programs as appropriate, and engaging in continuous assessment and improvement of the quality of care and services in the Department;
- (o) implementing the rules, regulations and policies approved by the Medical Staff Executive Committee;
- (p) coordinating the orientation and continuing medical educational programs within his own Department in order to meet the educational needs of all members of the Department as may be discerned through Department performance improvement activities; and with the programs of other Departments;
- (q) keeping Department records readily available and for forwarding all policies adopted by the Department and any Department recommendations to the Medical Staff Executive Committee;
- (r) recommending space and other resources needed by the Department for patient care;
- (s) participating in the assessment and recommendation of outside providers for needed patient care, treatment and services that cannot be provided in the Department or the Hospital;
- (t) consulting with the members of his Department or Section in decisions affecting the scope and patterns of professional practice of members of a Department or Section, or pertaining to the anticipated addition of full time or part time salaried staff;
- (u) having final departmental authority in matters of patient care in the Department;



- (v) designating another qualified member of the Department to administer the Department when the Chair is unavailable;
- (w) engaging in investigative and other peer review actions on behalf of all Medical Review Committees, when requested by such Committees; and
- (x) performing such other duties of the office as may from time to time be reasonably requested by the Medical Staff Executive Committee or the Board of Trustees.

**6.3.4 Performance of Department Chair.** The performance of the Department Chair will be reviewed periodically by the Senior Vice President-Chief Medical Officer. Such assessments will include recommendations regarding reappointment to the office.

**6.3.5 Removal of Department Chair.** A Department Chair may be removed from office by Chief Executive Officer or his designee, with the approval of the Medical Staff Executive Committee and Board of Trustees.

**6.3.6 Vice Chair.**

- (a) The Department Chair may choose to appoint a Vice Chair. The qualifications of the Vice Chair shall be consistent with those of the Chair as identified in Section 6.3.1.
- (b) The Vice Chair shall provide additional administrative support for projects and programs in the Department, and shall assume the duties and responsibilities of the Department Chair when the Department Chair is temporarily unavailable due to illness, vacation or scheduling conflicts. In the event of a vacancy in the Department Chair position, the Vice Chair shall become the Interim Department Chair and assume the responsibilities of the Department Chair until a new Department Chair is appointed.
- (c) The Vice Chair shall be appointed through the following process. Upon acceptance of the resignation of a current Vice Chair or in the event of a vacancy, the Department Chair shall nominate a candidate for the Vice Chair position and shall recommend the candidate to the Medical Staff Executive Committee. The Medical Staff Executive Committee will review the recommendation and will forward its recommendation to the Professional and Quality Review Committee, which in turn will forward its recommendation to the Board of Trustees for final ratification.
- (d) A Vice Chair may be removed from office by the Department Chair, with the approval of the Medical Staff Executive Committee and Board of Trustees.
- (e) Vice Chairs shall serve at two (2) year term. A two (2) year term may be renewed for an additional two (2) years.

- (f) The performance of the Vice Chair will be reviewed periodically by the Department Chair. A formal review will be conducted, at minimum, following the first two (2) year term. The review will include a recommendation as to whether reappointment to a second term will be recommended. Approval of a subsequent term is subject to the process identified in “c” above.

### **6.3.7 Associate Chair**

- (a) The Chair may choose to appoint Associate Chair(s). The qualifications of any Associate Chair shall be consistent with those of the Chair as identified in Section 6.3.1. The Associate Chair is selected from among the members of the Active Medical Staff.
- (b) The Associate Chair represents the interests of a group of practitioners at a facility that is considered part of the Hospital’s vertical network overseeing the day to day provision of care and operations and providing on site administrative support to the Chair at that location.
- (c) The Associate Chair shall be appointed through the following process: Upon acceptance of the resignation of a current Associate Chair or in the event of a vacancy, the Department Chair shall nominate a candidate for the Associate Chair position and shall recommend the candidate to the Medical Staff Executive Committee. The Medical Staff Executive committee will review the recommendation and will forward its recommendation to the Professional and Quality Review Committee which, in turn, will forward its recommendation to the Board of Trustees for final ratification.
- (d) An Associate Chair may be removed from office by the Department Chair with the approval of the Medical Staff Executive Committee and Board of Trustees.
- (e) Associate Chairs serve a two (2) year term which may be renewed for an additional two (2) year term. The performance of the Associate Chair will be reviewed periodically by the Department Chair. A formal review will be conducted, at minimum, following the first two (2) year term. The review will include a recommendation as to whether reappointment to a second term will be recommended. Approval of a subsequent term will be subject to the process identified in “c” above.

#### **6.4. SECTION CHIEFS**

There shall be a Section Chief or Acting Section Chief responsible for each clinical Section within a Department.

**6.4.1 Qualifications of Section Chiefs.** The Section Chief shall be a member of the Active Medical Staff who is board certified by the appropriate Specialty Board or other equivalent certifying board, and who specializes in the professional practice of that Section.

**6.4.2 Appointment of Section Chief.** The Section Chief shall be appointed or re-appointed by the Department Chair with the approval of the Medical Staff Executive Committee and the Board of Trustees.

- (a) The appointment of a Section Chief, other than a physician employee of Bridgeport Hospital or NEMG, or a successor organization, shall be limited to not more than five (5) years. The Section Chief may be recommended for reappointment by the Department Chair with approval of the Medical Staff Executive Committee and Board of Trustees.
- (b) A Section Chief may be removed by the Chair of the Department for performance-related reasons with the approval of the Medical Staff Executive Committee

#### **6.4.3 Duties and Responsibilities of Section Chief.**

- (a) The Section Chief shall be responsible to the Department Chair for the professional practice of the Medical Staff, Affiliated Health Care Professional Staff, Resident Staff and Clinical Fellows assigned to the Section.
- (b) The Section Chief shall hold Section meetings in accordance with Department policies.
- (c) The Section Chief shall be responsible to the Department Chair for the Performance Management program for the Section.
- (d) The Section Chief is authorized to take investigative and other peer review actions regarding the professional practice of the Medical Staff in the Section on behalf of all Medical Review Committees of the Hospital.
- (e) The Section Chief shall promote, facilitate and coordinate the overall continuing medical educational programs within the Section and support the medical education of the Resident Staff and Clinical Fellows in the Section.

**6.4.4 Acting Section Chief.** In the event of a vacancy in the Section Chief position, an Acting Section Chief may be appointed by the Chair of the Department from the Active Medical Staff members specializing in the professional practice of that Section. Such appointments shall be subject to the approval of the Medical Staff Executive Committee and the Board of Trustees. The duties and responsibilities shall be the same as those of a Section Chief.

An Acting Section Chief may be removed by the Department Chair with the approval of the Medical Staff Executive Committee and Board of Trustees.

## **6.5. INDEMNIFICATION**

The role of the Department Chairs, Interim Department Chairs, Vice Chair, Associate Chair, Section Chiefs, and Acting Section Chiefs under these Bylaws and Rules and Regulations is to assist the Medical Staff and the Hospital in assuring proper patient care. It is not intended that such an individual is to personally be involved in the care provided by any member of his Department or Section or be in any way liable for such care. As in the case of all Medical Staff members who serve in official Medical Staff positions, such individuals shall be entitled to indemnification in the event of any suits or claims arising out of their Medical Staff position in accordance with the indemnification provisions of the Connecticut Nonstock Corporation Act as amended from time to time.

## **6.6. TERMINATION OF EMPLOYMENT OF A MEDICAL STAFF MEMBER IN MEDICAL-ADMINISTRATIVE POSITIONS**

Those members of the Active Medical Staff in medical-administrative positions shall be subject to periodic evaluation to assess their administrative and clinical performance.

The evaluation of such Medical Staff member's administrative performance shall be the responsibility of the Chief Executive Officer of the Hospital or his designee, with input from the Medical Staff where appropriate. Those Medical Staff members found deficient by the Chief Executive Officer of the Hospital or his designee shall be removed from the administrative position by the Chief Executive Officer of the Hospital. Such Medical Staff member's membership on the Active Medical Staff shall be determined pursuant to the terms of their contractual agreement with the Hospital.

The evaluation of such Medical Staff member's clinical performance shall be according to the same written criteria by which the Active Attending Medical Staff members of the Section are evaluated. The clinical performance evaluation shall be carried out by an Active Attending Medical Staff member of the applicable Section or Department.

## **ARTICLE VII MEDICAL STAFF OFFICERS**

### **7.1 OFFICERS OF THE MEDICAL STAFF**

The officers of the Medical Staff shall consist of a President, a Vice President, an Immediate Past President (if elected pursuant to these Bylaws), a Secretary, and a Treasurer.

### **7.2 ELECTION OF OFFICERS**

**7.2.1 Election of President, Vice President and Immediate Past President.** The President and Vice President shall be elected by a majority vote of the Active Medical Staff present at the annual meeting of the Active Medical Staff at which a quorum is present. In addition, if elected by a majority of the Active Medical Staff, the Immediate Past President shall serve as an officer of the Active Medical Staff.

A member (defined as employed by, or contracted through an exclusive Professional Services Agreement with) of NEMG or Yale Medicine (YM) may be elected as one of the above officers. If this were to occur, a “Community Based Physician” shall also be elected to preserve the one member community physician majority as defined in Article VIII, Section 8.2.1.

**7.2.2 Vacancy in President Position.** Should the position of President of the Medical Staff become vacant, the Vice President shall become the President of the Medical Staff until the next annual meeting of the Active Medical Staff.

**7.2.3 Vacancy in Vice President or Immediate Past President Position.** Should the position of Vice President or Immediate Past President of the Medical Staff become vacant, the members of the Medical Staff Executive Committee shall elect, at its next meeting, one of its at-large-members to serve in the vacated position until the next annual meeting of the Medical Staff.

**7.2.4 Election of Secretary and Treasurer.** The Secretary and the Treasurer of the Medical Staff shall be members of the Medical Staff Executive Committee and each shall be elected by the Medical Staff Executive Committee at the January meeting. The two (2) offices may be held by the same individual. In the event of a vacancy in the position of Secretary or Treasurer, the members of the Medical Staff Executive Committee shall elect, at its next meeting, one of its members to serve in such position.

### **7.3 TERM OF OFFICE**

The officers of the Medical Staff shall be elected for a term of one year, provided, however, the President, Vice President and Immediate Past President may not be elected for more than two consecutive terms to each office.

## 7.4 REMOVAL OF OFFICERS

Any member of the Active Medical Staff may initiate the recall election of a medical staff officer. Such recall action shall require a vote of two-thirds of the Active Medical Staff present at a regular or special meeting of the Active Medical Staff at which a quorum is present. The intent to remove must be published with the notice of the meeting.

## 7.5 DUTIES OF OFFICERS

**7.5.1 President of the Medical Staff.** The President of the Medical Staff shall have the following duties:

- (a) Preside at all meetings of the Medical Staff.
- (b) Serve as a member of the Board of Trustees during his term of office.
- (c) Bring the concerns of the Medical Staff to the attention of the Chief Executive Officer of the Hospital, and the Medical Staff Executive Committee.
- (d) Bring to the attention of the Board of Trustees, through his membership on the Board of Trustees, those matters which the Medical Staff may wish to have brought before the Board of Trustees.
- (e) Serve as an ex-officio member of every Medical Staff committee with the right to vote.
- (f) Appoint, except as otherwise provided in these Bylaws, all Medical Staff committees.
- (g) Appoint, except as otherwise provided in these Bylaws, all Medical Staff Committee Chairs.
- (h) Appoint, except as otherwise provided in these Bylaws, all Medical Staff representatives to Hospital committees.
- (i) Serve as Chair of the Medical Staff Executive Committee.
- (j) Appoint members of any sub-committee of the Medical Staff Executive Committee.
- (k) Appoint an alternate member of the Medical Staff Executive Committee to serve as a member-at-large in the event of a vacancy of an at-large position on the Medical Staff Executive Committee.

**7.5.2 Vice President of the Medical Staff.** The Vice President of the Medical Staff, in the absence of the President, or the President's inability to serve, shall assume all the duties and have all the authority of the President of the Medical Staff (except as provided in Section 8.2.3).

