BYLAWS

OF THE

MEDICAL STAFF

OF GREENWICH HOSPITAL

Effective April 10, 2025

TABLE OF CONTENTS

BYLAWS OF
THE MEDICAL STAFF OF
GREENWICH HOSPITAL
PREAMBLE

Greenwich Hospital (hereinafter referred to as "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.

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.

In order to discharge these duties and responsibilities to the Hospital in an orderly fashion, the physicians, podiatrists, and Dentists practicing in Greenwich Hospital hereby organized into a Medical Staff which 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
DEFINITIONS AND INTERPRETATION

SECTION 1: DEFINITIONS

(a) AFFILIATED HEALTH CARE PROFESSIONAL means individuals who are appointed to the Affiliated Health Care Professional category including nurse anesthetists, nurse practitioners, physician assistants and nurse midwives. Licensed clinical psychologists who are appointed after October 1st, 2019 shall also be included as well as any other types of practitioners in the future consistent with the requirements of Article VI.

(b) "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.

(c) "BYLAWS" means these Greenwich Hospital Medical Staff Bylaws.

(d) "CMO" means the Chief Medical Officer of the Hospital.

(e) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the permission granted to Medical Staff members to provide patient care.

(f) "DENTISTS" means any person who holds the degree of Doctor of Dental Surgery or Doctor of Medical Dentistry and has graduated from an accredited College of Dentistry engaged in the practice of dentistry limited to oral and maxillofacial surgery, or other dentists who are appropriately trained and credentialed to practice in a hospital environment.

(g) "DEPARTMENT" means one of the Clinical Departments of the Medical Staff of the Hospital as identified in Article XVII of these Bylaws.

(h) "DEPARTMENT CHAIR" means the Director of a Department who has been appointed in accordance with the provisions of Article XVII, Section 2 of these Bylaws.

(i) FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) means a process whereby the Medical Staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the Hospital.

(j) "HEALTH SYSTEM" means Yale New Haven Health System Corporation.

(k) "HOSPITAL" whenever capitalized means Greenwich Hospital and includes all of its locations and satellites.

(l) "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.

(m) MEDICAL EXECUTIVE COMMITTEE (MEC)" means the Medical Executive Committee (MEC) of the Medical Staff as further defined in Article XVIII, Section 2 of these Bylaws.

(n) "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 Chairs, Section Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, the CMO (as defined above), and experts or consultants retained to perform peer review. Documents prepared in advance of and as a work product of such committees, or studies of morbidity and mortality undertaken by such committees, are considered as privileged and confidential under the CGS 19a-17b or 19a-25, to the fullest extent available under the law and should be clearly identified.

(o) "MEDICAL STAFF" means all practitioners who have been appointed to the Medical Staff of the Hospital.

(p) "ONGOING PROFESSIONAL PRACTICE EVALUATION" or "OPPE" means the continual monitoring and professional practice evaluation of members of the Medical Staff and Affiliated Health Care Professional Staff with Clinical Privileges.

(q) "PODIATRIST" means any person who holds the degree of Doctor of Podiatric Medicine and has graduated from an accredited College of Podiatric Medicine and is engaged in the practice of podiatric medicine or surgery.

(r) "PRESIDENT" means the Chief Executive Officer of the Hospital.

(s) "RULES AND REGULATIONS" means the Hospital Medical Staff Rules and Regulations.

(t) "SECTION CHIEF" means a Section Chief appointed in accordance with the provisions of Article XVII, Section 2 of these Bylaws.

(u) "YALE NEW HAVEN HEALTH SYSTEM AFFILIATED HOSPITAL" means Bridgeport Hospital, Lawrence + Memorial Hospital, Westerly Hospital, Yale New Haven Hospital and any other hospital that affiliates with Yale New Haven Health System.

SECTION 2: INTERPRETATION

Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.
In the event that any law or regulation or mandatory The 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.

The MEC will be provided the opportunity to review and provide input in any Hospital policies and procedures that impact or have the potential to impact the Medical Staff on an ongoing basis.

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 in these Bylaws shall prevail.

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 approved by the Board, as written.

Except as described herein, when a function described in these Bylaws is not able to be carried out by a named member, the responsible individual may delegate performance of that function to an appropriately qualified designee. If the function to be delegated delineates a committee to perform the function, the delegate must also serve the same committee. The Chief of Staff and the Chief Medical Officer shall be notified of such delegation including the name of the designee, function to be covered and the duration of time for which the coverage will be necessary.

SECTION 3: NON-DISCRIMINATION

In accordance with Hospital and Medical Staff policy, all provisions of the Bylaws shall be interpreted and applied so that no person, member 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.

Neither the Hospital nor the Medical Staff shall discriminate in granting Medical 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.

ARTICLE II

NAME AND AUTHORITY

SECTION 1: NAME

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

SECTION 2: AUTHORITY

These Bylaws, Rules and Regulations of the Medical Staff of Greenwich Hospital are created under the authority of the Greenwich Hospital Bylaws Article VI Section 3.

ARTICLE III

OVERVIEW AND PURPOSES

SECTION 1: OVERVIEW

The Medical Staff provides oversight of the quality of care, treatment and services delivered by practitioners who are credentialed and privileged through the Medical Staff process. The Medical Staff is also responsible for the ongoing evaluation of the competency of the practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners and providing leadership in performance improvement activities throughout the Hospital.

SECTION 2: PURPOSES

The purposes of the Medical Staff are:

(a) To promote the goal that all patients admitted and treated in any Hospital facility, Department or service of the Hospital shall receive high quality medical care;

(b) To promote a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of Clinical Privileges that each practitioner may exercise in the Hospital, through review and evaluation of each practitioner's performance in the Hospital and through adherence to appropriate standards of professional behavior;

(c) To initiate and maintain, in cooperation with the Board, rules and regulations for the self-governance of the Medical Staff;

(d) To assist the Board in maintaining the quality of clinical services provided in the Hospital;

(e) To provide an appropriate educational setting for the Medical Staff that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

(f) 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 Hospital Administration

ARTICLE IV
MEDICAL STAFF MEMBERSHIP

SECTION 1: GENERAL STATEMENTS REGARDING MEDICAL STAFF MEMBERSHIP

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 the applicant's application, whether or not the applicant is granted appointment or Clinical Privileges. The following requirements also apply during and after the time of any appointment, reappointment, or granting of Clinical Privileges.

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) in accordance with the procedures outlined in these Bylaws.

(a) Membership as a Privilege

Appointment to the Medical or Affiliated Health Care Professional Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians, Dentists, Podiatrists and other practitioners who continuously meet the eligibility requirements set forth in these Bylaws, the Rules and Regulations, and the policies and directives of the Hospital. All persons practicing in the Hospital, unless accepted by special provisions of these or the Hospital's Bylaws, must first have been appointed to the Medical or Affiliated Health Care Professional Medical Staff.

(b) No Automatic Right to Membership

Medical Staff membership is considered a privilege, not a right. No practitioner shall be entitled to appointment to the Medical Staff or Affiliated Healthcare Professional Staff or to the exercise of Clinical Privileges in the Hospital merely by virtue of the fact that such practitioner is licensed to practice their profession in Connecticut or any other state, that they are a member of any particular professional organization, that they have in the past, or currently has, medical staff appointment or Privileges in another hospital, or that they have established a practice in the Town of Greenwich.

SECTION 2: ELIGIBILITY REQUIREMENTS

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

2.1 Bylaws, Rules, Regulations and Policies

Applicants and current Medical Staff members must agree to abide by Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff policies and procedures.

2.2 Identity Verification

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

2.3 Licensure

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

Applicants for Initial Appointment

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

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

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

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

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

Current Members

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

Article XII outlines the consequences of various licensure actions.

2.4 Federal and State Drug Control Registration

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

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

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

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

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

2.5 Education

Physicians:

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

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

Dentists:

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

Podiatrists:

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

CRNAs:

Certified Registered Nurse Anesthetists must be graduates of a state approved basic nursing education program and graduates of an education program accredited by the

American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education Programs.

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

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

Other Affiliated Health Care Professionals:
Must be graduates of appropriately accredited educational programs relevant to their practice area.

2.6 Training

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

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

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

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

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

2.7 Competence

Applicants for Initial Appointment

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

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

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

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

Current Members

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

a) Have admitted or cared for a sufficient number of patients in the Hospital inpatient and/or outpatient settings to allow evaluation of continuing competence by the Department Chair of the relevant Department. This requirement is considered not applicable for individuals seeking appointment to the Referring or Referring Affiliated Health Care Professional categories.

b) Absent a sufficient volume of patient care activity at the Hospital, verification of competence and activity from another Hospital and/or from appropriate peers, acceptable to the Department Chair and Credentials Committee must be supplied in the form of references. References must be submitted consistent with the process and forms required by Medical Staff Administration. This requirement is considered not applicable for individuals seeking appointment to the Referring or Referring Affiliated Health Care Professionals categories.

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

2.8 Health Status

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

New Applicants and current Medical and Affiliated Health Care Professional Staff must disclose any limitations with their current physical or mental health that affects, or has the potential to affect, their ability to safely exercise the requested Clinical Privileges.

Following review and consideration by the relevant Department Chair and the CMO, new applicants may be required to undergo a specific health evaluation or testing as part of their appointment process.

Additionally, new applicants and current Medical and Affiliated Health Care Professional Staff members must provide sufficient documentation to evidence fulfillment of requirements for mandatory vaccinations and any other standard health testing consistent with Medical Staff policies in order to be or remain eligible for membership and Privileges.

Applicants and current Medical and Affiliated Health Care Professional Staff members who fail to comply will be considered ineligible until all requirements are fulfilled.

Current Medical and Affiliated Health Care Professional Staff members who do not comply will be automatically terminated.

Article XII, Section 2.4 outlines the consequences for failure to comply with health status requirements.

2.9 Federal or State Health Care Programs

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

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

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

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

Article XII, Section 2.3 outlines the consequences of actions taken against current Medical Staff members relative to participation in federal or state governmental health care programs.

2.10 Insurance Coverage

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

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

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

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

Article XII, Section 2.8 outlines the consequences of failure to maintain malpractice insurance coverage.

2.11 Response Time

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

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

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

2.12 Continuing Education/Medical Staff Education

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

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

Successful completion of any Medical Staff education training required at the time of initial and reappointment must be done for an application for initial or reappointment to

be deemed complete. The appointment and privileges of Medical Staff who fail to complete Medical Staff education training before their current appointment lapses will be automatically terminated. Under these circumstances, the Medical Staff member will be eligible for reinstatement once there is evidence that training has been successfully completed.

Article XII, Section 2.5 outlines the consequences for failure to comply with the requirements related to continuing medical education or completion of Medical Staff education training.

2.13 Medical Staff Dues.

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

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

The Greenwich Hospital Medical Staff Dues and Fund Policy describes the process for Medical Staff dues collection. Medical Staff members subject to dues payment will be appropriately informed by the Medical Staff Treasurer or their designee of the required response time and consequences for failure to pay dues in a timely manner.

2.14 Contracted and Exclusively Contracted Services

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

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

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

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

2.15 Ethics and Professional Behavior

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

Since the date of initial licensure to practice their profession, applicants and current members must have never been convicted of any felony or misdemeanor relevant to Medical Staff responsibilities. The relevance of any such felony or misdemeanor to the practice and responsibilities of the Medical Staff member shall be assessed by the Department Chair and the CMO. The matter may be referred to the Credentials Committee or Medical Staff Professionalism Committee, as applicable.

2.16 Board Certification

Board Eligibility/Certification Requirements for Physicians, Dentists and Podiatrists

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

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

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

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

The requirement for initial U.S. board certification is applicable only to individuals who applied for initial appointment after June 22, 2009. The requirement for re-certification applies only to members of the Medical Staff appointed after April 10, 2025.

U.S. Board Re-Certification Requirements for Physicians, Dentists and Podiatrists

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

Exceptions to Board Certification Requirements

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

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

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

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

Physicians

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

Dentists

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

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

Podiatrists

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

Article XII, Section 2.9 outlines the consequences for failure to meet requirements for board certification.

