

BYLAWS OF THE MEDICAL STAFF

Stamford, Connecticut



Carol Fucigna, MD
President, Medical Staff



Kathleen A. Silard, RN
President & CEO



Mark DeWaele, D.M.D.
Chairman, Board of Directors

APPROVED BY:

MEC 08/31/2009, 01/03/2011, 06/03/2013, 9/8/15, 9/5/16, 10/4/16, 9/12/2018, 1/6/2020
Medical Staff 09/2009, 03/2011, 07/01/2013, 9/25/15, 10/27/16, 9/27/2018, 1/24/2020
Board of Trustees 09/23/2009, 05/18/2011, 07/24/2013, 11/19/15, 11/16/16, 9/26/2018, 1/29/2020

**STAMFORD HOSPITAL
MEDICAL STAFF BYLAWS**

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STAMFORD HOSPITAL

PREAMBLE

BECAUSE THE STAMFORD HOSPITAL is a non-profit corporation organized under the laws of the State of Connecticut; and

BECAUSE, it is recognized that the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of medical staff, the Chief Executive Officer and the Board of Directors are necessary to fulfill the hospital's obligations to its patients;

NOW THEREFORE, the physicians practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

BYLAWS OF THE MEDICAL STAFF

ARTICLE I

DEFINITIONS

- 1.1. The term "medical staff" means all physicians, surgeons, dentists and podiatrists appointed to a division of the medical staff in accordance with these bylaws.
- 1.2. The term "Board of Directors" means the governing body of the hospital as described in the bylaws of the hospital.
- 1.3. The term "Medical Executive Committee" means the governing body of the medical staff described in Article VIII of these bylaws.
- 1.4. The term "Chief Executive Officer" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the hospital (i.e., the administrator).
- 1.5. The term "practitioner" means an individual duly licensed to practice medicine, surgery, podiatry, dentistry, oral surgery and the ancillary staff.
- 1.6. The term "ancillary staff" means those health care professionals granted clinical privileges in accordance with Section 6.6 of these bylaws.
- 1.7. The term "house staff" means an intern, resident or fellow, who has graduated from an approved medical school, and is receiving education and providing clinical care under the direction of the Residency Program Director.
- 1.8. The "Chief Physician Executive" means "SVP of Medical Affairs" and "Chief Medical Officer", a member of the active medical staff, also a member of the hospital administration, reporting to the Chief Executive Officer, in accordance with section 9.8 of these bylaws.
- 1.9. The term "division" or "clinical division" means an organized specialty division of a department of the medical staff.

- 1.10. The term “s/he”, “him/her” or “his/her” as used herein means the masculine, feminine, or neuter gender as the context may require.
- 1.11. The term “primary care physician” means a practitioner whose practice is limited to family medicine, general internal medicine, or pediatrics.
- 1.12. The term “staff patient” means a patient who does not have a personal physician on the medical staff.
- 1.13. The term “hospital” includes Stamford Hospital and all other health care facilities operated by or affiliated with Stamford Health System, Inc.
- 1.14. The term “Organized Medical Staff” means all voting members of the Medical Staff.

ARTICLE II

NAME

- 2.1. The name of this organization shall be the STAMFORD HOSPITAL MEDICAL STAFF.

ARTICLE III

PURPOSES

- 3.1. The purposes of this organization are:
 - a.) To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive high quality medical care.
 - b.) To ensure a high level of professional performance of all practitioners authorized to practice in the hospital, through the appropriate exercise of professional judgment in the hospital, and through an ongoing review and evaluation of each practitioner's performance in the hospital.
 - c.) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous improvement in professional knowledge, and skill for the entire medical staff and ancillary personnel.
 - d.) To initiate and maintain rules and regulations for self-government of the medical staff.
 - e.) To provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the Board of Directors and the Chief Executive Officer.
 - f.) To encourage cooperation with other hospitals, educational institutions, medical schools, and health care facilities.
 - g.) To set forth the process by which practitioners can obtain Medical Staff membership and clinical privileges and fulfill their obligations and requirements associated with Medical Staff membership and clinical privileges.