**7.5.3 Secretary of the Medical Staff.** The Secretary of the Medical Staff shall have the following duties:

- (a) Take minutes of all meetings of the Medical Staff Executive Committee and of the Medical Staff;
- (b) Conduct official correspondence of the Medical Staff Executive Committee and of the Medical Staff.

**7.5.4 Treasurer of the Medical Staff.** The Treasurer of the Medical Staff shall have the following duties:

- (a) Collect and deposit in the Medical Staff bank accounts all Medical Staff funds;
- (b) Issue payments as instructed by the Medical Staff Executive Committee and maintain an accounting of such funds;
- (c) Submit a financial report annually, and as otherwise requested, to the Medical Staff Executive Committee.

## **ARTICLE VIII MEDICAL STAFF AND OTHER COMMITTEES AND MEETINGS**

### **8.1. GENERAL**

**8.1.1 Types of Committees.** The Medical Staff has established standing and special committees in order to support the clinical departments' activities and to assist the officers of the Medical Staff in fulfilling their governance responsibilities. The Medical Staff Executive Committee may establish ad hoc committees or task forces to address specific issues.

**8.1.2 Appointment and Removal of Committee Members.** Unless otherwise specified in these Bylaws, the Chair and medical staff members of all committees shall be appointed by the President of the Medical Staff with the approval of the Medical Staff Executive Committee. A member of a committee may be removed from the committee for cause by the President of the Medical Staff, subject to the approval of the Medical Staff Executive Committee. To be eligible to serve as Chair of any committee, newly appointed practitioners must have successfully completed and fulfilled the obligations associated with routine FPPE.

**8.1.3 Term of Committee Members.** Unless otherwise specified in these Bylaws, committee members shall be appointed for a term of two (2) years and shall serve until the end of this period or until the member's successor is appointed. Members may be reappointed to a committee and thus serve for more than two (2) years.

**8.1.4 Meetings of Committees.** The mandate of each committee and its frequency of meetings shall be determined by the Medical Staff Executive Committee except for the Medical Staff Executive Committee itself. All Medical Staff committees shall report timely to the Medical Staff Executive Committee.

**8.1.5 Voting.** Only Active and Affiliated Health Care Professional Staff members on any Medical Staff Committee may vote.

The Chief Executive Officer of the Hospital or his designee may attend all meetings of the Medical Staff and its committees, without voting rights.

**8.1.6 Quorum.** Unless otherwise specified in these Bylaws, a quorum for any meeting of a committee of the Medical Staff shall consist of three (3) members of the Medical Staff or Affiliated Health Care Professional Staff of that committee.

### **8.2. MEDICAL STAFF EXECUTIVE COMMITTEE**

**8.2.1 Composition.** The Medical Staff Executive Committee shall consist of the following members:

- (a) President of the Medical Staff



- (b) Senior Vice President-Chief Medical Officer
- (c) Vice President of the Medical Staff
- (d) Immediate Past President of the Medical Staff if elected pursuant to Section 7.2.1.
- (e) Members-at-large who are Assistant, Associate and Senior Attending Medical Staff who have been members of the Active Medical Staff for at least three (3) years and who are elected by a majority vote of the Active Medical Staff present at the annual meeting of the Active Medical Staff at which a quorum is present.
- (f) Chairs of the Departments of Anesthesiology, Emergency Medicine, Medicine, Obstetrics & Gynecology, Pathology, Pediatrics, Psychiatry, Radiology and Surgery.
- (g) A member of the Affiliated Health Care Professional Staff who shall attend as a member without a vote.
- (h) Chief Executive Officer of the Hospital, or his designee, who shall attend each Medical Staff Executive Committee meeting as an ex-officio member without a vote.

At all times, the number of Community-Based Medical Staff members on the Medical Staff Executive Committee shall exceed by one (1) member the number of hospital-based Medical Staff members (including Department Chairs and the Senior Vice President-Chief Medical Officer) on the Medical Staff Executive Committee.

**8.2.2 Terms of Members-at-Large.** The members-at-large of the Medical Staff Executive Committee shall be elected for a term of one (1) year. Members-at-large may not be elected for more than four (4) consecutive terms as at-large members.

**8.2.3 Chair.** The President of the Medical Staff shall serve as Chair of the Medical Staff Executive Committee. In the event of his absence, the Vice President or the Immediate Past President, in that order, shall serve as Chair pro-tempore.

**8.2.4 Quorum.** A quorum for a meeting of the Medical Staff Executive Committee is a majority of the committee members.

**8.2.5 Meetings.** The Medical Staff Executive Committee shall meet at least nine (9) times per year.

All Active Medical Staff members who are not members of the Medical Staff Executive Committee may attend meetings and participate therein, but shall have no voting rights. Written notification of a Medical Staff member's intent to attend a Medical Staff Executive Committee meeting shall be forwarded to the President at least two (2) weeks before the meeting.

The Medical Staff Executive Committee shall maintain a permanent record of its proceedings and actions. The Committee shall report at all quarterly Medical Staff meetings.

**8.2.6 Voting and Proxies.** Each Medical Staff Executive Committee member shall have a single vote. Any Medical Staff Executive Committee member, when unable to attend a meeting, may be represented by a proxy who shall have voting privileges, provided notification of the proxy has been given to the Chair of the Medical Staff Executive Committee by the absentee member. This proxy shall not be another member of the Medical Staff Executive Committee. For members-at-large, the proxy preferably shall be one of the alternate members of the Medical Staff Executive Committee. For all other members, the proxy may be designated by this member. A proxy shall be a member of the Active Medical Staff.

**8.2.7 Responsibilities of the Medical Staff Executive Committee.**

- (a) The Medical Staff Executive Committee is responsible to the Board of Trustees for the quality of clinical work in the Hospital.
- (b) The Medical Staff Executive Committee is empowered to act for the Medical Staff in the intervals between Medical Staff meetings, subject to review by the Medical Staff at the next quarterly meeting.
- (c) The Medical Staff Executive Committee is responsible for making Medical Staff recommendations to the Board of Trustees for approval. Such recommendations shall include but shall not be limited to the following:
  - (d) The Medical Staff structure;
  - (e) The mechanism used to review credentials and to delineate individual clinical privileges;
  - (f) Recommendations of individuals for Medical Staff membership;
  - (g) Recommendations for delineated clinical privileges for each eligible individual;
  - (h) The participation of the Medical Staff in Hospital Performance Improvement activities;
  - (i) The mechanism by which Medical Staff membership may be terminated including the hearing and appellate review processes.
  - (j) The Medical Staff Executive Committee shall review and act upon the reports and recommendations of the Medical Staff committees and clinical Departments.

- (k) The Medical Staff Executive Committee shall be responsible for implementation of policies concerning the improvement of the quality of patient care in the Hospital.
- (l) The Medical Staff Executive Committee can recommend amendment of these Bylaws or Rules and Regulations as provided in Article XI (Bylaws) and Article XII (Rules and Regulations).
- (m) The Medical Staff Executive Committee will develop and adopt such policies and procedures as it deems necessary, and forward such policies to the Board of Trustees for informational purposes.
- (n) The Medical Staff Executive Committee shall request an evaluation of a Medical Staff member when there is doubt about an applicant's ability to perform the privileges requested or granted.
- (o) The Medical Staff may remove any of the above authority from the Medical Staff Executive Committee, or delegate additional authority to the Medical Staff Executive Committee, by amending these Bylaws pursuant to Article XI.

#### **8.2.8 Conflicting Actions of the Medical Staff.**

- (a) All actions of the Medical Staff Executive Committee can be overruled by a majority vote of the Active Medical Staff present at the next regular or special meeting at which a quorum is present, provided that notice of such meeting contains a statement of the action to be voted upon. This notice requirement shall be satisfied by including the minutes of the relevant Medical Staff Executive Committee meeting in the materials circulated for the Medical Staff meeting.
- (b) Action initiated by the Active Medical Staff, other than actions to amend these Bylaws, shall be referred to the Medical Staff Executive Committee for approval, change or other action, and be completed within a reasonable period of time. Any changes from the Active Medical Staff action, or rejection of it by the Medical Staff Executive Committee, shall be referred back to the Active Medical Staff for further consideration at its next regular meeting. In all cases, the action to be considered must be included in the notice of the particular meeting.
- (c) At times the medical staff may disagree with the Medical Staff Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto.

#### **8.2.9 Disagreements between the Medical Staff and the Medical Staff Executive Committee on such issues will be resolved using the following mechanism:**

- (a) Any challenge by the medical staff must be agreed to in writing by a minimum of 25 members of the Active Medical Staff. This

petition will be submitted to the Chair of the Medical Staff Executive Committee.

- (b) The Medical Staff Executive Committee shall discuss the concern at their next regularly scheduled meeting. If the Medical Staff Executive Committee agrees with the concern, they will modify the Rule and Regulation or Policy and submit the revision to the Medical Staff and as appropriate to the Board of Trustees for approval.
- (c) If the Medical Staff Executive Committee does not concur with the disagreement, the Chair of the Medical Staff Executive Committee will appoint a committee of six (6) members of the Medical Staff Executive Committee and six (6) additional members from the active medical staff who are not members of the Medical Staff Executive Committee, at least three (3) of whom shall come from the petitioning group. This committee by majority vote shall submit their recommendation to the Medical Staff Executive Committee for review and approval and if necessary to the Board of Trustees for final approval.
- (d) If the medical staff disagrees with this action of the Medical Staff Executive Committee, the medical staff by a two thirds vote of the members in attendance at a meeting at which a quorum is present, may adopt a Rule and Regulation or Policy and propose alternate language directly to the Board of Trustees. The Board shall review the differing recommendations concerning the Rules and Regulations or Policies from the Medical Staff Executive Committee and the medical staff and shall have final authority to resolve the differences between the two parties. The process that will be followed is the responsibility of the Board.

### **8.3. COMMITTEES OF THE MEDICAL STAFF**

#### **Bylaws Committee**

Charge: The Bylaws Committee is responsible for periodic reviews of the Medical Staff Bylaws, Rules and Regulations. The Bylaws Committee shall recommend to the Medical Staff Executive Committee changes to these Bylaws from time-to-time as appropriate.

Composition: The Chair shall be appointed by the President of the Medical Staff. Other members shall include the Chief Medical Officer and six members of the Active Medical Staff appointed by the President of the Medical Staff only two of whom shall be current Department Chairs.

Meetings: As needed

#### **Cancer Committee**

Charge: The Cancer Committee is responsible for monitoring and advising the Medical Staff Executive Committee and the Hospital on all aspects of cancer care as required by the American

College of Surgeons' (ACOS) Committee on Cancer as well as to oversee clinical cancer activities including monitoring and analyzing the quality of care provided to cancer patients at Bridgeport Hospital facilities.

Composition: The Chair shall be a physician actively caring for cancer patients at Bridgeport Hospital. Representatives will include physicians from the following departments: medical oncology, surgical oncology, gynecologic oncology, diagnostic and therapeutic radiology, pathology and palliative care medicine; the Cancer Liaison Physician to the ACOS, a Performance Management nurse, and representatives from Hospital administration, nursing, social work, tumor registry, clinical nutrition, pharmacy and rehabilitation services.

Meetings: A minimum of ten (10) per year

### **Continuing Medical Education Committee**

Charge: The Continuing Medical Education Committee is a multidisciplinary committee responsible for encouraging Medical Staff participation in and support of the Hospital's continuing medical education programs. The Committee shall assist the Department Chairs in the continuing medical education efforts within the Department and shall assure compliance with the requirements of external agencies for continued accreditation of the Hospital's Continuing Medical Education Program. The Committee shall encourage a commitment to lifelong learning by the Medical Staff at Bridgeport Hospital.

Composition: The Designated Institutional Officer (DIO) / Chair of Medical Education shall serve as Chair of this Committee. Other members shall be recommended by the Chief Medical Officer and appointed by the President of the Medical Staff.