The above and other qualifications will be verified according to current accreditation and other relevant standards.

Section 3. WAIVER OF ELIGIBILITY CRITERIA

As indicated in Sections 1 and 2 above, applicants and current Medical Staff members are expected to fulfill the eligibility requirements as stated. Under exceptional circumstances and upon the recommendation and support of the CMO, relevant Department Chair, the Credentials Committee and the MEC, the Board may consider waiving select aspects of the eligibility requirements.

In the event an applicant wishes to seek a waiver, the applicant is responsible for providing a written request to the Medical Staff Administration Department, requesting a waiver. The applicant bears the burden of demonstrating exceptional circumstances that form the basis for their request for waiver. The individual who is the subject of the waiver will bear the full burden of providing any documentation requested for consideration of such waiver in a timely manner.

Following submission of the request for waiver and any additional information requested by the MEC, the requested waiver will be reviewed by the MEC. The MEC will make a recommendation to the Board regarding the request for waiver. The Board will then make a determination regarding whether or not to grant the waiver requested.

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 or an adverse action of any kind.

Waivers are granted on an individual basis and the granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

Section 4. ADDITIONAL REQUIREMENTS

4.1 Practice History

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

1. has been convicted of or charged with or pled guilty or nolo contendere to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent thereof.

2. has been denied any license, certification, controlled substances permit, hospital appointment or privilege;

3. has had any license, certification, controlled substance permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily;

4. has been the subject of disciplinary action including allegations related to any form of impairment, disruptive behavior or unprofessional conduct;

5. has any condition that would compromise their ability to practice with reasonable skill and safety; and

6. is currently engaged in illegal drug use or dependent upon any controlled substance of alcohol.

If any such actions were ever taken with respect to (1) through (6) above, details will be required as part of the initial appointment or reappointment process.

4.2 Focused Professional Practice Evaluation (FPPE)

Consistent with the Medical Staff policy on Focused Professional Practice Evaluation (FPPE), a period of focused review is required for all new Privileges granted to new or existing members of the Medical Staff. The duration of monitoring is defined in the Medical Staff Policy on FPPE. Types of monitoring may include, but are not limited to chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other practitioners and Hospital employees. The relevant Department Chair, Section Chief or, for Affiliated Health Care Professionals, the supervising or collaborating physician, as applicable, shall be responsible for conducting FPPE and providing evaluation as required by Medical Staff Policy of the Department in which the individual has Clinical Privileges.

ARTICLE V

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board consistent with the process described in Article IV Section 2, except as provided in Section 6 of this Article V with respect to changes in Medical Staff category.

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.

(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 the Hospital as a principal site of hospital practice by actively participating in caring for patients at the Hospital (a physician, Dentist or Podiatrist may also be deemed to have utilized the Hospital as a principal site of practice during any period in which the practitioner has made a reasonable, good faith effort to do so);

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 Chair or Section Chief consistent with applicable Medical Staff Policies and Rules and 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 Chair or Section Chief;

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 Section meetings including quality review programs and teaching conferences;

xi. pay Medical Staff dues.

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 they are a member, consistent with the requirements of these Bylaws;

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

iii. are eligible to serve in departmental and sectional leadership roles, consistent with the requirements of Article XVI Section 1;

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

v. are eligible to be a voting member or Chair of any Medical Staff committee, consistent with the requirements of Article XVIII; 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 Chair. The decision of the Department Chair 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 whose hospital-based practice is primarily at another hospital 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).

i. have a clinical practice site in Greenwich, CT or a neighboring 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 Chair or Section Chief consistent with applicable Medical Staff Policies and Rules and 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. 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;

viii. 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 Chair. The decision of the Department Chair 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 Medical Staff 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 IV with the exception of any requirements related to Hospital patient care activity.

(d) Members of the Referring Medical Staff 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 other than as set forth in Section 1 above;

viii. 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 other than as set forth in Section 1 above;

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 Medical Staff 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 Bylaws and Rules & Regulations, 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 VII. 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 Medical Staff category, a member must meet all eligibility requirements as stated in Article IV of the Bylaws with the exception of those related to office location.

(d) Members of the Telemedicine Medical 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 they are 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: HOUSE STAFF AND ROTATING CLINICAL FELLOWS

1. The House Staff shall consist of residents appointed to Medical Staff membership in this category by the Board upon recommendation of the applicable Department Chief to the Medical Executive Committee. Such appointments are subject to review by the Board as circumstances may warrant.

2. Rotating Clinical Fellows are Postdoctoral Fellows or subspecialty residents who are in training under a program that is not sponsored by the Hospital. Rotating Clinical Fellows spend a period of time at the Hospital and function under supervision as defined under a Program Letter of Agreement between the sponsoring program and the Hospital. Rotating Clinical Fellows function as trainees and are appointed to Medical Staff membership in the same manner as House Staff.

3. House Staff and Rotating Clinical Fellows do not have Clinical Privileges.

4. House Staff and Rotating Clinical Fellows must meet the basic eligibility requirements as applicable and stated in Article IV.

5. Physicians currently appointed as Clinical Fellows at another Health System Affiliated Hospital are not required to complete the application for appointment to the Medical Staff.

6. Clinical Fellows from sponsoring institutions or organizations that are not part of a Health System Affiliated Hospital who seek to participate in a rotation at the Hospital under a Program Letter of Agreement must complete an appropriate application.

7. House Staff and Rotating Clinical Fellows may be required to take call in their capacity as trainees. They may attend meetings of their applicable Department or Section, as applicable, but have no voting rights. They may not serve on any Medical Staff Committees as defined in these Bylaws or serve as a Medical Staff officer, Department Chair or Section Chief. They are not required to pay Medical Staff dues.

8. House Staff and Rotating Clinical Fellows who, following completion of their training, are qualified for and seek Medical Staff membership and Clinical Privileges must, as applicable, apply for and be granted such in accordance with Article VII before practicing independently.

9. House Staff and Rotating Clinical Fellow appointments to the Medical Staff are co-terminus with the training appointment as defined in the Program Letter of Agreement.

10. The various provisions of these Bylaws shall apply to members of the House Staff and Rotating Clinical Fellows only as specifically provided. Provisions relating to appeals, hearing and appellate review shall not apply to the House Staff and Rotating Clinical Fellows.

SECTION 6: HONORARY MEDICAL STAFF

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

ARTICLE VI

AFFILIATED HEALTH CARE PROFESSIONAL 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 licensed clinical 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 V, 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 Patient Safety and Clinical Quality Committee of the Board.

(b) Individuals appointed in this category are not considered members of the Medical Staff and, as such, 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 Health Care Professional 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 their 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, such member must immediately notify Medical Staff Administration, 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 assistant 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 their 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 Professional 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 XIII, XIV and XV.

(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 VII

CLINICAL PRIVILEGES

SECTION 1: EXERCISE OF PRIVILEGES

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

Members of the Medical and Affiliated Healthcare Professional Staff who provide clinical services at the Hospital shall be authorized to exercise only those Clinical Privileges or specified services specifically granted by the Board and identified on the delineation of privileges with the understanding that it may not be safe or clinically appropriate to exercise all Privileges in all Hospital sites or locations. Said Privileges and services must be Hospital specific and within the scope of any license or certificate. No individual shall be required to perform an act which is in violation of their ethical, moral or professional principles, standards or good medical judgement.

Notwithstanding the above, in an emergency, a Medical Staff or Affiliated Health Care Professional member may perform any medical or surgical procedure permitted by their training, experience and applicable State of Connecticut license.

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.

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 their Privileges.

SECTION 2: DELINEATION OF PRIVILEGES IN GENERAL

Requests

With the exception of members seeking appointment in the Referring or Referring Affiliated Health Care Professional Staff categories, each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. Requests for Clinical Privileges during or between appointment cycles may be made at any time but must be supported by documentation of appropriate education, training and experience consistent with any requirements as specified on the privilege delineation or otherwise required during the review process outlined in Article VIII.

Basis for Determination of Clinical Privileges

Any applicant seeking Clinical Privileges must meet the eligibility requirements as stated in Article IV, Sections 2, 3 and 4.

Requests for Clinical Privileges shall be evaluated on the basis of the applicant's documented education, training, experience, demonstrated current competence, ability and judgment. Performance with respect to the ACGME six general competences (Patient Care, Medical/Clinical Knowledge, Practice Based

Learning & Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice) shall also be taken into account in the evaluation of applicants.

The basis for privilege determinations shall include observed 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 as applicable.

SECTION 3: TEMPORARY PRIVILEGES

Temporary Privileges may be granted to a qualified candidate for Medical or Affiliated Health Care Professional Staff by the President or the CMO as their designee under the two circumstances described below:

1) Complete, clean application pending review by the MEC and the Board following a favorable recommendation from the Credentials Committee; or
2) Urgent patient care need

Temporary Privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less.

In exercising temporary Privileges, the applicant shall act under the supervision of the Department Chair to which the applicant is assigned.

The President or the CMO as their designee may suspend or terminate temporary privileges at any time. If this occurs, the President will inform the Chief of Staff and the Chair of the Credentials Committee.

A candidate shall have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary Privileges or termination of such Privileges. In the event of any such termination, the individual's patients then in the Hospital shall be assigned to another practitioner by the Department Chair responsible for supervision. When feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

A. Complete, clean application pending approval:

A candidate shall not be considered qualified for temporary Privileges until the application for Clinical Privileges is complete consistent with Article VIII and a recommendation of the Department Chair / Section Chief and the Credentials Committee has been received.

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

- Failure to meet eligibility requirements as stated in Article IV, Sections 2, 3 and 4
- Previously successful challenges to licensure or registration in any state;
- Hospital Department Chair / Section Chief and or Credentials Committee recommendation is not to approve or refuses to make a recommendation; or
- Pending or prior arrests or convictions for any reason

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

B. Urgent Patient Care Need:

Temporary Privileges may be granted for urgent patient care need:

(1) for the care of a specific patient requiring special clinical expertise or training; or
(2) when necessary to prevent a lack or lapse of services in a needed specialty area.

Temporary Privileges for urgent patient care need may not be invoked to accommodate scheduling conflicts or issues.

In cases of bona fide urgent patient care need, the President or the CMO as their designee may grant temporary privileges for a specified period of time. Such Temporary Privileges will be time limited specifically to the dates of the specific services the physician is asked to provide and, as applicable, the specific patient(s). The decision by the President or the CMO as their designee to grant temporary privileges will occur following the recommendation of the Chief of Staff or a Department Chair, each of which are designated as designees to the Chief of Staff under this section.

The Credentials Committee and the MEC will be notified of all temporary privileges granted for urgent patient care need at its next regularly scheduled meeting.

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

1. Evidence demonstrating that the applicant meets eligibility requirements as outlined in Article IV, Sections 2, 3 and 4;
2. Verification of license;
3. Verification of malpractice insurance to cover services provided at the Hospital;
4. Verification of appointment and relevant Clinical Privileges at a Joint Commission (or equivalent) accredited hospital;
5. Verification of completion of education and appropriate training;
6. Evidence of current competence and ability to perform the requested Privileges with reasonable skill and safety as confirmed via the usual reference request form, written statement or a documented phone call from, at minimum, the Department Chair or section chief or the individual in a position with direct knowledge of the applicant's performance at the applicant's primary hospital;

SECTION 4: DISASTER PRIVILEGES

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

Individuals granted disaster Privileges under this provision are not considered to be members of the Medical Staff or applicants for membership.

SECTION 5: 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 6: TELEMEDICINE PRIVILEGES

The Medical Executive Committee (MEC) will approve all services to be provided through telemedicine link.

The appointment and privileging of practitioners who are currently appointed with full clinical privileges at a Health System Affiliated Hospital may occur by proxy in accordance with the YNHHS Policy entitled "Privileging of YNHHS Medical Staff for Telemedicine Services".

Individuals granted telemedicine Privileges will be subject to the Hospital's performance improvement, Focused Professional Practice Evaluations and peer review activities. The results of these performance improvement, 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 Affiliated Hospital or entity providing telemedicine services.

Practitioners who provide care exclusively via telemedicine link shall be appointed to the Telemedicine category as described in Article V Section 5.