ARTICLE IV
MEDICAL STAFF MEMBERSHIP

4.1. **GENERAL PRINCIPLES.**

- 4.1.1. **Staff Membership and/or clinical privileges:** Medical Staff membership and/or clinical privileges shall be extended only to professionally competent individuals who are duly licensed to practice medicine, surgery, podiatry, and/or oral surgery who meet the qualifications, standards and requirements set forth in these bylaws, and rules and regulations of the hospital and its medical staff, departments and clinical divisions.
- 4.1.2. **Uniform criteria:** The criteria specified in these bylaws for medical staff membership and/or clinical privileges shall be applied uniformly to all practitioners, and are designed to assure to the Board of Directors and medical staff that patients of the hospital will receive high quality medical care.
- 4.1.3. **Initial appointment:** Initial appointment to the medical staff and/or clinical privileges shall be contingent upon the hospital's ability to provide adequate facilities and supportive services for the applicant and his/her patients; the patient care needs for additional staff members with the applicant's skill and training; the applicant's ability to demonstrate skills in areas of identified need; and the applicant's ability to satisfy such additional criteria based on prior specialized training, experience or professional competence as may be approved from time to time by the Board of Directors.
- 4.1.4. **Dues.** On an annual basis, the Medical Executive Committee may set dues to be paid by members of the medical staff in order to support medical staff functions.

4.2. **QUALIFICATIONS FOR AND OBLIGATIONS OF MEMBERSHIP AND CLINICAL PRIVILEGES.**

The following professional criteria and qualifications constitute the basis for granting, denying or continuing medical staff membership and/or clinical privileges:

4.2.1. **General**

- 4.2.1.1. The applicant must document his/her education, training, and experience; current licensure; current physical and mental health; good reputation; adherence to the ethics of his/her profession; and ability to work with others. Such documentation shall be sufficient to assure the Medical Executive Committee and Board of Directors that patients treated by the applicant in the hospital will receive continuous and high quality medical care.
- 4.2.1.2. The applicant must submit documentation of current professional competence including any reasonable evidence of current ability to perform the privileges that may be requested.
- 4.2.1.3. The applicant must submit recommendations from professional colleagues who have first-hand knowledge of his/her character, ethics, clinical skills, professional deportment and judgment, including, where possible, recommendations from members of the medical staff of the hospital.

- 4.2.1.4. All applicants for initial appointment must have and maintain a current, valid and unrestricted license issued by the State of Connecticut which is not currently subject to any form of counseling, monitoring, supervision or any other ongoing review, condition, requirement or restriction of any kind, or be otherwise authorized to practice in accordance with Connecticut law. This requirement may be waived by the the Board of Directors after considering the recommendations of the Medical Executive Committee. The applicant must maintain any other licensure, registration, certification or other authorization required by any regulatory authority to permit the practitioner to provide appropriate health care services.
- 4.2.1.5. Practitioners may not have been excluded from or sanctioned by Medicare or Medicaid, or any other government program.
- 4.2.2. **Board Certification:** All physicians, oral surgeons, surgeons and podiatrists, who apply for initial appointment or clinical privileges on or after May 19, 2004 shall: have successfully completed a residency or fellowship approved by a specialty board recognized by the American Board of Medical Specialties (ABMS), the American Board of Oral and Maxillofacial Surgery, the American Osteopathic Board of Medical Specialties (AOBMS), the American Board of Podiatric Surgery, or by or an equivalent specialty board approved by the hospital Board of Directors after considering the recommendation of the Medical Executive Committee; must meet all requirements for attaining board certification in that specialty; and must have become board certified in that specialty or subspecialty within 5 years of completing residency or fellowship training as applicable. Board certification must be in the specialty which is appropriate for the practitioner's clinical practice. All members of the Medical Staff who are board certified must retain their specialty/subspecialty board certification and shall be recertified in the appropriate specialty or subspecialty within the time frame specified by those boards which require recertification to maintain board certification status, or within one year after board certification expires.
- 4.2.2.1. The Board of Directors may, for good cause shown by the practitioner, waive the board certification requirement or extend the time within which the applicant or practitioner is required to become board certified after considering the recommendations of the appropriate Division Director, Department Chair, the Credentials Committee and the Medical Executive Committee. Good cause shall be based on the demonstrated competence of the practitioner and the needs of the Hospital and the community it serves.
- 4.2.2.2. A request for waiver of the board certification requirement by a new applicant may be considered and acted upon by the Board of Directors before the applicant is permitted to submit an application for appointment to the medical staff. If the Board denies the request for waiver, the applicant shall be deemed not to meet the criteria for appointment to the medical staff and shall not be entitled to apply for medical staff membership or clinical

privileges. The proposed applicant shall not be entitled to a hearing or any other procedural rights or review with regard to any denial of a request for a waiver or extension by the Board.

