
**BYLAWS
OF THE
MEDICAL STAFF
OF
GREENWICH HOSPITAL**

Effective October 1, 2019

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**BYLAWS OF
THE MEDICAL STAFF OF
GREENWICH HOSPITAL
*PREAMBLE***

WHEREAS, Greenwich Hospital is a non-stock corporation organized under the laws of the State of Connecticut with the purpose of providing patient care, education and research; and

WHEREAS, the Board of Trustees of the Hospital, bearing responsibility for the quality of the professional services provided by individuals with Clinical Privileges, wishes to delegate to the Medical Staff and its officers and to the clinical Departments and committees of the staff and their chairs, duties and responsibilities to make recommendations to the Board concerning an applicant's appointment or re-appointment to the Medical Staff of the Hospital and the Clinical Privileges such applicant shall enjoy in the Hospital, and to recommend actions to be taken by the Board where the quality of clinical services provided by members of the Medical Staff is compromised.

THEREFORE, to discharge these duties and responsibilities to the Hospital in an orderly fashion, the physicians and dentists practicing in Greenwich Hospital hereby organized into a Medical Staff, shall function and act in accordance with the following Bylaws and procedures, which have been approved by the Board. The Hospital management shall cooperate with and assist the appointees to the Medical Staff in the accomplishment of these responsibilities to the Hospital.

ARTICLE I

NAME AND PURPOSE

SECTION 1: NAME

The name of this organization shall be the Medical Staff of Greenwich Hospital of Greenwich, Connecticut.

SECTION 2: PURPOSE

The purposes of this organization and these Bylaws are:

- (a) To provide quality medical care;
- (b) To assist the Board in maintaining the quality of clinical services provided in the Hospital;
- (c) To provide an appropriate educational setting for the Medical Staff and its assistants that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- (d) To provide a means whereby issues concerning the Medical Staff and the Hospital may be considered by the Medical Staff, the Board of Trustees and the Administration.

ARTICLE II

DEFINITIONS AND INTERPRETATION

- (a) "Board" means the Board of Trustees of Greenwich Hospital, which has the overall responsibility for the conduct of the affairs of the Hospital including those of the Medical Staff by virtue of the authority vested in it by law and charter and by its Bylaws.
- (b) "Bylaws" means these Greenwich Hospital Medical Staff Bylaws.

(c) “Clinical Privileges” or “Privileges” means the permission granted to Medical Staff members to provide patient care.

(d) “CQO” means the Chief Quality Officer of the Hospital or his designee.

(e) “Dentists” or “dentists” means individuals engaged in the practice of dentistry limited to oral and maxillofacial surgery, and may include other dentists who are appropriately trained and credentialed to practice in a hospital environment.

(f) "Hospital" means Greenwich Hospital.

(g) “Investigation” means a process specifically initiated by formal resolution of the Medical Executive Committee to determine whether an incident or pattern of incidents involving conduct or competence warrants corrective action.

(h) "Medical Executive Committee (MEC)" means the Medical Executive Committee (MEC) of the Medical Staff.

(i) “Medical Review Committee” means each committee or subcommittee created or referred to in or authorized by these Bylaws or the Bylaws of the Hospital, whenever such committee is engaged in a peer review activity. Such medical review committees may include but are not limited to: (1) all committees and subcommittees identified in or created pursuant to or under authority of these Bylaws; (2) all Departments and Sections of the Medical Staff and their committees and subcommittees; (3) the Board of Trustees and its committees and subcommittees; and (4) any individual gathering information or providing services for or acting on behalf of any such entity, including but not limited to Department Directors, Section Heads, committee and subcommittee chairs, the President and other officers of the Medical Staff, the SVPMS (as defined below), and experts or consultants retained to perform peer review. Documents prepared for such committees, or studies of morbidity and mortality undertaken by such committees, should be clearly identified.

(j) "Medical Staff" means all practitioners who have been appointed to the Medical Staff.

- (k) "President" means the Chief Executive Officer of the Hospital, or his designee.
- (l) "Rules and Regulations" means the Greenwich Hospital Medical Staff Rules and Regulations.
- (m) "SVPMS" means the Senior Vice President or Vice President, as applicable, of Medical Services of the Hospital, or his designee.
- (n) Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.
- (o) Unless the Bylaws provide differently, Robert's Rules of Order may be used as guidance at all Medical Staff and committee meetings, though the Chair presiding over the meeting shall have final authority with respect to the manner in which the meeting will be conducted.
- (p) When construing these Bylaws, the following principles shall apply:

If any provision of these Bylaws is determined by a court with competent jurisdiction to be invalid or in violation of any law or regulation, such provision shall be deemed to be severed from the Bylaws and the remainder of the Bylaws shall be given effect as if such invalid provision never had been part of the Bylaws.

In the event that any law or regulation or mandatory Joint Commission or other relevant CMS-deemed accrediting body requirement or other applicable accreditation requirement clearly requires the Hospital and its Medical Staff to take particular action in connection with credentialing or any other matter covered by these Bylaws, the practices of the Hospital and Medical Staff shall immediately change as necessary to comply and the meaning of such law, regulation or accreditation requirement shall be deemed incorporated into the Bylaws. The Medical Staff and Board shall work to promptly develop language for formally amending the Bylaws.

To the extent possible, these Bylaws, the Rules and Regulations, 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.

It is the intention of the Hospital and its Medical Staff that their Bylaws be construed as being consistent. If an apparent 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, as written. In the event of an apparently irreconcilable conflict, the Medical Executive Committee (MEC) and the Board Joint Conference Committee 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.

The provisions of this Section are not intended to alter or supersede other provisions of these Bylaws that specifically provide how the Bylaws are to be interpreted, construed, or applied.

In construing these Bylaws, the Medical Staff may take into account its usual and customary policies and practices, whether written or unwritten, and may also bring to bear the expert medical knowledge of members of the staff.

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

Except as described herein, when a function described in these Bylaws is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairman, may delegate performance of the function to one or more designees. The MEC may not delegate its responsibility for recommending individual applicants for appointment and Clinical Privileges, or modification of the same.

All captions and titles used in these Bylaws are 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.

ARTICLE III

QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

SECTION 1: GENERAL RULES

(a) The following requirements apply to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking Clinical Privileges at the Hospital. By applying for appointment, reappointment or Clinical Privileges, the applicant expressly accepts these conditions during the processing and consideration of his application, whether or not he is granted appointment or Clinical Privileges. The following requirements also apply during and after the time of any appointment, reappointment, or grant of Clinical Privileges.

(b) Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians and dentists who meet continuously the qualifications, standards and requirements set forth in these Bylaws, the Rules and Regulations, and the policies and directives of the Hospital. All persons practicing medicine and dentistry in the Hospital, unless accepted by special provisions of these or the Hospital's Bylaws, must first have been appointed to the Medical Staff.

(c) Medical Staff membership and Privileges may be granted, continued, modified or terminated only by the Board after receiving a recommendation of the Medical Executive Committee

(MEC), for reasons directly related to quality of patient care or otherwise in accordance with the Medical Staff Bylaws, and following the procedures outlined in these Bylaws.

(d) No physician or dentist shall be entitled to appointment to the Medical Staff or to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that he is licensed to practice medicine or dentistry in Connecticut or any other state, or that he is a member of any particular professional organization, or that he has in the past, or currently has, medical staff appointment or Privileges in another hospital, or that he has established a medical office in the Town of Greenwich.

(e) Neither the Hospital nor the Medical Staff shall discriminate in granting staff membership and/or Clinical Privileges on the basis of any of the following unrelated to the provision of patient care to the extent the applicant or member is otherwise qualified: national origin, culture, race, gender, color, age, marital or civil union status, ancestry, sexual orientation, gender identity, ethnic background, religion, disability, past alcohol or drug use, mental illness, genetic information, gender orientation or expression, or any other category protected by applicable state or federal law.

SECTION 2: CONDITIONS FOR APPOINTMENT AND REAPPOINTMENT

(a) Qualifications for Initial Appointment and Reappointment

(1) Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, practitioners must:

(i) have a current, unrestricted, or pending (initial application only), license to practice in Connecticut and have never had a license to practice revoked or suspended by any state licensing agency. Any individual whose application is processed while licensure is still pending shall immediately become ineligible for appointment and Clinical Privileges if licensure is not achieved or, when achieved, is restricted;

(ii) where required in order to exercise the requested Clinical Privileges, have a current, unrestricted, or pending (initial application only) DEA and

Connecticut controlled substance certificate or registration. Any individual who requires controlled substance prescribing authority in order to exercise the requested Clinical Privileges and whose initial Medical Staff application is processed while said certificate or registration is still pending shall immediately become ineligible for appointment and Clinical Privileges if the certificate or registration is not achieved or, when achieved, is restricted. The process to be followed with respect to any individual who upon reappointment does not have a current or unrestricted certificate or registration to prescribe controlled substances shall be as set forth in Article IX, Section 4(b) (Automatic Suspension);

(iii) be located close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital. Subject to approval of the MEC and Board of Trustees, the Departments may establish response times within which members of the Department must be available to satisfy this standard;

(iv) maintain in force professional liability insurance covering practitioner's professional practice in the Hospital in not less than the minimum amounts as from time to time may be jointly determined by the Board and the Medical Executive Committee (MEC);

(v) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse;

(vi) have never been, and are not currently, involuntarily or by agreement debarred, excluded or otherwise ineligible for Federal or State health care program participation;

(vii) are not at any time during appointment or re-appointment to the Medical Staff listed on the exclusions databases of the Office of Inspector General (OIG), the General Services Administration (GSA), the Office of Foreign Asset Control (OFAC), or the State of Connecticut Department of Social Services (DSS).

(viii) have never had Medical Staff appointment or Clinical Privileges denied, revoked, suspended for a term of more than 30 days (excluding precautionary suspension), or terminated by any health care facility for reasons related to clinical

competence or professional conduct and have never resigned appointment or relinquished Privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(ix) since the date practitioner first became licensed to practice his/her profession, have never been convicted of, or entered a plea of guilty or no contest, (a) to any felony or (b) to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(x) agree to fulfill all responsibilities regarding emergency call and clinic coverage, as may be determined by the applicable Department or Section and subject to approval by the Medical Executive Committee (MEC) and the Board;

(xi) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

(xii) have successfully completed an appropriate training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks Clinical Privileges, an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or such other appropriate training program recognized pursuant to a Medical Staff Policy. (This requirement is applicable only to those individuals who apply for initial appointment on or after June 22, 2009);

(xiii) have achieved board certification in the practitioner's primary area of practice at the Hospital at least one time since the practitioner became licensed to practice. Those applicants who have not achieved board certification at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment; however, in order to remain eligible, those applicants must achieve board certification in their primary area of practice at the Hospital within five (5) years from the date of completion of their residency or fellowship training. (This requirement is applicable only to those individuals who apply for initial staff appointment after June 22, 2009. All

individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments.);

(xiv) agree to abide by these Bylaws, the Rules and Regulations, all policies of Departments and Sections, and the Hospital's policies and procedures;

(xv) agree to abide by all protocols or document contemporaneously in the medical record why the different course of care was chosen;

(xvi) have paid any application fees, annual dues, and assessments, as applicable;

(xvii) work cooperatively with others so as not to adversely affect patient care;

(xviii) except for Medical Staff members without Clinical Privileges, have completed required training in the Hospital's electronic medical record (EMR) within sixty (60) days of appointment but in all cases prior to exercising Clinical Privileges; provided, however, that if required EMR training is not achieved within ninety (90) days following appointment, the individual shall be deemed to have voluntarily relinquished his/her appointment, without rights to a hearing or appeal; and

(xix) other reasonable indicators of continuing ability to provide quality patient care, which such indicators shall generally be the only other indicators considered to determine eligibility for appointment, reappointment or Privileges; provided, however, that the Board may consider other indicators not related to continuing ability to provide quality patient care only after hearing the recommendations of the Medical Executive Committee (MEC), if any.

(2) Waiver of Eligibility Criteria:

(i) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances that his qualifications are equivalent to, or exceed, the criterion in question.

(ii) A request for a waiver will be submitted to the individual's Department Director or Section Head for consideration. In reviewing the request for

a waiver, the Department Director or Section Head may consider the specific qualifications of the individual in question and the best interests of the Hospital and the communities it serves. Additionally, the Department Director or Section Head may, in his discretion, consider the application form and other information supplied by the applicant. The recommendation of the Department Director or Section Head will be forwarded to the Credentials Committee. Any recommendation to grant a waiver must include the basis for such.

(iii) The Credentials Committee will review the recommendation of the Department Director or Section Head and make a recommendation to the Medical Executive Committee (MEC) regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

(iv) The Medical Executive Committee (MEC) will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

(v) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a denial of appointment or Clinical Privileges.

(vi) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(vii) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(3) Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

- (i) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment;
- (ii) adherence to the ethics of the practitioner's profession;

- (iii) good reputation and character;
- (iv) ability to perform, safely and competently, the Clinical Privileges requested;
- (v) ability to work harmoniously with others, including, but not limited to interpersonal skills sufficient to enable the practitioner to maintain professional relationships with patients, families, and other members of health care teams;
- (vi) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care, and recognition that interpersonal skills at collaboration, communication and collegiality with patients, families, and other members of the health care team are essential for the provision of quality patient care;
- (vii) the practitioner's ability to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
- (viii) the practitioner's demonstrated knowledge of established and evolving biomedical, clinical and social sciences, and the application of the practitioner's knowledge to patient care and the education of others;
- (ix) the practitioner's ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices;
- (x) the practitioner's demonstrated behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward the practitioner's patients, profession, and society; and
- (xi) the practitioner's demonstrated understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

(b) Qualifications for Reappointment

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and Clinical Privileges and to reappointment.

(1) Eligibility Criteria:

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In addition to satisfying the eligibility criteria in Section 2(a) of this Article III above, to be eligible to apply for reappointment and renewal of Clinical Privileges, an individual must have, during the previous appointment term:

- (i) completed all medical records;
- (ii) completed all continuing medical education requirements;
- (iii) satisfied all Medical Staff responsibilities;
- (iv) continued to meet all qualifications, criteria and factors for

appointment and the Clinical Privileges requested, which shall be evaluated at time of reappointment; and

(v) had sufficient patient contacts (as defined in Article IV, Section 1(c) of these Bylaws) to enable the assessment of current clinical judgment and competence for the Privileges requested. Any individual seeking reappointment with Clinical Privileges who has minimal activity at the Hospital must submit such information relevant to the Clinical Privileges desired as may be requested (such as a copy of his confidential quality profile from his primary hospital, clinical information from his private office practice, and any other applicable data) before the application will be considered complete and processed further.

(2) Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

- (i) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
- (ii) participation in Medical Staff duties, including committee assignments and emergency call and clinic, if applicable.
- (iii) ability to work harmoniously with all members of the patient care team to promote quality patient care.
- (iv) the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information

concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified); and

- (v) review of verified complaints received from patients and/or staff.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board, except as provided in Section 6 of this Article IV with respect to changes in Medical Staff category.

All initial appointments to the Medical Staff for practitioners who are granted Clinical Privileges in any category shall be on a provisional basis as described in Article VI, Section 10 of these Bylaws.

SECTION 1: ACTIVE ATTENDING MEDICAL STAFF

The Active Attending category shall comprise the Active Medical Staff and include Physicians, Dentists and Podiatrists. It shall also include licensed clinical psychologists appointed to the Medical Staff prior to October 1, 2019 and who achieve the clinical contacts required by Section 1(b)(xii) below.

(a) The Active Attending Staff shall consist of selected physicians, dentists, and podiatrists, and shall also include licensed clinical psychologists appointed to the Medical Staff prior to October 1, 2019, who demonstrate substantial commitment to the welfare and programs of the Hospital as well as its purposes, objectives and mission.

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

i. utilize Greenwich 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);

ii. 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;

- iii. eligible for admitting, consulting and any other privileges for which they are qualified;
- iv. demonstrate a willingness to participate in teaching programs;
- v. demonstrate a willingness to serve on committees, boards, or in administrative positions;
- vi. must assume responsibility for call, clinic and/or consultation, and for providing other services as requested by the relevant Department Director or Section Head consistent with applicable Medical Staff Policies and Rules & Regulations;
- vii. 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 Director or Section Head;
- viii. demonstrate a willingness to have patients participate as part of teaching;
- ix. demonstrate a willingness, with the concurrence of both the patient and the physician, to participate in research efforts;
- x. participate in Departmental and Sectional meetings including quality review programs and teaching conferences;
- xi. pay medical staff dues; and
- xii. except for the practitioners described in this Article IV, Section 1(c)(v) below, achieve an average of at least 25 clinical contacts (as defined below) per year, as measured prior to the conclusion of each two (2) year re-credentialing cycle.

(c) For purposes of these Bylaws, clinical contacts shall be determined as follows:

- i. A clinical contact is an admission, a consultation, a procedure, a surgery, an official interpretation of a diagnostic study, any other professional clinical service, of a hospital-registered inpatient or outpatient. All such clinical contacts described above, without exception, shall be documented in the Hospital EMR. When providing services in any of the Hospital's clinics, each hour of service shall constitute two (2) clinical contacts. Each hour of teaching by either rounding or by lecture in a hospital setting shall constitute one (1) clinical contact.

ii. The Medical Executive Committee (MEC) may deem other activities to be clinical contacts, subject to approval by the Board. Any such determinations shall be applied consistently to all applicants and Medical Staff members thereafter.

iii. The burden lies with the member to demonstrate compliance with the clinical contact requirements.

iv. Waiver. In response to a request by any applicant for appointment or reappointment, the responsible Department Director or Section Head shall have discretion, on a case-by-case basis, upon good cause shown, to waive the applicable clinical contacts requirement. The decision of a Department Director or Section Head to grant or refuse a waiver shall be subject to the approval of the Medical Executive Committee (MEC), and to the final approval of the Hospital's Board of Trustees.

v. The SVPMS shall remain a member of the Active Attending Staff category without regard to clinical contacts. In addition, any practitioner who has been on the Active Attending staff continuously since at least July 1, 2002 shall remain a member of the Active Attending Staff category without regard to clinical contacts. If the practitioner has no clinical contacts he will relinquish Clinical Privileges, which Privileges can be reapplied for if and when the member desires to exercise Clinical Privileges.