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

As with all other privileges, the Board will ultimately be responsible for granting telemedicine privileges in accordance with Article VII of these Bylaws.

SECTION 7: REQUESTS FOR MODIFICATION OF STAFF CATEGORY

A member of the Medical or Affiliated Health Care Professional Staff, as applicable, may, either in connection with reappointment or at any other time, request modification of their staff category or Departmental assignment by submitting the request in writing or via email to Medical Staff Administration. Requests shall be processed in substantially the same manner as provided in Article VIII for reappointment.

Any request for change in status category shall include the reason for the request and the member shall provide evidence that they meets all eligibility requirements and requirements for assignment to the category as outlined in Article V.

The Department Chair may make recommendations regarding any changes to Medical Staff category assignments. This recommendation shall be forwarded to the Credentials Committee, the MEC and then the Board for approval at its next scheduled meeting.

SECTION 8: CHANGES IN CLINICAL PRIVILEGES

Members seeking additional Clinical Privileges or who request removal of privileges they no longer require shall, in writing or via email, submit a request to Medical Staff Administration. An appropriate privilege delineation form will be provided to the member. The member will request the desired Privileges and provide documentation of education, training and experience as required to evidence current competence to meet applicable criteria.

Any requests for change in Privileges shall be forwarded by the Medical Staff Administration Department to the applicable Department Chair or Section Chief for recommendation and then the Credentials Committee, and Medical Executive Committee (MEC).

The Board shall approve all new Clinical Privileges recommended by the MEC.

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

SECTION 9: PRIVILEGES FOR NEW PROCEDURES

New treatments, procedures or major service changes at the Hospital are decided by the President, with Board approval, after reviewing the recommendation of the applicable Department Chair and the Medical Executive Committee (MEC). If it is recommended that the new treatment or procedure is to be offered, the Department Chair will develop criteria regarding the minimal education, training, and experience necessary to perform the new treatment/procedure.

Requests for additions to the current privilege delineation form(s) to include new procedures and associated criteria with respect to qualifications for education, training or experience necessary to be eligible for the new procedure shall be made by or transmitted to the Medical Staff Administration Department. Modifications to privilege delineation forms must be reviewed and recommended by the relevant Department Chair and, as applicable, Section Chief.

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

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

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

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

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

CHANGES TO PRIVILEGE DELINEATION FORMS

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

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 VIII

APPLICATIONS

SECTION 1. General Procedure

Through its Departments, committees and officers, the Medical Staff shall evaluate and consider every application for appointment or reappointment of physicians, Dentists, Podiatrists and Affiliated Health Care Professionals and each request for modification of membership status or Clinical Privileges. Recommendations shall be submitted to the Board.

The content of the application must enable the responsible Medical Staff leaders and committees as defined in these Bylaws to fully evaluate the candidate's qualifications for membership and privileges, as applicable.

Each recommendation regarding the appointment or reappointment of a member or potential member of the Medical or Affiliated Health Care Professional Staff and the Clinical Privileges to be granted, if applicable, shall be based upon whether the applicant meets the eligibility requirements as outlined in Article IV, Sections 2. 3 and 4 along with any and all other requirements or obligations associated with the Medical Staff category applicable to the individual member as outlined in these Bylaws.

SECTION 2. Requirements for Applicants for Initial Appointment and Reappointment

a. Meet the eligibility requirements as outlined in Article IV, Sections 2, 3 and 4;
b. Those who are eligible shall submit, as applicable, a request for specific Clinical Privileges requested along with any documentation to support the request or the application in general as well as any fees as required for the application to be deemed complete, and provide evidence of currently in force professional liability insurance coverage and the amount, which shall be no less than 1 million /3 million dollars;
c. Provide information concerning 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;
d. Complete and submit an appropriate application including responses to questions regarding the applicant’s practice history as required by eligibility standards outlined in Article IV, Section 2 along with complete explanations regarding any question answered affirmatively;
e. Acknowledge receipt of and having read the Bylaws, Rules and Regulations of the Medical Staff and agree to be bound by the terms thereof;
f. Agree to follow Hospital, Department and Section policies and procedures;
g. Agree to appear for personal interviews if requested, both during the application process and while on the Medical Staff;
h. Agree to provide for continuous care and supervision to all patients for whom the applicant has responsibility within the Hospital;
i. Sign the applicable authorization and release and, therein, attest to the accuracy and truthfulness of the contents of the application

The relevant Department Chair and Section Chief, CMO, Credentials Committee, Medical Executive Committee (MEC), or any individual designated on behalf of these individuals or committees may also require additional information to appropriately assess the education, training, clinical competence

and personal qualities for any Privileges requested and/or qualifications for initial or continued membership.

When such information can only be obtained from organizations or individuals that are not associated with the Hospital, consistent with Section 3 of this Article, it shall be the responsibility of the applicant to provide, cause to be provided or make such information available. Failure of the applicant to do so shall result in an application being deemed incomplete and processing will cease.

In accordance with the "Yale New Haven Health Medical Staff Telemedicine Policy", practitioners appointed at other Yale New Haven Health Affiliated Hospitals with full clinical privileges may be appointed and reappointed to the Telemedicine category by proxy.

SECTION 3. REFERENCES

Initial Appointment

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

Specific guidelines as to requirements for references are based on education and training as well as length of time in practice are described in Medical Staff policy and will be incorporated into the application for initial appointment.

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

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

Re-Appointment

Absent a sufficient volume of patient care activity at the Hospital, verification of competence and activity from another hospital and/or from appropriate peers, acceptable to the Department Chair and Credentials Committee must be supplied in the form of references. References must be submitted consistent with the process and forms required for initial appointment. This requirement is considered not applicable for individuals seeking appointment to the Referring or Referring Affiliated Health Care Professional categories.

SECTION 4: COMPLETION OF APPLICATION / RESPONSIBILITY OF APPLICANTS

All applicants, members and affiliated members of the Medical Staff are responsible for providing information deemed adequate for an appropriate evaluation of education, training, experience, current competence, ethics, personal qualities and qualifications to serve as an exemplary model for all staff and

for resolving any doubts that arise regarding their qualifications during the appointment or reappointment process.

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

If an applicant for appointment or re-appointment fails to provide, or cause to be provided, any requested information, the application shall be deemed "incomplete" and processing will cease. If this occurs during a re-appointment and the applicant's appointment lapses, they shall be considered to have voluntarily resigned from the Medical Staff until/unless required documentation can be provided and the application approved in accordance with this Article VIII.

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

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

Applicants for appointment and re-appointment attest that they understand that falsification, misrepresentation or omission of any material fact(s) will be sufficient cause for ceasing processing of an initial application or automatic relinquishment of appointment and Clinical Privileges without the right to request a hearing or appeal.

SECTION 5: INITIAL APPOINTMENT APPLICATION PROCESS

Applications for appointment to the Medical Staff shall be available electronically via the Hospital's website and submitted to Medical Staff Administration.

Applicants must apply for primary appointment in at least one of the Hospital Departments (See Article XVII) and must apply to a specific Section within that Department if the applicant requests approval to practice the clinical function delineated within that Section. The primary appointment shall be assigned based on the applicant's primary training and experience and intended area of clinical practice. In addition, an applicant may request a secondary appointment in another of the Hospital Departments and Sections if appropriate based on training and experience.

Licensure, education, relevant training and other experience and qualifications shall be verified for each applicant. Verification is obtained from the original source whenever possible and consistent with current accreditation and other relevant standards. Information may be sought from other sources as deemed appropriate during the credentialing process or to validate or seek clarification regarding information contained in the application for appointment.

Information will be obtained from the National Practitioner Databank as available and consistent with the requirements of the Health Care Quality Improvement Act of 1986.

Assessment of current competence to perform the Privileges requested by the applicant is evaluated through information provided by appropriate professional references which shall be obtained in accordance with Medical Staff policies and Section 3 of this Article. Performance with respect to the ACGME six general competences (Patient Care, Medical/Clinical Knowledge, Practice Based Learning & Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice) is taken into account in the evaluation of the applicant.

The applicant shall be notified if any information obtained during the verification process renders them ineligible for membership consistent with the eligibility requirements as stated in Article IV Section 2 or 4.

SECTION 6: REVIEW OF APPLICATION FOR INITIAL APPOINTMENT

6.1 Department Chair Review

Upon completion of processing, Medical Staff Administration shall submit applications and all supporting documentation to the Chair of the Department in which the applicant seeks Privileges.

The Department Chair shall review the application and supporting documentation and a personal interview with the applicant may be conducted. The Department Chair shall then transmit their recommendation regarding appointment, category, Department and Section (as applicable) assignment and Clinical Privileges to the CMO. Any special conditions, as applicable, will also be communicated. Generally speaking, special conditions shall be incorporated into the applicant's Focused Professional Practice Evaluation (FPPE).

The Departmental action shall include, when applicable, a review and recommendation regarding appointment and Clinical Privileges requested by the appropriate Section Chief prior to the Department Chair's recommendation.

The Department Chair or Section Chief may request additional information as they deem appropriate to assist in their evaluation of the candidate in order to make their recommendation. Under these circumstances, the application shall become incomplete consistent with Section 4 above and returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

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

6.2 CMO Review

The recommendation of the Department Chair and, as applicable, Section Chief, shall be submitted to the CMO. If the recommendation is for approval, a delineation of privileges (as applicable) signed by

the applicant and the Department Chair and, as applicable, Section Chief shall accompany the application. Should a difference of opinion arise between the Department Chair and the Section Chief, the recommendations of each shall be submitted to the CMO.

The CMO or their designee shall review the completed application and confirm its compliance with the eligibility requirements as stated in Article IV Sections 2 and 4

The CMO shall either recommend or withhold approval. If approval is withheld by the CMO or their designee, the application will be forwarded to the Credentials Committee along with the concerns of the CMO.

The CMO or their designee may determine that additional information is needed to appropriately assess the applicant's qualifications. Under these circumstances, the application shall become incomplete consistent with Section 4 above and is returned to Medical Staff Administration with instructions for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

6.3 Credentials Committee Review

Upon receipt of the recommendation of the Department Chair, Section Chief (as applicable) and CMO the Credentials Committee shall:

(a) Review and consider the recommendation of the relevant Department Chair, Section Chief (as applicable) and CMO;

(b) May solicit the expertise of the Department Chair, or any member of the Department, or an outside consultant, if additional information is required regarding an applicant's qualifications.

(c) May meet with the applicant to discuss any aspect of their application, qualifications and the requested Clinical Privileges.

Following its evaluation, the Credentials Committee may determine that it needs additional information to appropriately assess the applicant's qualifications. Under these circumstances, the application shall become incomplete consistent with Section 4 above and is returned to Medical Staff Administration with instructions for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

Once satisfied it has sufficient information, the Credentials Committee shall make its recommendation as to appointment and Clinical Privileges to the MEC.

The Credentials Committee may recommend the specific conditions related to the need to confirm appropriate professional behavior or clinical competence. Such conditions may include proctoring, consultation, medical record review, feedback from staff or leadership, etc. Any special conditions, if also approved by the MEC and Board will be incorporated into the Focused Professional Practice Evaluation (FPPE) process and communicated in writing to the applicant.

The Credentials Committee may also recommend to the MEC that appointment be granted for a period of less than three years. Typically, this will occur if information obtained in the credentialing process suggests that there may be concerns about the practitioner's performance or qualifications that are not of significant magnitude to deem the application ineligible for appointment or Clinical Privileges but warrant a period of initial monitoring. In such cases, the requirements and

expectations shall be articulated as part of the routine Focused Professional Practice Evaluation (FPPE) process and the applicant notified accordingly of such expectations and consequences of not fulling them in the manner or timeframe outlined.

6.4 Medical Executive Committee (MEC) Review

Upon receipt of the recommendations of the Credentials Committee, at its next scheduled meeting the Medical Executive Committee (MEC) shall review and consider the recommendations of the Credentials Committee with respect to each applicant.