- 4.2.2.3. The provisions of this section 4.2.2. shall apply to all medical practitioners applying for membership in any category of the medical staff after May 19, 2004. Any non-board certified practitioner who is a member in good standing of the Medical Staff on May 19, 2004 shall not be disqualified from membership or reappointment by reason of the absence of or ineligibility for board certification.
- 4.2.3. **Malpractice Insurance:** The applicant shall maintain and provide documentation of professional liability insurance with an insurer approved by the Board of Directors and which provides insurance coverage for the privileges being exercised in the minimum amount and in such form as may be approved by the Board of Directors. The Board of Directors in consultation with the Medical Executive Committee shall from time to time review the adequacy of professional liability insurance recommended by the departments and divisions to assure consistency with the hospital's risk management program.
- 4.2.4. **Call Response:** The applicant practitioner, or his/her prearranged coverage, shall at all times be within such distance from the hospital as needed to ensure prompt response in accordance with Medical Staff and Hospital rules, regulations, policies and procedures. Failure to adhere to these response times may be subject to corrective action as defined in Bylaws Article XIII, and may include termination of medical staff privileges. These response times may be superceded by more stringent departmental requirements.
- 4.2.5. **Clinical Privileges:** Individuals who are licensed and permitted by law to provide patient care services and are members of the ancillary staff as that term is defined in Article I of these bylaws, are not eligible for admitting privileges or medical staff membership, but may be granted clinical privileges in accordance with Section 6.6 of these bylaws.
 - 4.2.5.1. No applicant shall be denied membership or clinical privileges on the basis of physical handicap, sexual orientation, sex, race, creed, color, religion or national origin.
 - 4.2.5.2. No applicant shall be entitled to membership on the medical staff or to particular clinical or hospital privileges solely by virtue of the fact that s/he is duly licensed to practice in this or any other state, that s/he is a member of some professional organization, or that s/he had in the past, or presently has, privileges at this or another hospital.
 - 4.2.5.3. When the granting of clinical privileges is made contingent upon a practitioner obtaining or maintaining appointment to the faculty of a medical, dental or other health professional school, loss of faculty status in such school shall automatically result in the termination of the practitioner's clinical privileges at the hospital.
- 4.2.6. **Telemedicine/Telehealth Privileges:**
 - 4.2.6.1. Telemedicine otherwise known as Telehealth is defined as the medical diagnosis,

management, evaluation, treatment or monitoring of injuries or diseases through the use of communication technology. The Board of Directors will determine what clinical services may be provided through telemedicine after considering the recommendations of the appropriate department chair, the Credentials Committee and the Medical Staff Executive Committee.

4.2.6.2. Practitioners who exclusively diagnose and treat Hospital patients via telemedicine link shall not be members of the Medical Staff but shall be privileged and credentialed in accordance with these Bylaws. If permitted by law, regulations and any applicable accreditation standards the Hospital may obtain and rely on information and documentation related to the practitioner's qualifications and competence provided by the organization with which the practitioner is affiliated if that organization is Joint Commission accredited and is accredited by Medicare as a participating hospital or is an entity which complies with the Medicare Conditions of Participation. The Hospital may verify directly through original sources such information as the Hospital deems appropriate.

4.2.6.3. All practitioners providing telemedicine services must be properly licensed, certified, and/or permitted to practice in the State of Connecticut.

4.2.6.4. The granting of telemedicine privileges shall be in the discretion of the Board of Directors. Such privileges may be terminated or withdrawn at any time by the Board of Directors or Hospital CEO, with or without cause, after consultation with the Chair of the appropriate department and the President of the Medical Staff. Practitioners who only have telemedicine privileges shall not be entitled to hearing or other review procedures pursuant to these Bylaws unless action is taken with regard to a practitioner who is required to be reported to the National Practitioner Data Bank or a state licensing or disciplinary agency.

4.3. **APPLICATION FOR APPOINTMENT AND/OR CLINICAL PRIVILEGES.**

4.3.1. **Application:** All practitioners requesting application for membership on the medical or ancillary staff shall submit a request in writing to the Medical Staff Office. The Medical Staff Office will send the applicant a pre-application questionnaire to assess the individual's qualifications, training and experience; the hospital's ability to provide adequate facilities and supportive services for the applicant and his/her patients; and the applicant's qualifications in areas of identified need. Upon receipt, the questionnaire will be reviewed by the Chief Physician Executive. If the pre-application is approved, an application for membership to the medical staff will be provided. All applications for appointment to the medical staff shall be submitted in writing, shall be signed and verified by the applicant, and shall be submitted on a form prescribed by the Board of Directors after consultation with the Medical Executive Committee.