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

i. may vote in Medical Staff elections, on adoption or amendment of the Bylaws 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, consistent with the requirements of these Bylaws;

ii. eligible for election to serve as a Medical Staff Officer, consistent with the requirements of Article XIV Section 1;

iii. eligible to serve in departmental and sectional leadership roles, consistent with the requirements of Article XV Section 2;

iv. eligible to serve as Members of the Medical Executive Committee, Credentials Committee and Bylaws Committee, consistent with the requirements of Article XVI Sections 2, 3 and 4;

v. eligible to be a voting member or Chair of any medical staff committee, consistent with the requirements of Article XVI; and

vi. may, after serving for a period of time designated by each Department (which period shall be at least 25 years), 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 Director. The decision of the Department Director shall be subject to approval by the Medical Executive Committee.

SECTION 2: COURTESY MEDICAL STAFF

(a) The Courtesy Medical Staff shall consist of Physicians, Dentists and Podiatrists who are eligible for Medical Staff membership and who satisfy the requirements set forth below in this Section 2(a). It shall also include licensed clinical psychologists who are appointed to the Medical Staff prior to October 1, 2019 and who satisfy all other requirements set forth below in this Section 2(a), including but not limited to the clinical contacts required by subparagraph (vii) below.

- i. have a practice located in the Greenwich Hospital community;
- ii. are eligible for admitting, consulting and any other privileges for which they are qualified;
- iii. must assume responsibility for call, clinic and/or consultation, and for providing other services as requested by the relevant Department Director or Section Head consistent with applicable Medical Staff Policies and Rules & Regulations;
- iv. may attend meetings of the Medical Staff and their Department or Section;
- v. are not eligible to vote at any Medical Staff or Department or Section meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;
- vi. are not eligible for election to serve as a Medical Staff Officer;
- vii. eligible to serve as a voting member on any Medical Staff Committee, except not the Medical Executive Committee, Credentials Committee or Bylaws Committee, and may not serve as Chair of any Committee;
- viii. are required to have a minimum of one (1) clinical contact per year. In the event that activity exceeds twenty-four (24) clinical contacts per year, the

practitioner will automatically be reassigned to the Active Attending category and expected to fulfill any and all requirements associated with that status; and

ix. are required to pay medical staff dues.

(b) Members of the Courtesy Staff may, after serving for a period of time designated by each Department (which period shall be at least 25 years), 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 Director. The decision of the Department Director shall be subject to approval by the Medical Executive Committee.

SECTION 3: REFERRING MEDICAL STAFF

(a) Referring Staff is a membership-only 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. It shall also include licensed clinical psychologists who are appointed to the Medical Staff prior to October 1, 2019 and who satisfy all other requirements set forth below in this Section 3. 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.

(b) Physicians, Dentists and Podiatrists, and psychologists as described above, qualify for Referring status by:

i. maintaining an active ambulatory practice and utilizing the Hospital facilities for their patients;

ii. 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

iii. 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

(c) 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.

(d) Members of the Referring category:

- i. 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;
- ii. 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 (d)(i) immediately above);
- iii. are encouraged to follow their patients when hospitalized under the care of another physician and to participate in that care by communicating any pertinent information to the responsible practitioner to support the care while the patient is hospitalized and/or post-discharge;
- iv. may visit their hospitalized patients socially and view their medical records;
- v. 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;
- vi. may attend and participate in Departmental and other Medical Staff and Hospital meetings including educational meetings such as Grand Rounds and other CME activities, however may not vote at Departmental, Section or Medical Staff meetings;
- vii. are not eligible for election to serve as a Medical Staff Officer;
- viii. eligible to serve as a voting member on any Medical Staff Committee, except not the Medical Executive Committee, Credentials Committee or Bylaws Committee, and may not serve as Chair of any Committee;
- ix. are required to pay Medical Staff dues; and
- x. are exempt from Ongoing Professional Practice (OPPE) and Focused Professional Practice Evaluation (FPPE)

(e) Members of the 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.

(f) Requests for clinical privileges will be reviewed individually relative to evidence of current competence and consistent with the relevant Sections of Article V Proctoring may be required.

SECTION 4: 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.

(a) 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.

(b) 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.

(c) 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.

(d) Members of the Telemedicine staff:

i. may exercise such clinical privileges as granted but will never have primary responsibility for any patient;

ii. as possible, may attend meetings of the Department or Section to which he/she is appointed but may not vote;

iii. 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;

iv. 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

v. are required to pay Medical Staff dues

SECTION 5: 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, except that this category shall also include those practitioners who were appointed to the Honorary Outpatient Dental Staff prior to October 1, 2019.

- (a) Members of the Honorary staff:
 - i. do not have clinical privileges;
 - ii. are not required to undergo reappointment;
 - iii. are not required to have malpractice insurance;
 - iv. are not eligible to vote;
 - v. cannot serve as medical staff officers;
 - vi. cannot serve on Hospital committees except with permission of the Chief of Staff and under unique circumstances involving special expertise;
 - vii. may attend Medical Staff and Departmental and Section meetings of an educational nature;
 - viii. may participate in Medical Staff social events;
 - ix. are appointed for life and may be removed only for cause by the Medical Executive Committee; and
 - x. do not pay medical staff dues.

SECTION 6: CHANGES IN MEDICAL STAFF CATEGORY

When a member of the Medical Staff ceases to be eligible for membership in the Medical Staff Category to which he is presently assigned (for example, but not limited to, if the member ceases to satisfy the Category's clinical contacts requirement), except with respect to those practitioners exempt from the clinical contacts requirement as set forth in Article IV, Section 1(b)(10)(iii) above, the member shall be transferred into the appropriate Medical Staff Category for which the member is

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eligible, as determined by the Department Director or Section Head, and then approved by the Credentials Committee and Medical Executive Committee (MEC). In the event the change in Category is due to the clinical contacts requirements of these Bylaws, such transfer shall be effective at the time of recredentialing. (For example, if a member has no clinical contacts during a two-year credentialing cycle, the member shall be moved to the Community Staff Category at the time of recredentialing.) The relevant Department Director or Section Head shall provide the individual with written notice of this transfer not less than two (2) weeks prior to the effective date of the transfer, and the individual shall be entitled to an opportunity to meet with the Department Director or Section Head to discuss the transfer determination, including any disagreement with said determination. Thereafter, in the event of a continued disagreement regarding said determination, the individual shall be entitled to an opportunity to meet with the Department Director or Section Head, Chief of Staff and SVPMS to discuss the matter. The final decision with respect to Medical Staff Category in the circumstances described in this Section 9(a) shall reside jointly with the Chief of Staff and SVPMS.

(a) When a member of the Medical Staff wishes to initiate a change into a different Medical Staff Category than the Category to which the member is presently assigned, provided the individual meets all of the eligibility requirements for the requested Category, the member shall apply in writing to the appropriate Department Director or Section Head. A form approved by the MEC will be available for such purpose, and such form is the only form to be used. The request shall state specifically and in appropriate detail the different Category sought and the reasons and justifications therefor. Such request shall be approved by the Department Director or Section Head, then by the Credentials Committee and Medical Executive Committee (MEC).

(b) Within ninety (90) days of any amendment to these Bylaws that results in a change in the eligibility criteria for any Medical Staff category, the Medical Staff Office shall assess the category assignments of all Medical Staff members and members shall be reassigned as appropriate to the correct Medical Staff category based on the new eligibility criteria. Any member appropriate for reassignment shall receive written notice of at least sixty (60) days, following which such change in category shall be made.

(c) The Board of Trustees shall be given notice of an individual's change in Medical Staff Category and the reason(s) therefor, but shall not be required to approve or ratify such change.

ARTICLE IV A

AFFILIATED HEALTH CARE PROFESSIONALS STAFF

SECTION 1: AFFILIATED HEALTH CARE PROFESSIONAL STAFF

(a) Affiliated Health Care Professionals shall include the following: nurse anesthetists, licensed nurse midwives, nurse practitioners, physician assistants, and psychologists (except those psychologists appointed to the Medical Staff prior to October 1, 2019 who are eligible for membership in the Active Attending, Courtesy or Referring Staff categories as set forth in Article IV, Sections 1, 2 and 3 above). 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 (MEC) and with approval by the Quality and Safety Committee of the Board of Trustees.

(b) 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.

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

(d) Supervision

i. 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.

ii. 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 Office, provide the name of the new supervising or collaborating physician or be deemed to have voluntarily resigned.

iii. 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.

iv. 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.

v. 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.

(e) Appointment and Privileging

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

ii. 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.

iii. 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.

iv. 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; nurse practitioners; and licensed nurse midwives, who are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms.

(f) Affiliated Health Care Professionals:

i. may not serve as Medical Staff Officers or in any Medical Staff leadership roles

ii. 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;

iii. are not required to pay medical staff dues; and

iv. are eligible to serve as a voting member on any Medical Staff Committee, except not the Medical Executive Committee, Credentials Committee or Bylaws Committee, and may not serve as Chair of any Committee.

SECTION 2: Referring Affiliated Health Care Professionals

(a) 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.

(b) 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.

SECTION 3: Medical Staff Bylaws, Rules and Regulations, Medical Ethics

(a) 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 Articles XI, XII and XIII.

(b) 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.

ARTICLE V

CLINICAL PRIVILEGES

SECTION 1: EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at this Hospital shall be entitled to exercise only those Clinical Privileges specifically granted by the Board as defined in the pertinent Department's delineation of privileges form. Said Privileges and services must be Hospital specific, within the scope of any license, certificate or other legal restrictions, and shall be subject to the pertinent Department's delineation of privileges form. Medical Staff Privileges may be granted, continued, modified, or terminated only by the Board:

- (a) after receiving a recommendation of the Credentials Committee and the Medical Executive Committee (MEC);
- (b) for reasons related to the quality of patient care, or otherwise in accordance with
- (c) the Medical Staff Bylaws; and
- (d) following the procedures outlined in these Bylaws.

All individuals who are permitted by law and by the Hospital to provide patient care services in the Hospital independently, including but not limited to all physicians and dentists, shall have delineated Clinical Privileges.

All individuals who are granted Clinical Privileges shall have substantially equivalent access to such resources as are made available by the Hospital to effectively exercise these Privileges.

SECTION 2: DELINEATION OF PRIVILEGES IN GENERAL

(a) Each application for appointment and re-appointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by the member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of training and/or experience.

(b) Clinical Privileges shall be granted on the basis of the member's education, training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical performance, appropriateness of utilization patterns, ability to perform the Privileges requested competently and safely, information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable, availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability, adequate professional liability insurance coverage for the Clinical Privileges requested, the Hospital's available resources and personnel, any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of

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such licensure or registration, any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or Clinical Privileges at another hospital, practitioner-specific data as compared to aggregate data, when available, morbidity and mortality data, when available, and professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises Clinical Privileges.

SECTION 3: TEMPORARY PRIVILEGES

(a) Eligibility to Request Temporary Clinical Privileges:

(1) Applicants. Temporary Privileges may be granted by the President, upon recommendation of the Chief of Staff, SVPMS, Department Director or Section Head when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Executive Committee (MEC) and Board, following a favorable recommendation of the Credentials Committee. Prior to temporary Privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the Privileges requested and current professional liability coverage; compliance with Privileges criteria; and consideration of information from the National Practitioner Data Bank. In order to be eligible for temporary Privileges an individual must demonstrate that (i) there are no current or previously successful challenges to his licensure or registration, and (ii) he has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility. Temporary Privileges in this situation will be granted for a maximum period of 90 consecutive days

(2) Important Patient Care Needs. Temporary Privileges may also be granted for important patient care needs by the President, upon recommendation of the Chief of Staff, SVPMS, Department Director or Section Head when there is an important patient care,

treatment, or service need. Specifically, temporary Privileges may be granted for situations such as the following:

- (i) the care of a specific patient; or
- (ii) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary Privileges in these situations: current licensure, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank. The granting of Clinical Privileges in these situations will not exceed 90 days. In exceptional situations, this period of time may be extended in the discretion of the President after consideration of the recommendations of the Chief of Staff and SVPMS.

(3) **Locum Tenens.** The President may grant temporary admitting and Clinical Privileges to an individual serving as a locum tenens for a member of the Medical Staff. This will be done in the same manner and upon the same conditions as set forth in Section 3(a)(2) above, except with respect to time periods. The individual serving as a locum tenens may exercise Privileges for a maximum of 90 days, consecutive or not, any time during the 24-month period following the date they are granted.

(4) **Compliance with Bylaws and Policies.** Prior to any temporary Privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

(b) All appointments for temporary Privileges will be reviewed by the Medical Executive Committee (MEC) at its first meeting following a grant of temporary Privileges.

(c) **Supervision Requirements:** In exercising temporary Privileges, the individual shall act under the supervision of the Department Director or physician(s) designated by the Medical Executive Committee (MEC). Special requirements of supervision and reporting may be imposed on any individual granted temporary Clinical Privileges.

(d) **Termination of Temporary Clinical Privileges:**
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(1) The President may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the Department Director, terminate temporary admitting Privileges. Clinical Privileges shall be terminated when the individual's inpatients are discharged.

(2) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary Privileges, the President, the Department Director, or the Chief of Staff may immediately terminate all temporary Privileges. The Department Director or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until the patients are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(3) The granting of temporary Privileges is a courtesy and may be terminated for any reason.

(4) Neither the denial nor termination of temporary Privileges shall entitle the individual to a hearing or appeal.

SECTION 4: DISASTER PRIVILEGES

(a) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President, SVPMS or the Chief of Staff may use a modified credentialing process to grant disaster Privileges to eligible volunteer Physicians and Allied Health Professionals ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(b) Disaster Privileges are granted on a case-by-case basis after verification of identity and licensure.

(1) A volunteer's identity may be verified through valid government-issued photo identification (i.e., driver's license or passport).

(2) A volunteer's license may be verified in any of the following ways: (i) current hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(c) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(d) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (i) the reason primary source verification could not be performed in the required time frame; (ii) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (iii) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(e) The Medical Staff will oversee the care provided by volunteer Physicians and Allied Health Professionals. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

SECTION 5: EMERGENCY PRIVILEGES

(a) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(b) In an emergency situation, a Member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of Department status or specific grant of Clinical Privileges.

(c) When the emergency situation no longer exists, the patient shall be assigned by the Department Director or the Chief of Staff to a Member with appropriate Clinical Privileges, considering the wishes of the patient.

SECTION 6: ORAL AND MAXILLOFACIAL SURGERY AND HOSPITAL DENTISTRY PRIVILEGES

The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as all other Clinical Privileges. A medical history and physical examination of the patient shall be made and recorded before dental surgery shall be performed by an appropriately credentialed physician who holds an appointment to the Medical Staff or by a dentist who holds an appointment to the Medical Staff and is authorized by law and credentialed to perform a medical history and physical examination.

SECTION 7: TELEMEDICINE PRIVILEGES

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Director, the Credentials Committee and the Medical Executive Committee (MEC) consistent with Section 9(a) of this Article V.

(b) A practitioner who is granted telemedicine privileges shall be appointed to the Telemedicine category of the Medical Staff if the practitioner provides clinical services at the Hospital only from a distance via electronic communications, but if the practitioner also applies for and is granted other Clinical Privileges then he/she shall be placed in another appropriate Medical Staff category for which the practitioner is eligible and qualified.

(c) Individuals applying for telemedicine Privileges will meet the eligibility criteria for Medical Staff appointment and reappointment outlined in these Bylaws, except for those requirements relating to geographic residency and coverage arrangements.

(d) Telemedicine Privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

(e) Requests for initial or renewed telemedicine Privileges shall be processed through one of the following options, as determined by the President in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such case, the individual must satisfy all of the qualifications and requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or at a telemedicine entity (as that term is defined by Medicare), and the distant hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(f) confirmation that the practitioner is licensed in Connecticut; a current list of privileges granted to the practitioner; information indicating that the individual has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(g) a signed attestation that the individual satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(h) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(i) any other attestations or information required by the agreement or requested by the Hospital.

(j) This information received about the individual requesting telemedicine Privileges will be provided to the Department Director or Section Head for review and recommendation, then to the Credentials Committee for review and recommendation, then to the Medical Executive Committee for review and recommendation, and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine Privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the eligibility criteria set forth in these Bylaws.

(k) Telemedicine Privileges, if granted, will be for a period of not more than two years.

(l) Individuals granted telemedicine Privileges will be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities. The results of these performance improvement, ongoing and focused professional practice evaluations and peer review activities, including any adverse events and complaints filed about the individual providing telemedicine services from patients, other practitioners or staff, will be shared with the distant hospital or entity providing telemedicine services.

SECTION 8: CHANGES IN CLINICAL PRIVILEGES

(a) When a member of the Medical Staff wishes to be granted additional or different Clinical Privileges, he shall apply in writing to the appropriate Department Director or Section Head.
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A form approved by the MEC will be available for such purpose, and such form is the only form to be used. The application shall state specifically and in appropriate detail the additional or different Privileges sought and the reasons and justifications therefore. Provided that the individual is eligible to apply for the requested Privileges, the processing shall be as for application for initial Clinical Privileges, unless the request is made at the time of an application for reappointment.

(b) Conditions: Changes in Privileges granted warrant focused professional practice evaluation, through provisional status (as described in Article VI, Section 10 below), for a period of time deemed necessary by the particular Department Director, Credentials Committee and Medical Executive Committee (MEC). Such requirement is not disciplinary or adverse, but rather an instrument of quality assurance.

SECTION 9: PRIVILEGES FOR NEW PROCEDURES

(a) Requests for Clinical Privileges to perform a significant treatment/procedure not currently being performed at the Hospital, a significant new technique to perform an existing treatment/procedure, or to have existing privileges offered as telemedicine privileges ("new procedure") will not be processed until (1) a determination has been made that the new procedure will be offered by the Hospital and (2) criteria to be eligible to request those Clinical Privileges have been established.