The MEC may determine that it needs additional information to appropriately assess the applicant's qualifications. Under these circumstances, the application shall become incomplete consistent with Section 4 above and is returned to Medical Staff Administration with instructions for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

Once satisfied it has sufficient information, the MEC shall make its recommendation as to appointment and Clinical Privileges, as applicable, including any special conditions if recommended by the Credentials Committee.

When the recommendation of the MEC is favorable to the applicant, the MEC shall promptly forward it to the Board.

When the recommendation of the MEC is unfavorable in whole or in part to the applicant, the unfavorable recommendation is considered an adverse action. In such cases, the applicant shall be notified in writing and entitled to the Procedural Fairness Process as set forth in Article XIII.

Appointments of Less than Three Years: The MEC may recommend an appointment of less than three (3) years to the Board under the circumstances described in Section 6.3 above. The recommendation of an appointment of less than three (3) years is not considered an adverse action and the applicant is not eligible for a hearing.

6.5. Board Action

The recommendations of the MEC shall be forwarded to the Board for final action.

The Board may act upon the recommendations itself or delegate its responsibilities to a committee, consisting of at least two Board members, to make final determinations regarding appointment, reappointment, and Clinical Privileges. In order for the Board to delegate its responsibilities the recommendations of the Credentials Committee and the Medical Executive Committee (MEC) must be favorable to the applicant and there must be 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.

Determinations for appointment and Clinical Privileges (as applicable) made by a Board Committee shall be effective immediately and shall be forwarded to the Board for consideration at its next meeting.

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.

If the Board determines to reject a favorable recommendation of the Medical Executive Committee (MEC) or a favorable decision of the Board Committee, it shall 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 applicant shall be notified promptly and informed of their right to request a hearing.

SECTION 7. NOTIFICATION TO APPLICANTS

All applicants shall be notified of the Board's decision by way of a letter which includes the following: (1) the category to which the applicant is appointed, (2) the Department and, as applicable, Section to which the applicant is assigned, (3) the Clinical Privileges the applicant may exercise and (4) the obligations and expectations of the applicant concerning the Focused Professional Practice Evaluation (FPPE) process for any new privileges, (5) the Ongoing Professional Practice Evaluation (OPPE) process and (6) any special conditions associated with the appointment.

All efforts shall be made to provide this notification to applicants within thirty (30) days of the Board's decision.

In the event of the denial or revocation of appointment and/or Clinical Privileges the applicant shall likewise be notified and the decision reported as required, to appropriate entities.

SECTION 8. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible for appointment or Clinical Privileges until such applicant is able to provide sufficient documentation evidencing that the concerns which led to the initial adverse decision have been addressed. A new application will be required and it shall be processed as an initial application.

SECTION 9: REAPPOINTMENT PROCESS

At least every three years, every member of the Medical and Affiliated Health Care Professional Staff seeking continuation of membership and clinical privileges shall be required to request reappointment in the primary Department/Section and, if desired and applicable, in a secondary Department/Section.

In addition to the information outlined in Section 2 above, the following shall be required for reappointment:

a. Satisfactory fulfillment of any obligations associated with the Medical Staff category to which reappointment is sought as described in Article IV, Sections 2 and 4.

b. Satisfactory fulfillment of any applicable Departmental or Sectional specific criteria for reappointment and any other Medical Staff obligations.

c. Submission of a complete reappointment application which shall be made available via email at least one hundred and twenty (120) days prior to the expiration of the present appointment.

The following factors shall be considered 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.

Except for good cause, applications for reappointment must be completed and submitted to Medical Staff Administration within thirty (30) days of receipt. Failure to return the application, with all required information in sufficient time to allow processing and approval shall be considered a voluntary resignation effective as of the date of expiration of the individual's current appointment.

Reappointment applications shall be processed in the same manner as applications for initial appointment and consistent with Sections 5-7 above except that review of the file by the CMO and interviews as noted are not required but may be conducted as deemed necessary to allow an appropriate assessment of the applicant's qualifications for reappointment.

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) and prior to the end of the individual's current term of appointment.

Reappointment shall be for a period of no more than three years.

SECTION 10: TIME PERIOD FOR PROCESSING

Notwithstanding the other provisions of this Article relating to the time for processing completed Medical Staff applications, all efforts will be made to expeditiously process completed applications for initial appointment, reappointment as well as requests for additional privileges and present them

for final Board approval within ninety (90) days of completion and submission according to the processes set forth in this Article.

SECTION 11: AUTHORIZATION TO OBTAIN INFORMATION

(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 [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, Affiliated Health Care Professional 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 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.

ARTICLE IX

MEDICAL STAFF CODE OF CONDUCT

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

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

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

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

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

- use of threatening, abusive or hostile language, comments or behaviors that belittle, berate, degrade, intimidate, demean and/or are threatening to another individual

- inappropriate physical contact or threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;

- Use of loud, profane, or similarly offensive language;

- derogatory comments or criticisms about the quality of care provided by the Hospital, another Medical Staff member, or any other individual made outside of an appropriate forum;

- impertinent or inappropriate comments (or illustrations) made in medical records or other official documents concerning the quality of care provided by the Hospital or another individual

- willful disregard of Medical Staff and Hospital requirements, policies and procedures, failure to cooperate on assigned responsibilities or an unwillingness to work collaboratively with others

- written or oral statements which constitute the intentional expression of falsehoods, or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others

- retaliation against any person who addresses or reports violations of the Code of Conduct

- deliberate destruction of any Hospital property

- possession of any unauthorized firearm or weapon

- gross immoral, fraudulent or indecent conduct

- Harassment: The Hospital prohibits all forms of unlawful and unacceptable harassment, including harassment due to race, religion, sex, national origin, age, marital status, sexual orientation and disability.

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

- verbal: innuendoes, epithets, derogatory slurs, jokes, propositions, graphic commentaries, threats and/or suggestive or insulting sounds;

- visual: derogatory posters, cartoons or drawings; suggestive objects or pictures; leering and/or obscene gestures;

- physical: unwelcome physical contact including touching, interference with an individual's movement and/or assault;

- other: making or threatening retaliation as a result of an individual's negative response to harassing conduct

Violations of the Medical Staff code of conduct shall be referred to and reviewed by the MSPC and referred to the credentials committee or MEC as deemed appropriate.

ARTICLE X

LEAVES OF ABSENCE

A leave of absence from the Medical Staff may be either: (1) requested by a member or (2) activated by the Chief Medical Officer in consultation with the applicable Department Chair and the Chief of Staff.

A leave of absence is defined as a period of time during which the member's membership and Clinical Privileges are temporarily inactive. During the period of a leave, the member may not exercise Clinical Privileges at any Hospital inpatient or outpatient setting, provide care via telemedicine link or hold office or other positions. All other membership rights, duties and obligations shall also be inactive.

In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

10.1 Leaves of Absence Requested by Members

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

In order to request a leave of absence, the Medical Staff member must personally submit a written or email notice to the applicable Department Chair and Chief Medical Officer, copied to Medical Staff Administration. The request for a leave must include the reason for the leave, the start date and anticipated return date. The period of time for a leave of absence may not initially exceed six (6) months. A leave of absence may be renewable upon written request by the Medical Staff member, up to a maximum of one (1) year.

Medical Staff members are expected to request a leave of absence any time they are away from Medical Staff or patient care responsibilities for longer than thirty [30] days due to circumstances which affect, or have the potential to affect, the ability to perform their Privileges with reasonable skill and safety.

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

10.2 Approval of Leave of Absence

The applicable Department Chair and Chief Medical Officer shall approve all leaves of absence, their duration and any extensions. The Credentials Committee, Medical Executive Committee (MEC), and the Board will be notified regarding these leaves of absence at their next regularly scheduled meeting.

In the event that the applicable Department Chair and Chief Medical Officer believe that a leave of absence is not sufficiently justified despite discussion with the Medical Staff member requesting the leave, the Medical Staff member may request that the MEC consider the request.

10.3 Leave of Absence Activated by the Chief Medical Officer

At any point after becoming aware that a member of the Medical Staff is away from patient care responsibilities and cannot personally request a leave of absence due to limitations in their current physical or mental health, or due to circumstances which affect, or have the potential to affect, the ability to perform their privileges with reasonable skill and safety, the Chief Medical Officer may automatically place a member on leave of absence. The Chief Medical Officer shall first consult with the Department Chair and other Medical Staff leaders or the Medical Staff Health Committee as deemed necessary. The Credentials Committee, and MEC and Board will be notified regarding any CMO activated leaves of absence at their next regularly scheduled meeting.

10.4 Notification

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

10.5 Return from a Leave of Absence

In order to return from leave of absence, a member must request to do so personally in writing via a letter or email to the applicable Department Chair and Chief Medical Officer, copied to Medical Staff Administration. All applicable eligibility requirements as identified in Article IV Sections 2 and 4 must be fulfilled in order to return from leave of absence.

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

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

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

Applicable State of Connecticut licensure, DEA and state controlled substance registration and professional liability insurance coverage must be current and any reappointment application

materials must be received in order for the member to return from a leave of absence.

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

10.6 Failure to Request an Extension of a Leave of Absence or Reinstatement/Return from Leave of Absence

Failure to request renewal of a leave at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave.

10.7 Systemwide Notification

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

ARTICLE XI

PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE OR BEHAVIOR

SECTION 1: GROUNDS FOR ACTION

Any person may provide information or report situations or incidents that might be cause for concern related to a practitioner's clinical competence or behavior to an appropriate medical staff leader. This includes, but is not limited to: the Department Chair, Section Chief, Chief of Staff, Assistant Chief of Staff and/or Chief Medical Officer.

Upon receipt of a report or otherwise becoming aware of a concern regarding a practitioner's clinical competence or behavior, the medical staff leader 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) 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.

In the event that proctoring or monitoring is indicated, the medical staff leader shall notify the Professional Practice Evaluation Committee (PPEC) or Medical Staff Professionalism Committee (MSPC), as applicable. The PPEC or MSPC shall oversee any for cause FPPE or voluntary monitoring plans if deemed appropriate.

If any collegial intervention is deemed not appropriate under the circumstances, or if attempted but unsuccessful, the Medical Staff leader(s) will refer the matter to the MSPC or PPEC consistent with applicable medical staff policies.

The PPEC or MSPC shall review all identified concerns and, if unable to resolve them via collegial interventions at this level, refer the matter to the Medical Executive Committee (MEC).

SECTION 2: INQUIRY AND INVESTIGATION

(a) Within thirty (30) days following recommendation of the PPEC or MSPC, the 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 Medical Staff 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) 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.

(d) 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.

(e) 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 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 XII, Section 2(d) above). If the practitioner in question is a member of the Medical Executive Committee (MEC), practitioner shall be excluded from all deliberations that relate to the case.

(f) Partners or associates of the affected practitioner shall not participate in the Investigation, nor shall any Medical Staff member who is in direct economic competition with the 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.

(g) 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).

(h) 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 XII, Section 7 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.

(i) 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 XI, 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 XI, 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 XIII, 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 XIII, Section 1(a)) will be forwarded to the President, who will promptly inform the individual by special notice (pursuant to Article XIII, Section 3).

ARTICLE XII

NOTIFICATION REQUIREMENTS, AUTOMATIC RELINQUISHMENT, TERMINATION OR SUSPENSION AND PRECAUTIONARY SUSPENSION

SECTION 1. NOTIFICATION REQUIREMENTS

1.1 Medical Staff Members Obligation to Report

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

a) any change in malpractice insurance coverage;
b) loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation and/or fine), whether voluntary or involuntary, taken regarding a professional license in Connecticut or any other state;
c) loss (other than for routine non-renewal), suspension, consent order or any other action whether voluntary or involuntary that is taken with regard to state or federal authority to prescribe controlled substances;
d) loss (other than routine non-renewal or resignation of unused clinical privileges), suspension, reduction, resignation, relinquishment, limitation (or any other action arising out of concerns related to competence or professional deportment of membership or clinical privileges) at any other health care facility;
e) initiation of formal investigation at any other health care facility;
f) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and
g) any arrest or the filing of any criminal charge by local, state or federal authorities.