4.3.2. **Grounds for Not Providing Application Package:** No application for appointment or reappointment shall be provided to an individual, nor shall an application be accepted from

a proposed applicant, if the Chief Physician Executive after consulting with the Department Chair, determines that:

- a.) Stamford Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant,
- b.) The requested membership, assignment, or privileges would be inconsistent with Stamford Hospital's mission and plan of development, including the mix of patient care services to be provided, as currently being implemented,
- c.) The prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of Stamford Hospital and the communities it serves, including any medical staff development plan.
- d.) Stamford Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis and the prospective applicant will not be associated with the individual or group having the exclusive contract,
- e.) The prospective applicant has been listed in the Healthcare Integrity and Protection Data Bank as a health care provider who has been excluded from participation in Medicare or Medicaid, or has been sanctioned by Medicare or Medicaid,
- f.) The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or other requirements established by these bylaws,
- g.) The prospective applicant is not a type of allied health professional approved by the Board of Directors to provide patient care services in the Hospital as a member of the Ancillary Staff,
- h.) The prospective applicant has provided false or misleading information on any pre-application questionnaire or in connection with any pre-application review process.
- i.) The practitioner has a state license that is subject to any form of counseling, monitoring, supervision, probation or any other ongoing review, condition, requirement or restriction or limitation of any kind.
- j.) The practitioner has been convicted of a felony or convicted of a misdemeanor related to the practitioner's fitness to practice medicine.
- k.) The applicant's clinical privileges are currently suspended at, or have been involuntarily terminated by any other hospital or health care facility.
- l.) The practitioner has provided materially false or misleading information on any pre-application questionnaire or in connection with the appointment or reappointment process.

4.3.3. An applicant who has previously been a member of the Medical Staff and who has received

a final adverse decision concerning appointment, reappointment, or clinical privileges relating to the practitioner's professional conduct, competence or quality of care, or who has resigned or failed to apply for reappointment after being notified in writing that he/she is under investigation or that an investigation is being initiated, or following an adverse recommendation by the Credentials Committee or Medical Executive Committee for matters relating to the practitioner's professional conduct, competence or quality of care, shall not be eligible to reapply for a period of five (5) years unless the Board of Directors expressly provides otherwise. Upon any reapplication, the applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision no longer exists.

- 4.3.4. Any individual who is refused an application shall be notified in writing of the reasons why they were refused an application and may, within thirty (30) days after receipt of such notice, submit any additional information the individual wishes the Hospital to consider. The Hospital President/CEO or designee, in consultation with the Medical Staff President or Vice President, shall consider any such information submitted and then make a final decision concerning whether the individual is entitled to receive an application. No individual shall be entitled to a hearing pursuant to the Fair Hearing and Appellate Review Plan or any other procedural rights as a result of a refusal by the Stamford Hospital to provide an application form to such individual.
- 4.3.5. All applications for appointment to the medical staff and/or for clinical privileges shall be submitted in writing, shall be signed and verified by the applicant, and shall be submitted on a form prescribed by the Board of Directors after consultation with the Medical Executive Committee. The applicant shall specify the clinical privileges and staff category desired and shall provide detailed information concerning the applicant's professional qualifications, which shall include:
 - a.) the names of at least four persons, including, where feasible, professional peers, the Director of any residency or fellowship program in which the applicant has participated within the preceding five (5) years, and the applicant's most recent Department Chair. It is expected that whenever possible these persons shall have had experience in observing and working with the applicant and that they will be able to discuss the applicant's professional current competence and ethical character;
 - b.) information as to the applicant's educational background;
 - c.) information as to internships, residencies, fellowships, preceptorships and teaching appointments;
 - d.) documentation of honors or distinctions received;
 - e.) a list of scientific papers written or published;