(b) The Credentials Committee will make a preliminary recommendation as to whether a significant new treatment/procedure should be offered to the community if the President or his/her designee has first determined to authorize the necessary resources be dedicated to the new treatment/procedure or if the President requests the recommendation of the Credentials Committee as a prerequisite to making such a determination. Factors to be considered by the Credentials Committee and the Medical Executive Committee (MEC) include, but are not limited to, the recommendation of the relevant Department Director or Section Head, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new treatment/procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the

Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new treatment/procedure.

(c) If it is recommended that the new treatment/procedure be offered, the Credentials Committee will conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new treatment/procedure, and (2) the extent of monitoring and supervision that should occur if the Privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new treatment/procedure is appropriate.

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee (MEC), which will review the matter, including all considerations set forth above, and forward its recommendations to the Board for final action.

SECTION 10: MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTS DECISION MAKING

If the President determines that an exclusive physician contract is in the Hospital's best interests, the Board and the MEC shall be presented with evidence concerning the benefits of an exclusive contract, and the Board shall consider the recommendations, if any, of the Medical Executive Committee (MEC) in making its determination whether to authorize entry into an exclusive physician contract.

ARTICLE VI

APPLICATIONS

An application for Medical Staff membership is a practitioner's written request for such membership and/or Clinical Privileges in the form required, completed as to the requirements listed below in combination with the applicant's statements of the acknowledged undertakings listed in Section 3 of this Article and releases and authorizations listed in Section 4 of this Article, all fully, truthfully and

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timely presented in proper context without intention to mislead, signed by said applicant and submitted with any fee as may be required and with all necessary additionally required information, references, statements, reports, et cetera. Notwithstanding the other provisions of this Article relating to the time for processing completed medical staff applications, efforts will be utilized to expeditiously process such completed applications and present them for final Board approval within ninety (90) days of completion and submission according to the rules set forth below. Applications for re-appointment will be handled in accordance with Section 11 below.

SECTION 1: APPLICATION INFORMATION

Applications for appointment to the Medical Staff shall be on forms approved by the SVPMS, the Medical Staff Credentials Committee, and the Medical Executive Committee (MEC). Applications for membership and/or Privileges that are not available, whether as a result of exclusive contracting or a medical staff development plan approved by the Board, will not be processed. The Hospital's refusal to permit a potential applicant to submit an application for such reasons shall in no way be construed to be an action of the Medical Staff or be subject to appeal under these Bylaws.

Properly completed forms will contain essential information about the potential applicant sufficient to enable the President, the SVPMS, the Department Director, the Credentials Committee and the Medical Executive Committee (MEC) to compare the candidate's fitness and desirability to the defined needs and requirements for staff membership. Applications shall provide detailed information concerning the applicant's professional qualification, including:

- (a) references pertaining to the applicant's professional competence and character from sources consistent with the requirements set forth in the application;
- (b) information as to whether the applicant's Medical Staff appointment or Clinical Privileges have ever been denied, revoked, suspended, surrendered, reduced, restricted or not renewed at any other hospital or health care facility;
- (c) information as to whether the applicant's membership in local, state or national professional societies or license to practice any profession in any state, or state or federal narcotics

license has ever been suspended, surrendered, denied, modified, restricted, terminated, or not exercised by agreement with a governmental authority. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as the applicant's narcotics registration. The applicant must disclose information not only about previous adverse actions against the applicant, but also about pending challenges by licensing agencies and/or Drug Enforcement Administration including consent or other agreements and voluntary relinquishment or withdrawal;

(d) information as to whether the applicant has currently in force professional liability insurance coverage and the amount, which shall be no less than 1 million / 3 million dollars, and classification of such coverage;

(e) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition;

(f) a consent to the release of information from present and past malpractice insurance carriers, hospitals and other institutions as appropriate and employers as may be relevant;

(g) information on any felony accusations with details and outcomes;

(h) a request for specific Clinical Privileges desired by the applicant accompanied by attestation by the applicant's current Department Director or Section Head as to appropriateness or context as related to current and prior Privileges, training, current abilities and level of functioning;

(i) current information regarding the applicant's ability to safely and competently exercise the Clinical Privileges requested. The applicant shall sign the application and certify that he or she is able to perform the Privileges requested and the responsibilities of appointment;

(j) a copy of a government-issued photo identification; and

(k) such other information as the Medical Staff or Board may require and any other information not specifically requested that is necessary to prevent misleading conclusions. The applicant shall produce adequate information for a proper evaluation of his competence, character, ethics and other qualifications. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.

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SECTION 2: COMPLETENESS OF APPLICATION

(a) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall be deemed incomplete if the need arises for new, additional or clarifying information any time during the evaluation. It is the burden of the applicant to be sure that the application is complete, including adequate responses from references. An incomplete application will not be processed. The SVPMS or the Credentials Committee will determine whether an application is complete and will advise the applicant that the application will not be considered until it is complete, including the required letters of reference and supplemental material. In addition to completeness, the application must provide a sufficiency of information to resolve any doubts about all particular matters (for example, the applicant's performance in the residency program or current surgical competence).

(b) Any necessary further investigation of the application shall be conducted or coordinated by the Office of the SVPMS. If additional information is required of the candidate, said executive or designee shall request it in writing. These activities may lengthen the time required for final action on the application. Without the required information, the application is incomplete. Failure of the candidate to provide such information within 30 days of the request shall be construed as a withdrawal of the application; under such circumstances, the SVPMS shall consider the file closed and reclaim it from the Credentials Committee.

(c) If a Medical Staff member requesting a modification of Clinical Privileges or Department assignments fails to timely furnish the information necessary to evaluate the request, the application shall be deemed voluntarily withdrawn.

SECTION 3: UNDERTAKINGS

Every application for staff appointment shall be signed by the applicant and shall contain:

(a) a statement that the applicant has received and read a copy of the Bylaws, Rules and Regulations of the Medical Staff as are in force at the time of his application and that he has agreed to be bound by the terms , and as amended from time to time, in all matters relating to consideration of his application without regard to whether or not he is granted appointment to the Medical Staff and/or Clinical Privileges, and such statement shall signify receipt of fair and adequate notice through said Bylaws of any and all rights thereunder;

(b) a statement of willingness to appear for personal interviews in regard to his application;

(c) the applicant's specific acknowledgement of his obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients for whom he has responsibility within the Hospital;

(d) the applicant's agreement to obtain continuing medical education as required, and to timely provide to his Department Director and the Continuing Medical Education Committee official certification of each course taken;

(e) his agreement to abide by all Bylaws and policies of the Hospital, including all Bylaws, Rules and Regulations of the Medical Staff and of Departments and Sections as shall be in force during the time he is an appointee to the Medical Staff of the Hospital; and

(f) his agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the Medical Staff.

SECTION 4: AUTHORIZATION TO OBTAIN INFORMATION; IMMUNITY

(a) The purpose of this Section is to enable the Hospital and Medical Staff to gather information to use in order to carry out their obligations under these Bylaws, and further to enable information related to matters covered by these Bylaws with respect to practitioners who are employed by the Hospital or a Hospital affiliate within the Yale New Haven Health System to be shared with the Administration or Human Resources (as appropriate) to the extent relevant for purposes of employment (For example, information needed for purposes of credentialing, Investigations, disciplinary action
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[including precautionary suspension], hearings and appeals, quality assurance, and all other Medical Staff Hospital and employment activities). This Section is intended to provide full access to such information and to assure that those who use and provide such information will not be subject to harassment.

(b) The provisions of this Section apply:

(1) to all persons subject to these Bylaws and Rules and Regulations, including Medical Staff members, and applicants for appointment, re-appointment or Clinical Privileges;

(2) to all matters referred to in these Bylaws and Rules and Regulations;

(3) automatically and regardless of whether specific authorizations or releases are requested or provided.

(c) For purposes of this Section, the following definitions apply:

(1) "Hospital" means the Hospital and its Medical Staff and all persons who are employees or agents of either in connection with Medical Staff activities including the Board;

(2) "practitioner" means any person subject to these Bylaws and Rules and Regulations including, but not limited to Medical Staff members, Allied Health Care Professionals Staff, and applicants for membership or Privileges; and

(3) "third parties" means any person or entity that provides information or opinions.

(d) Each practitioner authorizes the Hospital to seek, obtain, and use all information and opinions that it deems necessary for purposes of these Bylaws and Rules and Regulations and, with respect to employed practitioners, for purposes of employment, and authorizes all third parties to release such information and opinions to the Hospital and to the Hospital's affiliates within the Yale New Haven Health System.

(e) To the greatest extent permitted by law, the practitioner releases from liability the Hospital and all third parties, and agrees not to make any claims against any of them arising from the seeking, obtaining, release, and use of such information and opinions, including otherwise privileged and confidential information and opinions.

SECTION 5: INITIAL REVIEW OF APPLICATIONS

(a) The completed application for Medical Staff appointment, along with any application processing fee as may be recommended by the Medical Executive Committee (MEC) and approved by the Board, shall be submitted by the applicant to the SVPMS.

The SVPMS shall review the application to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed.

The SVPMS, will gather information regarding the applicant, including verifying relevant information and querying the National Practitioner Data Bank, and evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested Clinical Privileges. This interview may be conducted by a combination of any of the following:

the Department Director or Section Head, the Credentials Committee, a Credentials Committee representative, the Chief of Staff, the SVPMS, the Medical Executive Committee (MEC) or the CQO.

SECTION 6: DEPARTMENT DIRECTOR PROCEDURE

(a) The SVPMS shall transmit the complete application and all supporting materials to the Director of each Department in which the applicant seeks Clinical Privileges.

(b) Each Director shall provide a recommendation in writing regarding whether the applicant has satisfied all of the qualifications for appointment and the Clinical Privileges requested within 30 days.

(c) If a Department Director has not provided a recommendation within 30 days, the Department Director must notify the Credentials Committee and shall work expeditiously to submit his report as soon as reasonably practicable.

SECTION 7: CREDENTIALS COMMITTEE PROCEDURE

Upon receipt of the completed application for appointment the Credentials Committee shall take the following steps:

(a) The Credentials Committee shall review and consider the report prepared by the relevant Department Director and shall make a recommendation within 30 days.

(b) The Credentials Committee may use the expertise of the Department Director, or any member of the Department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) As part of the process of formulating its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of his application, his qualifications and the requested Clinical Privileges;

(d) After considering all the pertinent information, the Credentials Committee shall provide a recommendation for acceptance, deferral, or rejection of the application for staff appointment. The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. If a favorable recommendation is made, the Credentials Committee will delineate provisional Departmental assignment and provisional Clinical Privileges.

(e) If the Credentials Committee has not prepared its written report within 30 days, the Credentials Committee must notify the Medical Executive Committee (MEC) and shall work expeditiously to submit its report as soon as reasonably practicable.

SECTION 8: MEDICAL EXECUTIVE COMMITTEE (MEC) PROCEDURE

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee (MEC) shall within 30 days: (1) adopt the findings and recommendation of the Credentials Committee as its own; or (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee (MEC) prior to its final recommendation; or (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the Medical Executive Committee (MEC) is to appoint, the recommendation shall be forwarded to the Board through the President.

(c) If the recommendation of the Medical Executive Committee (MEC) would entitle the applicant to request a hearing, the Medical Executive Committee (MEC) shall forward its recommendation to the President, who shall promptly send special notice to the applicant. The President shall then hold the application until after the applicant has completed or waived a hearing and appeal.

(d) If the Medical Executive Committee (MEC) has not prepared its written report within 30 days, the Medical Executive Committee (MEC) must notify the Board and shall work expeditiously to submit its report as soon as reasonably practicable.

SECTION 9: BOARD ACTION

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and Clinical Privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee (MEC) and there is no evidence of any of the following:

- (1) a current or previously successful challenge to any license or registration; or
- (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or Privileges at any other hospital or other entity; or
- (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

(b) Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for consideration at its next meeting.

(c) Upon receipt of a recommendation for appointment and Clinical Privileges, or a decision of the Board Committee, the Board may:

- (1) appoint the applicant and grant Clinical Privileges as recommended by the Medical Executive Committee (MEC) or ratify the appointment and clinical privileges granted by the Board Committee, as applicable and appropriate; or
- (2) refer the matter back to the Credentials Committee or Medical Executive Committee (MEC) for additional research or information; or
- (3) reject or modify the recommendation.

(d) If the Board determines to reject a favorable recommendation of the Medical Executive Committee (MEC) or a favorable decision of the Board Committee, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the Medical Executive Committee (MEC). If the Board's determination remains unfavorable to the applicant, the President shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(e) Any final decision by the Board to grant, deny, revise or revoke appointment and/or Clinical Privileges shall be delivered to the applicant within thirty (30) days of said decision and shall be disseminated to appropriate individuals and, as required, reported to appropriate entities.

SECTION 10: PROVISIONAL STATUS

(a) Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of Clinical Privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

(b) Focused Professional Practice Evaluation: Consistent with the medical staff policy on Focused Professional Practice Evaluation (FPPE), a period of focused review is required for new members of the medical staff with Clinical Privileges during the provisional period. During this period, the individual's exercise of the relevant Clinical Privileges will be evaluated by the Director of the Department in which the individual has Clinical Privileges. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other practitioners and Hospital employees. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

(c) Duration of Provisional Period: The period of provisional appointment shall ordinarily be for up to three (3) years concluding at the first reappointment after initial appointment. All individuals will be treated equally with respect to the length of the provisional appointment unless there is justification to extend the provisional period and/or the period of FPPE.

SECTION 11: RE-APPOINTMENT APPLICATION

(a) An application for reappointment shall be furnished to members at least 6 months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the SVPMS at least 4 months prior to the expiration of the member's current term.

(b) Reappointment applications shall be processed in the same manner as applications for initial appointment.

(c) If an application for reappointment was submitted timely and is complete, the Board shall act on it at its next regularly scheduled meeting after receiving the recommendation of the Medical Executive Committee (MEC) prior to the end of the individual's current term of appointment.

(d) Reappointment shall be for a period of not more than three years.

ARTICLE VII

DEPARTMENT

DEFINITIONS.

“Harassment” means verbal or physical activity directed against any individual (e.g., against another Medical Staff member, hospital employee, or patient) on the basis of any of the following: national origin, culture, race, gender, color, age, marital or civil union status, ancestry, sexual orientation, gender identity, ethnic background, religion, disability, past alcohol or drug use, mental illness, genetic information, gender orientation or expression, or any other category protected by applicable state or federal law.

“Sexual Harassment” means unwelcome verbal or physical conduct of a sexual nature that may include verbal or written harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, interference with movement or work), and visual

harassment (such as the display of derogatory cartoons, drawings, or posters). It includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, credentialing and recredentialing, or other aspects of employment or Staff membership; or (2) this conduct substantially interferes with the individual's employment or Staff membership or creates an intimidating, hostile, or offensive work environment.

“Disruptive Behavior” means any conduct or behavior including, without limitation, sexual harassment or other forms of inappropriate behavior, which: (i) jeopardizes or is inconsistent with quality patient care or with the ability of others to provide quality patient care at the hospital; (ii) is unethical; or (iii) constitutes the physical or verbal abuse of patients or others involved with providing patient care at the hospital.

PURPOSE.

To promote patient safety and quality improvement through facilitating communication and cooperation among health care professionals by describing prohibited behavior involving medical staff members and delineating the response to be followed in all cases of allegations of such prohibited behavior involving members of the Medical Staff and Allied Health Professional Staffs.

The behavior of members and applicants for membership on the Medical Staff and Allied Health Professional Staffs constitutes an essential component of professional activity and personal relationships with the Hospital. Civil department fosters an environment conducive to excellent patient care. Accordingly, in addition to the qualifications set forth above, a member of the Medical Staff or of the Allied Health Professional Staff at all times shall demonstrate an ability to interact on a professional basis with members of the Staff, patients, and others, and to behave in a professional and civil manner. More specifically, no member of the Medical Staff or the Allied Health Professional

Staff shall engage in Disruptive Behavior, Sexual Harassment, or Harassment, as defined in this Article. Behavior that indicates that the member of the Medical or Allied Health Professional Staff suffers from a physical, mental or emotional condition will be responded to in accordance with the Medical Staff's Practitioner Health Policy concerning impaired physicians.

This requirement is not in any way intended to interfere with a Staff member's right: (1) to express opinions freely and to support positions whether or not they are in agreement with those of other Staff members or Hospital administration; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) engage in the good faith criticism of others.

Violations of the requirements set forth in this Article may be grounds for corrective and other action under these Bylaws.

ARTICLE VIII

LEAVES OF ABSENCE

(a) A request for a leave of absence shall be filed with the Director of the Department in which the individual holds Privileges. The Department Director shall consider the impact of the leave upon patient services. During the period of the leave, the member shall not exercise Clinical Privileges at the Hospital, and membership rights and duties shall be inactive.

(b) Leaves may be granted for good cause for up to six (6) months. Each such request will be considered on its own merits and extension of leave is not automatic. Individuals may request an extension of leave prior to the expiration of the initial leave granted so long as the total leave of absence granted does not exceed one (1) year.

(c) The Department Director's recommendation, along with the request for leave or extension of a leave, shall be transmitted to the Credentials Committee, which shall review the

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request and then transmit its recommendation with respect to whether to grant or deny the request to the Medical Executive Committee (MEC), which shall determine whether to grant or deny the request.

(d) At least 30 days prior to termination of the leave of absence, or at any earlier time, the practitioner may request reinstatement of Privileges by submitting a written notice to that effect to the Department Director. The practitioner shall file a report to his Department Director regarding his professional activities, if any, during the absence and any information that is relevant to the returnee's professional skills and competence, health, or events or circumstances that may affect appointment or Privileges. The Department Director shall make a recommendation to the Credentials Committee concerning the reinstatement of the practitioner's Privileges. If a practitioner fails to request reinstatement of Privileges prior to termination of the leave of absence, the practitioner's Medical Staff appointment and Clinical Privileges shall be deemed to have expired as of the date of termination of the leave of absence previously granted. Likewise, if the practitioner's Medical Staff appointment and Clinical Privileges are scheduled to expire prior to the termination of the leave of absence in accordance with the regular credentialing cycle, the practitioner must either participate in the re-appointment process and submit a reappointment application in order to maintain the appointment and Clinical Privileges or, if the practitioner does not do so, the practitioner's Medical Staff appointment and Clinical Privileges shall expire at the conclusion of the regular credentialing cycle and shall be treated in the same manner as if the practitioner had not been on a leave of absence and had failed to submit a reappointment application.