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

The circumstances surrounding any of the above occurrences, or failure to comply with the requirement to report them, will be evaluated individually in terms of pursuing disciplinary or other action. The procedural fairness process or appellate review rights are not applicable under circumstances in which practitioners fail to meet eligibility requirements as outlined in Article IV, Section 2 and 4.

1.2 Adverse Professional Review Actions, Investigations or For Cause FPPE

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

- an adverse professional review action regarding appointment or clinical privileges for reasons related to clinical competence or professional conduct including, but not limited to, denial, revocation or suspension (excluding precautionary suspension) of membership or clinical privileges; or

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

- resigned appointment or relinquished clinical privileges during a Medical Staff investigation or in exchange for not conducting such an investigation at another institution

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

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

If currently privileged in the area of practice related to the action taken at the other hospital, related privileges shall be automatically relinquished pending review and recommendation by Credentials Committee, MEC and approval by the Patient Safety and Clinical Quality Committee of the Board of Trustees (PSCQ).

SECTION 2. AUTOMATIC SUSPENSION AND TERMINATION

The following outlines situations upon which Medical Staff membership and Clinical Privileges of a Medical Staff member are subject to automatic relinquishment, termination or suspension. No hearing rights shall be afforded under any of the following circumstances in this Section leading to automatic relinquishment, termination or suspension of membership and Privileges.

Medical and Affiliated Health Care Professional Medical Staff members whose membership and Privileges have been automatically relinquished, suspended, or terminated have the right to, upon documentation of satisfactory fulfillment of the relevant requirement and complete resolution of the pertinent matter, be considered for reinstatement to the Medical Staff. The circumstances surrounding the relinquishment, suspension or termination, time that has elapsed and relevant regulatory requirements or requirements of these Bylaws will factor into the determination as to whether reinstatement will occur.

2.1 Licensure: The following licensure actions shall be cause for automatic relinquishment of Clinical Privileges and Medical Staff membership as of the effective date of the action:

i. Revocation, voluntary relinquishment or voluntary surrender, or suspension of a license in any state;
ii. Agreement with a governmental entity not to exercise a license to practice;
iii. Permanent licensure restriction;
iv. Lapse of a license to practice in the State of Connecticut due to failure to renew.

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

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

2.2 Federal and State Drug Control Registration: The following shall be cause for automatic relinquishment of Clinical Privileges and Medical Staff membership as of the effective date of the action:

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

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

2.3 Federal or State Health Care Programs: In the event that a current member of the Medical Staff is identified and verified with the source organization as debarred, excluded or precluded from participation in any federal or state health care program, the Chief Medical Officer and relevant Department Chair will be immediately notified and the appointment and privileges of the Medical Staff member will be automatically terminated.

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

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

2.4 Health Status: Failure to comply with any health status requirements as outlined in Article IV, Section 2 will result in automatic termination from the Medical Staff.

2.5 Continuing Education / Medical Staff Education: Failure to attest to or provide evidence when requested of compliance with State of Connecticut requirements for continuing medical education or failure to complete any required Medical Staff education training at the time of initial or reappointment will result in automatic termination of Medical Staff appointment and privileges.

2.6 Medical Staff Dues: The membership and privileges of members who fail to pay Medical Staff dues shall be suspended, as described in the "Greenwich Hospital Medical Staff Dues Assignment, Collections and Disbursement Policy". Membership and Privileges may be immediately restored if payment is received within an additional thirty (30) days assuming that reappointment applications or any other required documentation has been submitted by the member. All others will be required to reapply in accordance with Article IV Section 2 of these Bylaws.

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

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

Members who have been approved for a leave of absence in accordance with Article X of these

Bylaws may pay Medical Staff dues upon receipt of notice or upon return from leave of absence.

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

2.7 Leave of Absence: Failure to request renewal of a leave of absence at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and Clinical Privileges effective as of the end date of the leave of absence.

A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

2.8 Insurance Coverage: Failure of a Medical Staff member to maintain professional liability

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

2.9 Board Certification: Failure of a Medical Staff member to obtain or maintain board

certification consistent with the requirements, as applicable, as outlined in Article IV, Section 2 shall result in automatic termination.

2.10 Cooperation with Peer Review Activities: As a matter of routine proceedings, the PPEC , the MSPC, or the Credentials Committee may request that a member of the Medical Staff participate in a review of their Hospital cases, aspects of Hospital based practice, or matters involving professional behavior. Clinical Privileges and Medical Staff membership may be considered automatically relinquished for refusal to cooperate in good faith with such reviews when requested until the necessary input has been provided.

SECTION 3. NOTICE

Once it has been determined that a condition or circumstance exists warranting automatic relinquishment, suspension, or termination of Medical Staff membership and/or Clinical Privileges, the practitioner shall be notified of such determination. The notification shall include the reason for such action, its effective date, and, if applicable, the conditions under which any such suspension, as applicable, shall be lifted.

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

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

SECTION 4. TERMINATION OF AUTOMATIC SUSPENSION

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

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

SECTION 5: IMPAIRED PHYSICIANS

The Medical Staff maintains a "Medical Staff 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 Staff Health Committee's 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, XIII, XIV, XV 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 Affiliated Health Care 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.

SECTION 7: PROVISIONS AND BASIS FOR PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

7.1 The Chief of Staff, the CMO, the Chairman of the Medical Executive Committee (MEC), the President, and the Chair 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 X.

7.2 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.

7.3 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.

7.4 A precautionary suspension shall become effective immediately upon imposition, shall be immediately reported in writing to the practitioner in accordance with Article XII, Section 7 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).

7.5 The imposition or continuation of a precautionary suspension or restriction shall not constitute grounds for a hearing pursuant to Article XIII of these Bylaws.

SECTION 8: MEDICAL EXECUTIVE COMMITTEE (MEC) REVIEW OF PRECAUTIONARY SUSPENSIONS

8.1 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).

8.2 If the individual is a member of the Affiliated Health Care Professional Staff, the relevant supervising/collaborating Physician will be notified of the precautionary suspension or restriction.

8.3 Within a reasonable time, not to exceed ten (10) calendar days (except if the tenth (10^{th}) 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.

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

a. 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;

b. 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;

c. to submit written statements and other information to the Medical Executive Committee (MEC);

d. to propose ways, other than precautionary suspension or restriction, to protect patients, employees, or others while the matter is being reviewed; and

e. 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.

8.5 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.

8.6 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.

8.7 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 CMO 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 XI of these Bylaws, including the requirements set forth in Article XI, Section 2(i) requiring that an Investigation be completed within ninety (90) days.

8.8 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 above (except if the fourteenth (14^{th}) 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:

a. review and determine whether the precautionary suspension or restriction should be continued, modified, or lifted; and

b. 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 (MEC) will take action to remedy the delay and cause the inquiry or investigation to proceed more expeditiously.

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

a. 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 XII, Section 7 as soon as the meeting is scheduled;

b. 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;

c. 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);

d. 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;

e. to propose ways, other than precautionary suspension or restriction, to protect patients, employees, or others while the matter continues to be reviewed; and

f. 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.

8.10 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 9: CARE OF PATIENTS FOR PRACTITIONERS UNDER PRECAUTIONARY SUSPENSION

Immediately upon the imposition of a precautionary suspension, the appropriate Department Chair or Section Chief or in their absence the CMO 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 Chair have a duty to cooperate with the President in enforcing suspensions.

SECTION 10: DEPARTMENTAL SUPERVISION OF PRACTITIONER'S UNDER PRECAUTIONARY SUSPENSION

10.1 Without imposing a precautionary suspension, but based on the need to assure quality medical care, a Department Chair may act, with the support of the CMO, 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 Department Chair may be based upon reasonable doubts regarding the practitioner's competence; concerns about possible impairment, ability to adhere to the Bylaws, Rules & 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.

10.2 When such a decision is made, the practitioner shall be informed by the Department Chair 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 Chair to the CMO. 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 Department Chair to lighten the duties of the practitioner, such as by temporary removal from on-call or other duty rotations.

10.3 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.

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

10.5 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.

10.6 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 Chair has the authority to impose such supervision as they believe is required. Therefore, all members of the Medical Staff release the Department Chair, 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 Medical Staff membership.

ARTICLE XIII

PROCEDURAL FAIRNESS PROCESS

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 their 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 XII [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 -XII, Section 2 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 their 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 Clinical 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 of absence;
(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 de; or
(13) restriction or limitation of Clinical Privileges (of the nature described in paragraph (a)(7) above) for less than or equal to thirty (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 Medical or Affiliated Health Care Professional 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 7, and shall state the substance of the proposed report.

(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, such affected individual shall be deemed to

have waived their 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 this 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 fifteen (15) days after receipt of the hearing request, if practicable, 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 their rights under these Bylaws. Except as set forth below, the hearing shall begin as soon as is practicable, but not less than thirty (30) days, nor more than sixty (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 petitioner 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. Additions may be made to the charge before and during the hearing if the petitioner and their 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 XIII.

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

Hearing Panel shall be appointees to the Active Attending 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. The Hearing Panel Chairman shall rule on the admissibility of evidence and any 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 their responsibilities. The Hearing Officer may not act as a prosecutor or an advocate for the Medical Staff or Hospital. The Hearing Officer is not a member of the Hearing Panel and may not vote, however they 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 XIV

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 their choice to examine witnesses and present their case. At least ten (10) days before the hearing, the petitioner shall inform the President in writing of the identity of their 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 their 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 their own behalf, they may be called and examined by the other party. No party shall be permitted private communication with the Hearing Panel or any of its members on the matters pending before the Hearing 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 Hearing Panel may request, written memoranda to be submitted

during, at, or after the close of the hearing. The Hearing 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 Hearing 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 their case. Both parties may make short closing statements.

SECTION 6: ATTENDANCE BY HEARING PANEL

If a member of the Hearing Panel is absent, they 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 Hearing 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 XV

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 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 ten (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 twenty (20) days nor more than forty (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 fourteen (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 Review 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 thirty (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 Panel or President.

(c) The Review Panel determination is a recommendation to the Board, which shall then make a final decision. Within thirty (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 Hearing 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 thirty (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 themself 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.

ARTICLE XVI

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 to hold office as Chief of Staff and Assistant Chief of Staff. 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 Chair 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 their term of office, such member may serve the remainder of their term of office, but may not be re-elected unless and until Active Attending status is restored.

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

(d) The term of office for all other officers of the Medical Staff shall be one (1) 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. A candidate must obtain a majority vote to be elected.

(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 (MEC) may be effectuated by a two-thirds (2/3) vote of the entire Medical Executive Committee (MEC), 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 Medical Executive (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 its 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 Medical 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 Chairman of all clinical Departments or Section Chief (except as otherwise provided herein), and appoint the members of all committees except as otherwise set forth in Article XVIII below. The Chief of Staff shall also call all special meetings. The Chief of Staff shall be an ex officio member of all Medical Staff committees. The Chief of Staff shall present the views, policies, needs, and grievances of the Medical Staff to the Board and to the President. The Chief of Staff 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. The Chief of Staff 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 Conflict of Interest 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 Conflict of Interest Disclosure Form to the Chairman of the Medical Executive Committee (MEC), the President of the Hospital, and the Chairman of the Hospital's Board, each of whom shall,

within five (5) business days of receipt, notify the Medical Staff office of any concerns regarding conflicts of 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 *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 Medical Executive Committee (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 Patient Safety and Clinical Quality 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 shall be subject to the Hospital's Conflict of Interest Policy that applies to all members of the Board, 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 (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 XVII

CLINICAL DEPARTMENTS

SECTION 1: LIST OF DEPARTMENTS

The Departments of the Medical Staff shall be as follows:

(a) Department of Anesthesiology & Perioperative Medicine
(b) Department of Emergency Medicine
(c) Department of Radiology
(d) Department of Medicine
(e) Department of Obstetrics & Gynecology
(f) Department of Orthopedics
(g) Department of Pathology
(h) Department of Pediatrics
(i) Department of Psychiatry
(j) Department of Surgery
(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 Chairman 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 Chairs and Section Chief 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 CHAIRS AND SECTION CHIEFS

(a) The Directors of the Clinical Departments and Section Chiefs of the Medical Staff shall be board certified in their specialty. They shall be appointed annually by the MEC after receiving the recommendation of the Chief of Staff. Before making such appointments, the Assistant Chief of Staff, the CMO, and the President of the Hospital shall be consulted. Additionally, the evaluations outlined in subparagraph (b) below shall be considered. The Department Chairs and Section Chiefs 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 Chair and Section Chief by the Chief of Staff, who

shall give due consideration to the opinions of the physician members of each Department concerning their Department Chair'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 Department Chair'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 Chiefs shall have the same qualifications in their respective specialties as Department Chairs. In addition, they shall be appointed and reappointed in the same manner and have the same, and parallel responsibilities the Department Chair has for their Department, in their respective Section. They shall report to their Department Chair.