- f.) information as to the applicant's present and past membership status at other hospitals or institutions, and whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, restricted, voluntarily relinquished or reduced, or not otherwise renewed at any hospital or health care institution;
- g.) information as to the applicant's present and past professional licensure and registration status in all local, state, federal and foreign jurisdictions; whether a licensing authority in any jurisdiction has ever suspended, revoked or restricted the applicant's professional license to practice or prescribe medication; whether the applicant has ever voluntarily relinquished his/her professional license or registration; whether the applicant has ever been reprimanded, censured or otherwise disciplined, or is the subject of any pending investigation or proceeding initiated by such a licensing authority;
- h.) information as to whether the applicant's membership in any local, state or national medical society or other professional organization has ever been suspended, terminated, restricted or voluntarily surrendered; whether the applicant has been reprimanded, censured or otherwise disciplined by such a society or organization; and whether the applicant is the subject of any pending investigation, monitoring, or disciplinary proceeding initiated by such a society or organization;
- i.) information as to whether the applicant has ever been convicted of any crime in any jurisdiction, is the subject of a pending criminal charge, or is the target of a pending federal or state grand jury investigation;
- j.) information as to whether the applicant has ever been found guilty of malpractice or negligence in the practice of his/her profession, is a defendant in pending civil litigation in which malpractice or negligence in the practice of his/her profession is alleged, or has settled, prior to final judgment, any allegation of malpractice or negligence in the practice of his/her profession;
- k.) information as to the applicant's involvement in continuing medical education activities;
- l.) information concerning the applicant's current professional liability insurance coverage and claims paid history.

4.3.6. **Undertakings:** By filing an application for staff membership, the applicant expressly acknowledges and verifies that:

- a.) the information set forth in the application is true, accurate and complete;
- b.) the applicant has received and had an opportunity to read a copy of the bylaws and rules and regulations of the medical staff, and agrees to be bound and abide by the terms thereof without regard to whether or not s/he is granted staff

- membership and/or clinical privileges and in all matters relating to consideration of his/her application;
- c.) the applicant authorizes the hospital and its duly authorized representatives to consult with administration and with members of the medical staffs of other hospitals or institutions with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications;
 - d.) the applicant consents to the hospital and its duly authorized representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges s/he requests as well as of his/her moral and ethical qualifications for staff membership, and agrees to furnish such information regarding his/her physical and mental health as may be requested by the hospital;
 - e.) the applicant agrees to appear for interviews in regard to his/her application;
 - f.) the applicant will, if accepted as a member of the Medical Staff, provide continuous care and supervision to all patients for whom s/he has responsibility; and shall provide satisfactory arrangements for their continuous care during periods of his/her absence;
 - g.) the applicant will abide by all bylaws, policies and directives of the hospital, including all bylaws, rules, regulations, policies and directives of the medical staff and its departments and clinical divisions, as shall be in force during the time s/he is a member of the staff;
 - h.) the applicant will accept committee, consultation, and staff call assignments, and such other reasonable duties and responsibilities, as may properly be assigned to him;
 - i.) the applicant will accept whatever reasonable clinic coverage and teaching assignments as may be made to him;
 - j.) the applicant will actively participate in the medical staff quality assurance and performance improvement program, and will respond promptly to any inquiries regarding the appropriateness of care s/he may have provided;
 - k.) the applicant will abide by the Principles of Medical Ethics of the American Medical Association and applicable surgical and specialty Codes of Ethics, including the American College of Surgeons Statements of Principles, as well as the Code of Conduct for members of the Medical Staff. The ancillary staff applicant shall abide by all applicable codes of ethics appropriate to his/her licensure. Specifically, the applicant pledges that s/he will not receive from, or pay to, another practitioner,

either directly or indirectly, any part of a fee received by him/her for professional services, except to the extent permitted by law;

- l.) the applicant will, if granted clinical privileges, practice within the scope of his/her approved privileges;
- m.) except as otherwise provided in Article XV, the applicant authorizes, and absolutely and unconditionally releases from liability and covenants not to sue, all individuals and organizations that provide information to the hospital in connection with the applicant's initial application for privileges and while the practitioner is on provisional status concerning the applicant's competence, ethics, character or other qualifications for staff membership and/or clinical privileges;
- n.) the applicant agrees that the release from liability required in 4.3.6. and the immunities from liability set forth in Article XV of these bylaws are express conditions to consideration of the applicant's application for, or exercise of, staff membership and/or clinical privileges at the hospital; and
- o.) the applicant agrees to execute releases in accordance with the tenor and import of this Section 4.3.6 in favor of the persons and organizations specified in this Section, subject to applicable requirements of the laws of this state.
- p.) agrees to notify the President of the Medical Staff and the Medical Staff Office immediately in writing upon learning that he/she:
 - (i) is the subject of a formal investigation by any licensing or disciplinary authority of any state or federal agency,
 - (ii) has been charged with a felony or with a misdemeanor that may relate to the practitioner's suitability to practice medicine or maintain Medical Staff membership and privileges,
 - (iii) has been notified that their professional liability insurance carrier intends to cancel, not renew, restrict or impose any conditions or deductibles on their professional liability insurance for any reason related to the individual's claims history,
 - (iv) has been notified of the loss of their DEA number or exclusion from the Medicaid or Medicare program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid,
 - (v) if the subject has been recommended for any disciplinary action, including any modification of clinical privileges, restriction of clinical privileges, or placing of conditions on clinical privileges (including any form of monitoring), by any other Hospital or health care facility,