Meetings: A minimum of three (3) per year.

### **Credentials Committee**

Charge: The Credentials Committee shall (1) review all applications for initial appointment to all categories of the Medical Staff, investigate and consider the educational qualifications, previous professional experience, character, residence, licensure and specialized training of the applicant; consult with the Department Chairs and Section Chiefs; and shall report its findings and make recommendations to the Medical Staff Executive Committee regarding each applicant and (2) receive and review recommendations from each Department Chair for all reappointments to the Medical Staff; shall consult with the Department Chairs concerning these recommendations; and shall forward its recommendations concerning reappointment to the Medical Staff Executive Committee. The Credentials Committee may opt to appoint a Sub-Committee to act on its behalf with respect to applicants for appointment that are eligible for temporary privileges consistent with these Bylaws and relevant Medical Staff Policies.

With approval from the Medical Executive Committee, some or all 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 Bridgeport 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 Staff Executive Committee for action.

Composition: The Immediate Past President of the Medical Staff shall serve as Chair. Other members shall include seven (7) Active Medical Staff members, at least one (1) from each of the following Departments: Internal Medicine, Surgery, OB/GYN and Pediatrics and at least one (1) of whom is a member of the Medical Staff Executive Committee.

Meetings: A minimum of eight (8) per year.

### **Graduate Medical Education Committee (GMEC)**

Charge: The GMEC shall be responsible for monitoring and advising the Medical Staff Executive Committee and the Hospital regarding all aspects of resident education as required by the Accreditation Council on Graduate Medical Education (ACGME). Specific responsibilities include, but are not limited to, oversight of program compliance with ACGME and Residency Review Committee regulations and monitoring the quality and safety of patient care provided by participants in the GME programs. The GMEC will provide an annual written report of its activities to the Medical Staff Executive Committee.

Composition: The Designated Institutional Officer (DIO) / Chair of Medical Education shall serve as Chair of the GMEC. Additional members shall include the Chief Medical Officer or his/her designee, Graduate Medical Education specialty and subspecialty program directors, and representatives from among the resident and clinical fellow staff.

Meetings: A minimum of ten (10) per year.

### **Infection Control Committee (ICC)**

Charge: The ICC will define, survey, correlate, review, evaluate, revise and institute any measures and/or policies necessary to prevent, contain, investigate and control healthcare-associated infections and other infectious diseases among patients, staff and others through the Hospital deliver network. The ICC will advise the Medical Staff Executive Committee on all aspects of infection prevention and provide an annual written report of activities to the Medical Staff Executive Committee.

Composition: The Chief of Hospital Epidemiology and Infection Prevention shall serve as Chair of the ICC. The members shall include physician representation from the following departments: Internal Medicine, Surgery, Emergency Medicine, Obstetrics and Gynecology and Pathology. The ICC will also include Hospital staff representatives from Occupational Health, Nursing, Environmental Services, Food and Nutrition, Infection Control, Pharmacy, Ambulatory Services Departments and Hospital Administration.

Meetings: Monthly.

### **Medical Records Committee**

The Medical Records Committee is responsible for oversight of the content and quality of the medical record to include completeness, timeliness, and documentation integrity for provision of patient care, reimbursement, and to ensure regulatory compliance. Advises the Medical Executive

Committee (MEC), and where appropriate, Administration and Clinical personnel in matters pertaining to medical records and clinical information.

Composition: Members include representatives from the following areas: Department of Medicine, Department of Surgery, Department of Emergency Medicine, Department of Psychiatry, Teaching Service, Nursing, Accreditation and Regulatory Affairs and Health Information Management.

The Chief Medical Officer shall recommend membership to the President of the Medical Staff.

Meetings: At least 6 times per year.

Responsibilities:

The Medical Records Committee implements the provisions of the Rules and Regulations that pertain to the charge of the Committee; develops a program for continuing review of medical records as to adequacy and quality of content; provides feedback and education to medical staff members in appropriate documentation practices as deemed appropriate. Provides a written report to the Medical Executive Committee which includes ongoing monitoring activities, findings and recommendations; alerts the MEC of any medical staff who exhibit patterns of non-compliance with approved documentation guidelines for review and appropriate administrative action.

**Medical Staff Evaluation Committee**

Charge: The Medical Staff Evaluation Committee shall be responsible to review and attempt to resolve disagreements between members of the Medical Staff and their respective Department Chairs relative to matters related to clinical privileges and/or change in Medical Staff status. The Committee shall report to the Medical Staff Executive Committee.

Composition: The President of the Medical Staff shall serve as Chair. An Active Attending Medical Staff member from each Department shall comprise the remaining membership. No other member of the Medical Staff Executive Committee shall be a member of the Medical Staff Evaluation Committee.

Meetings: As needed.

**Medical Staff Professionalism Committee (MSPC)**

Charge: The MSPC shall have the following responsibilities and authority: (a) review alleged violations of the Medical Staff Code of Conduct referred to the MSPC by the President of the Medical Staff, Chief Medical Officer or any Department Chair or Section Chief; (b) review grievances referred to the MSPC in accordance with Section 9.1 of these Bylaws; (c) facilitate mechanisms for correction of problems identified including, but not limited to, referral of practitioners to external programs or counseling as appropriate; (d) make recommendations to the Medical Staff Executive Committee for the initiation of an investigation if and as appropriate; (e) assist the Hospital in maintaining compliance with the requirements of The Joint Commission; (f) report to the Medical Staff Executive Committee regarding institutional concerns related to practitioner behavior; (g) refer issues, if and as applicable, having to do with alleged violations of the Code of Conduct to the Medical Staff Executive Committee, for deliberation; and (h) communicate with and involve individuals whose practice or aspects of practice are under review

as well as with the President of the Medical Staff, the Chief Medical Officer and the applicable Department Chair or Section Chief. Such functions as described herein shall be peer review activities of the MSPC, as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence. The Chief Medical Officer shall act between meetings of the MSPC to address issues of immediate concern having to do with compliance with the Code of Conduct. The MSPC shall report to the Medical Staff Executive Committee.

Composition: The Immediate Past President of the Medical Staff shall serve as Chair. Other members shall include the President of the Medical Staff, the Vice President of the Medical Staff, the Chief Medical Officer or designee, two Community-Based Medical Staff members of the Medical Staff Executive Committee, the Chair of the Credentials Committee, and the Senior Vice President of Human Resources or designee if the practitioner at issue is an employee of the Hospital or another Yale New Haven Health System entity. The Committee shall be supported by a Legal & Risk Services representative.

Meetings: At least annually.

### **Nominating Committee**

Charge: The Nominating Committee shall be responsible for nominating the President, Vice President, an Immediate Past President of the Medical Staff (if deemed appropriate in the discretion of the Committee), and the Members at Large to serve on the Medical Staff Executive Committee. Two alternates to serve on the Medical Staff Executive Committee shall also be nominated. The Nominating Committee shall also propose a representative from among the Affiliated Health Care Practitioner Medical Staff category to serve as the non-voting participant in the Medical Staff Executive Committee. This nomination shall be made at the same time as the nominations for physician members.

Nominations shall occur in accordance with guidelines adopted by the Medical Staff.

The Committee shall report its recommendations to the Medical Staff Executive Committee in November for informational purposes and to the Medical Staff at its annual meeting in December for approval. The Committee shall elect its Chair from among the Active Attending Medical Staff members at its first meeting.

Composition: Four (4) Active Medical Staff members who do not currently serve as members of the Medical Staff Executive Committee. No member will serve more than two (2) consecutive years on the Nominating Committee, and all Committee members shall be appointed by the Medical Staff President in such a manner that not less than three (3) different Departments are always represented.

Meetings: At least one a year

### **Nutrition, Pharmacy and Therapeutics Committee**

Charge: The Nutrition, Pharmacy and Therapeutics Committee provides direction and oversight in the use of pharmaceuticals, including nutritional support. The Committee shall recommend and review appropriate drug use evaluation studies. It shall report its findings and recommendations to the Medical Staff Executive Committee.



Composition: Membership shall be recommended by the Chief Medical Officer and appointed by the President of the Medical Staff

Meetings: At least four (4) times per year

### **Practitioner Health Committee**

Charge: The Practitioner Health Committee is responsible for evaluating the ability of practitioners to exercise their clinical privileges with reasonable skill and safety, arranging appropriate assessments and evaluations, and overseeing any relevant monitoring as indicated for practitioners who are referred for review. The Practitioner Health Committee will make recommendations as indicated to the Credentials Committee or Professional Practice Evaluation Committee (PPEC). Such functions as described herein shall be peer review activities of the Practitioner Health Committee, as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence.

The Committee shall report to the Medical Staff Executive Committee at least annually.

Composition: The Chief Medical Staff Officer shall serve as Chair. Additional members shall include five Active Attending physicians, one each from Psychiatry and Geriatrics, and two at-large members. The Director of Risk Management shall serve as a consultant to the Committee.

Meetings: As needed.

### **Professional Practice Evaluation Committee (PPEC)**

Charge: The PPEC is responsible for conducting peer review activities related to practitioner competency as further described in the Medical Staff Policy regarding Peer Review. These activities include, but are not limited to, the implementation of a clinical risk plan and a mortality review process. The Committee shall report relevant findings and recommendations to the Medical Staff Executive Committee. The functions of this Committee shall be considered peer review activities as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence.

Composition: The President of the Medical Staff shall serve as Chair. Other members include representatives from the Departments of Surgery, Medicine, Pediatrics, Obstetrics & Gynecology, Emergency Medicine and Anesthesia. The Chief Medical Officer, Sr. Vice President of Patient Care Services and Directors of Risk Management and Quality Management shall serve as non voting members.

Meetings: A minimum of eight (8) per year.

## **8.4. MEETINGS OF THE ACTIVE MEDICAL STAFF**

**8.4.1 Meeting Schedule.** The Active Medical Staff shall hold quarterly meetings in March, June, September and December each year, for the transaction of the business of the Medical Staff and for receiving and acting upon the minutes of the Medical Staff Executive Committee meetings. The Annual Meeting of the Active

Medical Staff shall be the December meeting each year. Notice of each meeting of the Active Medical Staff shall be provided to each voting member of the Active Medical Staff.

A special meeting of the Active Medical Staff shall be called promptly by the President of the Medical Staff on receipt of a written request, signed by twenty (20) voting members of the Active Medical Staff.

The agenda for all meetings of the Active Medical Staff must be presented to each voting Medical Staff member at least one (1) week prior to the meeting.

**8.4.2 Attendance.** All members of the Active Medical Staff are encouraged to attend at least fifty percent (50%) of the meetings of the Medical Staff each year. Attendance records shall be kept by the Secretary of the Medical Staff.

Non-members may be invited to attend the Medical Staff meeting at the discretion of the President of the Medical Staff.

**8.4.3 Quorum.** A quorum will consist of ten percent (10%) of the voting members of the Active Medical Staff. If a quorum is not present at any Medical Staff meeting, any action of the Medical Staff Executive Committee submitted for approval by the Medical Staff will be considered approved, except for proposed Bylaw changes.

**8.4.4 Voting.** All members of the Active Medical Staff may vote at meetings of the Medical Staff.

A majority vote of those present and voting, at a meeting at which a quorum is present, shall be the action of the Medical Staff, except as may be otherwise indicated in these Bylaws.

**8.4.5 Amendment of Bylaws.** The process by which these Bylaws may be amended by the Active Medical Staff is set forth in Article XI of these Bylaws.

## **8.5. DEPARTMENT MEETINGS**

Members of the Active Medical Staff in each Clinical Department shall meet at least quarterly to attend to the business of the Department. The Department Chair shall preside at the Department meetings. Each member of the Active Medical Staff in the Department is encouraged to attend. Attendance records will be kept by the Department Chair or his designee.