(d) Each Department Chair and Section Chief shall designate one or more individuals who shall serve in the capacity of the Department Chair or Section Chief, respectively, in the event of their absence or unavailability, provided that the Chief of Staff shall have the right to approve all such designees. In the event any Department Chair or Section Chief 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 Chair or Section Chief shall be authorized to carry out all responsibilities of the Department Chair or Section Chief during the Department Chair's or Section's Head's absence or unavailability, except that said individual(s) shall not vote or count towards a quorum at Medical Executive Committee (MEC) meetings. With the approval of the Medical Executive Committee (MEC) Chair, the individual may attend Medical Executive (MEC) meetings as a guest.

(e) Department Chairs, Section Chief, 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 CHAIRS

Each Department Chair shall be accountable to the Medical Executive Committee (MEC) for all professional activities and for performance improvement within their Department. Each Department Chair shall make specific recommendations and suggestions regarding their 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 their Department, and shall report continually and at the time of reappointment to the Credentials Committee as to such Medical Staff members. Each Department Chair shall be responsible for implementation of the Hospital Bylaws, and of the Medical Staff Bylaws, Rules and Regulations within their Department. Each Department Chair shall be responsible for implementation within their Department of actions taken by the Medical Executive Committee (MEC). Each Department Chair shall transmit to the Credentials Committee their recommendations concerning Medical Staff classifications and re-appointment and delineation of the Clinical Privileges of members of their Department. Each Department Chair 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. Each Department Chair shall be responsible for the teaching, education and research programs in their Department. Each Department Chair shall assist in the preparation of such periodic reports (including budgetary planning) pertaining to their 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 Chair 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 Affiliated Health Care Professionals and who provide patient care services; (12) the continuous assessment and 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 Chair 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 such member 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 Chairman 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 Chair 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 XVIII

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 MEC after receiving the recommendation of 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 XVIII, 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 the 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 committee 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. There shall be no limit to how many terms may be served by members of Medical Staff committees.

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

(b) After receiving the recommendation of the Chief of Staff, the MEC shall appoint the Chairman of all committees other than as set forth in this Article XVIII. 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 CMO 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 Medical 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 (3) 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 Chair of the Credentials Committee, the Director of Hospitalist Medicine, the President, the CMO, 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 Chairmen ex officio of all eleven (11) Hospital clinical Departments (i.e., Anesthesiology & Perioperative Medicine; Emergency Medicine; Medicine; Obstetrics & Gynecology; Orthopaedics; Pathology; Pediatrics; Psychiatry; Radiation Oncology; 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, and the Chief Nursing Officer of the 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 (3) year term, may serve two (2) consecutive three (3) year terms, and shall not be eligible for re-election until the lapse of three (3) years from the conclusion of their second three (3) year term.

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

(4) The members of the Medical Executive 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 (3) months after the vacancy occurs, by regular election by the Medical Staff. If the tenure of the successor is for one year or less, such successor 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 XVII, Section 1 concerning election of officers.

(6) In the event that a Department Chair is elected to serve as Chief of Staff, Assistant Chief of Staff, Secretary of the Medical Staff, Treasurer of the Medical Staff, Chairman of the MEC, the Chairman of the Credentials Committee, or the Director of the Hospitalist Program, during such Department Chair's term, the Department Chair may serve both roles within the MEC simultaneously without having to vacate either position and without a vacancy being created. Despite serving the MEC in dual capacities, any such individual shall only count as one individual for quorum and shall have only one vote in all matters requiring votes of the MEC.

(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 (3) 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 Medical Executive 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 Medical Staff 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 Medical Staff that comes before the Medical 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 themself from the meeting during that time, although they 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 ten (10) days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in their own behalf prior to the taking of any vote on their 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 Medical 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.

(3) Attendance at Medical Executive Committee (MEC) meetings is not assignable for voting purposes. Proxy voting is not allowed. A substitute may, with the approval of the Chair, attend a meeting but may not vote and will not count towards a quorum.

SECTION 3: CREDENTIALS COMMITTEE

(a) Credentials Committee – Composition

(1) The Credentials Committee shall consist of the following voting members: President, the CMO, 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 (3) 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 Medical Staff that comes

before the Credentials Committee, that member shall neither participate in the discussion nor vote on the matter and shall absent themself from the meeting during that time, although they may be asked and may answer any questions concerning the matter before leaving.

(d) 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 MEC (after receiving the recommendation of 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, CMO, 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.

(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).

SECTION 5: PROFESSIONAL PRACTICE EVALUATION COMMITTEE

(a) Composition.
A Chair of this Committee who will be a member of the Medical Staff appointed by the MEC (after receiving the recommendation of the Chief of Staff), Chief of Staff, Assistant Chief of Staff, Chief Medical Officer, and other members appointed by the MEC (after receiving the recommendation of the Chief of Staff).

(1) Ad hoc advisors - Previous Chief of Staff, Legal & Risk Services representative, and YNHHS Exec Director of Medical Staff Services.

(b) Duties. The duties of the Professional Practice Evaluation Committee shall include:

(1) oversee the gathering and analysis of data and information among clinical departments of Hospital and the committees of the Medical Staff for purposes of: evaluating and improving the quality of health care services ordered or delivered by health care professionals; studying and reducing morbidity and mortality; conducting medical audits; considering the appropriate utilization of institutional resources; and analyzing clinical practices. In some circumstances, malpractice claims review may also be conducted;
(2) receive reports from Medical Staff committees and sub-committees and Hospital departments, services, and sections conducting peer review;
(3) designate and appoint members or other Hospital personnel to evaluate and conduct root cause analyses as the Committee specifically authorizes or directs, including, but not limited to serious safety events and other significant unanticipated outcomes at the Hospital, reports the results of these activities to the Committee;
(4) designate the Chief Medical Officer to act between meetings to address issues of immediate concern having to do with Medical and Affiliated Medical Staff including, but not limited to, general competence;
(5) facilitate mechanisms for correction of problems identified;
(6) assist the Hospital in maintaining compliance with the requirement of The Joint Commission;
(7) report to the Medical Executive Committee and the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding institutional concerns related to patient safety and practitioner performance;
(8) refer issues, as applicable, having to do with qualifications for credentialing and privileging to the Credentials Committee for deliberation; and
(9) communicate accordingly with, and involve individuals whose practice, or aspects of practice, are under review as well as with the applicable Chair or Section Chief.

Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17h(a)(2) and shall be kept in strict confidence. The Committee shall carry out such additional quality improvement activities as it deems appropriate. Reports as needed to the Medical Executive Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

(c) Meetings: Monthly.

SECTION 6: MEDICAL STAFF PROFESSIONALISM COMMITTEE

(a) Composition.

A Chair of this Committee who will be a member of the Medical Staff appointed by the MEC (after receiving the recommendation of the Chief of Staff), Chief of Staff, Assistant

Chief of Staff, Chairman of MEC, Chief Medical Officer, and other members appointed by the MEC (after receiving the recommendation of the Chief of Staff).

Ad hoc advisors - Previous Chief of Staff, Legal & Risk Services representative, and YNHHS Exec Director of Medical Staff Services.

(b) Duties:

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

Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17h(a)(2) and shall be kept in strict confidence. The Committee shall carry out such additional quality improvement activities as it deems appropriate. Reports as needed to the Medical Executive Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees

Meetings: Monthly.

SECTION 7: MEDICAL STAFF HEALTH COMMITTEE

(a) Composition.
The Chief of Staff, Assistant Chief of Staff, CMO, the Chair of the MEC, and the relevant Department Chair. Other Hospital staff may participate ex officio as appropriate.

(b) Duties:
(1) To establish and maintain a mechanism for educating Medical Staff and trainees to recognize the signs and symptoms of potential or actual health impairment among colleagues;
(2) to assist in identifying such potential or actual health impairment;
(3) to implement Medical Staff policy when incidents of actual or potential health impairment require evaluation; and

(4) to make recommendations to the Medical Executive Committee regarding Medical Staff Health policy changes and report as needed.

Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17h(a)(2) and shall be kept in strict confidence. The Committee shall carry out such additional quality improvement activities as it deems appropriate. Reports as needed to the Medical Executive Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees

(c) Meetings: Meets as needed.

ARTICLE XIX

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 they deem 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 Medical 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 encouraged 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

Regularly scheduled, informational Medical Staff meetings with no agenda items requiring vote may be called to order by the Chief of Staff without any regard to a quorum. The annual meeting of the Medical Staff at which elections occur with respect to which a quorum shall consist of fifteen percent (15%) of the membership of the Active Attending Medical Staff. This quorum may be adjusted by the Medical Executive Committee (MEC) in accordance with the size of the available Medical Staff. A majority vote of the Active Attending Staff members present is required to pass any motion. Members may be present in person or by an electronic or other remote method acceptable to the MEC. 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.

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 XX

CONFIDENTIALITY

(a) Subject to paragraphs (b) and (c) below, any member of the Medical Staff may review information concerning them 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 CMO. 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. All Practitioner File reviews shall be governed by the terms of the Yale New Haven Health Policy and Procedure entitled, "Applicant/Members Access to Files & Correction of Information/Hospital Networks.\

(b) 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 Medical Executive Committee (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.

(c) 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 CMO or President of the Hospital.

(d) Following a member's review of their Practitioner File requested pursuant to the Yale New Haven Health Policy & Procedure entitles, "Applicant/Members Access to Files & Correction of Information/Hospital Networks, 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 CMO, 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 CMO).

(e) Disputes. Should any dispute arise over access to information, the dispute shall be resolved by the CMO 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 hearing or appeal.

ARTICLE XXI

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 Article.

(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 (MEC), 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 fourteen (14) days prior to the vote by the Medical Executive Committee (MEC). Any member of the Active Attending Staff may submit written comments on the amendments to the Medical Executive Committee (MEC).

(4) The Medical Executive Committee (MEC) 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 fourteen (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 CMO 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 CMO prior to becoming effective. Before submission of any such proposed amendment to the CMO for approval, the Medical Executive Committee (MEC) must review the proposed amendment and may make a recommendation to the CMO 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 CMO 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 Medical Executive Committee (MEC) Chair shall be present at the meeting; if the issue concerns policies and procedures, the Medical Executive (MEC) Chair and the CMO 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 CMO 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 Article 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 XXII

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 (MEC) as per Article XVIII, 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 (30) 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 XXIII. 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 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 (2) 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

_____ _____

Chief of Staff Secretary of the Medical Staff

Approved by the Boards on _____

_____

Secretary, Board

Effective:

RULES AND REGULATIONS

of the

GREENWICH HOSPITAL

for the

MEDICAL STAFF

Effective March 29, 2018

MEC Approved: ***March 8, 2018***

Board of Trustees Approved: ***March 29, 2018***

TABLE OF CONTENTS

GREENWICH HOSPITAL

Rules and Regulations

for the Medical Staff

ACCEPTANCE OF PATIENTS

Rule No. 1 Acceptance of Patients

The Hospital shall accept for care patients suffering from all types of disease dependent only upon available facilities and personnel.

STAFF PRIVILEGES

Rule No. 2 Patient Care Privileges and Physician of Record

Only physicians, dentists[1] and podiatrists who have been duly appointed to membership on the Medical Staff by the Board of Trustees, hold admitting privileges to care for patients in the Hospital, and who are in good standing, are eligible to act as the Physician of

[1] The term dentist as used in these Rules and Regulations shall be as defined in the Medical Staff Bylaws.