(e) Consistent with the provisions of Article VI, Section 11, the Credentials Committee shall review the credentials and information presented and shall make a recommendation to the Medical Executive Committee (MEC) concerning reinstatement. Reinstatement may be recommended for the prior or a different staff category or different Clinical Privileges. The Credentials Committee may also recommend limitation or modification of the Privileges of the returning individual, which action may entitle the member to procedural rights, or to other conditions as provided in Article V, Section 7(b) that do not trigger procedural rights.

(f) Reinstatement shall occur only after review by the Medical Executive Committee (MEC) and approval of the Board.

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(g) Upon return from any absence of more than two weeks, which absence was other than a planned vacation, leave of absence, the practitioner shall provide a statement from his treating physician that he is medically able to resume clinical practice and Hospital duties. However, even in the case of a planned leave or absence of more than two weeks, the practitioner may be required to provide such a statement from his treating physician, or to provide a statement regarding his activities while on vacation, leave of absence, if deemed appropriate by the SVPMS, Department Director, Section Head, Chief of Staff or Assistant Chief of Staff.

(h) A form to request a leave of absence, extension of a leave of absence and reinstatement from leave of absence approved by the MEC will be available for such purposes, and such form is the only form to be used.

ARTICLE IX

PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE OR BEHAVIOR

SECTION 1: GROUNDS FOR ACTION

Upon receipt of a report or otherwise becoming aware of a concern regarding a practitioner's clinical competence or behavior, the Department Director, Section Head, Chief of Staff, Assistant Chief of Staff, Chair of the Medical Executive Committee (MEC) and/or SVPMS shall evaluate such concern and may initiate a collegial intervention if such Medical Staff leader(s) determines that such intervention may be effective at addressing and resolving the concern at issue. 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 practitioner's clinical practice or conduct, including: (i) advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely completion of medical records; (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.

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If, however, any such collegial intervention is deemed not appropriate under the circumstances, or if it is attempted but unsuccessful, then any such Medical Staff leader(s) may refer the matter to the Medical Executive Committee (MEC) in accordance with this Section 1. Medical Staff leadership may also initiate an alternative appropriate process described in any relevant Medical Staff policy, such as policies concerning practitioner health and disruptive behavior.

Any Department Director or Section Head, the Chief of Staff, Assistant Chief of Staff, Chair of the Medical Executive Committee (MEC), SVPMS, the Chair or a majority of any committee, the Chair of the Board, or the President may notify the MEC in writing whenever he has reason to suspect -- on the basis of information or belief -- that a member of the Medical Staff or a practitioner with Clinical Privileges has a problem in regard to any of the following (for purposes of these Bylaws, references to "member" shall apply equally to practitioners with Clinical Privileges who are not members of the Medical Staff except where the context of a particular provision indicates otherwise):

- (a) clinical competence;
- (b) care or treatment of a patient or patients or management of a case;
- (c) known or suspected violation of the policies of the Hospital, the Bylaws, rules or regulations of the Medical Staff relating to professional activity; or
- (d) non-compliance with the ethics of the individual's profession or the Medical Staff Bylaws, Hospital policies, or the Rules and Regulations of the Medical Staff regarding conduct or behavior

Any person may provide information or report situations or incidents that might be cause for inquiry to the Medical Executive Committee (MEC). The Medical Executive Committee (MEC) shall evaluate all such reports and shall determine whether further inquiry is warranted. The Chairman of the Medical Executive Committee (MEC) shall notify the President promptly in writing of all requests for action under this Article and keep him fully informed of all action taken.

SECTION 2: INQUIRY AND INVESTIGATION

(a) Within thirty (30) days following receipt of a notice or information described in Section 1 of this Article, the Medical Executive Committee (MEC) shall, at its discretion, commence an inquiry into the matter or appoint a subcommittee to do so or refer the matter to a standing or specially named committee. The inquiry may involve, but neither requires nor is necessarily limited to, interviewing witnesses, interviewing the practitioner (on an informal basis, without the presence of counsel), gathering facts and documents, external review, and such other actions as deemed appropriate by the Medical Executive Committee (MEC) or by the inquiring body, as applicable. If the practitioner will be interviewed, the practitioner shall be apprised, at least generally, of the nature of the concerns at issue.

(b) If the inquiry reveals that the reported information is sufficiently credible and significant, the Medical Executive Committee (MEC) may address the matter collegially or, through formal resolution, initiate an Investigation.

(c) 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 practitioner's clinical practice or conduct, including: (i) advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely completion of medical records; (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.

(d) If the Medical Executive Committee (MEC) does not direct that an Investigation be made following its inquiry, the Medical Executive Committee (MEC) must then so inform the Board

and then the Board may, if the inquiry reveals that the reported information is sufficiently credible and significant, appoint an ad hoc committee comprised of two (2) or more members of the Medical Staff of the Board's choosing, to Investigate and report to the Medical Executive Committee (MEC), which then shall have the opportunity to reconsider the matter.

(e) If the Medical Executive Committee (MEC) resolves to initiate an Investigation, the MEC may conduct the Investigation itself or may appoint a subcommittee to do so or may refer the matter to a standing or specially named committee.

(f) If an Investigation is initiated, the affected practitioner shall be apprised of the nature of the concerns, with as much specificity as would enable the practitioner to respond and as the Medical Executive Committee (MEC) deems appropriate under the circumstances. The practitioner shall be afforded an opportunity to make an appearance before the Medical Executive Committee (MEC) or the designated investigating committee, as applicable, to discuss, explain or refute the concerns prior to its taking action. This appearance shall not constitute a hearing, but shall be preliminary and investigative in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. Presence of counsel for the parties shall not be permitted. A summary or a record of the interview, if held, shall be made by the Medical Executive Committee (MEC) or the designated investigating committee, as applicable, and shall be included with its report to the Medical Executive Committee (MEC) (and to the Board-designated ad hoc committee if one is established pursuant to Article IX, Section 2(d) above). If the practitioner in question is a member of the Medical Executive Committee (MEC), he shall be excluded from all deliberations that relate to the case.

(g) Partners or associates of the affected practitioner shall not participate in the Investigation, nor shall any staff member who is in direct economic competition with the practitioner. The Medical Executive Committee (MEC) 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.

(h) The Medical Executive Committee (MEC) 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 Executive Committee (MEC). This report shall summarize the facts and circumstances concerning the activity or conduct of the practitioner that served as a basis for the corrective action request and the conclusions reached. The report shall state either a finding of a support or of no support for corrective action, and make appropriate recommendation(s).

(i) Despite the status of any Investigation, at all times the Medical Executive Committee (MEC) has the authority and discretion to take whatever action it may deem warranted by the circumstances, including precautionary suspension, termination of the Investigation or other action permitted by these Bylaws. Likewise, all officers identified in Article X, Section 1(a) with respect to the authority to impose a precautionary suspension, and such other individuals to whom authority to take action has been expressly granted pursuant to these Bylaws, may take such actions as deemed warranted by the circumstances in accordance with these Bylaws regardless of the status of any Investigation.

(j) In the event a practitioner is subject to a precautionary suspension that is imposed prior to the commencement of an Investigation, the Investigation shall be completed and the Medical Executive Committee (MEC) shall take such action or make such recommendation as described in Article IX, Section 3 below within ninety (90) days after the commencement of the Investigation. In the event a practitioner is subject to a precautionary suspension that is imposed after an Investigation has commenced, the Investigation shall be completed by the Medical Executive Committee (MEC) and the Medical Executive Committee (MEC) shall take such action or make such recommendation as described in Article IX, Section 3 below within ninety (90) days after the imposition of the precautionary suspension.

SECTION 3: PROCEDURE THEREAFTER

(a) The Medical Executive Committee (MEC) may accept, modify, or reject any recommendation it receives from an investigating body following an inquiry or Investigation. Specifically, the Medical Executive Committee (MEC) may:

- (1) determine that no action is justified;
- (2) issue a letter of guidance, counsel, warning, or reprimand;
- (3) impose conditions for continued appointment;
- (4) require monitoring, proctoring or consultation;
- (5) require additional training or education;
- (6) recommend reduction or restriction of clinical privileges or scope of practice;
- (7) recommend suspension of clinical privileges or scope of practice for a term;
- (8) recommend revocation of appointment or clinical privileges or scope of practice; or
- (9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Medical Executive Committee (MEC) that does not entitle the individual to request a hearing (pursuant to Article XI, Section 1(c)), will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Medical Executive Committee (MEC) that would entitle the individual to request a hearing (pursuant to Article XI, Section 1(a)) will be forwarded to the President, who will promptly inform the individual by special notice (pursuant to Article XI, Section 3).

SECTION 4: AUTOMATIC SUSPENSION

In the following situations, a member's Privileges or membership may be suspended or limited. In such event, the practitioner may request a review by the Medical Executive Committee (MEC), which, if requested, shall be limited to the issue of whether the grounds for automatic suspension exist.

(a) Whenever a member's license to practice in the State of Connecticut is surrendered, revoked, suspended, or not exercised because of an agreement with a governmental authority, Medical Staff membership and Clinical Privileges shall be automatically revoked. Whenever a member's license to practice in the State of Connecticut is on probation, limited or restricted by consent, order or agreement with any licensing board or private or governmental body, the matter shall be evaluated taking into account the relevance of the probation, limitation or restriction on the member's Clinical Privileges at the Hospital, and a determination shall be made regarding whether the probation, limitation or restriction shall result in automatic revocation of Medical Staff membership and Clinical Privileges or whether, instead, the member's Clinical Privileges at the Hospital shall be automatically subject to the same probation, limitation or restriction. Such evaluation shall be made by Department Director or Section Head, the Credentials Committee and the Medical Executive Committee (MEC), which shall then make a recommendation to the Board for final action. The member shall promptly provide any such consent, order or agreement to the SVPMS, and the facts that led to the action by a State or Federal agency may become the basis for Investigation or corrective action by the Medical Executive Committee (MEC).

(b) If a member requires a certificate or registration to prescribe controlled substances in order to exercise Clinical Privileges and the member's certificate or registration is surrendered, revoked, limited, suspended, or not exercised because of an agreement with a governmental authority any of which are related to an investigation for violation of law, the member's Medical Staff membership and Clinical Privileges shall be automatically revoked. If, however, the matter is unrelated to a violation of law, there shall be an evaluation and determination by the Department Director or Section Head, Credentials Committee, Medical Executive Committee (MEC) and the Board for final action, such action either being to automatically revoke the member's Medical Staff membership and Clinical Privileges, or to allow continued membership and Clinical Privileges

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subject to the same restrictions on the member's ability to prescribe controlled substances as were determined by the state or federal government.

(c) Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee (MEC). A limited suspension, in the form of a withdrawal of admitting and other related Privileges until medical records are completed, shall be imposed by the Medical Executive Committee (MEC) or in accordance with such process as may be established by the Medical Executive Committee (MEC) pursuant to a Medical Staff Policy after the practitioner has been notified of delinquency in the completion of medical records. For the purpose of this Section, "related Privileges" means voluntary on-call consulting on Hospital cases and providing professional services within the Hospital for future patients. Suspension for incomplete records shall apply to all members and they may not admit or attend patients as dictated by the Medical Executive Committee (MEC). Vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee (MEC). Care of patients of suspended practitioners is described in Article X, Section 3.

(d) Failure to maintain professional liability insurance coverage as required by these Bylaws shall be grounds for automatic suspension of a member's Clinical Privileges. If the member does not provide evidence of required professional liability insurance within 30 days after written warnings of the delinquency, the member shall be deemed to have automatically resigned from the medical staff.

(e) Conviction of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse. If the member does not provide evidence that such conviction is overturned, reversed or otherwise nullified within 120 days of entry, the member shall be deemed to have automatically resigned from the medical staff.

(f) Voluntary or involuntary debarment, exclusion, termination or other ineligibility to participate in any Federal or State health care program, or being listed on the exclusions databases of the Office of Inspector General (OIG), the General Services Administration (GSA), the Office of Foreign Asset Control (OFAC), or the State of Connecticut Department of Social Services (DSS). If the member does not provide evidence of reinstatement or other eligibility for Federal or State health

care program participation or removal from any such exclusions database, as applicable, within 30 days after the same became effective, the member shall be deemed to have automatically resigned from the medical staff.

(g) Conviction, entry of guilty plea, or entry of plea of no contest (a) to any felony or (b) to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence. If the member does not provide evidence that such conviction or plea is overturned, reversed or otherwise nullified within 120 days of entry, the member shall be deemed to have automatically resigned from the medical staff.

(h) Failure to continue to satisfy any eligibility criteria as set forth in these Bylaws. If the member does not provide evidence of satisfying the relevant eligibility criteria within 30 days after written warnings of the delinquency, the member shall be deemed to have automatically resigned from the medical staff.

Notwithstanding any other provision set forth in these Bylaws to the contrary, a member's resignation from the medical staff and consequent relinquishment of appointment and Privileges as provided in this Article IX, Section 4 for failure to satisfy any of the above-referenced threshold eligibility criteria shall be without the member's entitlement to a hearing and appeal.

SECTION 5: IMPAIRED PHYSICIANS

The Medical Staff maintains a Practitioner Health Policy concerning impaired physicians, which establishes the process for addressing matters of physician health. If a member of the Medical Staff does not abide by said policy, or does not agree to accept the Medical Executive Committee's (MEC) recommendations to address an Impairment (as defined in the Policy), the provisions of this Article shall be triggered.

SECTION 6: CONFIDENTIALITY; INDEMNITY

(a) All information relating to actions taken under Articles IX, X, XI, XII, and XIII shall be kept confidential and is intended to be protected from disclosure to the extent permitted by law.

(b) All participants acting in good faith (as defined by law), including members of the staff serving on panels or committees, as well as all persons testifying or providing information, are deemed to be acting on behalf of the Hospital, the Medical Staff, and the Board, and shall be entitled to all applicable protections of law.

(c) All members of committees and panels shall be deemed to be serving on "medical review committees" and "professional review bodies" to the extent such designation is consistent with relevant provisions of law.

(d) The Hospital shall defend and indemnify any member of the Medical Staff arising out of such member's good faith conduct in furtherance of such member's service on any Hospital or Medical Staff committee or assisting in peer and professional review (including peer and professional review of Allied Health Professionals) or quality management activities involving care provided at the Hospital, provided that the Hospital shall have the unfettered right to control such defense and indemnity, which right shall include the right to select and engage counsel. In the event the Hospital provides such defense and indemnity and the Medical Staff member is, after costs and expenses have been incurred by the Hospital, determined by a court of competent jurisdiction not to have acted in good faith in furtherance of such member's service on behalf of the Hospital, such member shall reimburse the Hospital in full for all such costs and expenses incurred.

ARTICLE X

PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES; SUPERVISION

SECTION 1: PROVISIONS AND BASIS FOR PRECAUTIONARY SUSPENSION

(a) The Chief of Staff, the SVPMS, the Chairman of the Medical Executive Committee (MEC), the President, and the Director of a practitioner's clinical Department, each shall have the authority, whenever failure to take action may result in imminent danger to the health and/or safety of any individual, to first (1) afford the practitioner an opportunity to voluntarily refrain from exercising Clinical Privileges or scope of practice while the matter is being reviewed, or if such practitioner does not accept the offer to voluntarily refrain from exercising Clinical Privileges, to (2) precautionary suspend or restrict all or any portion of the practitioner's Clinical Privileges or scope of practice. A practitioner's voluntary agreement to refrain from exercising all or any portion of Clinical Privileges shall not preclude an inquiry, Investigation or other action to address concerns regarding clinical competence or behavior in accordance with Article IX.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee (MEC) that would entitle the practitioner to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the practitioner and review the concerns that support the suspension and afford the practitioner an opportunity to respond.

(c) Precautionary suspension or restriction is an interim step in the professional review activity and is not a professional review action in and of itself, may be taken on the limited facts available, and does not imply any final finding regarding the concerns supporting the precautionary suspension or restriction.

(d) A precautionary suspension shall become effective immediately upon imposition, shall be immediately reported in writing to the practitioner in accordance with Article X, Section 2 of

these Bylaws and to the Chairman of the Medical Executive Committee (MEC), and shall remain in effect unless or until modified or withdrawn by the Medical Executive Committee (MEC).

(e) The imposition or continuation of a precautionary suspension or restriction shall not constitute grounds for a hearing pursuant to Article XI of these Bylaws.

SECTION 2: MEDICAL EXECUTIVE COMMITTEE (MEC) REVIEW

(a) Within three (3) calendar days of the imposition of a precautionary suspension or restriction, the practitioner will be provided with a brief written description of the reason(s) for the suspension/restriction, including the names and medical record numbers of the patient(s) involved (if any).

(b) If the individual is a member of the Allied Health Professional Staff as an Advanced Dependent Practitioner, the relevant Supervising/Collaborating Physician will be notified of the precautionary suspension or restriction.

(c) Within a reasonable time, not to exceed ten (10) calendar days (except if the tenth (10th) day falls on a Saturday, Sunday or federal holiday, in which case on the next business day) of the imposition of the precautionary suspension or restriction, the Medical Executive Committee (MEC) will meet to review the precautionary suspension or restriction and determine whether the precautionary suspension or restriction should be continued, modified, or lifted.

(d) As part of the MEC's initial review of the precautionary suspension or restriction as described in Section 2(c) above, the practitioner will be afforded the following rights:

- (1) to be notified by the Medical Executive Committee (MEC) of the date and time for this Medical Executive Committee (MEC) meeting as soon as the meeting is scheduled;
- (2) to meet with the Medical Executive Committee (MEC), provided however that the Medical Executive Committee (MEC) will hold its meeting without the practitioner if the practitioner is unwilling or unable to attend;

- (3) to submit written statements and other information to the Medical Executive Committee (MEC);
- (4) to propose ways, other than precautionary suspension or restriction, to protect patients, employees, or others while the matter is being reviewed; and
- (5) to propose modifications to the precautionary suspension or restriction that would make it less restrictive, but still allow for the protection of patients, employees, or others.