## **ARTICLE IX**

### **GRIEVANCES, CORRECTIVE ACTION AND SUSPENSIONS**

#### **9.1 GRIEVANCES CONCERNING PROFESSIONALISM**

**9.1.1 Initiation of Grievance.** Any member of the Medical Staff or hospital employee who has a serious concern about the professional behavior of a member of the Medical Staff, including but not limited to the member's compliance with the Policy on Professionalism, may submit a grievance to the President of the Medical Staff, the Chief Medical Officer or the Chair of the member's Department. Grievances shall be in writing and specific in nature. Grievances concerning a member of the Medical Staff and filed by someone who is not a member of the Medical Staff shall be referred to the Chief Executive Officer of the Hospital, who at his discretion may submit the grievance to the President of the Medical Staff, the Chief Medical Officer or the relevant Department Chair to consider action in accordance with the provisions of this Section 9.1. All concerns related to professionalism shall follow the procedures set forth in the Policy on Professionalism and these Bylaws; provided that in the event of a conflict between the Policy on Professionalism and these Bylaws, these Bylaws shall govern; and further provided that to extent reasonably practicable, both the Policy on Professionalism and these Bylaws shall be applied.

**9.1.2 Referral to the Medical Staff Professionalism Committee (MSPC).** Following receipt of a grievance concerning professionalism and validation that the grievance is credible, the President of the Medical Staff, Chief of Staff or Department Chair shall consider whether the incident can be addressed through informal inquiry, discussion, counseling and the like in accordance with the Policy on Professionalism, or whether the grievance should be referred to the MSPC for further action. Incidents that have not been resolved after attempts at informal inquiry, discussion, counseling and the like, that are reasonably unlikely to be so resolved, and/or that are of a serious nature or demonstrate a pattern of inappropriate behavior, will be referred to the MSPC.

#### **9.1.3 MSPC Procedures.**

- (a) The MSPC shall review the grievance, and whenever possible, attempt to resolve the grievance collegially.
- (b) At the discretion of the MSPC, the involved Medical Staff member may meet with the MSPC for the purpose of resolving the grievance. The MSPC may also elect to obtain input from others involved in or with knowledge of the relevant incident(s).
- (c) The procedures for the MSPC handling grievances shall be informal and shall not be subject to the provisions of Article X of these Bylaws. For example, there shall be no right to a hearing or representation by a lawyer.

**9.1.4 MSPC Action.** The MSPC may decide (a) that a grievance has no merit, (b) that an informal resolution is appropriate and sufficient to address the matter, or (c) to implement a collegial intervention. Such actions may include a referral for counseling, education, and related steps to address concerns about a member's professionalism. The foregoing decisions of the MSPC are not professional review actions and shall be deemed final. Alternatively, the MSPC may decide that a grievance is of sufficient severity or represents a pattern of behavior that warrants a referral to the Medical Staff Executive Committee, which referral shall be in writing and may include a recommendation for the Medical Staff Executive Committee to conduct a further inquiry into the matter or to initiate a formal investigation. In such event, the Medical Staff Executive Committee shall decide the appropriate course of action, including possible corrective action in accordance with the provisions of Section 9.2.

## **9.2 CORRECTIVE ACTION**

**9.2.1 Initiation of Corrective Action.** Whenever the activity or conduct of any member of the Medical Staff is alleged to be in violation of any of the provisions of these Bylaws or Rules and Regulations, or the policies of the Medical Staff or of its Departments or Sections, or to be disruptive of the operations of the Hospital or its Medical Staff, or raises concerns about clinical competence and/or patient care issues, corrective action may be requested by any officer of the Medical Staff, the Chair of any Department, the Senior Vice President-Chief Medical Officer, the Chief Executive Officer of the Hospital, the Medical Staff Professionalism Committee, the Medical Staff Executive Committee or the Board of Trustees. All requests for corrective action shall be addressed to the President of the Medical Staff in writing, and shall be supported by specific reference to the activities or conduct constituting grounds for the request.

**9.2.2 Referral to Medical Staff Professionalism Committee.** If the activity or conduct at issue concerns professional behavior, consideration shall be given to whether, based on the nature of the specific concerns at issue, the concerns should first be addressed in accordance with the initial procedures outlined in the Policy on Professionalism or by referral to the MSPC in accordance with Section 9.1 of these Bylaws.

### **9.2.3 Referral to the Medical Staff Executive Committee; Inquiry and Investigation.**

- a) If the request for corrective action reveals that the reported information is sufficiently credible, significant and appropriate for referral to the Medical Staff Executive Committee, including but not limited to if the concerns relate to professional competency or deportment, the referral should be made and the Medical Staff Executive Committee shall be informed with specificity of the activities or conduct constituting the grounds for the request for corrective action.

- b) The Medical Staff Executive Committee shall forward a copy of a request for corrective action to the Chair of the Department in which the involved Medical Staff member has privileges.
- c) Upon receipt of a request for corrective action from the Medical Staff Executive Committee, the Department Chair shall immediately appoint an ad hoc committee, composed of a minimum of three (3) Medical Staff members, to conduct an inquiry into the matter. The ad hoc committee shall be composed of individuals who have no conflicts of interest and who are not in direct economic competition with the Medical Staff member at issue.
- d) If the Department Chair initiated the request for corrective action, the President of the Medical Staff shall appoint the ad hoc committee. The ad hoc committee shall be composed of individuals who have no conflicts of interest and who are not in direct economic competition with the Medical Staff member at issue.
- e) At the beginning of its inquiry, the ad hoc committee shall notify the involved Medical Staff member of the request for corrective action, inform him of the substance of the request for corrective action, and provide him with an opportunity for an informal interview with the ad hoc committee.
- f) A report of the inquiry by the ad hoc committee shall be forwarded to the Medical Staff Executive Committee within a reasonable period of time.
- g) If the inquiry report reveals that the reported information is sufficiently credible and significant, the Medical Staff Executive Committee may, in its discretion, determine to address the matter collegially, determine that further inquiry is needed, or may, through formal resolution, initiate an investigation. The Medical Staff Executive Committee may also determine that no further action is needed, in which case that decision shall be final.
- h) Any collegial intervention taken is part of the ongoing and focused professional practice evaluation, performance improvement, and peer review activities of the Medical Staff and Hospital. Such efforts may include pursuing counseling, education, and related steps to address questions raised about a member's clinical practice or conduct, including, but not limited to: (i) advising colleagues of applicable policies; (ii) proctoring, monitoring, consultation, and letters of guidance; and (iii) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- i) If the Medical Staff Executive Committee determines that further inquiry is needed, it may conduct the inquiry itself or may appoint an ad hoc subcommittee to do so. If a subcommittee conducts the inquiry, the results of the inquiry shall be reported to and reviewed by the Medical Staff Executive Committee. Following consideration of this inquiry, the Medical Staff Executive Committee may in its discretion determine to address the matter collegially or may, through formal resolution, initiate an investigation.

- j) If the Medical Staff Executive Committee determines to initiate an investigation, it shall do so by formal resolution. The Medical Staff Executive Committee may conduct the investigation itself, may appoint an ad hoc subcommittee to do so, or may refer the matter to a standing or specially named committee.
- k) If an investigation is initiated, the affected member shall be apprised of the nature of the concerns, and shall be afforded an opportunity to make an appearance before the Medical Staff Executive Committee or the designated investigating committee, as applicable, to discuss, explain or refute the concerns prior to its taking action or making a recommendation.
- l) If the member under investigation is a member of the Medical Staff Executive Committee, he shall be excluded from all deliberations that relate to the case. Partners or associates of the affected practitioner shall not participate in the investigation, nor shall any Medical Staff member who is in direct economic competition with the member.
- m) The Medical Staff Executive Committee or the designated investigating committee, as applicable, shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use appropriate outside consultants as deemed appropriate by the committee conducting the investigation.
- n) The Medical Staff Executive Committee or the designated investigating committee, as applicable, shall make a written report of the investigation. If an investigating committee was designated, the report shall be submitted to the Medical Staff Executive Committee. This report shall summarize the facts and circumstances concerning the activity or conduct of the member that served as a basis for any corrective action request and the conclusions reached, and shall include a summary or a record of the interview with the member, if held. The report shall state either a finding of a support or of no support for corrective action, and make appropriate recommendation(s).
- o) The Medical Staff Executive Committee, upon receipt of the report and recommendations of the investigating body, shall immediately review the report and determine appropriate action. During such review, the Medical Staff Executive Committee may conduct additional interviews, study pertinent documents, and meet informally in an interview with the member.
- p) The Medical Staff Executive Committee may, without limitation, accept, modify or reject the recommendation(s) of the investigating body, and may impose appropriate corrective action.
- q) The type of corrective action that may be taken includes but is not limited to the following: a letter of concern; a letter of reprimand; imposition of terms of probation or a requirement for clinical consultation; recommendation of

reduction, suspension or revocation of clinical privileges and/or revocation of Medical Staff membership and clinical privileges.

- r) Any final action by the Medical Staff Executive Committee recommending reduction, suspension, significant limitation on, or revocation of Medical Staff membership or clinical privileges, shall entitle the involved Medical Staff member, at his request, to a hearing and appellate review as provided in Article X of these Bylaws. If the final action of the Medical Staff Executive Committee does not entitle the member to a hearing and appellate review, the action shall take effect immediately without any further action and without rights to a hearing or appeal.
- s) The provisions and procedural rules of Article X of these Bylaws concerning hearings and appellate reviews shall not apply to inquiries, investigations and proceedings conducted under this Section 9.2, all of which shall be informal, preliminary and investigative in nature. Counsel for the Medical Staff member shall not be permitted to participate or be present during the interviews or proceedings described in this Section 9.2.
- t) The Chair of the Medical Staff Executive Committee shall promptly notify the Chief Executive Officer of the Hospital in writing of all requests for corrective action and shall continue to keep the Chief Executive Officer of the Hospital fully informed of all action taken.

#### **9.2.4 Trustees Medical Staff Executive Committee Action.**

- a) Following the receipt of the report of the ad hoc committee, the Medical Staff Executive Committee shall invite the involved Medical Staff member to meet with the Medical Staff Executive Committee. A record of such meeting shall be made by the Medical Staff Executive Committee. After meeting with the involved Medical Staff member or providing him with a reasonable opportunity for a meeting, the Medical Staff Executive Committee shall decide whether or not to take corrective action and the type of corrective action to be taken.
- b) The type of corrective action that may be taken includes but is not limited to the following: a letter of concern; a letter of reprimand; imposition of terms of probation or a requirement for clinical consultation; recommendation of reduction, suspension or revocation of clinical privileges and/or revocation of Medical Staff membership and clinical privileges.
- c) Any final action by the Medical Staff Executive Committee recommending reduction, suspension, significant limitation on, or revocation of Medical Staff membership or clinical privileges, shall entitle the involved Medical Staff member, at his request, to a hearing and appellate review as provided in Article X of these Bylaws.
- d) The Chair of the Medical Staff Executive Committee shall promptly notify the Chief Executive Officer of the Hospital in writing of all requests for corrective

action and shall continue to keep the Chief Executive Officer of the Hospital fully informed of all action taken.

### 9.3 SUMMARY SUSPENSION

**9.3.1 Criteria for Initiation.** Whenever action must be taken immediately against a member of the Medical Staff where a failure to do so may result in an imminent danger to the health or safety of any individual, all or any portion of the clinical privileges of a member of the Medical Staff may be suspended summarily by any one of the following: any officer of the Medical Staff, any Department Chair, the Senior Vice President-Chief Medical Officer, the Chief Executive Officer of the Hospital, or the Chair of the Board of Trustees. Such summary suspension shall become effective immediately upon imposition, and shall be reported immediately to the Chief Executive Officer of the Hospital, the President of the Medical Staff, the Senior Vice President-Chief Medical Officer and the applicable Department Chair or Chairs.

Immediately upon the imposition of a summary suspension, the responsible Department Chair shall have authority to assign another member of the Medical Staff to care for the patients of the suspended Medical Staff member who are in the Hospital at the time of such suspension.

**9.3.2 Notice of Summary Suspension.** A member of the Medical Staff whose clinical privileges have been suspended summarily in whole or in part shall be notified immediately and be entitled to request that the Medical Staff Executive Committee conduct a hearing in accordance with the provisions of this Section 9.3 and Article X.