Record for patients within the Hospital. The Physician of Record is the physician primarily responsible for the management of a patient's care within the Hospital.[2]

Rule No. 3 Call Coverage and Clinic Duties

Each Department Director or Section Head is responsible for providing physician coverage sufficient to meet patient care needs in the Hospital's Emergency Department, inpatient units and clinics. The Department Director and Section Head will assign members of his/her Active and, if appropriate, Affiliate Staff to provide full coverage.

It is the expectation of the Medical Executive Committee (MEC) that call coverage schedules be fair and justified by patient care needs. The MEC would expect all members of both Staff categories, Active and Affiliate, be fairly treated within each category and commensurate with member privileges.

In the event the Department Director or Section Head is unable to provide physician coverage sufficient to meet patient care needs, the Department Director or Section Head shall bring the matter to the MEC for adjudication. In addition, Affiliate and Active Staff Members shall have the right to appeal coverage arrangements of their Department or Section to the Medical Executive Committee. The MEC will determine whether the contested coverage arrangement is or is not fair, appropriate or sufficient to meet patient care needs in the Emergency Department, inpatient units and clinics.

If the MEC determines that a coverage arrangement is either unfair or inappropriate, the MEC shall establish an alternative coverage arrangement in the Department or Section at issue. The determination of the MEC shall be binding on all members of that Department or Section, subject to Board review and final approval if requested by either the MEC, relevant Department Director or Section Head, President, Sr. VP of Medical Services, or any affected member of the Medical Staff.

If the MEC determines that a coverage arrangement is insufficient to meet patient care needs, the MEC shall recommend to the Board an alternative coverage arrangement or other

[2] The term Physician of Record is used to refer both to the Physician of Record as well as to his/her designees, including qualified covering physicians, all of whom shall be physician or oral surgeon members of the Medical Staff.

solution to address the insufficiency. The Board shall consider the recommendation of the MEC, and shall establish the coverage arrangement in the Department or Section at issue.

The Hospital's Board of Trustees shall have ultimate authority to review and determine whether coverage arrangements in any Department or Section are fair, appropriate and sufficient to meet patient care needs in the Emergency Department, inpatient units and clinics. Prior to making any determination concerning coverage arrangements, the Board shall in all instances request and consider any recommendations of the MEC.

Rule No. 4 Limitations of Professional Privileges

All Members of the Medical Staff shall function within the scope of their approved delineated clinical privileges, with the understanding that it may not be safe or clinically appropriate to exercise all privileges in all Hospital sites or locations. Notwithstanding this general rule, in an emergency, a member of the Medical Staff or Allied Health Care Professionals Staff may perform any medical or surgical procedure permitted by their respective training and experience and Connecticut license.

In the event of a formally declared Hospital emergency, members of the Medical Staff or Allied Health Care Professionals Staff may be asked by the Chief of Staff or their designee to assist at the Hospital in a role atypical for his/her usual practice. In such cases and for the duration of the assignment, members of the medical staff and Allied Health Care Professionals Staff shall be accountable directly to the Chief of Staff or their designee.

Requests for changes or additions to the current privilege delineation form(s) shall be made by or delivered to the Medical Staff Office. Modification of a delineation form must be reviewed by the relevant Department Director, Section Head or designee. Modifications will be approved by the Credentials Committee, Medical Executive Committee and Board of Trustees. A member of the Medical Staff requesting an additional privilege must apply for that privilege and must be credentialed through the normal credentialing process.

Rule No. 5 Privileges of Allied Health Care Professionals

Individuals appointed to the Allied Health Care Professionals Staff shall participate in the management of patients in accordance with the Hospital's Policy concerning Allied Health

Staff. Delineation of specific activities of Allied Health Care Professionals shall be recommended by the Department Director or Section Head and shall be subject to approval through the credentialing process.

Rule No. 6 Reporting Requirements

All members of the Medical Staff shall report immediately to the Sr. VP of Medical Services and Chief of Staff the following: (a) loss (other than for routine non-renewal), suspension or any other action (including censure, reprimand and/or fine) taken regarding a professional license in Connecticut or any other state; (b) loss (other than for routine non-renewal), suspension or any other action taken with regard to state or federal authority to prescribe controlled substances; (c) loss (other than routine non-renewal), suspension or limitation (other than routine surrender of unused clinical privilege) of clinical privileges at another health care facility; (d) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and (e) the filing of any criminal charge by state or federal authorities (other than a minor motor vehicle accident). These reporting requirements are in addition to the information that is collected at the time of initial credentialing and at recredentialing.

ADMISSION AND DISCHARGE OF PATIENTS

Rule No. 7 Admitting Principles

No patient shall be admitted to the Hospital unless a provisional diagnosis has been stated.

Rule No. 8 Protection of Patients

The member of the Medical Staff who admits a patient shall give to appropriate Hospital personnel such information concerning their patients as may be required to enable the Hospital to protect the patient and other patients from possible sources of danger. Every member of the Medical Staff must have a coverage arrangement that assures continuity of care for their patients. This should be affected by means of an agreement with another appropriately credentialed member of the Medical Staff. Other coverage arrangements will require Departmental approval.

Rule No. 9 Patient-Doctor Assignment

A patient who does not request a specific doctor shall be assigned to an appropriate member of the Medical Staff to serve as the Physician of Record. Requested doctors shall be assigned if available. Assignment of a Physician of Record shall be based on the call coverage schedule.

All patients admitted for dental services shall be assigned to the Section of Oral Surgery of the Department of Surgery. In addition to the dental history and examination recorded by the dentist, a history and physical examination pertinent to the admission must be performed and recorded by a physician member of the Medical Staff or by a dentist member of the Medical Staff who is legally authorized and holds clinical privileges to do so, who shall serve as the Physician of Record.

INPATIENT CARE

Rule No. 10 Patient-Doctor Relationship

Within 24 hours of a patient's admission or transfer to the inpatient service, the Physician of Record shall personally examine the patient, establish a personal and identifiable relationship with the patient if such was not established prior to the admission or transfer, and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment. The Physician of Record is responsible for continuing evaluation of the care of the patient and plans for treatment. The Physician of Record is responsible for ensuring communication to the patient of the treatment plan and realistic goals of care, as well as subsequent communication about significant variances from expected outcomes that occur during medical treatment or surgery.

Rule No. 11 Medical Students

Appropriately prepared medical students are permitted to function within the facility. Medical students always function under supervision, but the supervision need not necessarily be in-person. The type and intensity of supervision required is determined by responsible Medical staff, including house staff.

Medical students may participate with the patient care team in rendering clinical care, may perform a history and physical examination and may enter progress notes in the patient hospital record. Such history and physical examinations and progress notes shall not be considered authentic unless they are validated by a qualified member of the Medical Staff. Patient care orders may be entered in the medical record by medical students but remain in suspension until signed by an authorized prescriber. Medical students are not responsible for, among other things, obtaining informed consent for procedures or surgery or disclosing

adverse events or unanticipated outcomes to patients or family. Medical students may not dictate operative reports or discharge summaries, nor may they enter limitation of treatment orders or restraint orders.

Rule No. 12 House Staff

For purposes of these Rules and Regulations, "house staff" refers to medical school graduates in a post-graduate medical education training program (e.g., PGY-1, -2, etc.). House staff are not members of the Hospital's Medical Staff.

When house staff are assigned to care for a particular patient in the Hospital, a member of the Medical Staff in the Department of Medicine shall be designated to supervise the performance and delivery of care by the house staff. All such supervision shall be in accordance with Medical Staff and departmental policies. Types of supervision can include, but are not limited to, in person, electronic or telephonic supervision, review of documentation, and submission and review of performance evaluations. In general, the designated member of the Department of Medicine will determine the nature of the required supervision, based on the complexity of the patient care situation, the level of training and experience possessed by the resident, and departmental guidelines concerning graded resident responsibility and resident supervision.

Consistent with other Medical Staff Rules, the house staff may enter in the medical record all types of diagnostic and treatment orders for patients, except as otherwise set forth in Hospital or Medical Staff Policies and Procedures and in these Rules and Regulations. House staff may not enter orders for oncology chemotherapy. Orders to withhold or withdraw life support systems and do not resuscitate orders (DNR) may be entered by house staff, but such orders may not be implemented until counter-signed by the Physician of Record, and in the case of DNR orders, the Physician of Record must countersign within 24 hours.

Rule No. 13 Consultations

It is the duty of all members of the Medical Staff and house staff to request consultants as needed. Consultants shall be contacted directly by the requesting practitioner and shall convey the reason for the consult and urgency of the response. Such consultants should be qualified to give an opinion in their respective fields.

Consultation notes must be entered directly into the Hospital's computerized electronic medical record system. A brief note or other direct communication from the consultant to the requesting practitioner may be entered at the time of consultation, provided that a complete note be entered within twenty-four hours of a consultation. If documentation of a consultation is provided by a member of the house staff, the entry must be reviewed, edited if necessary, and electronically counter-signed within twenty-four hours by the physician designated with supervisory responsibility. The consulting physician will define the frequency

of follow-up, if any, and continue to document findings and recommendations until signing off the case.

In the event that a consultation results in the immediate performance of an operative procedure by the same physician, the consultation and operative reports may be combined and must be dictated immediately after the procedure. (See Rule #24)

Rule No. 14 Informed Consent

The Hospital's Consent for Procedures and Treatment Policy (YNHHS Policy #__) shall be followed in all respects.

Rule No. 15 Tissue Removed at Operation

Tissue, and all foreign bodies including implants, removed at operation shall be sent to the Hospital pathologist who shall make such examination as may be considered necessary to arrive at a pathological diagnosis. A pathology report of the findings shall be prepared and signed by the pathologist. Pathology department policy may exempt certain tissues from submission; however, under no circumstances may the entire surgical specimen be delivered to any outside agency.

In all instances where a patient's medical, surgical, oncologic, invasive radiological, or therapeutic radiologic course is based on a histological or cytologic examination performed in another institution, the Physician of Record is expected to make arrangement for a timely review of such specimens in the Hospital prior to the commencement of the therapy planned. If emergency therapy is indicated, pathologic review should be obtained as soon as feasible thereafter.

Rule No. 16 Treatment and Patient Care Orders

As a condition of appointment to the Medical Staff with Clinical Privileges, all members of the medical staff shall be trained in the use of the Hospital's electronic medical record.

All orders for inpatient care and treatment shall be entered in the electronic medical record.

Initial admission diagnostic and treatment orders may be entered by the Physician of Record, podiatrist or dentist, or may be entered by house staff, a PA or nurse practitioner as appropriate. Orders shall be entered only with the approval or under the supervision of the Physician of Record. Once services are requested of a Hospital-contracted Department whose members may not otherwise have admitting privileges, providers in that Department may enter orders relevant to the services requested. Orders not entered by the Physician of Record shall be regularly reviewed by the Physician of Record.

The physician who orders diagnostic tests or procedures, or the physician covering for the ordering physician, is responsible for appropriate follow-up.

In an emergency, verbal orders may be dictated by a physician or a dentist to a registered nurse, dietitian, pharmacist, or respiratory therapist.

All orders must be signed electronically within 24 hours by the prescriber or another physician directly responsible for the patient's care.

Orders for restraints or seclusion must be entered by a member of the Hospital's Medical Staff, House Staff, or other independent licensed clinician permitted by law and by their scope of clinical privileges to provide patient care services without direction or supervision. The Physician of Record, if not the ordering physician, must be notified as soon as possible after an order for restraints or seclusion has been entered. These orders shall be time-limited in accordance with Policy #PCII-44.

Orders for withholding or withdrawing life support systems and DNR must be entered by the Physician of Record. See Rule 12 for special rules concerning house staff with respect to orders for withholding, withdrawing and DNR.

At the time a patient is transferred from recovery room, critical care area, or from one service to another, the patient's transferring physician shall review all of the patient's current orders and shall write or discontinue orders as appropriate.

All Schedule II controlled drugs shall be renewed or discontinued after 7 days.

DISCHARGES

Rule No. 17 Discharges

The decision to discharge a patient is up to the Physician of Record. The Physician of Record is responsible for reconciliation of the patient's discharge medications and for the content of the clinical resume and other appropriate forms as required.