(e) After considering the reasons for the suspension or restriction, any information provided by the practitioner, and any other information that is available and relevant to the matter, the Medical Executive Committee (MEC) will determine whether to continue, modify, or lift the precautionary suspension. Continuation of the precautionary suspension or restriction requires approval by a two-thirds vote of the Medical Executive Committee (MEC) at a meeting at which a quorum is present.

(f) If the Medical Executive Committee (MEC) decides to continue the suspension or restriction, it will send the practitioner written notice of its decision, including the basis for it.

(g) If the Medical Executive Committee (MEC) decides to continue the suspension or restriction, it shall immediately commence an inquiry or investigation and shall either appoint itself as the inquiring body or investigating committee, appoint an inquiring body or investigating committee, or delegate to an individual (such as the SVPMS or Chief of Staff) the responsibility for appointing an inquiring body or investigating committee as soon as possible. Thereafter, the inquiry or investigation shall proceed in accordance with Article IX of these Bylaws, including the requirements set forth in Article IX, Section 2(j) requiring that an Investigation be completed within ninety (90) days.

(h) Following the initial review of a precautionary suspension or restriction as described above, the Medical Executive Committee (MEC) will continue to meet to review the precautionary suspension for so long as a precautionary suspension or restriction is continued. The first such meeting shall occur within fourteen (14) calendar days of the initial meeting described in Section 2(c) above (except if the fourteenth (14th) day falls on a Saturday, Sunday or federal holiday, in which case on the next business day), and subsequent meetings shall occur at least monthly thereafter (whether as part of

any regularly scheduled meeting of the Medical Executive Committee (MEC) or at a special meeting convened for this purpose). At each such meeting, the Medical Executive committee (MEC) will:

- (1) review and determine whether the precautionary suspension or restriction should be continued, modified, or lifted; and
- (2) review the progress of the inquiry or investigation to verify that the process is proceeding with due diligence and, if it is not and any unreasonable delay cannot be attributed to the practitioner or to factors outside of the Hospital's or Medical Staff's control (for example, a delay related to the length of time necessary to obtain a specialized external review), the Medical Executive Committee will take action to remedy the delay and cause the inquiry or investigation to proceed more expeditiously.

(i) As part of the Medical Executive Committee's ongoing review of continuing precautionary suspensions and restrictions, the practitioner will be afforded the following rights:

- (1) to be notified by the Medical Executive Committee (MEC) of the date and time for each Medical Executive Committee (MEC) meeting that takes place pursuant to this Article X, Section 2 as soon as the meeting is scheduled;
- (2) to meet with the Medical Executive Committee (MEC), provided however that the Medical Executive Committee (MEC) will hold its meeting without the practitioner if the practitioner is unwilling or unable to attend;
- (3) to provide information to the Medical Executive Committee regarding any unreasonable delay in the inquiry or investigation process (whether caused by the practitioner or by the inquiring body or investigating committee);
- (4) to provide any new (not previously submitted) information to the Medical Executive Committee (MEC) that is relevant to whether the precautionary suspension or restriction should be continued, modified, or lifted;
- (5) to propose ways, other than precautionary suspension or restriction, to protect patients, employees, or others while the matter continues to be reviewed; and

(6) to propose modifications to the precautionary suspension or restriction that would make it less restrictive, but still allow for the protection of patients, employees, or others.

(j) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction. The procedures outlined above are deemed to be fair under the circumstances.

SECTION 3: CARE OF SUSPENDED INDIVIDUAL'S PATIENTS

Immediately upon the imposition of a precautionary suspension, the appropriate Department Director or Section Head or in his absence the SVPMS or the Chief of Staff shall assign to another member or members of the Medical Staff responsibility for care of the suspended practitioner's patients in the Hospital at the time of such suspension until such time as they are discharged, giving all possible consideration to each patient's wishes. The Chief of Staff and the Department Director have a duty to cooperate with the President in enforcing suspensions.

SECTION 4: DEPARTMENTAL SUPERVISION OF A PRACTITIONER

(a) Without imposing a precautionary suspension, but based on the need to assure quality medical care, a Department Director may act, with the support of the SVPMS, Chief of Staff, Assistant Chief of Staff and Chair of the Medical Executive Committee (MEC), to require non-disciplinary supervision of a practitioner's clinical activities. Non-disciplinary supervision includes all proctoring and monitoring that does not restrict the individual's Privileges, while excluding supervision that does restrict the individual's Privileges (e.g. mandatory consultation requirements, where the supervisor must approve the plan of care before the individual can proceed). This decision by the Director may be based upon: reasonable doubts regarding the practitioner's competence; concerns about possible impairment, ability to adhere to the Bylaws, Rules, and Regulations of the Medical Staff or Hospital or requirements of law; or ability to work harmoniously and effectively with other staff or with due regard to patient care and safety.

(b) When such a decision is made, the practitioner shall be informed by the Department Director in writing, explaining the reasons for and the terms of the supervision requirement, and a copy of such writing shall be sent by the Department Director to the SVPMS. Such supervision may be observational, education and/or directional. The supervision shall be designed to minimize disruptive effect upon the practitioner's activities while fulfilling the Department's need for quality control. However, reasonable doubts or concern for the convenience of the practitioner shall permit the Director to lighten the duties of the practitioner, such as by temporary removal from on-call or other duty rotations.

(c) Supervision imposed under this Section shall not be construed to be a corrective action or disciplinary or adverse action, or a limiting or suspension of Clinical Privileges requiring or entitling the practitioner to an Investigation, or a hearing or an appeal as provided in other Sections of these Bylaws.

(d) However, the failure to comply with the terms of supervision may be grounds for corrective action.

(e) The affected practitioner, in the belief that the supervision is unfair or unduly restrictive, may communicate in writing with the Chairman of the Medical Executive Committee (MEC), requesting that the terms of the supervision be relaxed. The Medical Executive Committee (MEC) should then promptly review and act upon the matter, with due regard for the practitioner, the circumstances and medical quality assurance. The Medical Executive Committee (MEC) may take reasonable steps as needed. Failure of the Medical Executive Committee (MEC) to act upon the practitioner's request, or its denial of the request, shall not trigger a right to an Investigation, or hearing and appeal.

(f) By virtue of their membership, all members of the Medical Staff shall be deemed to have consented to the provision in paragraph (a) of this Section that a Department Director has the authority to impose such supervision as the Director believes is required. Therefore, all members of the Medical Staff release the Department Director, the Medical Executive Committee (MEC), all persons appointed as supervisors, the Hospital and its employees and Board, and all others from any

and all liability arising from the supervision. This release shall remain effective even in the event of subsequent termination or relinquishment of the practitioner's Privileges or staff membership.

ARTICLE XI

PROCEDURAL FAIRNESS

SECTION 1: GROUNDS FOR HEARING

(a) No recommendations or action other than the following shall constitute grounds for a hearing:

- (1) revocation of Medical Staff appointment;
- (2) denial of Medical Staff re-appointment;
- (3) denial of initial Medical Staff appointment
- (4) denial of requested initial Clinical Privileges
- (5) denial of requested increased Clinical Privileges;
- (6) restriction of Clinical Privileges lasting 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 judgment in a professional setting (e.g., mandatory concurring consultation requirement);
- (7) suspension of Clinical Privileges lasting more than 30 days (except not including: (i) precautionary suspension pursuant to Article X [which shall be subject to the limited review right by the Medical Executive Committee (MEC) set forth therein], and (ii) any Automatic Suspension pursuant to Article IX, Section 4 hereof [which shall be subject to the limited review right set forth therein]; and
- (8) revocation of Clinical Privileges.

(b) The hearing and appellate review mechanisms are each available to the practitioner only once for any given cause at issue. In addition, if a suspension if upheld would result in

permanent suspension of all Clinical Privileges or of Medical Staff membership, the entire issue shall be the subject of a single hearing and review; under such circumstances, the practitioner who is permanently suspended will not be entitled to another hearing and review in connection with denial or re-appointment. Upon the upholding of a permanent suspension, the practitioner shall be deemed to have been removed from the Medical Staff.

(c) None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

- (1) a letter of guidance, counsel, warning, or reprimand;
- (2) conditions, monitoring, proctoring, or a general consultation requirement;
- (3) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;
- (4) automatic relinquishment of appointment or privileges;
- (5) a requirement for additional training or continuing education;
- (6) precautionary suspension;
- (7) denial of a request for leave of absence or for an extension of a leave;
- (8) removal from the on-call roster or any reading or rotational panel;
- (9) the voluntary acceptance of a performance improvement plan option;
- (10) determination that an application is incomplete;
- (11) determination that an application will not be processed due to a misstatement or omission;
- (12) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract; or

(13) restriction or limitation of clinical privileges (of the nature described in paragraph (b)(7) above) for less than or equal to 30 days.

SECTION 2: INITIATION OF A HEARING

An applicant or a person holding a Medical Staff appointment shall be entitled to a hearing in accordance with the provisions of this Article whenever grounds for a hearing (as listed in Section 1 of this Article) exist. The applicant or staff member must exhaust the remedies afforded by these Bylaws before resorting to any form of legal action, and agrees not to bring any action or proceeding or complaint against the Hospital or Medical Staff or any of its members, employees, or agents unless there has been a clear failure to substantially follow the provisions of these Bylaws.

SECTION 3: NOTICE OF RECOMMENDATION

(a) When a recommendation is made that entitles an individual to a hearing prior to a final decision of the Board, the applicant or Medical Staff appointee, as the case may be, shall be given notice promptly by the President, by hand delivery (same or next business day) or by next business day delivery via a nationally recognized overnight mail courier (e.g., Federal Express) that provides written evidence of receipt. This written, special notice shall contain the recommendation made and a statement of the reasons for the recommendation. Special notice shall also provide notice of the right to a hearing pursuant to this Article, and state that a hearing must be formally requested by the petitioner in a letter addressed to the President within 30 days of the receipt of the notice, which letter shall be sent by hand delivery (same or next business day) or by next business day delivery via a nationally recognized overnight mail courier (e.g., Federal Express) that provides written evidence of receipt. The written notice to the practitioner also shall summarize the procedural rights of the practitioner under these Bylaws. Such notice shall also state that if a final action of the Board adversely affects the Clinical Privileges of a physician or dentist is based upon an issue of competence or professional conduct, such action will be reported to the National Practitioner Data Bank, in accordance with Article XIII, Section 8, and shall state the substance of the proposed report.

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(b) If pertinent, patient records or information supporting the recommendation shall be identified. The statement of charges may be amended or added to at any time, even during the hearing, so long as the material is relevant to the continued appointment or Clinical Privileges, and the person requesting the hearing is given sufficient time to study and attempt to rebut the material.

(c) In the event the affected individual does not request a hearing within the time and in the manner set forth, which shall be no less than 30 days, he shall be deemed to have waived his right to a hearing and appeal and to have accepted the recommendation or action involved, which shall become effective immediately after Board decision.

(d) The provisions of the Section for discovery of information are exclusive and the parties may not issue subpoenas or take other action not authorized by these Bylaws.

SECTION 4: TIME, PLACE AND NOTICE FOR HEARING

(a) The President shall schedule the requested hearing and shall promptly, but within a period of no more than 15 days after receipt of the hearing request, give notice by next business day delivery via a nationally recognized overnight mail courier (e.g., Federal Express) that provides written evidence of receipt, to the person who requested the hearing (hereinafter called the "petitioner") of its time, place and date, with a summary of his rights under these Bylaws. Except as set forth below, the hearing shall begin as soon as is practicable, but not less than 30 days, nor more than 60 days, from the date that the hearing request is received, unless otherwise agreed to by all of the parties.

(b) Except as otherwise allowed above, postponement of the hearing beyond a previously-scheduled hearing date shall be granted only with the consent of all parties.

(c) As a part of or together with the notice of hearing, the petitioner shall be given a statement of the acts or omissions with which he is charged, a list of the charts (if any) in question, and the pending recommendation that is being challenged by the request for hearing, or the reasons for the denial of a request made by him. Additions may be made to the charge before and during the hearing if the petitioner and his counsel are given time to review and rebut them.

(d) At least ten days prior to the hearing, the petitioner or the Hospital, by written notice, shall furnish a written list of the names and addresses of the individuals who, so far as is then reasonably known, will give testimony or evidence at the hearing. The names and addresses of additional witnesses shall be provided as soon as known. The witness list of either party may, in the discretion of the Hearing Panel Chairman, be supplemented or updated at any time during the course of the hearing, with notice to the other party.

(e) The petitioner shall have the right to inspect and copy documents or other evidence considered by the Medical Executive Committee (MEC) in making its recommendation or action, including any information gleaned through Investigation that is exculpatory in nature. The petitioner shall be entitled to receive all evidence that will be made available to the Hearing Panel.

(f) The Hearing Panel Chairman shall have the role described in Section 5 of this Article XI.

SECTION 5: HEARING PANEL

(a) When a hearing is requested, the President, the Chief of Staff and the Chairman of the Board shall jointly appoint a Hearing Panel that shall be composed of not less than three individuals, at least one of whom shall be a peer of the individual requesting the hearing, and one of whom shall be designated as Chairman of the Hearing Panel. The physician or dentist members of the Panel shall be appointees to the Active Staff who shall not have participated actively in the consideration of the matter involved at any previous level. One member of the Panel shall be a non-Medical Staff member of the Board. Knowledge of the matter involved shall not preclude a person from serving as a member of the Hearing Panel. No member of a Hearing Panel shall have a conflict of interest or be in direct economic competition with the petitioner.

(b) The Hearing Panel Chairman shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant evidence, that decorum is maintained throughout the hearing, and that no intimidation is permitted. The Hearing Panel Chairman shall determine the order of procedure, and shall have the authority and discretion to rule on all matters of procedure and the admissibility of evidence. He shall rule on the admissibility of evidence and any

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request for access to information in accordance with these Bylaws. In all instances, the Hearing Panel Chairman shall act in such a way that all information relevant to the continued appointment or Clinical Privileges of the petitioner is considered by the Hearing Panel in formulating its report and recommendations, but shall have the duty to exclude repetitious testimony.

SECTION 6: THE HEARING OFFICER

The President may appoint a Hearing Officer to preside at the hearing or to assist the Hearing Panel Chairman in carrying out his responsibilities. The Hearing Officer may not act as a prosecutor or an advocate for the Medical Staff or Hospital. He is not a member of the Hearing Panel and may not vote, however he may participate in the deliberations of the Hearing Panel in a legal and technical capacity.

SECTION 7: POSTPONEMENTS AND EXTENSIONS

Postponements and extensions beyond the times expressly permitted herein may be requested in writing, but shall be permitted only by the Hearing Panel or its Chairman on a showing a good cause.

ARTICLE XII

HEARING PROCEDURE

SECTION 1: FAILURE TO APPEAR

Failure by the petitioner without good cause to appear personally and continually at a hearing shall constitute acceptance of the recommendations or actions pending, which then shall become final and effective immediately.

SECTION 2: REPRESENTATION

(a) The petitioner shall be entitled to be represented at the hearing by an attorney or a physician of his choice to examine witnesses and present his case. At least 10 days before the hearing, the petitioner shall inform the President in writing of the identity of his representative.

(b) The President, acting for the Board, shall appoint a representative who may be a member of the Medical Staff or an attorney to present the Hospital's or Medical Staff's position and to examine and cross-examine witnesses, and to present evidence in support of the adverse action against the petitioner.

SECTION 3: RECORD OF HEARING

The Hearing Panel shall maintain a record of the hearing by having it transcribed by a court reporter or tape recording it. The cost shall be borne by the Hospital. If requested, copies of any transcript(s) shall be provided to the petitioner at his expense. The Hearing Panel may, but shall not be required to, order that oral evidence be taken only under oath or affirmation.

SECTION 4: RIGHTS OF BOTH SIDES; LENGTH OF HEARING

(a) Both sides shall have the following rights: to call and examine witnesses; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; and to rebut any evidence. If the petitioner does not testify in his own behalf, he may be called and examined by the other party. No party shall be permitted private communication with the Panel or any of its members on the matters pending before the Panel.

(b) Both sides are required to prepare their cases so that a hearing shall be concluded after a maximum of fifteen hours of hearings, or three hearing sessions. In its sole discretion, the Hearing Panel may continue a hearing.

SECTION 5: EVIDENCE

(a) Any relevant oral or documentary evidence may be presented to the Hearing Panel. Each party also may submit, and the Panel may request, written memoranda to be submitted during, at, or after the close of the hearing. The Panel may question the witnesses, call additional witnesses, or request documentary evidence.

(b) The Hearing Panel Chairman shall have the discretion to take official notice of any matters relating to the issues under consideration that could be officially noticed by courts or administrative agencies. Participants in the hearing shall be informed of matters to be officially noticed, and such matters shall be noted in the record of the hearing. Either party may request that a matter be officially noticed or refute the noticed matter, by introduction of evidence or by written or oral statements. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence officially noticed. In addition, physician members of the Panel may take into consideration their own experience as physicians, and their own technical and specialized medical knowledge.

(c) The Board or Medical Executive Committee (MEC) shall first present evidence to support the recommendation that triggered the request for a hearing. The petitioner then may present his case. Both parties may make short closing statements.

SECTION 6: ATTENDANCE BY PANEL

If a member of the Hearing Panel is absent, he shall listen to a tape of the hearing, or read a transcript or detailed notes. Vote shall be by majority of all Hearing Panel members.

SECTION 7: BASIS OF HEARING PANEL'S RECOMMENDATION

The recommendation of the Hearing Panel shall be based on the evidence introduced at the hearing.