**9.3.3 Medical Staff Executive Committee Action.** Within 24 hours of the summary suspension, the President of the Medical Staff shall appoint a sub-committee composed of five (5) members of the Medical Staff Executive Committee. The person who imposed the summary suspension shall not be a member of this sub-committee. The first hearing shall be held within seven (7) calendar days of the summary suspension. Notices of and hearings on summary suspensions shall be held in accordance with the provisions of Article X except as otherwise specified in this Section 9.3.

After the summary suspension hearing(s), the sub-committee, may recommend modification, continuance or termination of the summary suspension. If, as a result of the hearing(s), the Medical Staff Executive Committee or its sub-committee does not recommend immediate termination of the summary suspension, the Medical Staff Executive Committee shall review the summary suspension at its next regularly scheduled meeting. If the Medical Staff Executive Committee upholds the summary suspension, the Medical Staff Executive Committee shall then consider and recommend appropriate corrective action to be taken as set forth in Article IV of these Bylaws. The involved Medical Staff member shall be entitled to request appellate review by the Board of Trustees as provided in Article X; however, the terms of the summary suspension, as sustained or modified by the



Medical Staff Executive Committee, shall remain in effect pending a final decision by the Board of Trustees.

#### **9.4 NOTIFICATION REQUIREMENTS, TERMINATION AND SUSPENSION FROM THE MEDICAL STAFF**

##### **9.4.1. Medical Staff Members Obligation to Report**

All members of the Medical Staff shall immediately report the occurrence of any of the following to the Chief Medical Officer:

- (a) loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation and/or fine) whether voluntary or involuntary that is taken regarding a professional license in Connecticut or any other state;
- (b) 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;
- (c) 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);
- (d) initiation of formal investigation at any other health care facility;
- (e) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and
- (f) 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 credentialing and at recredentialing.

##### **9.4.2. Adverse Professional Review Actions, Investigations or For Cause FPPE**

Continuation of medical staff membership and privileges for current members of the medical staff who become subject to any of the following at another hospital or health care facility shall be addressed as described below:

- (a) 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
- (b) any formal investigations or for cause Focused Professional Practice Evaluation (FPPE) pending resolution or completion at another institution; or

- (c) 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.

**9.4.3 Automatic Suspensions and Terminations.** The following outlines situations upon which Medical Staff membership and clinical privileges of a Medical Staff member may be subject to automatic relinquishment, termination or suspension.

- (a) 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:
  - i. Revocation, voluntary relinquishment or voluntary surrender or suspension of a license in any state;
  - ii. Agreement with a governmental entity not to exercise a license to practice;
  - iii. Permanent licensure restriction;
  - iv. 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, Professional Practice Evaluation Committee or Medical Staff Professionalism 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) Whenever a Medical Staff member who is on the Courtesy Medical Staff no longer has active medical staff membership at another Connecticut hospital, his Medical Staff membership and clinical privileges at Bridgeport Hospital shall be automatically terminated.
- (c) The following shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:
  - i. Agreement with a Federal or State governmental agency not to exercise a permit to prescribe controlled substances related to investigation by the agency; or
  - ii. 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.

- (d) 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.

- (e) Failure to comply with any health status requirements as outlined in Section 3.3.8. 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.

- (f) 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.
- (g) 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.

Members who have been approved for a Leave of Absence in accordance with Article XX 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.

- (h) 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.
- (i) 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. Hearing rights are not afforded under these circumstances.
- (j) Failure of a Medical Staff member to obtain or maintain board certification consistent with the requirements, as applicable, as outlined in Section 3.6.4 shall result in automatic termination. Hearing rights are not afforded under these circumstances.

- (k) Failure to respond within fifteen (15) calendar days to a written request by the Credentials Committee or Medical Staff Executive Committee for information regarding disciplinary or malpractice actions taken or pending against the Medical Staff member shall result in automatic suspension of the member's clinical privileges. If the Medical Staff member does not provide such requested information within thirty (30) calendar days after written notice from Medical Staff Administration of the suspension, his Medical Staff membership shall be automatically terminated.
- (l) Failure to, within a reasonable timeframe as determined by the Medical Staff Executive Committee, undergo a requested physical and/or psychological/psychiatric examination, drug screening, outside clinical evaluation of the Medical Staff member's clinical competence, or to participate in continuing medical education programs required by the Credentials Committee or the Medical Staff Executive Committee, in connection with the respective Committee's evaluation of clinical competence or conduct as part of its credentialing and ongoing professional practice evaluation (OPPE) activities, shall result in automatic suspension of the Medical Staff member's clinical privileges. If the Medical Staff member does not correct such failure within two (2) months after written notice of the suspension from Medical Staff Administration, his Medical Staff membership shall be automatically terminated.
- (m) If a medical staff member is convicted of a felony related to the practice of medicine his medical staff membership and clinical privileges shall automatically be terminated.
- (n) Failure of a Medical Staff member to abide by these Bylaws, Rules and Regulations of the Medical Staff, or any applicable Hospital, Department or Medical Staff policy shall result in automatic suspension of a member's clinical privileges. In connection with any such suspension, the Medical Staff member shall be provided with a written notice that describes in reasonable detail the non-compliance that is the basis for the suspension. The Medical Staff member must, to the satisfaction of the Medical Staff Executive Committee within six months of the initiation of such a suspension, either satisfy the relevant eligibility criteria or, if satisfaction of the relevant eligibility criteria is not possible during a suspension, then demonstrate a commitment to satisfying the relevant eligibility criteria upon the suspension being lifted. Failure to do so shall result in the Medical Staff member's membership and clinical privileges being automatically terminated.

**9.4.4 Investigation/Corrective Action.** The facts that led to any action by a State or Federal agency as described in Section 9.4.1 above may become the basis for an investigation which may result in additional corrective action in accordance with Section 9.2 of these Bylaws.

**9.4.5 Assignment of Patients.** Care of the patients of suspended members of the Medical Staff shall be arranged in accordance with the provisions of Section 9.3.1 of these Bylaws.

**9.4.6 No Right of Review.** A Medical Staff member subject to automatic suspension or termination shall not be entitled to any procedural rights of review pursuant to these Bylaws or otherwise. If a hearing on the automatic suspension or termination is requested by the involved Medical Staff member, it shall be limited solely to the

issue of whether the grounds for automatic suspension or termination exist. The automatic suspension shall remain in place pending the outcome of the hearing.

## **ARTICLE X**

### **HEARING AND APPELLATE REVIEW PROCEDURE**

#### **10.1 RIGHT TO HEARING AND APPELLATE REVIEW**

**10.1.1 Grounds for a Hearing.** A Medical Staff member or applicant with the exception of the Affiliated Health Care Professional Staff which is described in Section 10.10 shall have a right to a hearing only under the following circumstances:

- a) an application for initial Medical Staff membership or clinical privileges has been denied; or
- b) an application for reappointment to the Medical Staff has been denied or, in connection with reappointment, clinical privileges have been revoked or clinical privileges that were requested have been denied; or
- c) Medical Staff membership or clinical privileges have been suspended in whole or in part, or terminated (for reasons other than an automatic suspension or termination under Section 9.4).
- d) restriction of clinical privileges for more than 30 days that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgement in a professional setting (e.g. a mandatory concurring consultation requirement).

**10.1.2 No Hearing Right.** A Medical Staff member or applicant shall have no right to a hearing or procedural right of review for all other recommendations or actions, including but not limited to:

- a) proceedings solely involving Grievances;
- b) decisions involving Resident Staff or Clinical Fellows, for whom there is an appeal mechanism within the policies of the Hospital's Department of Medical Education;
- c) whenever these Bylaws require alternative procedures;
- d) failure to process an application for Medical Staff membership because it is incomplete or because required information has not been provided;
- e) expiration of appointment for Medical Staff membership for failure to timely reapply or submit completed request for reappointment;
- f) failure to meet the requirements for board certification or eligibility as identified in 3.6.6
- g) termination of appointment to Medical Staff membership or clinical privileges pursuant to a contractual agreement with the Hospital;

- h) voluntary relinquishment of clinical privileges;
- i) imposition of any conditions on the exercise of temporary privileges;
- j) termination of disaster privileges;
- k) issuance of a warning or letter of reprimand; or
- l) removal from elected Medical Staff office, position of Department Chair or Section Chief, or committee appointment; or
- m) the voluntary acceptance of a performance improvement plan option
- n) actions as indicated in Section 9.4

**10.1.3 Disputes.** In the event that a dispute arises as to whether this Article X applies to a particular recommendation or decision, the Medical Staff Executive Committee or the Board of Trustees, as applicable, shall have the authority to determine whether or not such recommendation or decision is subject to the provisions of this Article X.

## **10.2 NOTICES, SCHEDULING, AND TIME PERIODS**

**10.2.1 Notice of Right to a Hearing.** Whenever a member of the Medical Staff is entitled to a hearing or appellate review, written notice of such right shall be provided by the Chief Executive Officer of the Hospital or his designee within fifteen (15) calendar days of the adverse recommendation or decision concerning such Medical Staff member. The notice shall:

- a) Advise the Medical Staff member of the adverse recommendation or decision and explain in detail the reasons for the adverse recommendation or decision.
- b) Advise the Medical Staff member of his right to a hearing on the adverse recommendation or decision and that a written request for such a hearing must be received by the Chief Executive Officer of the Hospital by certified mail, return receipt requested, within thirty (30) calendar days of receipt of the notice.
- c) State that failure to request a hearing within the specified time period shall constitute a waiver to any right to a hearing, appellate review or any other review of the adverse recommendation or decision.
- d) State that promptly following receipt of the Medical Staff member's request for a hearing, the Chief Executive Officer of the Hospital will notify him of the date, time and place of the hearing.
- e) Summarize the hearing rights of the Medical Staff member.



The failure of a Medical Staff member to request a hearing or appellate review within thirty (30) calendar days after the date of receipt of notice of the right to a hearing or appellate review shall constitute a waiver of any right to the hearing or appellate review. In such case, the adverse recommendation or decision against the Medical Staff member shall be deemed to be final and the Medical Staff member shall be so advised.

**10.2.2 Notice of Hearing.** A Medical Staff member who requests a hearing or appellate review shall send his written request to the Chief Executive Officer of the Hospital within thirty (30) calendar days of receipt of the notice of right to a hearing. All notices and requests shall be sent by certified mail, return receipt requested.

- a) Within fifteen (15) calendar days of receipt of a timely request for a hearing, the Chief Executive Officer of the Hospital shall schedule and begin a hearing and shall notify the Medical Staff member of the date, time and place of the hearing. If the adverse recommendation or decision is a summary suspension, the Medical Staff member may request that the hearing be held sooner.
- b) The notice of hearing shall set forth the time, date, and place of the hearing. The notice shall include a list of witnesses expected to testify in support of the adverse recommendation or decision. The notice shall also advise the Medical Staff member that at least ten (10) calendar days before the hearing, the Medical Staff member shall be required to forward to the Chief Executive Officer of the Hospital a written list of witnesses to the Medical Staff member expects to testify against the adverse recommendation or decision. The Medical Staff member is responsible for arranging for the attendance of his witnesses. The Medical Staff member shall be afforded timely access to relevant medical records and shall be given copies of the records upon request. The Chief Executive Officer shall rule on other requests for access to information by the Medical Staff member.

### **10.3 CONFIDENTIALITY OF HEARING AND APPELLATE REVIEW PROCEEDINGS**

All hearing and appellate review proceedings are considered to be Medical Review proceedings subject to and protected by State and Federal law. The details of all proceedings shall be kept confidential by all persons and not disclosed except as provided in these Bylaws or as required by law.

## **10.4 HEARING COMMITTEE**

**10.4.1 Composition of Hearing Committee.** The composition of the Hearing Committee is determined based upon the action that is the subject of the hearing.