The Physician of Record shall be obligated to communicate to a referring doctor all appropriate medical information, and shall provide the same information on approved forms to any institution or agency to which a patient is referred following discharge from the Hospital. In those instances in which a patient is to be transferred directly from the Hospital to another institution, the patient will not be permitted to leave the Hospital until the transfer information, including a printed Discharge Summary, has been completed.

Whenever possible and appropriate, a responsible physician should be identified who will provide follow-up care for each patient discharged from the Hospital. The follow-up physician will be informed of the course of the patient's hospitalization, the patient's discharge date, medications, and need for continuing care via the discharge summary or other means of communication if and as appropriate.

It is the responsibility of the Physician of Record to plan discharge in a timely fashion. The discharge date must be coordinated with the house staff (when appropriate), nursing staff and case management staff. The nursing and case management staff as well as the patient and patient's family, need to be informed of the anticipated discharge date as soon as possible. Patients and their families should be notified on the day prior to discharge of the scheduled discharge time, if possible, so that transportation and support services can be arranged.

OPERATIVE/INVASIVE PROCEDURES

PRE- AND POST-OPERATIVE EVALUATIONS

Rule No. 18 Pre-Procedure Protocol

The Physician of Record, proceduralist, or their designee (which may include residents in training or other licensed independent practitioners with knowledge of the invasive procedure or treatment), will document in the medical record, as appropriate: (i) the provisional diagnosis and the results of any indicated diagnostic tests; (ii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the procedural area, except in emergencies. In addition, a properly executed informed consent will be documented in the medical record in accordance with the Consent for Procedures and Treatment Policy.

The following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

(a) the proceduralist is in the Hospital;

(b) the procedure site is marked, as applicable; and

(c) a "time out" is conducted immediately before starting the procedure, as described in the YNHHS Universal Protocol for Surgical / Invasive Procedures Policy.

Rule No. 19 Post-Procedure Protocol

An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include, specimens sent to pathology in addition to specimens removed.

(a) the patient's name and hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient's operation;

(e) procedure(s) performed and description of the procedure(s);

(f) findings;

(g) estimated blood loss;

(h) any unusual events or complications, including blood transfusion reactions and the management of those events;

(i) the type of anesthesia/sedation used;

(j) specimen(s) removed, if any; and

(k) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

In addition to a dictated report, a brief operative note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the surgeon. The note must record:

(a) the names of the physician(s) responsible for the patient's care and physician assistants;

(b) procedure(s) performed;

(c) findings;

(d) estimated blood loss, when applicable or significant;

(e) specimens removed;

(f) complications; and

(g) post-operative diagnosis.

ANESTHESIA SERVICES

PRE-, DURING AND POST-ANESTHESIA EVALUATIONS

Rule No. 20 Anesthesia Services - Pre-Anesthesia Procedures

A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours prior to an inpatient or outpatient procedure requiring anesthesia services.

The evaluation will be recorded in the medical record and will include:

(a) a review of the medical history, including anesthesia, drug and allergy history;

(b) an interview and examination of the patient;

(c) notation of any anesthesia risks;

(d) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

(e) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and

(f) any additional pre-anesthesia evaluations that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

Rule No. 21 Anesthesia Services - Monitoring During Procedure Involving Anesthesia

All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(a) the name and Hospital identification number of the patient;

(b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

(c) the name, dosage, route time, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions or problems occurring during anesthesia and the patient's status upon leaving the operating room.

Rule No. 22 Anesthesia Services - Post-Anesthesia Evaluations

A post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area, including a patient room. The evaluation can occur in the PACU/ICU or other designated recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge or by a follow up phone call if the patient has already been discharged.

The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(a) respiratory function;

(b) cardiovascular function;

(c) mental status;

(d) temperature;

(e) nausea and vomiting; and

(f) post-operative hydrations.

The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible given the patient's medical condition.

Patients will be discharged from the recovery area by a qualified practitioner or according to criteria approved by the clinical leaders. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

When anesthesia services are performed on an outpatient basis, the patient will be provided with printed instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

MEDICAL RECORDS

Rule No. 23 Medical Records — Preparation

Every member of the Medical Staff shall be required to document in the electronic medical record system all patient care and treatment rendered within the Hospital, including any Hospital inpatient and outpatient setting.

Medical History & Physical Examination Requirements

A medical history and physical (H&P) examination must be completed for the following:

(1) all inpatient admissions;

(2) outpatients receiving ongoing primary care; and

(3) any outpatient or inpatient undergoing a surgical or invasive procedure involving sedation or anesthesia

a) "Complete H&P": inpatients and outpatients (non invasive procedure/non-surgical) (excludes "c" below)

History shall include the following:

- presenting symptoms or indication for admission or outpatient services;
- past medical and surgical history (if nursing assessment needs supplementation);
- problem pertinent review of systems;
- allergies;
- current medications

Physical shall include age and condition-appropriate examination and documentation of the following:

- vital signs;
- skin
- head and neck
- heart and lung
- abdomen (including genital and rectal, if indicated);
- neurologic and mental status
- extremities (including vessels).

Relevant results of diagnostic tests, diagnostic assessment and plan for care shall also be reviewed and considered.

b) "Surgical / Invasive Procedure H&P":

Patients undergoing a surgical or invasive procedure involving sedation or anesthesia
History shall include the following (excludes "c" below):

- Indications for and history relevant to the procedure;
- pre-operative diagnosis(es);
- complete past medical history;
- pertinent review of systems;
- current medications;
- allergies

Physical shall include age and condition-appropriate examination and documentation of the following:

- vital signs;
- heart and lung
- exam of body areas relevant to procedures and necessary to safely perform the procedure and planned sedation/anesthesia;

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

These medications/infusions may include, but are not limited to, the following:

blood transfusion, chemotherapy, apheresis, remicaid, biphosphanates and other therapeutic infusions.

For procedures that do not involve sedation or anesthesia, the correct diagnosis and procedure must be documented and a consent obtained but neither a "Complete" nor a "Surgical / Invasive Procedure" H&P is required.

All patient orders within the Hospital shall be entered through the electronic medical record system.

For all inpatients, the Physician of Record is obligated at a minimum:

i. At the time of transfer to the care of another Physician of Record, indicate in a note the identity of the new responsible practitioner. In addition, a physician accepting transfer of a patient must change the Physician of Record designation in the Hospital's clinical information system.

ii. Ensure that a daily progress note has been entered by a member of the Medical Staff, Allied Health Professional Staff, or house staff. The Physician of Record must enter progress notes with a frequency that reflects appropriate involvement based on the patient's medical condition.

iii. Dictate or cause to be produced as soon as possible after discharge, (but no later than 72 hours), and sign or countersign upon receipt a Discharge Summary for each patient discharged from the Hospital:

1) Normal delivery of term pregnancy, with or without outlet forceps, providing that the ante partum and postpartum courses were completely uncomplicated.

2) Normal newborn, including both those not requiring admission to the Newborn Intensive Care Unit and those admitted to the Newborn Intensive Care Unit for 48 hours or less for observation only.

For the above listed exceptions, complete and sign, or cause to be completed and countersign, an appropriate discharge note.

House staff under supervision (see Rule #12) may record appropriate progress notes in the record.

For patients with a primary discharge diagnosis of a neoplastic disease, physicians must indicate the clinical or pathological (if available) TNM staging (or equivalent) in the medical record. This applies to both inpatients and ambulatory surgery patients.

All practitioners shall comply with Hospital Health Information Management Policies and Procedures governing medical record content requirements.

Rule No. 24 Medical Records –Electronic Medical Record

Every member of the Medical Staff with Clinical Privileges shall participate in electronic medical record mandatory training and certification requirements as a condition of appointment with Clinical Privileges. Newly appointed members of the Medical Staff with Clinical Privileges shall be trained and certified in the Hospital's electronic medical record prior to exercising clinical privileges in the Hospital.

Rule No. 25 Medical Records – Completion

The Hospital's Medical Record Completion Policy (YNHHS Policy #__) shall be followed in all respects.

Rule No. 26 Medical Records – Removal

Printed medical records shall not be removed from the Hospital except with the approval of the Health Information Management Department or Hospital counsel pursuant to proper authorization, court order, subpoena or other lawful means to allow disclosure. Handling of all other Hospital patient electronic medical records and protected health information shall be in accordance with Hospital policies and procedures.

GENERAL RULES AND REGULATIONS

Rule No. 27 Confidentiality

Pursuant to state and federal law, including HIPAA, and Hospital policy, all medical records and patient-specific information, records of peer review and morbidity and mortality review proceedings, risk management material including incident reports, medical staff credentialing records and files, minutes of Medical Staff and Hospital meetings, and other confidential Hospital and Medical Staff records, data, and information, are the property of the Hospital and may not be used for purposes other than patient care, peer review, risk management, approved research, education, and other proper Hospital and Medical Staff functions. Such records, materials, files, minutes, and other confidential information (referred to below collectively as "confidential materials") may not be removed from the Hospital, duplicated, transmitted, or otherwise disclosed to parties outside of the Hospital without proper authorization in accordance with Hospital and Medical Staff policies or specific requirements of law.

Access to confidential materials by members of the Medical and other Staffs of the Hospital, Hospital employees, and others, is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or some other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and therefore applies equally to information stored in hard copy form or electronically stored.

Sharing of and/or misuse of passwords or access to electronic systems that contain patient and/or other confidential material is prohibited. Medical staff privilege suspensions will be reported as required to the Connecticut licensing board(s) and/or the National Practitioner Data Bank.

In addition to the measures set forth in the above paragraph, any member of the Medical Staff who misuses, has improper access to, or alters, removes, or improperly uses confidential materials, is subject to appropriate disciplinary action or proceedings.

Rule No. 28 Peer Review Materials; Studies of Morbidity and Mortality; the Protection of Documents

In Connecticut, Peer Review is the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review. Both Peer Review and morbidity and mortality reviews are granted protections as long as the statutory criteria are met. Wherever possible, materials produced for or generated in these reviews should be clearly identified as peer review or M & M reviews, and circulation of these documents should be limited to that necessary to accomplish the necessary peer or morbidity and mortality reviews.

Rule No. 29 Protective Clothing – Operation Areas

All persons who enter the semi-restricted and restricted areas of the surgical or other appropriate operative or treatment areas shall wear approved, clean scrubs and cover head and facial hair. A surgical mask must be worn in restricted areas where open sterile items and equipment are in use. Additional protective attire shall be worn when exposure to blood or potentially infectious material is reasonably anticipated.

Rule No. 30 Autopsies

Every member of the Medical Staff is expected to consider the appropriateness of an autopsy and, if so, shall request permission from an authorized representative unless the patient or family has previously declined permission.

Rule No. 31 Departmental Rules

Members of the Medical Staff should refer to departmental rules and regulations for specific items pertaining to their respective departments. Where departmental and Medical Staff Rules appear inconsistent, Medical Staff Rules will supercede departmental rules.

Rule No. 32 Clinical Research

Research involving human subjects shall be conducted so as to assure that the welfare, health and safety of the subjects are paramount. Prior approval must be obtained from the Institutional Review Board (IRB). Rights, including the right of privacy, shall be preserved, and an informed consent shall be obtained from the patient or the patient's authorized representative in accordance with IRB rules.

Rule No. 33 Responsibilities for Infection Prevention/Standard Precautions and Transmission Based Precautions

Members of the Medical Staff will comply with infection prevention policies, including but not limited to the Medical Staff policy regarding hand hygiene and isolation precautions. Routine hand hygiene is to be performed before and after any patient contact. Standard precautions are to be used in the care of all patients. The responsible physician, nurse and/or hospital Infection Control Officer or a designee is to determine the need for additional transmission based precautions. Orders for such precautions are to be entered into the applicable order-entry system and a note will be placed in the patient's chart delineating the reasons for initiating precautions. The Infection Control Committee, as authorized by the Medical Executive Committee, shall determine the initiation and/or discontinuation of transmission based precautions.

Rule No. 34 Revision Procedure

These Rules and Regulations may be amended in the manner set forth in the Medical Staff Bylaws.