SECTION 8: ADJOURNMENT AND CONCLUSION

The Hearing Panel Chairman may adjourn and reconvene the hearing at the convenience of the participants without special notice. Upon conclusion of the presentation of evidence and the submission of written statements, if any, the hearing shall be concluded. The Hearing Panel shall thereupon, outside of the presence of any other person except the hearing officer, if any, conduct its deliberations. Within fourteen (14) days of conclusion of the hearing or the receipt of post-hearing memoranda, whichever is later, the Panel shall prepare a report and recommendation. The President shall communicate the report and recommendation to the Medical Executive Committee (MEC), and to the petitioner by hand delivery (same or next business day) or by a nationally recognized overnight mail courier (e.g., Federal Express) that provides written evidence of receipt.

SECTION 9: APPLICABLE PROVISION OF LAW

All hearings and appeals are intended to comply with the Health Care Quality Improvement Act of 1986 (the “Act”) and other applicable provisions of law, as enacted or amended from time to time. In reaching its decision, the hearing panel may consider Section 11112 of the Act, dealing with standards for professional review actions.

ARTICLE XIII

APPEAL

SECTION 1: TIME FOR APPEAL

Within 10 days after the petitioner is notified of a recommendation by the Hearing Panel, or of a recommendation by the Board modifying a hearing Panel's recommendation, the petitioner or the Medical Executive Committee (MEC) (referred to as the “appellant”) may request an appellate review by the Board. The written request shall be sent to the President by hand delivery (same or next business day) or by next business day delivery via a nationally recognized overnight mail courier (e.g., Federal Express) that provides written evidence of receipt, and shall include a brief

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statement of the reasons for appeal. If appellate review is not requested, the petitioner and the Medical Executive Committee (MEC) shall be deemed to have accepted the recommendation and it shall become final and effective immediately after Board decision.

SECTION 2: GROUNDS FOR APPEAL

The grounds for appeal from an adverse recommendation of the Hearing Panel are that:

- (a) there was substantial failure on the part of the Hearing Panel to comply with the Hospital or Medical Staff Bylaws in the conduct of the hearing and the resulting recommendation so as to deny the petitioner a fair hearing; or
- (b) the Hearing Panel's recommendation was made arbitrarily, capriciously or prejudicially; or
- (c) the recommendation of the Hearing Panel was not supported by the evidence.

SECTION 3: TIME, PLACE AND NOTICE

Whenever an appeal is requested, the President shall within 10 days after receipt of the request schedule and arrange for an appellate review. The Board shall give the practitioner and the proponent of the adverse recommendation, or the practitioner and the Medical Executive Committee (MEC) if the Medical Executive Committee (MEC) is the appellant, notice of the time, place and date of the appellate review. The date of such review shall not be less than 20 days nor more than 40 days from the date of receipt of the request. However, when a request for appellate review is from an individual who is at the time under a suspension, the appellate review shall be held as soon as the arrangements may reasonable be made, but not more than 14 days from the date of notice of said review. However, the time for appellate review may be extended by the President for good cause.

SECTION 4: NATURE OF APPELLATE REVIEW

(a) The President shall appoint a Review Panel composed of not less than three (3) Board members, one of whom shall be designated as chair, to consider the record upon which the recommendation was made. Each party shall have the right to present a written statement in support of its position. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The appeal proceeding is not to be a rehearing or an opportunity to show new facts or information not presented to the Hearing Panel; however, in its sole discretion, the Review Panel may accept limited additional oral or written evidence.

(b) Private communications between a member of the Review Panel and the parties involved are prohibited to the extent that they are related to matters pending before the Panel. The Review Panel's decision must be based solely on information that is in the record or has been presented at the appeal proceedings. The Review Panel shall recommend final action to the Board.

SECTION 5: FINAL DECISION OF THE BOARD

(a) If the Review Panel determines that the recommendation of the Hearing Panel was defective for a reason set forth in Section 2 of this Article, the Review Panel may appropriately modify the decision of the Hearing Panel so that it no longer is defective, and the decision shall then stand as modified. Except on a showing of good cause or agreement of the parties, review shall not exceed 30 days.

(b) During the period when an appeal is pending before the Review Panel, the Hearing Panel's decision shall be in full force and effect, unless ordered otherwise by the Review Committee or President.

(c) The Review Panel determination is a recommendation to the Board, which shall then make a final decision. Within 30 days after the conclusion of the proceedings before the Review Panel, the Board shall render a final decision, which shall be sent to the petitioner and to the Medical Executive Committee (MEC), by personal delivery or by certified mail, return receipt requested. The

final decision shall affirm the decision of the Hearing Panel if the Panel's decision is supported by substantial evidence.

SECTION 6: FURTHER OR EXTENDED REVIEW

Except where the matter is referred for further action and recommendation in accordance with Section 5(b) of this Article, the final decision of the Board at the conclusion of the appellate review shall be effective immediately and shall not be subject to further review. However, if the matter is referred for further action or recommendation, subsequent action shall be promptly taken, or subsequent recommendation promptly made to the Board. Any extended review process and the resulting report to the Board shall not exceed 30 days unless directed by the Board.

SECTION 7: RIGHT TO ONE APPEAL ONLY

As a matter of right, a petitioner shall not be entitled to more than one appellate review on any single proceeding.

SECTION 8: DUTY TO REPORT ADVERSE ACTION

(a) Reporting. The Hospital shall report adverse actions as required by law, including but not limited to applicable state or federal law (e.g., the Health Care Quality Improvement Act of 1986).

(b) Opportunity to Meet. The Hospital will inform a member who was the subject of an adverse action of a report required to be filed by the Hospital, and the member will be granted the opportunity to meet with the Chief of Staff and the Hospital's authorized representative to review and discuss the proposed report before it is filed. The member shall make himself available within not more than two (2) business days after being so informed by the Hospital to ensure that the Hospital timely satisfies its reporting obligations. The foregoing opportunity to meet is offered as a courtesy by the Hospital and shall not delay, hinder, inhibit or otherwise preclude the Hospital's compliance with any filing deadline or requirement.

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ARTICLE XIV

OFFICERS AND REPRESENTATIVES OF THE MEDICAL STAFF

SECTION 1: OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be Chief of Staff, Assistant Chief of Staff, Secretary, Treasurer, and such other officers who may be from time to time elected by the Active Attending Staff. Candidates for these offices shall be nominated by members of the Active Attending Staff at the monthly staff meeting preceding the annual meeting of the Medical Staff, with elections occurring at the annual meeting of the Medical Staff.

(a) Qualifications: Only those members of the Active Attending Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

- (1) be appointed in good standing to the Active Attending Staff, and have served on the Active Staff for at least five (5) years, except that Active Attending Staff are eligible to hold office as Secretary or Treasurer after two (2) years of becoming a member of the Active Attending Staff;
- (2) not presently be serving as a Medical Staff officer, Board member or Department Chief at any other hospital and shall not so serve during their term of office;
- (3) be willing to faithfully discharge the duties and responsibilities of the position;
- (4) have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
- (5) attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;
- (6) have demonstrated an ability to work well with others; and

(7) be willing to commit sufficient time to service in the leadership position to which they are elected.

(b) Notwithstanding Section 1(a)(1) above, if a member of the Medical Staff who holds a Medical Staff office is transferred from Active Attending status to another Medical Staff category during his term of office, he may serve the remainder of his term of office, but may not be re-elected unless and until Active Attending status is restored.

(c) The Chief of Staff may serve three one-year terms and shall not be eligible thereafter for re-nomination for that office. The same rules apply to the Assistant Chief of Staff.

(d) The term of office for all other officers of the Medical Staff shall be one year, without any limitation on the number of terms that may be served.

(e) If there is more than one candidate for a particular office, vote shall be by written ballot or by such other method as may be available at the meeting at which voting occurs, and the votes of a majority of the qualified voters present shall be required for election. In the event that there are more than two candidates for one office and no election occurs from the first ballot, the candidate receiving the lowest number of votes shall be dropped from the second ballot, and so on, until a majority vote is obtained.

(f) The Medical Staff shall have the right to change the titles of officers, provided the duties of such officers do not change.

(g) Removal of an elected officer or a member of the Medical Executive Committee may be effectuated by a two-thirds (2/3) vote of the entire Medical Executive Committee, or by the Board at a meeting at which a quorum is present, for:

- (1) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
- (2) failure to perform the duties of the position held;
- (3) conduct detrimental to the interests of the Hospital and/or its Medical Staff;

or

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office.

Either the MEC or the Board may initiate any such removal action upon its own volition, or shall consider such action at its next regularly scheduled meeting (or at a special meeting held for such purpose if so determined by the Chair) if requested to do so by a petition signed by not less than one half (1/2) of the Active Attending Staff. At least ten days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board prior to a vote on removal. If the individual is a member of the body considering removal, the individual shall be recused from all deliberations and voting concerning removal.

SECTION 2: DUTIES OF THE CHIEF OF STAFF

The Chief of Staff is the administrative head of the Medical Staff. This officer is responsible for directing the activities of the staff in a manner that shall provide for optimal medical care for the patients at the Hospital and performance improvement. The Chief of Staff shall preside at all meetings of the Medical Staff, appoint the Directors of all clinical Departments or Section Heads (except as otherwise provided herein), and appoint the members of all Committees except as otherwise set forth in Article XVI below. The Chief of Staff shall also call all special meetings. He shall be an ex officio member of all Medical Staff committees. He shall present the views, policies, needs, and grievances of the Medical Staff to the Board and to the President. He shall receive and interpret the policies of the Board to the Medical Staff and report to the Board at its regular meetings on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care. He shall also appoint all Medical Staff designees to committees of the Board consistent with the Hospital's corporate bylaws.

SECTION 3: DUTIES OF THE ASSISTANT CHIEF OF STAFF

The Assistant Chief of Staff shall be an ex officio member of all Medical Staff committees. In the incapacity or absence of the Chief of Staff, the Assistant Chief of Staff shall assume the duties of the office of Chief of Staff with limitation as stated in Section 7 of this Article.

SECTION 4: SUCCESSION

In the absence of both the Chief of Staff and the Assistant Chief of Staff, the Chairman of the Medical Executive Committee (MEC) shall assume the duties of the office of Chief of Staff.

SECTION 5: DUTIES OF SECRETARY

The Secretary shall keep a complete and legible record of the transactions of all staff meetings and a record of members present and shall perform such duties appropriate to the office. The Secretary shall be a member ex officio of the Medical Executive Committee (MEC) and serve as its Secretary.

SECTION 6: TREASURER

The Treasurer shall keep complete and legible records of all financial business of the Medical Staff, including payment and receipt of all Medical Staff fees and dues, and shall perform such duties appropriate to the office. The Treasurer shall be a member ex officio of the Medical Executive Committee (MEC).

SECTION 7: VACANCIES OF OFFICERS

(a) If a Chief of Staff is unable to complete the term of office, the Assistant Chief of Staff shall assume the duties of that office for a maximum of three months, during which time a new Chief of Staff shall be selected by the voting staff to fill the unexpired term.

(b) If the Assistant Chief of Staff is unable to complete the term of office, the office shall remain vacant for a period of up to three months, during which time a new Assistant Chief of Staff shall be elected by the Active Attending Staff to fill the unexpired term.

(c) If the Secretary of the Staff is unable to complete the term, the Chief of Staff shall appoint an eligible member of the Active Attending Staff to serve until a new Secretary is elected by the Active Attending Staff within three months.

(d) If the Treasurer of the Staff is unable to complete the term, the Chief of Staff shall appoint an eligible member of the Active Attending Staff to serve until a new Treasurer is elected by the Active Attending Staff within three months.

SECTION 8: ASSUMPTION OF OFFICE

The officers of the Medical Staff shall assume office as of 12:01 a.m. on January 1 of each year, or at the close of such other meeting at which an election has occurred in the case of an election to fill an interim vacancy.

SECTION 9: CONFLICTS OF INTEREST

All nominees for election or appointment to Medical Staff offices or the Medical Executive Committee (MEC) shall, promptly following nomination, disclose in writing, using the Hospital's standard Conflicts of Interest Disclosure Form or such other approved form, those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the Hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Nominees shall submit their completed Disclosure Forms to the Medical Staff Office within two (2) business days following nomination. The Medical Staff Office shall, in turn, promptly forward a copy of each Disclosure Form to the Chairman of the Medical Executive Committee (MEC), the President of the Hospital, and the Chairman of the Hospital's Board of Trustees, each of whom shall, within five (5) business days of receipt, notify the Medical Staff Office of any concerns regarding conflicts of

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interest, including whether an actual or potential conflict exists sufficient to preclude any nominee(s) from serving in the position for which the nominee was nominated or from serving as a member of the Board Trustee *if* the nominee were to be elected and would otherwise be eligible to serve on the Board. If no such concerns are communicated to the Medical Staff Office within said timeframe, then it shall be assumed that none exist. Once any such notices have been received by the Medical Staff Office, the Medical Staff Office shall distribute to the Active Attending Staff a detailed summary of all disclosures along with notice of the MEC Chairman's, President's and Board Chair's concerns, if any, regarding the existence of an actual or apparent conflict that may affect eligibility for the position for which the nominee was nominated and for Board service if applicable for the position.

SECTION 10: BOARD REPRESENTATION

(a) Subject to any provision in the Hospital's Bylaws to the contrary, the Medical Staff shall have the following right of representation on the Board: the Chief of Staff, Assistant Chief of Staff, the Chair of the Credentials Committee and the Chair of the Medical Executive Committee (MEC) shall be Trustees of the Board, *ex officio*, with voting power. The immediate-past Chief of Staff shall be an *ex officio* invitee to Board meetings without voting power. The following shall be *ex officio* members of the Board Quality and Safety Committee, with vote: the Chief of Staff, the Assistant Chief of Staff, the Chair of the Medical Executive Committee (MEC) and the Chair of the Credentials Committee.

(b) Medical Staff representation on the Hospital's Board of Trustees shall be subject to the Hospital's Conflict of Interest Policy that applies to all members of the Board of Trustees, and any determination made pursuant to said Policy that an irreconcilable conflict exists shall be determinative of any Medical Staff representative's eligibility to serve on the Hospital's Board of Trustees (notwithstanding any provision in these Bylaws to the contrary).

(c) In the event any Medical Staff representative identified in subsection (a) of this Section 10 is precluded from service on the Board due to the existence of a conflict as per subsection (b) of this Section 10, the Secretary of the Medical Staff shall be appointed *ex officio* in the place of

the conflicted representative; and if a second Medical Staff representative identified in subsection (a) of this Section 10 is likewise precluded from Board service due to a conflict as per subsection (b) of this Section 10, then the Treasurer of the Medical Staff shall be appointed *ex officio* in the place of the second conflicted representative; provided that at such time as the *ex officio* Medical Staff representative(s) identified in subsection (a) of this Section 10 regain eligibility to serve on the Board (e.g., due to the removal or resolution of the identified conflict, or the election or appointment of a non-conflicted individual to the *ex officio* position at issue), the Secretary and/or Treasurer, as applicable, shall cease to serve on the Board.

ARTICLE XV

CLINICAL DEPARTMENTS

SECTION 1: LIST OF DEPARTMENTS

The Departments of the Medical Staff shall be as follows:

- (a) Department of Anesthesiology and Perioperative Medicine
- (b) Department of Emergency Medicine
- (c) Department of Radiology
- (d) Department of Medicine
- (e) Department of Obstetrics and Gynecology
- (f) Department of Orthopedics
- (g) Department of Pathology
- (h) Department of Pediatrics
- (i) Department of Psychiatry
- (j) Department of Surgery

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(k) Department of Radiation Oncology

(l) Such other Departments that may from time to time be established by recommendation of the Credentials Committee, subject to approval by the Medical Executive Committee (MEC) and the Board.

Each Department shall be organized as a separate part of the Medical Staff and shall have a Director who shall be responsible for the overall supervision of the clinical work within this Department. Each Department may have Sections representing sub-specialties as established or removed following a recommendation by the Credentials, subject to approval by the Medical Executive Committee (MEC) and the Board. It shall be the duty of the Department Directors and Section Heads to supervise and assist in the promotion and maintenance of quality care through the analysis, periodic review and evaluation of the clinical practice that exists within their Departments or Sections.

SECTION 2: QUALIFICATIONS AND TENURE OF DEPARTMENT DIRECTORS AND SECTION HEADS

(a) The Directors of the Clinical Departments and Section Heads of the Medical Staff shall be board certified in their specialty and shall be appointed annually by the Chief of Staff after consulting with the Assistant Chief of Staff, the SVPMS, the Medical Executive Committee (MEC) and the President. Prior to making such appointments, the Chief of Staff shall consider the evaluations described in subparagraph (b) below. The Department Directors and Section Heads of the medical Departments of the Hospital who are employed by the Hospital shall be appointed and reappointed annually by the President after appropriate consultation with the aforementioned officers and the Chief of Staff. All such appointments shall be effective as of 12:01 a.m. on January 1 of each year, or at such time as an appointment is made to fill an interim vacancy.

(b) Prior to appointment and on an ongoing basis, there shall be an evaluation and, as applicable, re-evaluation of each Department Director and Section Head by the Chief of Staff, who

shall give due consideration to the opinions of the physician members of each Department concerning their Director's professional qualifications for continued leadership, as well as to the opinions of other Hospital and Medical Staff leaders and any other individuals if and as appropriate regarding the Director's professional qualifications for continued leadership. A form developed by the Medical Staff Office will be available for such purpose, and such form is the only form to be used.

(c) Section Heads shall have the same qualifications in their respective specialties as Department Directors. In addition, they shall be appointed and reappointed in the same manner and have the same, and parallel responsibilities the Department Director has for their Department, in their respective Section. They shall report to their Department Director.

(d) Each Department Director and Section Head shall designate one or more individuals who shall serve in the capacity of the Department Director or Section Head, respectively, in the event of his/her absence or unavailability, and shall notify the SVPMS and the Medical Staff Office of said designation, provided that the Chief of Staff shall have the right to approve all such designees. In the event any Department Director or Section Head fails to so designate an alternative to serve in the event of absence or unavailability, the Chief of Staff or, in the absence of the Chief of Staff, the Assistant Chief of Staff, shall so designate such alternative. The individual(s) so designated by the Department Director or Section Head shall be authorized to carry out all responsibilities of the Department Director or Section Head during the Department Director's or Section's Head's absence or unavailability, except that said individual(s) shall not serve on, attend or otherwise participate in the Medical Executive Committee (MEC).