- a) If a hearing relates to a summary suspension, the Hearing Committee shall be established as provided in Section 9.3.3
- b) If a hearing relates to any adverse recommendation or decision of the Medical Staff Executive Committee other than a summary suspension, the Medical Staff Evaluation Committee shall serve as the Hearing Committee subject to the provisions of Section 10.4.1(d) and 10.4.1(e) below. If the adverse recommendation or decision originated in the Medical Staff Evaluation Committee, the hearing shall be conducted by an ad hoc Hearing Committee of the Medical Staff consisting of not fewer than five (5) members of the Active Medical Staff appointed by the President of the Medical Staff.
- c) If a hearing relates to an adverse recommendation or decision of the Board of Trustees that is contrary to the recommendation of the Medical Staff Executive Committee, the Board of Trustees shall appoint a Hearing Committee. At least one representative from the Medical Staff shall serve on this hearing committee.
- d) No person who has actively participated in the making of an adverse recommendation or decision shall serve as a member of any hearing committee or review committee to review such adverse recommendation or decision.
- e) No person who is in direct economic competition with the Medical Staff member who is the subject of an adverse recommendation or decision shall serve as a member of any hearing committee or review committee to review such adverse recommendation or decision.
- f) The Hearing Committee shall elect one of its members as its Chair.
- g) A hearing officer shall be appointed by the entity appointing the Hearing Committee. The hearing officer may be a (but is not required to be) a physician, provided that if the hearing officer is a physician, such physician is not in direct economic competition with the Medical Staff member who is the subject of the hearing.

## **10.5 ONE HEARING AND APPELLATE REVIEW**

Notwithstanding any other provision of these Bylaws, no Medical Staff member shall be entitled to more than one hearing and one appellate review on any matter or group of related matters that was the subject of action by the Medical Staff Executive Committee, or by the Board of Trustees or a duly authorized committee of the Board of Trustees, or by both.

## 10.6 CONDUCT OF HEARINGS

### 10.6.1 Attendance.

- a) At least three (3) of the members of a Hearing Committee shall be present during the hearing. If a member of the Hearing Committee is absent for an extended period of time, he shall not be disqualified from participation and voting if he listens to a recording or reads a transcript or detailed minutes covering the proceedings during his absence. The Hearing Committee may take action by the majority vote of the members present; three (3) members shall constitute a quorum.
- b) No hearing shall be conducted without the presence of the Medical Staff member who is the subject of the hearing. If a Medical Staff member fails to appear without good cause, and such absence is not excused by the Hearing Committee, he shall be deemed to have waived his right to a hearing and appellate review and to have accepted voluntarily the adverse recommendation or decision.

**10.6.2 Record of the Hearing.** An accurate record of the hearing shall be made, which at the discretion of the Hearing Committee may be by means of a court reporter, electronic recording unit, detailed transcription or detailed minutes. If the Hearing Committee selects a court reporter to record the hearing, the Hospital shall bear the cost of attendance of the court reporter. If the Medical Staff member who is the subject of the hearing requests that the record of the hearing be transcribed by the court reporter, the costs of such transcription shall be borne equally by the Medical Staff member who is the subject of the hearing and the Hospital.

**10.6.3 Representation by Attorney.** The Medical Staff member shall be entitled to be accompanied by and represented at the hearing by an attorney or other person of his choice including a member of the Medical Staff in good standing or a member of his local professional society. The Medical Staff member shall provide the Chief Executive Officer of the Hospital with the name of his representative at least seven (7) calendar days prior to the hearing.

- a) The Medical Staff Executive Committee, or the Board of Trustees, when its action is the subject of the hearing, shall also be entitled to be represented by an attorney at the hearing and shall appoint one of its members or some other representative to present the facts in support of its action.

**10.6.4 Presiding Officer.** The Chair of the Hearing Committee, or a hearing officer, shall preside at the hearing and determine the order of presentation, assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, and maintain decorum. He shall have the authority and discretion to make all rulings on matters of procedure or other questions that arise during the hearing.

**10.6.5 Pre-Hearing Conference.** The attorney for the Medical Staff member who is the subject of the hearing and the attorney for the Hearing Committee must attend a

pre-hearing conference to resolve all procedural issues in advance of the hearing. Both parties must present all documentary evidence to be submitted at the hearing and must resolve any objections to documents at this time. Evidence unrelated to the reasons for the adverse recommendation or decision and any documentation not provided and agreed upon in advance of the hearing can be excluded by the hearing officer.

#### **10.6.6 Hearing.**

- a) All reasonably relevant information shall be heard or accepted into evidence. The legal rules of evidence shall not apply.
- b) The participants at the hearing shall have the following additional rights during the hearing:
- c) to call, examine, and cross-examine witnesses;
- d) to present all reasonably relevant information to the Hearing Committee regardless of its admissibility in a court of law; and
- e) to submit written statements at the close of the hearing or at any other stage of the hearing.
- f) The Hearing Committee may recess the hearing for the convenience of the participants or the Committee, or for the purpose of obtaining new or additional evidence or consultation.
- g) Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

### **10.7 HEARING COMMITTEE RECOMMENDATIONS**

**10.7.1 Deliberations.** The Hearing Committee shall at a convenient time conduct its deliberations outside the presence of the parties and the court reporter.

#### **10.7.2 Consideration of Evidence.**

- a) The Hearing Committee may consider all of the evidence introduced at the hearing including the testimony of all of the witnesses, the comments and arguments of all persons presented at the hearing, any written statements submitted and anything contained in the various exhibits submitted.
- b) The Hearing Committee may not consider evidence or information that was not introduced at the hearing. However, in evaluating the evidence presented at a hearing, members of the Hearing Committee may take into consideration their own expertise as professionals. A Hearing Committee also may take notice of generally recognized facts and medical reference works.

**10.7.3 Burden of Proof.** The member of the Medical Staff who is the subject of the hearing shall be responsible for demonstrating to the Hearing Committee that the adverse recommendation or decision lacks any basis, or that the adverse recommendation or decision is arbitrary, unreasonable or capricious, or is not supported by the evidence.

**10.7.4 Recommendation and Notice.**

- a) By majority vote, the Hearing Committee may uphold an adverse recommendation or decision taken by the Hospital or take other action authorized by these Bylaws if the Hearing Committee concludes that the Hospital's determination:
  - is supported by evidence that was introduced at the hearing; and
  - is reasonable under the circumstances; and
  - is not, in the view of the Hearing Committee, arbitrary or capricious.
- b) Within fifteen (15) calendar days after the close of the hearing, the Hearing Committee shall prepare a written report setting forth its recommendation and the reasons for it. The Hearing Committee shall forward its report, the hearing record and all other documentation including any available transcript of the hearing, to the Medical Staff Executive Committee or to the Board of Trustees, and to the Medical Staff member who is the subject of the hearing. The report may recommend confirmation, modification, or rejection of the original adverse recommendation or decision.

**10.8 APPEAL TO THE BOARD OF TRUSTEES**

**10.8.1 Request for Appellate Review.**

- a) The Medical Staff member may request an appellate review by the Board of Trustees in writing within fifteen (15) calendar days after receipt of the notice of the recommendation of the Hearing Committee.
- b) Within thirty (30) calendar days after the Board of Director's receipt of a timely request for appellate review, the Board of Trustees shall schedule a date and begin such review and provide notice to the Medical Staff member requesting the review of the date, time and place of the review.

**10.8.2 Scope of Appellate Review.** An appellate review shall be limited in scope exclusively to the following issues:

- a) Whether the procedures set forth in the Medical Staff Bylaws regarding the hearing and any subsequent review were substantially complied with; and
- b) Whether based upon the evidence in the record, the adverse recommendation or decision is unreasonable, arbitrary, capricious, without basis or not supported by the evidence.

**10.8.3 Appellate Review Committee.** The appellate review shall be conducted by the Board of Trustees, or by a duly appointed appellate review committee of not less than three (3) members. Where appropriate, members of the Medical Staff who are not members of the Board of Trustees may be appointed to an appellate review committee.

**10.8.4 Conduct of Appellate Review.**

- a) An appellate review shall be limited to the record on which the adverse recommendation or decision was based. There shall be no new evidence or testimony entered at the appellate review.
- b) The Medical Staff member who is the subject of the review shall have access to and, upon request, copies of the Hearing Committee's report and records and all other material that was considered in making the adverse recommendation or decision.
- c) The Medical Staff member who is the subject of the review shall have the right to submit a written statement on his own behalf prior to or at the appellate review.

A written statement also may be submitted by the Medical Staff Executive Committee or by the Chair of the Hearing Committee that presided over the hearing.

- d) Both the Medical Staff member who is the subject of the review and/or his representative shall have the right to present oral argument, and answer all questions posed by the Appellate Review Committee. The Appellate Review Committee shall have the right to set reasonable time requirements on arguments and appellate review.

**10.8.5 Decision of Appellate Review Committee.** After considering the record and holding the review, the Appellate Review Committee shall determine whether or not the adverse recommendation or decision was reasonable and supported by the evidence.

The Appellate Review Committee may affirm, modify or reverse the recommendation or decision of the Hearing Committee, or refer the matter back to the Medical Staff Executive Committee or Hearing Committee for further review and recommendation. Such referral to the Medical Staff Executive Committee or Hearing Committee may include a request that further hearings be held or consultations be obtained.

## **10.9 FINAL DECISION BY BOARD OF TRUSTEES**

If the Hearing Committee's report under Section 10.7.4 recommends rejection of the original adverse recommendation or adverse action, the Medical Staff member's clinical privilege shall be immediately restored pending final determination of the Board of Trustees.

After the conclusion of the appellate review, or any further proceedings directed by the Board of Trustees or its Appellate Review Committee, the Board of Trustees shall make its decision at its next regularly scheduled meeting. The Board of Trustees shall send notice within fifteen (15) calendar days of its decision to the Medical Staff Executive Committee and to the Medical Staff member who is the subject of the review. The decision shall be in writing and shall set forth the bases for the Board of Director's decision. If the decision is in agreement with the Medical Staff Executive Committee's last recommendation in the matter, it shall be effective immediately and shall be final.

If the decision is contrary to the last recommendation of the Medical Staff Executive Committee, the matter shall be referred to an ad hoc committee composed of three (3) members of the Board of Trustees and three (3) members of the Medical Staff Executive Committee for further review and recommendation. The members will be appointed by the Chairs of the respective bodies. A final decision will not be made by the Board of Trustees until the ad hoc committee forwards its recommendation to the Board of Trustees. At its next meeting after receipt of the ad hoc committee's recommendation, the Board of Trustees shall make its final decision.

## **10.10 FAIR HEARING PROCESS FOR AFFILIATED HEALTH CARE PROFESSIONAL STAFF**

- a) Affiliated Health Care Professional Staff shall have a fair hearing process available to them as follows: Adverse recommendations with respect to the denial of reappointment, or with respect to the denial or removal of clinical privileges may be appealed by the Affiliated Health Care Professional Staff member to the Medical Staff Executive Committee. The appeal shall be in writing and addressed to the Chair of the Medical Staff Executive Committee.
- b) The Affiliate Health Care Professional Staff member and the applicable Department Chair shall file written statements with the Medical Staff Executive Committee explaining the circumstances of the appeal. In its sole discretion, the Medical Staff Executive Committee, or an ad hoc committee of no more than five (5) members of the Medical Staff Executive Committee appointed by the Chair of the Medical Staff Executive Committee, may meet with the Affiliated Health Care Professional Staff member and the applicable Department Chair to receive information from both parties. The Medical Staff Executive Committee or the ad hoc committee appointed for this purpose shall render a decision in writing and, to the extent possible, set forth the reasons for its decision.
- c) The Department Chair or the Affiliated Health Care Professional Staff member may appeal the decision of the Medical Staff Executive Committee or the ad hoc committee to the Board of Trustees. If an appeal is requested,

the Chair of the Board of Trustees shall appoint an ad hoc committee of no more than five (5) members of the Board of Trustees. The ad hoc committee shall determine whether to meet with both parties and/or receive written testimony. The decision of the ad hoc committee of the Board of Trustees shall be in writing and shall be final.