- (vi) has voluntarily or involuntarily relinquished, or agreed not to exercise any licensure, registration, medical staff membership or clinical privileges, or has had any medical staff membership, clinical privileges, certification, licensure or registration suspended, terminated, restricted, limited, reduced or modified in any way,
 - (vii) has entered into a contract or agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder, or
 - (viii) has developed any mental or physical illness or sustained any injury which could have an affect on the exercise of the individual's clinical privileges.
- q.) agrees to provide any information or documentation, including appropriate medical records, which may be requested to answer any questions or resolve any issues concerning the practitioner's clinical competence or conduct, or to provide information concerning any matters or actions set forth in section (p) above.
- r.) agrees to immediately notify the Medical Staff Office in writing of any change in the practitioner's home or office addresses or telephone numbers or email addresses so that the Medical Staff Office has current addresses and telephone numbers at all times. The practitioner further agrees that any notice delivered to the home or office address of the practitioner which is on file in the Medical Staff Office shall be deemed to have been received by the practitioner. Any notice sent by regular mail shall be deemed to have been received on the seventh business day after the date the notice was mailed.
- s.) agrees to submit any evidence of current health status which may be reasonably requested by the chair of the appropriate department, the President of the Medical Staff or the Medical Executive Committee, and to submit to such mental or physical examination, including providing blood, urine or other samples, as the department chair, President of the Medical Staff, Chief Executive Officer, or Medical Executive Committee might require.
- t.) agrees to provide upon request access to and copies of the practitioner's office charts and records relating to the treatment of patients who have been treated in Stamford Hospital or related facilities if deemed necessary for the review of the practitioner's professional activities and current clinical competence. Acknowledges that the granting of Medical Staff membership and clinical privileges shall not make the practitioner an employee of Stamford Hospital for any purposes, and the practitioner shall at all times be an independent practitioner unless the

practitioner has a separate employment relationship with Stamford Hospital above and beyond having Medical Staff membership and clinical privileges.

- u.) acknowledges that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, shall be grounds for immediate denial of the application for appointment or reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the practitioner is appointed or reappointed.
- v.) acknowledges that the failure to provide complete and accurate information in connection with any investigation concerning the practitioner's Medical Staff membership, or clinical privileges, shall be grounds for immediate suspension and termination of Medical Staff membership and clinical privileges.
- w.) agrees to perform a physical examination and medical history no more than 30 days before or 24 hours after a patient is admitted to the Hospital, in accordance with such requirements or procedures as may be set forth in Hospital or Medical Staff rules, regulations or policies.
- x.) agrees to prepare and complete in a timely fashion the medical and other required records for all patients for whom the member provides care in the Hospital
- y.) History and Physical (H&P) A history and physical examination must be performed for all patients admitted to the hospital and any outpatient undergoing procedural sedation, or regional or general anesthesia. A full or complete history and physical must include: chief complaint, reason for admission, planned procedure, details of present illness and patient's condition, relevant past, social and family histories appropriate to the patient's age, system review, physical examination, diagnosis or problem list, and plan of care. For children and adolescents, the history must include an evaluation of the patient's developmental age, immunization status, and home environment.