(e) Department Directors, Section Heads, and any individual(s) designated to serve in their absence or unavailability shall be a member(s) of the Active Attending Staff for at least two (2) years, unless no such individual(s) is available to serve as determined by the Chief of Staff.

SECTION 3: FUNCTION OF DEPARTMENT DIRECTORS

Each Director shall be accountable to the Medical Executive Committee (MEC) for all professional activities and for performance improvement within his Department. He shall make specific
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recommendations and suggestions regarding his own Department in order to assure the quality of patient care and the adequacy of the type and scope of services provided, and shall maintain continuing review of the professional performance of all staff members with Clinical Privileges in his Department, and shall report continually and at the time of reappointment to the Credentials Committee as to such staff members. He shall be responsible for implementation of the Hospital Bylaws, and of the Medical Staff Bylaws, Rules and Regulations within his Department. He shall be responsible for implementation within his Department of actions taken by the Medical Executive Committee (MEC). He shall transmit to the Credentials Committee his recommendations concerning staff classifications and re-appointment and delineation of the Clinical Privileges of members of his Department. He shall participate in every phase of the Departmental administration and in cooperation with the Nursing Department and Hospital Administration regarding matters of patient care including standing orders, special regulations and techniques, personnel and supply. He shall be responsible for the teaching, education and research programs in his Department. He shall assist in the preparation of such periodic reports (including budgetary planning) pertaining to his Department as may be required by the Medical Executive Committee (MEC), the President, or the Board. Notwithstanding the foregoing provisions of this Section 3, each Department Director is also responsible for the following: (1) all clinically related activities of the Department, (2) all administratively related activities of the Department unless otherwise provided for the by the Hospital, (3) continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges; (4) recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department; (5) recommending Clinical Privileges for each member of the Department; (6) assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the Department or the organization; (7) the integration of the Department or service into the primary functions of the organization; (8) the coordination and integration of interdepartmental and intradepartmental services; (9) the development and implementation of policies and procedures that guide and support the provision of services; (10) the recommendations for a sufficient number of qualified and competent persons to provide care or service; (11) the determination of the qualifications and competence of Department or service personnel who are not Physicians or Allied Health Professionals and who provide patient care services; (12) the continuous assessment and

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improvement of the quality of care and services provided; (13) the maintenance of quality control programs, as appropriate; (14) the orientation and continuing education of all persons in the Department or service, and (15) recommendations for space and other resources needed by the Department or service.

SECTION 4: FUNCTIONS OF DEPARTMENTS

Each clinical Department shall establish its own criteria consistent with the policies of the Medical Staff and the Board for the granting of Clinical Privileges, performance improvement within the Department, and the holding of office in the Department. An important function of a Department is to review activity that helps in the assurance that all practitioners in the Department meet the Hospital's criteria of practice and that they comply with these Bylaws, as well as with the applicable standards of care for the patients. Therefore, each Department will:

(a) Hold regularly scheduled meetings at least quarterly. Department-level meetings may, but are not required to, include review and consideration of cases that present problems or issues in treatment, including, but not limited to lack of improvement or resistance to treatment, complications, notable infections, extended stay, errors in diagnosis or treatment, problems in interdepartmental relations that affect or are likely to affect care, questions regarding professional cases of academic interest, cases of selected deaths, and other such matters as are believed to be important in the evaluation and provision of quality of patient care, including the clinical work of members of the Department. Such activities are part of the ongoing professional practice evaluation activities of the Medical Staff and Hospital. A report of each Department-level meeting shall be submitted to the Medical Executive Committee (MEC).

(b) Conduct on-going review and study of utilization of clinical services if and as deemed necessary and appropriate by the Department Director and, in that event, report any recommended changes to the Medical Executive Committee (MEC).

(c) Evaluate medical factors involved in the continuance of Hospital services for particular patients. A member of the Utilization Review Committee shall not participate in the

review of an extended stay case if he is a treating or consulting physician for the patient involved. The Utilization Review Committee will consult with the attending physician before making a decision of inappropriate hospitalization. In cases of significant difference of opinion between the Utilization Review Committee and the attending practitioner, the Director of the Department may be consulted to advise on the issue.

(d) In addition, each Department shall recommend the need for Affiliated Health Professionals within the Department. Together with the Credentials Committee, the Department Director shall recommend the qualifications, status and clinical duties as well as responsibilities that might be assigned to qualified Affiliated Health Care Professional Members of the Department.

SECTION 5: ASSIGNMENTS TO DEPARTMENTS

After consideration of the recommendations of the Clinical Department, the Credentials Committee will recommend to the Medical Executive Committee (MEC) initial and subsequent Department assignments for all Medical Staff members. The Medical Executive Committee (MEC) shall, in turn make a recommendation to the Board for final action.

ARTICLE XVI

SELECTION OF COMMITTEES, THEIR FUNCTION AND DUTIES

SECTION 1: STANDING COMMITTEES

(a) The membership of all Medical Staff committees shall be appointed annually by the Chief of Staff, except as set forth below in Section 2 through 4 with respect to the Medical Executive Committee, Credentials Committee and Bylaws Committee. In addition to those Committees described below in Sections 2 through 4 of this Article XVI, the Chief of Staff shall annually establish such other standing and ad hoc committees as are necessary to:

- (1) develop standards of patient care;

(2) actively measure, assess, and improve the quality of patient care through the process of peer review, taking into account sentinel event and patient safety data, including medical assessment and treatment of patients, information about adverse privileging decisions, use of medications, use of blood and blood components, use of operative and other procedures, appropriateness of clinical practice patterns, significant departures from established patterns of clinical practice, accurate, timely, and legible completion of medical records, the required content and quality of history and physical examinations and the time frame for their completion as set forth in the Rules and Regulations, use of developed criteria for autopsies, the Hospital's and individual practitioners' performance on clinical improvement measures endorsed by Greenwich Hospital or required by accrediting or regulatory organizations, education of patients and families, and coordination of care with other practitioners and Hospital personnel, as relevant to the care of the individual patient.

(3) safeguard patient rights;

(4) assess staffing needs of the institution;

(5) oversee programs of graduate and continuing medical education;

(6) meet the mandated requirements of accrediting and licensing bodies;

(7) review of the findings of the assessment process that are relevant to an individual's performance. The Medical Staff is responsible for determining the use of this information in ongoing evaluations of a practitioner's competence; and

(8) provide for various Medical Staff or institutional needs as may occasionally arise.

Medical Staff Committee members may be appointed from such Medical Staff categories as permitted by these Bylaws. The Chief of Staff shall make all Committee appointments effective as of 12:01 a.m. on January 1 of each year, or at such time as an appointment is made to fill an interim vacancy. There shall be no limit to how many terms may be served by members of Medical Staff Committees.

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From time to time the Chief of Staff may appoint such special committees as he shall deem necessary.

(b) The Chief of Staff shall appoint the Chairman of all committees other than as set forth in this Article XVI. Committee members who, pursuant to these Bylaws, shall be elected, shall be so elected by nomination and vote of the Active Attending Staff. The composition of appointed committees shall be of sufficient representation to accomplish efficiently the purpose of each committee, and may, when consistent with the function and purpose of the committee, include non-physician representatives. Committees shall confine their work to the purpose for which they were appointed. They shall meet on a timely and periodic basis and shall submit copies of meeting minutes to the Medical Executive Committee (MEC) at its next regularly scheduled meeting. Standing committees may from time to time establish ad hoc committees that are responsible to, and report to, the parent committee.

(c) A majority of the voting members of a committee shall constitute a quorum. A majority vote of the members of the committee present at a meeting at which a quorum exists shall be required for action. The Chief of Staff, the Assistant Chief of Staff, the SVPMS and the President shall be ex officio members of all committees. All members of a committee including the ex officio members shall have a vote.

(d) Interim vacancies occurring on staff committees shall be filled by appointment by the Chief of Staff. For the elected committees, appointment shall be on a pro tem basis; permanent replacement for the completion of the unexpired term shall be filled within three months after the vacancy occurs, by regular election by the Medical Staff.

(e) If any committee member is unavailable to attend a committee meeting, the committee Chair may permit the unavailable member to invite another person to attend the meeting in the member's absence. With the prior approval of the unavailable committee member and the committee Chair, as documented in the meeting minutes, the substitute member may vote at the meeting.

(f) In addition to the committees listed in this Article, the Medical Staff may, from time to time, establish additional standing committees of the Medical Staff. The composition, charge, and requirements for meeting of each of these standing committees are maintained and available for inspection in the Medical Staff office. All additional standing and ad hoc committees shall be designated as such in the minutes of the Medical Executive Committee (MEC) and by such designation shall be deemed to have been referred to in these Bylaws. At all times, the Medical Executive Committee (MEC) shall maintain an up-to-date list of such committees and such list shall be deemed to be a part of these Bylaws by this reference.

SECTION 2: MEDICAL EXECUTIVE COMMITTEE (MEC)

(a) Medical Executive Committee (MEC) – Composition

(1) The Medical Executive Committee (MEC) shall consist of the following voting members: the Chief of Staff, the Assistant Chief of Staff, the Secretary of the Medical Staff, the Treasurer of the Medical Staff, the President, the SVPMS, six (6) members elected from the Active Attending Staff each of whom must have been a member of the Active Attending Staff for at least two (2) years, and the Directors *ex officio* of all ten (10) Hospital clinical Departments (i.e., Anesthesiology and Perioperative Medicine; Emergency Medicine; Medicine; Obstetrics & Gynecology; Orthopaedics; Pathology; Pediatrics; Psychiatry; Radiology; and Surgery) plus such other clinical Departments as may be established from time to time in accordance with these Bylaws; and the following non-voting members: the Chief Operating Officer, Chief Quality Officer (if such person is not the SVPMS) and the Chief Nursing Officer of Greenwich Hospital.

(2) Election of the six (6) Active Attending Staff members shall occur on a staggered basis such that two (2) Active Attending Staff members shall be elected by the Active Attending Staff at each annual meeting of the Medical Staff. Each member so elected from the Active Attending Staff shall serve a three-year term, may serve two consecutive three-year terms, and shall not be eligible for re-election until the lapse of three years from the conclusion of their second three-year term.

(3) The President or his designee shall attend each Medical Executive Committee (MEC) meeting.

(4) The members of the Committee shall elect their own Chair from any of the six (6) elected Active Attending Staff members, provided that the Chair must be a member of the Committee for at least one (1) year before being elected as Chair.

(5) Vacancies occurring for any cause shall be filled within three months after the vacancy occurs, by regular election by the Medical Staff. If the tenure of the successor is for one year or less, he shall be eligible for a full term at the next annual meeting. Elections shall be by ballot and shall conform to the process outlines in Article XIV, Section 1 concerning election of officers.

(b) Medical Executive Committee (MEC) – Duties. The duties of the Medical Executive Committee (MEC) shall be:

(1) to represent and to act on behalf of the Medical Staff between meetings of the Medical Staff, without requirement of subsequent approval, subject only to any limitations imposed by these Bylaws. If the Medical Staff believes that the Medical Executive Committee (MEC) is not representing its views on issues of patient safety and quality of care, the Medical Staff may remove the elected members of the Committee at a regular or special meeting of the Medical Staff, by a three quarters vote of the qualified voters present. In cases of removal, new members shall be elected in accordance with the election procedures set forth in these Bylaws;

(2) to coordinate the activities and general policies of the various Departments;

(3) to receive and act upon committee reports, including all Medical Staff committees and the Hospital's infection control committee, and to make recommendations concerning them to the President and the Board;

(4) to review and approve policies directly relating to medical care;

(5) to review, at least every three years, the Bylaws and policies of the Medical Staff and recommend changes that are necessary or desirable;

(6) to review, at least every three years, the Rules and Regulations of the Medical Staff, and to adopt any changes that are necessary or desirable;

(7) to implement policies of the Medical Staff that are not the responsibility of the Departments;

(8) to provide liaison among the Medical Staff and the President;

(9) to prioritize continuing medical education activities;

(10) to recommend directly to the Board on the following:

(i) matters of a medical and administrative nature, including Medical Staff structure;

(ii) the mechanism used to review credentials and to delineate individual Clinical Privileges;

(iii) individuals for Medical Staff appointment;

(iv) delineated Clinical Privileges for each eligible individual;

(v) participation of the Medical Staff in Hospital performance improvement activities;

(vi) the mechanism by which Medical Staff appointment and clinical privileges may be terminated; and

(vii) hearing procedures.

(11) to ensure that the Medical Staff is kept abreast of The Joint Commission or other relevant CMS-deemed accrediting body program requirements and Standards and informed of the accreditation status of the Hospital;

(12) to take all reasonable steps to ensure professionally ethical conduct and the enforcement of Hospital and Medical Staff rules including continuing medical education requirements as may be modified from time to time, all as are in the best interest of patient

care and of the Hospital on the part of all persons who hold appointment to the Medical Staff, and to make recommendations to the Board thereon;

(13) to review and facilitate further evaluation and treatment regarding any practitioner impairment concerns that are brought to the Committee's attention;

(14) to identify educational materials that address practitioner health and emphasize prevention, diagnosis and treatment of physical, psychiatric, and emotional illness;

(15) to manage impairment matters in a confidential fashion, keeping the President apprised of the matters under review;

(16) to discharge the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital and for performance improvement, including: commencing evaluation of practitioners when there is doubt about an applicant's ability to perform the privileges requested; making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns, reviewing quality indicators to promote uniformity regarding patient care services, providing leadership in activities related to patient safety, and providing oversight in the process of analyzing and improving patient satisfaction;

(17) to provide advice regarding the sources of clinical services to be provided through contractual agreements.

(18) to undertake all such additional responsibilities set forth in these Bylaws, including but not limited to making recommendations in consultation with the Credentials Committee for medical staff membership and delineated Clinical Privileges, making recommendations with respect to performance-improvement activities, and reviewing proposed changes in these Bylaws and rules and regulations.

In any instance where a member of the Medical Executive Committee (MEC) has a conflict of interest in any matter involving another appointee to the staff that comes before the Medical
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Executive Committee (MEC), or in any instance in which a member of the Medical Executive Committee (MEC) brings a complaint against another appointee, that member shall not participate in the discussion or vote on the matter and shall absent himself from the meeting during that time, although he may be asked and may answer any questions concerning the matter before leaving

The Medical Executive Committee (MEC) may, by a two-thirds majority vote at a meeting at which a quorum is present, remove any Medical Staff officer for conduct detrimental to the interests of the Hospital or the Medical Staff, providing that notice of the meeting at which such action takes place shall have been given in writing to such officer at least 10 days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his own behalf prior to the taking of any vote on his record.

(c) Medical Executive Committee (MEC) – Meetings, Reports and Recommendations

(1) The Medical Executive Committee (MEC) shall meet monthly or at such other intervals as the Chair deems necessary and appropriate to facilitate transacting pending business. The Secretary will maintain reports of all meetings, which reports shall include the minutes of the various committees and Departments of Medical Staff. Copies of all minutes and reports of the Medical Executive Committee (MEC) shall be transmitted to the President routinely as prepared, and important actions of the Medical Executive Committee (MEC) shall be reported to the staff as a part of the Medical Executive Committee (MEC)'s report at each staff meeting.

(2) A majority of the members of the Medical Executive Committee (MEC) shall constitute a quorum. Except as set forth in Section 3 below concerning removal of a Medical Staff officer, a majority vote of the members of the Medical Executive Committee (MEC) shall be required for action on a motion.

SECTION 3: CREDENTIALS COMMITTEE

(a) Credentials Committee – Composition

(1) The Credentials Committee shall consist of the following voting members: President, the SVPMS, the Chief of Staff, the Assistant Chief of Staff, and six (6) elected members from the Active Attending Staff each of whom must have been a member of the Active Attending Staff for at least two (2) years and elected by the Active Attending Staff. The term of office for elected members is three years, however, members are eligible for re-election. Nomination and election of these members shall take place in the same manner as provided for nomination and election of members of the Medical Executive Committee (MEC).

(2) Members of the Credentials Committee shall elect a Chair, provided that only those members who have served on the Committee for at least one (1) year shall be eligible to be elected as Chair, and further provided that the Chair may serve for a maximum of five (5) years and shall not be eligible for re-election as Chair until the lapse of three (3) years from the conclusion of any five (5) year term as Chair.

(b) Credentials Committees – Duties. The duties of the Credentials Committee shall be:

(1) to review the credentials of all applicants, to make such Investigations of and to interview applicants as may be necessary, and to make recommendations to the Medical Executive Committee (MEC) for appointment and delineation of Clinical Privileges, including specific consideration of the recommendations from the Department in which such applicant requests Privileges;

(2) to review periodically information available regarding the professional and clinical competence of persons currently appointed to the Medical Staff for granting, reducing or withdrawing Clinical Privileges, appointments and changes in the assignment of practitioners to the various Departments and Sections, and shall make recommendations regarding the same to the Medical Executive Committee (MEC); and

(3) to review reports on specific persons holding appointments to the Medical Staff that are referred by any Medical Staff committee or by the Chief of Staff, to the extent that those reports concern the Clinical Privileges of Medical Staff appointees and to make such recommendations as are provided by these Bylaws and by the procedures governing appointments to the Medical Staff.

(4) In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or appointee to the staff that comes before the Credentials Committee, that member shall neither participate in the discussion nor vote on the matter and shall absent himself from the meeting during that time, although he may be asked and may answer any questions concerning the matter before leaving.

(c) Credentials Committee – Meetings, Reports and Recommendations

(1) The Credentials Committee shall meet monthly or at such other intervals as the Chair deems necessary and appropriate to facilitate transacting pending business.

(2) The Committee shall maintain a permanent record of its proceedings and actions and shall submit its recommendations to the Medical Executive Committee (MEC) and report its actions, other than peer review information, to the Medical Staff.

(3) A majority of the members of the Credentials Committee shall constitute a quorum. A majority vote of the members of the Credentials Committee shall be required for action on a motion.