- d) The Medical Staff Executive Committee and the ad hoc committee of the Board of Trustees shall establish reasonable time limits to implement the provisions of the fair hearing process for Affiliated Health Care Professional Staff. No person with a conflict of interest shall serve as a member of a review body under this fair hearing process.
- e) If an Affiliated Health Care Professional Staff member terminates his employment or contractual relationship with the Hospital or a Medical Staff member and commences employment or a contractual relationship with another Medical Staff member, the Affiliated Health Care Professional Staff member must notify Medical Staff Administration of any changes in the Affiliated Health Care Professional Staff member's collaborating or supervising Physician. Notwithstanding the foregoing, membership on the Affiliated Health Care Professional Staff and clinical privileges of an Affiliated Health Care Professional Staff member shall automatically terminate in the event that the Affiliated Health Care Professional Staff member is no longer supervised by a Medical Staff member. Such termination of the membership and clinical privileges of the Affiliated Health Care Professional Staff member shall be without any right of hearing or appellate review.



## ARTICLE XI AMENDMENT OF BYLAWS

### 11.1 PROPOSED AMENDMENTS PROCEDURE

**11.1.1 By the Medical Staff.** Proposals to amend these Bylaws shall be in writing and in the form of a petition signed by twenty-five (25) members of the Active Medical Staff and may be made at any regular or special meeting of the Active Medical Staff. If seconded, such proposed amendment(s) will be posted for discussion purposes until the next regular or special Active Medical Staff meeting. Written notice of the proposed amendment, including the wording of the proposed change(s), shall be sent to all Active Medical Staff members in advance of the regular or special Active Medical Staff meeting at which action is to be taken on the proposed amendment. The affirmative vote of two-thirds (2/3) of the Active Medical Staff members present at a meeting at which a quorum is present, shall be the final action of the Medical Staff.

The proposed amendment will then be referred to the Professional and Quality Review Committee of the Board of Trustees, which shall review the proposed amendment(s) and make its recommendation to the Board of Trustees. The proposed amendment(s) shall become effective only after approved by the Board of Trustees.

**11.1.2 By the Medical Staff Executive Committee.** The Medical Staff Executive Committee may recommend amendment(s) to these Bylaws on its own initiative, by a two-thirds (2/3) vote of the members or proxies of the Medical Staff Executive Committee present at a meeting at which a quorum is present.

Following approval by the Medical Staff Executive Committee, each proposed amendment will be posted for discussion purposes until the next regular or special meeting of the Active Medical Staff. Written notice of each proposed amendment, including the wording of the proposed change(s), shall be sent to all Active Medical Staff members in advance of the regular or special Active Medical Staff meeting at which action is to be taken on each proposed amendment. All proposed amendments may be voted on together if agreed to by the majority of the Active Medical Staff present at a meeting at which a quorum is present. The affirmative vote of two-thirds (2/3) of the Active Medical Staff members present at a meeting at which a quorum is present, shall be the final action of the Medical Staff.

The proposed amendment will then be referred to the Professional and Quality Review Committee of the Board of Trustees which shall review the proposed amendment(s) and make its recommendation to the Board of Trustees. The proposed amendment(s) shall become effective only after approved by the Board of Trustees.

If the proposed amendment(s) is/are rejected by the Active Medical Staff, it may, by a majority vote of the Active Medical Staff present, be referred back to the

Medical Staff Executive Committee for further study. If the proposed amendment(s) is/are approved, it shall be the final action of the Medical Staff.

## **11.2 JOINT APPROVAL REQUIRED**

The Medical Staff Bylaws must be adopted by the Medical Staff as described in Section 11.1 above and approved by the Board of Trustees before becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws.

## **ARTICLE XII**

### **ADOPTION AND AMENDMENT OF RULES AND REGULATIONS**

#### **12.1 GENERAL PURPOSE OF RULES AND REGULATIONS**

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise the Rules and Regulations to comply with current professional practice.

The Rules and Regulations address matters that are necessary to facilitate the day-to-day functioning of the Medical Staff. The Medical Staff Rules and Regulations will be attached to these Bylaws and members of the Medical Staff shall be governed by the Rules and Regulations.

#### **12.2 PROCEDURE**

**12.2.1 Adoption of New Rule or Regulation.** A new Rule or Regulation may be adopted by the Medical Staff in either of the following ways:

- a) by the affirmative vote of a majority of the members and proxies of the Medical Staff Executive Committee present at a meeting at which a quorum is present and after communication of the new Rule or Regulation to the Active Medical Staff; or
- b) by the affirmative vote of a majority of the members of the Active Medical Staff present at any regular or special meeting of the Active Medical Staff at which a quorum is present and after communication of the new Rule or Regulation to the Medical Staff Executive Committee. No prior notice of the proposed new Rule or Regulation need be given in the notice of the Medical Staff Executive Committee meeting or the regular or special meeting of the Active Medical Staff.
- c) The proposed new Rule or Regulation shall become effective only after approved by the Board of Trustees.

**12.2.2 Amendment of an Existing Rule or Regulation.** An existing Rule or Regulation may be amended by the Medical Staff in either of the following ways:

- (a) by the affirmative vote of a majority of the members and proxies of the Medical Staff Executive Committee present at a meeting at which a quorum is present; or by the affirmative vote of a majority of the members of the Active Medical Staff present at any regular or special meeting of the Active Medical Staff at which a quorum is present.
- (b) Prior written notice of the proposed amendment, including the wording of the proposed change(s), shall be sent to all the members of the Medical Staff Executive Committee, in the case of the amendments proposed by the Active Medical Staff, or to the regular or special meeting of the Active

Medical Staff, in the case of amendments proposed by the Medical Staff Executive Committee.

- (c) The proposed amendment to the Rules or Regulations shall become effective only after approval by the Professional and Quality Review Committee and the Board of Trustees.

**12.2.3 Trustees Expedited Amendment to the Rules and Regulations.** In situations where the Medical Staff Executive Committee deems it advisable to adopt a new Rule and Regulation or amend the existing Rules and Regulations in order to comply with legal or regulatory requirements, the Medical Staff Executive Committee may provisionally adopt the new or amended rule and regulation and forward it to the Professional and Quality Review Committee and the Board of Trustees for approval. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the Active Medical Staff.

If the Medical Staff agrees with the provisional approval, the new/amended Rule and Regulation will stand. If there is disagreement on the part of the Active Medical Staff with the provisional Rule and Regulation, the Medical Staff Executive Committee will consider the concerns of the Medical Staff at their next regularly scheduled meeting, but the provisional Rule and Regulation shall remain in effect until formally repealed by the Medical Staff Executive Committee.

### **12.3 JOINT APPROVAL REQUIRED**

The Rules and Regulations must be adopted by the Medical Staff as described in Section 12.2 above and approved by the Professional and Quality Review Committee and the Board of Trustees before becoming effective. Neither body may unilaterally adopt or amend the Rules and Regulations.

### **12.4 CONFLICTS**

No Rule or Regulation may be adopted or amended in such a way that it conflicts with these Bylaws. If there is a conflict between these Bylaws and the Rules and Regulations, these Bylaws shall prevail.

### **12.5 DEFINED TERMS**

Terms defined in these Bylaws shall have the same meaning when used in the Rules and Regulations.

## **ARTICLE XIII ADOPTION**

These Bylaws together with the attached Rules and Regulations, shall become effective after adoption at a regular meeting of the Board of Trustees and shall replace any pre-existing Bylaws, Rules and Regulations.

DATE: \_\_\_\_\_

\_\_\_\_\_  
Monique Misra, M.D.  
Medical Staff President

DATE: \_\_\_\_\_

\_\_\_\_\_  
Karen E. Gibbs M.D. Chair  
Professional and Quality Review Committee

APPROVED BY THE BOARD OF TRUSTEES  
AND EFFECTIVE AS OF:

DATE: \_\_\_\_\_

\_\_\_\_\_  
Ed Rodriguez, Chair  
Board of Trustees

(December 5<sup>th</sup>, 2024)

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**APPENDIX I**  
**RULES AND REGULATIONS**

**1.0 ORDERS FOR PATIENT CARE**

All orders for patient care shall be in “writing” (as defined in Bylaws Section 1.2.12) or entered electronically by a person with authority to originate orders in this institution.

1.01 Members of the Medical Staff are authorized to originate orders for patient care. Emergency Department technicians may enter orders for patient care that are defined in the written patient care Emergency Department protocols.

1.02 The order shall be written and signed by the authorized individual. This is the ideal method and shall be used, except when not physically possible. When this situation exists, orders may be given as verbal orders or telephone orders to persons authorized to accept them and write them on the order sheet or enter electronically.

Persons authorized to accept and write telephone or verbal orders /enter electronically are: members of the Medical Staff; nurses; pharmacists; registered dietitians (limited to orders related to nutritional therapy and/or monitoring); speech therapists (limited to orders for changes in consistency of diet and liquids, modified barium swallow orders and speech/swallow evaluation) and Radiologic Technologists (limited to orders for modification of radiologic studies or contrast for radiologic studies). In addition, business-clerical personnel in the Emergency Department, emergency department technicians, and emergency department scribes can accept and write down orders for non-hazardous diagnostic tests. Such orders accepted by Radiologic Technicians, Emergency Department business-clerical personnel/scribes shall be forwarded to the appropriate credentialed member of the medical staff who originated the order for verification.

Licensed Respiratory Care Practitioners (RCP's) can only accept and transcribe verbal or telephone orders for Respiratory Therapy Services that are solely rendered by RCP's. This does not apply to those situations in which a nurse would be expected to also deliver some of the care included in the verbal or telephone order.

**1.1 VERBAL ORDERS**

1.1.1 A verbal order is one that is dictated in person to another individual authorized to accept and write down orders (“verbal order”). The authorized individual must read back the verbal order to the person giving the order after it is transcribed and before it is implemented. The identity of both individuals shall be documented in the record.

This requirement shall be so indicated with the notation "per V.O. Dr. \_\_\_\_\_."

This method is only allowed if the person dictating the order is physically occupied and unable to write the order at the moment; e.g. in Operating Room, Emergency Department or during Code procedures. They will be authenticated by the practitioner giving the order or another practitioner responsible for the care of the patient within 24 hours.

## 1.2.0 **TELEPHONE ORDERS**

- 1.2.1 Orders may be dictated over the telephone to a person authorized to accept and enter such orders ("telephone order"). The authorized individual must read back the telephone order to the person giving the order after it is entered into the record and before it is implemented. The identity of both individuals and the date and time of the order shall be documented in the record.

Orders in this form will be authenticated by the person accepting them, and will have the designation (per **T.O.** Dr.       ). They will be authenticated by the practitioner giving the order or another practitioner responsible for the care of the patient within 24 hours.

- 1.2.2 Telephone orders should be used only when access to a computer is unavailable and a delay in placing orders will place the patient at risk or significantly delay care.
- 1.2.3 Admission orders are a specific instance where there is particular risk of mis-transcription and loss of decision support. For this reason, in most circumstances it is expected that during usual office hours and in the early evening (prior to 22:00) that a physician will use remote access to place orders electronically when not present in the hospital. In the event that telephone admission orders are deemed necessary, physicians should recognize the impact on nursing time and limit such orders to those needed until such time as orders can be directly entered by the provider.

## 1.3.0 **SPECIAL CATEGORIES OF ORDERS**

### 1.3.2 **Discharge Orders**

Patients shall be discharged only on the order of the attending physician or dentist or designee.

### 1.3.3 **Standing Orders**

Standing Orders are written documents containing rules, policies, procedures, regulations, and Orders for the conduct of patient care in various stipulated clinical situations. The standing orders are formulated by the professional members of a Department. Standing Orders define the criteria for implementation and prescribe the action to be taken in caring for the patient, including the dosage and route of administration for a drug, or the schedule for the administration of a therapeutic procedure.

The responsibility for approval of Hospital wide standing orders shall rest with the Patient Care Review Committee and the Medical Staff Executive Committee.

### 1.3.4 **Restraint and/or Seclusion Orders**

Orders for restraint or seclusion must contain a time-limit and include the reason for the restraint or seclusion.