- (i) The medical history and physical examination must be completed no more than 30 days before or 24 hours after admission for inpatients and in any event, except in emergencies, prior to any surgical procedure, by a licensed independent practitioner or allied healthcare provider who has appropriate clinical privileges at the Hospital. An H&P completed by a practitioner who does not have clinical privileges for conducting H&P must be validated by the admitting licensed independent practitioner. Validation of the H&P includes: personally examine the patient, and document the review of the history and physical, any changes since the

- preadmission H&P was completed, time, date and sign the entry.
- (ii) Any H&P that is handwritten, and faxed for the purposes of `outpatient or ambulatory surgery must be legible, dated, timed and signed by the responsible examining practitioner.
 - (iii) If the history and physical was performed before the patient's admission, the admitting physician must, within 24 hours after admission, and in any event, except in emergencies, prior to any surgical procedure, review the preadmission H&P, personally examine the patient, and document any changes since the preadmission H&P was completed and time, date and sign the entry.
 - (iv) The completed medical history and physical examination must be placed in the patient's medical record within 24 hours after admission, and in any event, except in emergencies, prior to any surgical procedure.
 - (v) In the event the history and physical are dictated, the admitting physician shall, at the time of admission, write an initial progress note summarizing the patient's condition, the reason for admission and any pertinent information required to permit necessary evaluation and treatment to be provided.
 - (vi) The H&P should be reviewed before surgery and the pertinent findings confirmed the day of the procedure and prior to surgery. When a patient is scheduled for ambulatory surgery with local anesthesia, the history and physical exam may be a short H&P that addresses: the chief complaint, past medical and surgical history pertinent to the operative or invasive procedure being performed, relevant Past Psycho-Social History pertinent to the operative or invasive procedure being performed, a relevant physical examination of those body systems pertinent to the operative or invasive procedure performed, but including at a minimum appropriate assessment of the patient's cardiorespiratory status, a statement on the conclusions or impressions drawn from the history and physical examination. a statement on the course of action planned for the patient for that episode of care.
 - (vii) A complete medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

In the case of an Obstetrical admission, the record shall include a complete and timely history and physical and a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the

hospital before admission, but an interval admission note must be documented that includes pertinent additions to the history and any subsequent changes. A complete history and physical will be required if there is no prenatal record for the patient.

- 4.3.7. **Burden of Providing Information:** The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. The applicant shall also have the burden of establishing his/her qualifications for the specific clinical privileges s/he requests.
- 4.3.8. **Records:** Separate files shall be maintained by the hospital for each medical staff applicant, which shall contain all documents pertinent to the applicant's application and the hospital's consideration thereof.
- 4.3.9. **Submission/Interview:** The completed application shall be submitted to the Medical Staff Office. Once a completed application is received, including all supportive documentation, the Chair of the clinical department and/or designee will interview the applicant. After the interview is conducted, the Medical Staff Office shall transmit the application and all supporting materials, including the results of the interview with the Chair of the clinical department, to the Credentials Committee for evaluation of the applicant's credentials.
- 4.3.10. **Completeness and Verification:**
 - 4.3.10.1. The completed application for appointment, reappointment, clinical privileges, or change in Medical Staff category or status shall be reviewed by the Medical Staff Office for completeness and the references, licensure, certifications, malpractice insurance, education, training, Medicare and Medicaid sanction and other information shall be verified with original sources to the extent possible. When all of the information in the application has been verified, the application shall be sent to the chair of each department in which the applicant seeks privileges.
 - 4.3.10.2. Stamford Hospital shall not be required to accept any application for appointment, reappointment or changes of status for processing until all information and documents required have been provided and all verifications have been completed. An application for reappointment shall be considered to be incomplete if the practitioner has not paid any dues or fines that are currently due or has not provided requested information or documents, or not responded to requests for comments, in connection with any performance improvement, quality assurance, peer review or other review or investigation of the practitioner's qualifications, clinical practices or conduct, provided the staff member has been notified in writing of the requested information and has had a reasonable opportunity to respond. The applicant shall be notified of any

additional information or documentation required and shall, within thirty (30) calendar days, obtain the required information or verification and provide it to Stamford Hospital. If the applicant fails to submit the required information or verification within thirty (30) calendar days after being requested to do so, the application shall be deemed to be withdrawn, unless the time to obtain the information is extended, or the requirement to provide the information is waived, by the Medical Staff President and the Chief Executive Officer or his/her designee.

4.3.10.3. No application shall be considered to be complete until the appropriate department chair, Credentials Committee and Medical Executive Committee, have reviewed it and all have determined that no further documentation or information is required to permit consideration of the application. Additional information or documentation may be requested by any appropriate department chair, by the Credentials Committee or by the Medical Executive Committee. If the applicant fails to submit the requested information or verification within thirty (30) calendar days after being requested to do so, the application shall be deemed to be incomplete and withdrawn, unless the time to obtain the information is extended by the person or committee requesting the information.