SECTION 4: BYLAWS COMMITTEE

(a) Composition. The Bylaws Committee shall consist of such members from the Medical Staff who shall be appointed by the Chief of Staff from time to time, but at a minimum shall include the Chief of Staff (who shall serve as Chair or who shall appoint another member of the Committee as Chair), Assistant Chief of Staff, SVPMS, Chairman of the Medical Executive Committee (MEC) and Chairman of the Credentials Committee, all *ex officio*, plus at least two (2) additional members of the Active Attending Staff each of whom has been a member of the Active Attending Staff for at least two (2) years and selected by the Chief of Staff and approved by the Medical Executive Committee (MEC).

(b) Duties. The duties of the Bylaws Committee shall include:

(1) Conducting periodic reviews of the Medical Staff Bylaws and, Rules and Regulations;

(2) At the request of the Medical Executive Committee (MEC), submitting recommendations to the Medical Executive Committee (MEC) for changes in these documents as necessary to reflect current Medical Staff practices; and

(3) At the request of the Medical Executive Committee (MEC), receiving and evaluating for recommendation to the Medical Executive Committee (MEC) suggestions for modification of the items specified in subdivision (1).

ARTICLE XVII

MEDICAL STAFF MEETINGS

SECTION 1: REGULAR MEETINGS

All business concerning the Medical Staff at the Hospital shall be transacted at the regular or special meetings of the Medical Staff. The regular meetings shall occur at least four (4) times per year, shall take place at the Hospital, and shall be held on such other days as the Chief of Staff may elect.

SECTION 2: ANNUAL MEETING

The regular November meeting of the Medical Staff shall constitute the annual meeting. The agenda shall include election of officers and committee members from a previously adopted slate of nominees.

SECTION 3: SPECIAL MEETINGS

Special meetings of the Medical Staff at the Hospital shall be called by the Chief of Staff, Assistant Chief of Staff or Chairman of the Medical Executive Committee (MEC) when he deems them advisable or necessary. The Chief of Staff is required to call such special meetings at the request of either the Chairman of the Board, the President, or not less than one-quarter of the voting staff by way of a signed petition. At these specially called meetings, only such business as is responsible for the call should be considered.

SECTION 4: ATTENDANCE REQUIREMENTS

Members of the Active Attending Staff are expected to attend all meetings of the Medical Staff. If there is a requirement to attend a minimum number of meetings pursuant to applicable Joint Commission or other relevant CMS-deemed accrediting body Standards, state or federal laws, rules or regulations, or any Medical Staff or Hospital policy, Medical Staff members shall comply with any such applicable requirement.

SECTION 5: QUORUM

A quorum at any Medical Staff meeting shall consist of ten percent (10%) of the membership of the Active Attending Medical Staff, except for the annual meeting of the Medical Staff at which elections occur with respect to which a quorum shall consist of twenty-five percent (25%) of the membership of the Active Attending Medical Staff. During war-time or other continuing emergency, the quorum may be adjusted by the Medical Executive Committee (MEC) in accordance with the size of the

available Staff. A majority vote of the Active Attending Staff members present is required to pass any motion. Members must be present in person, and all such members present shall be counted for a quorum and vote. Voting shall not be permitted by absentee ballot or written proxy.

Notwithstanding the foregoing or any other provision in these Bylaws concerning a quorum and voting at a meeting of the Medical Staff, the Medical Executive Committee (MEC) may adopt a policy to permit any alternative method of being present at a meeting for purposes of a quorum and voting (e.g., by electronic or other remote method).

SECTION 6: EXECUTIVE SESSION

At the call of the presiding officer, any meeting of the Medical Staff as a whole (regular, annual or special) may go into executive session with attendance restricted to Medical Staff members, a recording secretary and such advisors or other attendees as the presiding officer may specifically request to attend.

ARTICLE XVIII

CONFIDENTIALITY

(a) Subject to paragraphs (b) and (c) below, any member of the Medical Staff may review information concerning him/herself that is included in the individual's "Practitioner File" (as defined herein). Review may be arranged by appointment with the Medical Staff Office following receipt of approval from the SVPMS. For purposes hereof, the "Practitioner File " shall mean that file concerning the individual member maintained by the Hospital's Medical Staff Office containing information concerning the individual relating to credentialing, quality assessment/performance improvement, and peer review and includes but is not limited to: written documents, minutes and reports of committees and departments; and any and all notes, minutes or other written memorialization of discussions and/or deliberations regarding credentialing, quality assessment/performance improvement, peer review, or other Medical Staff matters that take place at or on behalf of the Hospital.

(b) Notwithstanding paragraph (a) above, a Medical Staff member may review the following documents (“Category 2 documents”) only while in the presence of the individual’s Department Director, the SVPMS, or a designee of the Department Director or SVPMS, and may be shown document summaries if necessary to protect the identity of any individual who provided information. At this meeting, the Medical Staff member may be told the identity of any individual who provided the information only if, in the discretion of the Department Director, SVPMS, or designee, revealing the individual's identity would be conducive to quality and performance improvement and would not result in adverse consequences to the individual(s) or willingness of other individuals to document incidents.

“Category 2 documents” are the following:

(1) any reported concerns about the Medical Staff member which are placed into the file, along with any written explanations submitted by the individual (but not including information from references or other third parties concerning the Medical Staff member's training, clinical practice, professional competence, or conduct at any other health care facility or medical school, which are deemed “Category 3 documents”);

(2) any confidential correspondence and/or memos to the file prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual;

(3) any periodic review and appraisal forms completed by the appropriate Department Director or Section Head, including those completed at the time of appointment or reappointment;

(4) any routine peer review evaluation forms completed;

(5) any evaluations or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual;

(6) confidential reports and/or minutes (redacted) of peer review committees pertaining to the Medical Staff member;

(7) any correspondence setting forth formal MEC action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements,

or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits; and

(8) any written explanation to any of the above submitted by the Medical Staff member.

(c) Notwithstanding paragraphs (a) and (b) above, because of the heightened expectation of confidentiality on the part of individuals who submit the documents listed below (“Category 3 documents”), a Medical Staff member may not have access to these documents unless (i) the individual providing such information consents to the disclosure, or (ii) paragraph (d) below is applicable. However, a Medical Staff member may meet with the SVPMS or other Hospital or Medical Staff officer designated by the SVPMS to discuss any “Category 3 documents” and the information contained therein, and may review a written summary of the information (provided the summary does not reveal the identity of any individual who submitted the information).

“Category 3 documents” are the following:

(i) any and all confidential correspondence from references and other third parties including, but not limited to, letters of reference, confidential evaluation forms and other documents concerning the Medical Staff member's training, clinical practice, professional competence or conduct at any other health care facility or medical school; and

(ii) notations of telephone conversations with references and other third parties concerning the Medical Staff member's qualifications.

(d) Notwithstanding the foregoing, as part of any pre-hearing procedure pursuant to Article XI of these Bylaws, Medical Staff members may request and shall receive copies of any information relied upon by the MEC or the Board in reaching an adverse recommendation or decision that would entitle the individual to a hearing pursuant to these Bylaws. Members shall be responsible for paying all costs of photocopying.

(e) Except as set forth in paragraph (d) above, in no case shall a Medical Staff member remove the Practitioner File or any portions thereof from the Medical Staff Office or make copies of it without the express permission of the SVPMS or President of the Hospital.

(f) Following a member's review of his/her Practitioner File requested pursuant to paragraphs (a), (b) or (c) above, the member shall have the right to respond in writing to any information included in the individual's Practitioner File. The Medical Staff member's response shall be maintained in the Practitioner File along with the original communication or document. With the approval of the SVPMS, the Medical Staff Office shall correct or delete materials contained in a Practitioner File only after the individual has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Medical Executive Committee (MEC) (except that non-substantive corrections may be approved by the SVPMS).

(g) Disputes. Should any dispute arise over access to information, the dispute shall be resolved by the SVPMS and the Chief of Staff of the Medical Staff, after discussing the matter with the Medical Staff member involved, whose decision shall be final and not subject to appeal.

ARTICLE XIX

HISTORIES AND PHYSICAL EXAMINATIONS

(a) A complete medical history and physical examination must be performed and documented in the patient's medical record by an individual who has been granted privileges by the Hospital to perform histories and physicals (i) prior to surgery or any procedure, encounter or test requiring anesthesia services, (ii) within 24 hours after admission or registration for all other inpatient hospitalization, observation or with respect to a service for which a history and physical examination is required by the Medical Staff in a Medical Staff Policy, and (iii) within such shorter period of time as may be required by the Medical Staff in a Medical Staff Policy. The scope of the medical history and physical examination will include, as pertinent:

- (1) patient identification;

- (2) chief complaint;
- (3) history of present illness;
- (4) review of systems, to include at a minimum:
 - (i) cardiovascular;
 - (ii) respiratory;
 - (iii) gastrointestinal;
 - (iv) neuromusculoskeletal; and
 - (v) skin;
- (5) personal medical history, including medications and allergies;
- (6) family medical history;
- (7) social history, including any abuse or neglect;
- (8) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- (9) data reviewed;
- (10) assessments;
- (11) diagnosis;
- (12) plan of treatment; and
- (13) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.

In the case of a pediatric patient, the history and physical examination report must also include, if and as pertinent: (i) developmental age; (ii) length or height; (iii) weight; and (iv) head circumference (if appropriate).

(b) If a medical history and physical examination has been completed within the 30-day period prior to an admission or registration described in Paragraph (a)(i) immediately above, a durable, legible copy of this report may be used in the patient's medical record, provided that the patient has been evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. This update of the history and physical examination must be documented in the medical record and reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

(c) If there has been a history and physical as described in Paragraphs (a) or (b) above, and at a later point during a patient's admission the patient undergoes a surgical procedure or other procedure requiring anesthesia services, an update to the history and physical is not required as the daily progress notes serve as the updates.

(d) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure or before any other procedure or test requiring anesthesia services, the operation, procedure or test will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(e) A Short-Form history and physical, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient's present clinical

condition/physical findings, may be used for ambulatory or same-day procedures as approved by the Medical Executive Committee (MEC).

(f) The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

ARTICLE XX

RULES AND REGULATIONS; POLICIES

(a) In addition to these Medical Staff Bylaws, there shall be Medical Staff Rules and Regulations and Medical Staff policies and procedures. All Medical Staff Rules and Regulations and policies and procedures shall be adopted and amended in accordance with this Section.

(b) Adoption of and Amendments to Medical Staff Rules and Regulations.

(1) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

(2) An amendment to the Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee, subject to final Board approval prior to such amendment becoming effective.

(3) Notice of proposed amendments to the Rules and Regulations shall be provided to each member of the Active Attending Staff at least 14 days prior to the vote by the Medical Executive Committee. Any member of the Active Attending Staff may submit written comments on the amendments to the Medical Executive Committee.

(4) The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order

to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is conflict between the Medical Staff and the Medical Executive Committee over the provisional amendments, the provisional amendments shall stand, however the process for resolving conflicts set forth below shall be implemented.

(5) Amendments to Rules and Regulations may also be proposed by a petition signed by one-half (1/2) of the Active Attending Staff. All amendments so proposed by the Medical Staff must be approved by the Board prior to becoming effective. Prior to any such proposed amendment being submitted to the Board for approval, the Medical Executive Committee (MEC) must review the proposed amendment and may make a recommendation to the Board for or against the proposed amendment.

(c) Adoption of and Amendments to Medical Staff Policies and Procedures.

(1) The present Medical Staff policies and procedures are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present policy or procedure is inconsistent with these Bylaws, it is of no force or effect.

(2) A new Medical Staff policy and procedure, or amendments to an existing Medical Staff policy and procedure, may be adopted and shall be effective by the approval of the SVPMS and the Medical Executive Committee (MEC).

(3) All Medical Staff policies and procedures shall be posted on the Hospital intranet in a policy database accessible to all members of the Medical Staff.

(4) New and amended Medical Staff policies and procedures may also be proposed by a petition signed by one-half (1/2) of the Active Attending Staff. All amendments so proposed by the Medical Staff must be approved by the SVPMS prior to becoming effective. Before submission of any such proposed amendment to the SVPMS for

approval, the Medical Executive Committee (MEC) must review the proposed amendment and may make a recommendation to the SVPMS for or against the proposed amendment.

(d) Conflict Management Process.

(1) When there is a conflict between the Medical Staff and

(i) the Medical Executive Committee (MEC) with regard to proposed amendments to the Medical Staff Rules and Regulations, or

(ii) the SVPMS with regard to proposed new or amended Medical Staff policies and procedures, a special meeting of the Medical Staff will be called by the Chief of Staff. The agenda for that meeting will be limited to the Medical Staff Rules and Regulations or policies and procedures at issue. If the issue concerns the Rules and Regulations, the MEC Chair shall be present at the meeting; if the issue concerns policies and procedures, the MEC Chair and the SVPMS shall be present at the meeting. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies and procedures.

(iii) If following the special meeting a conflict remains with regards to the Rules and Regulations, a report of the outcome of the meeting shall be forwarded to the Board by the Medical Executive Committee (MEC), including any recommendations of the Medical Executive Committee (MEC) and the Medical Staff, for consideration by the Board. The Board shall determine in its exclusive discretion the appropriate resolution of the conflict, including whether to modify any prior action taken.

(iv) If following the special meeting a conflict remains with regards to Medical Staff policies and procedures, after considering the recommendations of the Medical Staff and the Medical Executive Committee (MEC), the SVPMS and the Chief of Staff shall together determine the appropriate resolution of the conflict, including whether to modify any prior action taken.

(v) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(vi) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the President, who will forward the request for communication to the Chair of the Board. The President will also provide notification to the Medical Executive Committee (MEC) by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE XXI

BYLAWS AMENDMENTS; ADOPTION

(a) Amendments to these Bylaws may be proposed by the Board, by the Medical Executive Committee (MEC), by the Bylaws Committee (at the request of the Medical Executive Committee as per Article XVI, Section 4), or by a petition signed by one-third (1/3) of the Active Attending Staff.

(b) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee (MEC) prior to presenting the proposed Bylaws to, and prior to a vote by, the Active Attending Staff members of the Medical Staff. The Medical Executive Committee (MEC), by the vote of not less than two-thirds (2/3) of those present and voting at a Medical Executive Committee (MEC) meeting at which a quorum is present, may recommend approval, disapproval, approval with modifications, or may refer the proposed amendments in whole or in part to the Bylaws Committee for initial review or re-evaluation.

(c) Following Medical Executive Committee (MEC) review, proposed amendments to these Bylaws shall be presented by the Medical Executive Committee (MEC) to the Medical Staff for

review and comment for a period of at least thirty (30) days. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose, provided such meeting occurs at least thirty (30) days prior to a vote on the proposed amendments by the Medical Staff.

(d) During such thirty day review and comment period, members of the Medical Staff with Active Attending status may provide comments on any amendments to these Bylaws to the Chief of Staff, Assistant Chief of Staff, or to the Chairs of the Bylaws Committee, Medical Executive Committee (MEC) or Credentials Committee.

(e) The Chief of Staff, Assistant Chief of Staff and the Chairs of the Bylaws Committee, the Medical Executive Committee (MEC) and the Credentials Committee shall review any comments received and shall assess whether or not the comments are material and require review by the full Medical Executive Committee (MEC) for further consideration of the proposed amendments, or whether the proposed amendments should proceed to a vote of the Medical Staff consistent with subparagraph (f) of this Article XXI. If this medical staff leadership determines that further consideration by the full Medical Executive Committee (MEC) is neither necessary nor appropriate, the proposed amendments shall be submitted for a vote consistent with subparagraph (f) below. If however the medical staff leadership deems it appropriate to refer the comments to the full Medical Executive Committee (MEC) for further consideration, then the Medical Executive Committee (MEC) shall review the comments at either its next regularly scheduled meeting or at a special meeting called for this purpose, at which time the Medical Executive Committee (MEC) may either decide, by the vote of not less than two-thirds (2/3) of those present and voting at a Medical Executive Committee (MEC) meeting at which a quorum is present, to submit the amendments as previously proposed for a vote of the Medical Staff consistent with subparagraph (f) below, or the Medical Executive Committee (MEC) may decide to modify the proposed amendments, in which case the process described above in paragraphs (b) through (e) shall again be followed.

(f) After such review and comment period, and after consideration of any comments by the medical staff leadership as described in subparagraph (e) above and, if applicable, reconsideration by the Medical Executive Committee (MEC), all amendments shall be submitted to the Active Attending Staff members of the Medical Staff. Active Attending Staff members shall be allowed a
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minimum of thirty (30) calendar days to respond to notification. Notification shall be sent electronically. Failure to respond by thirty (30) calendar days after notification will be considered a vote for approval. In the event twenty-five percent (25%) or more of the Active Attending Staff vote against any of the proposed amendments, their concerns will be transmitted to the Bylaws Committee for review. Any changes to the proposed amendments will be submitted by the Bylaws Committee to the Medical Executive Committee (MEC), which shall then review the proposed amendments and the process described above in paragraphs (b) through (e) shall again be followed. If fewer than twenty-five percent (25%) of the Active Attending Staff voice objection, the amendments shall be forwarded for action to the Board.

(g) The Medical Executive Committee (MEC) shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(h) Amendments or changes to these Bylaws shall be effective only when approved by the Board.

(i) If the Board has determined not to accept a recommendation for amendments to these Bylaws, the Medical Executive Committee (MEC) may request a conference between the officers of the Board, the officers of the Medical Staff and the Chair of the Medical Executive Committee (MEC). Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff and the Chair of the Medical Executive Committee (MEC) to discuss the rationale for the recommendation. Such a conference will be scheduled by the President within two weeks after receipt of a request. Irrespective of the conference, the action of the Board shall stand unless modified by the Board.

Approved by the Medical Staff

James Sabetta, M.D.
Chief of Staff

Erez Salik, M.D.
Secretary of the Medical Staff

Approved by the Board of Trustees on September 12, 2019.

Deborah Hodys
Assistant Secretary, Board of Trustees

Effective: October 1, 2019.