### 1.3.5 **Medication Orders**

- 1.3.5.1 All medication orders must be written on approved order forms or entered electronically.
- 1.3.5.2 Patient name and identification number must be on every medication order form
- 1.3.5.3 All medication orders must be legible
- 1.3.5.4 A complete medication order should contain: date, time, name of medication, strength or concentration, amount to be administered and by what route, frequency of administration, parameters if appropriate, and the signature of the licensed practitioner.
- 1.3.5.5 Doses less than one (1) must have a leading zero (i.e. 0.5). Trailing zeros (5.0) are not to be used.
- 1.3.5.6 Unapproved abbreviations may not be used.
- 1.3.5.7 "PRN" and "on-call" orders shall always indicate under what circumstances the drug is to be administered.
- 1.3.5.8 Range orders (e.g. 10-20 mg) are not to be used.

## 2.0 **PATIENT RECORDS**

- 2.1 The attending physician or dentist shall be held responsible for the completion of his portion of the medical record for each patient as defined by the Patient Care Review Committee. Failure to comply with regulations of the Patient Care Review Committee will result in temporary interruption of admitting privileges following notification and an opportunity to correct deficiencies.

Inasmuch as the medical record is a significant document for communication amongst the varied patient care providers, members of the Medical Staff are required to make every entry in the medical record clear and legible.

- 2.2 All records are the property of the Hospital and shall not be removed. In case of readmission of a patient, all previous records shall be available for the use of the attending physician or dentist. This shall apply whether he is attended by the same physician or dentist or another.
- 2.3 Free access to all medical records of all former patients shall be afforded to staff physicians or dentists in good standing for bona fide study and research, consistent with Health Insurance Portability and Accountability Act (HIPAA) policies and procedures. At the discretion of the Chief Executive Officer of the Hospital or his designee, former members of the Medical Staff shall be permitted access to information from the medical records of their patients.
- 2.4 The Attending physician is responsible to ensure that a daily progress note has been entered by a member of the Medical Staff or House Staff, except in circumstances as approved by the Chief Medical Officer. When the patient is stable and disposition/placement is the only active issue, the attending physician must enter a progress note at least once a week.

## 3.0 **THE HISTORY and PHYSICAL and CHART INPUT**

- 3.1 A history and physical examination shall be written or dictated within 24-hours after admission of all inpatients.

Some of the elements may have been completed ahead of time, but must meet the following criteria:

The history and physical must have been completed no more than 30 days before the patient was admitted or readmitted.

Any changes in the patient's condition since the above mentioned history and physical must be recorded at the time of admission. Prior to a procedure or the administration of anesthesia, the patient must be reexamined and the re-examination documented in the Medical Record.

- 3.2 All procedures that require anesthesia or sedation will require a history and physical examination. Outpatients who undergo procedures or treatments that do not require any form of sedation do not require a history and physical. When history and physical examinations have not been recorded before surgery or a procedure requiring anesthesia, the procedure shall be postponed until the history and physical has been completed unless the procedure is required as an emergency.
- 3.3 Patients of oral surgeons, dentists and podiatrists admitted for surgery must have a physical examination and history recorded by an individual authorized to complete a history and physical before surgery.

Oral surgeons, dentists and podiatrists are responsible for the part of their patient's history and physical examination that relates to their respective specialty.

- 3.4 History and physical exams recorded by physician assistants or a resident/fellow physician must be reviewed and authenticated by the attending physician within 24 hours.
- 3.5 All operations or invasive procedures shall be fully described immediately in the medical record by the practitioner. Complete operative or procedure reports, when required, shall be dictated or completed within 24 hours of the operation or invasive procedure.
- 3.6 All tissues removed at surgery, except those specimens specifically exempted from time-to-time by the Medical Staff Executive Committee, shall be sent to the Department of Pathology for examination, diagnosis and documentation.
- 3.7 Inpatients who are being admitted to the Hospice Service do not require a separate history and physical. The history and physical from the immediate prior admission and the discharge summary shall serve as the history and physical and update for the Hospice Service admission. The previous H&P must not be older than 30 days from the date it was performed and there must be an update.

4.0 **COMPLETION OF MEDICAL RECORDS**

Medical Records must be completed by the practitioner within 21 days of the patient's discharge from the hospital.

- 4.1 On a weekly basis, practitioners with any incomplete records which have not been completed within 7- days following the patient's discharge will be notified by the Director of Health Information Management (HIM) that these records must be completed by the date corresponding to 21 days following the date of discharge.
- 4.2 After the said 21-days, if the practitioner has not complied with completion of his records, the practitioner will be notified in writing by the Director of HIM that his clinical and admitting privileges have been suspended.
- 4.3 Once a practitioner is placed on suspension, the practitioner must complete his delinquent medical records before his clinical and admitting privileges are restored.
- 4.4 Practitioners who have not completed their medical records within 35 days after discharge will be alerted by certified letter from the Sr. Vice President-Chief Medical Officer, notifying each practitioner that if the specified records are not completed by a date corresponding to 60 days following the date of discharge, their medical staff membership shall be terminated.
- 4.5 If the physician fails to comply with Rule & Regulation 4.4 a certified letter stating membership is terminated will be sent by the Sr. Vice President-Chief Medical Officer.
- 4.6 Restoration of membership, which was terminated according to Rule & Regulation 4.4 shall be accomplished only by reapplication to the Medical Staff.
- 4.7 During an absence of greater than 7 days reported in advance to the Medical Staff Office, the practitioner will not be placed on suspension. However, the days absent will be included as part of the calculation of time in 4.4 – 4.5 required for completion of the medical record.

Upon the practitioners return, he will be given a 72-hour grace period to complete delinquent medical records.

## 5.0 **CONSULTATIONS**

- 5.1 Except when a valid emergency situation prevents it, consultation with another qualified physician or dentist shall be considered advisable in the following situations: -
- 5.2 In contemplated surgery in poor anesthesia risk patients and in all cases in which the diagnosis is persistently obscure; when there is doubt as to the best therapeutic measure to be used, in illness with an unsatisfactory response to treatment or when requested by the patient or the family. Judgment as to the seriousness of the illness and any uncertainty as to diagnosis and treatment rests with the physician or dentist responsible for the care of the patient.
- 5.3 It is the duty of the Medical Staff through its Executive Committee, department Chairs and sections chiefs to ensure that members of the Staff do not fail in the matter of calling consultants as needed.

- 5.4 A consultant must be qualified to give an opinion in the field in which is opinion is sought. A consultation shall include, where appropriate, an examination of the patient and of the record. A written opinion or report shall be made part of the record.
- 5.5 In preoperative consultation(s), the report should be available prior to operation, except in emergency situations.
- 5.6 Any patient admitted to the Hospital with an acute surgical problem must be seen in consultation by a surgeon as soon as possible after admission.

## 6.0 **MISCELLANEOUS**

### 6.1 **TYPES OF PATIENTS**

The Hospital shall accept for admission patients suffering from all types of diseases that it has the requisite resources to manage.

### 6.2 **ALLOCATION OF PATIENTS**

Except in special circumstances, a patient must be on the section or service that is managing his major illness.

### 6.3 **TRAUMA PATIENTS**

Multiple system traumatized patients must be admitted to a surgical service. If the reason for admission is a condition in which the injury is of a minor nature, or a single system injury, the patient may be admitted to the primary physician's or dentist's service. Patients with multiple systems injury will be admitted to the service of a surgeon until fully diagnosed and stabilized as per Department of Surgery policies.

### 6.4 **PATIENTS LOCATION IN HOSPITAL**

Assignment of bed locations within the Hospital shall be the decision of Administration. While such assignments shall be governed by the patient's requirements and the medical needs of the patient, the Administration shall have full authority to move a patient when it is required for his welfare or the welfare of other patients. The attending physicians or dentists shall be notified prior to transfer.

This authority may be delegated to the applicable department Chair or medical director of a clinical unit.

### 6.5 **SIGN-OUTS**

When a member of the Medical Staff plans to be unavailable to the Hospital for more than 72-hours, he shall sign-out in the Medical Staff Office and indicate who will assume responsibility for his hospitalized patients.

### 6.6 **CONTINUING MEDICAL EDUCATION REQUIREMENTS (CME)**

All physicians shall obtain CME credits as required by the State of Connecticut Department of Public Health (DPH). This includes any mandatory courses as deemed necessary by DPH. At least half of the CME credits earned on an annual basis must be relevant to the Medical Staff member's current clinical privileges. .

Members of the Medical Staff are individually responsible for ensuring that they participate in appropriate CME activities and for reporting these activities to the department Chair as requested.

Members who fail to achieve required CME shall be informed by the relevant Chair's office. This requirement is a prerequisite for reappointment to the Medical Staff.

Members of the Allied Staff shall provide documentation of Continuing Medical Education consistent with requirements established by their respective certifying organization.

#### 6.7 **PATIENT CARE BY RESIDENTS**

Resident physicians and clinical fellows may provide patient care under the supervision of an attending physician. The level of supervision may vary with the experience of the resident or fellow and shall be more specifically defined in the written policies of those departments having graduate medical education programs.

Involvement of a resident physician or clinical fellow in the care of any patient does not preclude an attending physician from writing orders on that same patient.

The attending physician shall review and cosign the history and physical, consultation, operative note, discharge summary as prepared by the resident physician or clinical fellow.

#### 6.8 **DRUGS/MEDICATIONS**

Drugs used shall be USP, N.F., and NNR with the exception of drugs used for bona fide clinical investigations. The Institution Review Committee alone shall approve the use of investigative drugs.

#### 7.0 **PRACTITIONER HEALTH**

If any member of the Medical Staff or Hospital Staff suspects in good faith that a member of the Medical Staff is or may be unable to practice medicine with reasonable skill or safety due to (1) physical illness or loss of motor skill, (2) emotional disorder or mental illness or (3) abuse or excessive use of drugs, alcohol, narcotics or chemicals, he shall report such information to the Health Assistance Intervention Education Network (HAVEN) Program.

#### 7.1 **MEDICAL SCREENING EXAMS**

Emergency Department medical screening exams may be performed by a physician on the Medical Staff. They may also be performed by physician assistants and advance practice registered nurses, in the Department of Emergency Medicine and Obstetrics & Gynecology, who have been authorized by the Chair of the respective Department.

Approved Medical Staff Executive Committee July 1, 1996

Approved Board of Trustees July 25, 1996

Approved Board of Trustees January 30, 1997

Approved Board of Trustees July 31, 1997

Approved Board of Trustees June 24, 1998

Approved Board of Trustees January 28, 1999

Approved Board of Trustees March 25, 1999

Approved Board of Trustees March 30, 2000  
Approved Board of Trustees July 26, 2001  
Approved Board of Trustees October 4, 2001  
Approved Board of Trustees February 7, 2002  
Approved Board of Trustees July 1, 2004  
Approved Board of Trustees April 7, 2005  
Approved Board of Trustees September 1, 2005  
Approved Board of Trustees April 5, 2007  
Approved Board of Trustees April 29, 2010  
Approved Board of Trustees June 24, 2010  
Approved Board of Trustees July 29, 2010  
Approved Board of Trustees January 27, 2011  
Approved Board of Trustees September 22, 2011  
Approved Board of Trustees January 26, 2012  
Approved Board of Trustees July 26, 2012  
Approved Board of Trustees September 27, 2012  
Approved Board of Trustees January 24, 2013  
Approved Board of Trustees March 21, 2013  
Approved Board of Trustees July 18, 2013  
Approved Board of Trustees November 14, 2013  
Approved Board of Trustees March 27, 2014  
Approved Board of Trustees July 24, 2014  
Approved Board of Trustees October 2, 2014  
Approved Board of Trustees July 23, 2015  
Approved Board of Trustees March 24, 2016  
Approved Board of Trustees September 27, 2018  
Approved Board of Trustees October 1<sup>st</sup>, 2020  
Approved Board of Trustees March 30, 2023  
Approved Board of Trustees December 5, 2024