4.3.11. Requests for New Clinical Privileges: Any practitioner who is already a member of the Medical Staff or has clinical privileges, and wishes to request new or additional privileges, shall submit to the Medical Staff Office a request in writing setting forth exactly the privileges requested and the practitioner's training and experience which qualifies the practitioner for such privileges. Any such request shall be processed in accordance with Hospital policy and in the same manner as an application for initial appointment and clinical privileges and the exercise of such new privileges shall be subject to a focused professional practice evaluation.

4.4. **INITIAL AND PROVISIONAL APPOINTMENTS:**

4.4.1. **Appointment:** The privileges granted to a practitioner shall be consistent with his/her skill, training and experience and based upon a certification in respect thereto by the Chair of his/her department. Every staff member shall be entitled to exercise only those privileges specifically granted to him/her by the Board of Directors, except as provided in Section 7.2 and 7.3 of these bylaws. Practice outside the scope of approved privileges by a staff member shall be grounds for corrective action pursuant to Section 13.1 of these bylaws.

4.4.2. **Duration:** Appointments to the medical staff and the granting of clinical privileges shall be for not more than two (2) years. Reappointments shall be for a period of up to two years

subsequent to the date of renewal. Appointments and reappointments may be for less than two (2) years if the Board of Directors determines it is necessary to establish an orderly system for renewal of appointments. In addition, the Board of Directors may, after considering the recommendations of the Medical Executive Committee, establish a shorter term providing for more frequent evaluations of individual practitioners if determined to be necessary to assure that the practitioner's care and/or conduct are appropriate. No practitioner shall be entitled to a hearing or other rights as set forth in Article XIV in connection with any recommendation or decision that the practitioner be appointed or reappointed, or granted clinical privileges, for a period of less than two (2) years.

4.4.3. **Assignment to Department:** The Medical Executive Committee shall assign each staff member to a staff category and to a department where his/her performance shall be evaluated by the Chair to determine his/her eligibility for reappointment and promotion and for continuation, decrease, or increase of his/her clinical privileges.

4.4.3.1 **Provisional Appointment:** Initial appointment to the Medical Staff shall be provisional for a minimum of one full year in the Medical Staff category requested. At the completion of one full year of Medical Staff membership, the Department Chair shall review the appointee's performance. Each newly appointed member's performance shall be monitored by the Department Chair in such manner as is deemed appropriate by the department or its chair. Such review shall include a focused professional practice evaluation and may include proctoring and/or chart review.

4.4.3.1.1. While on provisional status practitioners:

- a.) Shall not have the right to hold office or vote on medical staff or department matters, but may serve on and vote on committees. Department directors may serve on and vote on MEC while on provisional status.
- b.) May attend department and Medical Staff meetings.
- c.) Must participate in the on-call coverage of the Emergency Department and other specialty coverage programs as scheduled or required by the Medical Executive Committee and the Hospital.

4.4.3.1.2. While on provisional status practitioners shall have an obligation to admit and/or treat a sufficient number of patients to enable the Medical Staff to evaluate his/her current clinical conduct and competence. For those physicians having limited admitting or consulting activity in the Hospital, the Department Chair may request office records of care delivered to patients. These files shall be purged of all patient identifiers. Upon request of the Chair, the applicant shall supply copies of such office records within ten business days.

- 4.4.3.1.3. Prior to the completion of the initial twelve (12) month provisional appointment period, the Department Chair shall report his/her findings and recommendation to the Credentials Committee whether:
- a.) provisional status should be ended with the member treated as a non-provisional member of the staff in the category approved,
 - b.) provisional status should be continued for one additional year to permit additional evaluation of the practitioner, or
 - c.) the provisional member's appointment should be terminated, or
 - d.) such other action as the Department Chair deems appropriate.
- 4.4.3.1.4. The recommendation of the Department Chair shall be made after consideration of all performance improvement, quality and patient safety, peer review, utilization review, outcomes management information relating to the practitioner and shall address the following:
- a. Patient care
 - b. Medical/clinical knowledge
 - c. Practice-based learning and improvement
 - d. Interpersonal and communication skills
 - e. Professionalism
 - f. Systems-based practice
- 4.4.3.1.5. If the recommendation of the Department Chair is adverse to the practitioner, the practitioner shall be notified in writing of the recommendation and the reasons for it and provided an opportunity to present to the Credentials Committee any additional information the practitioner wishes to have considered. The Credentials Committee shall consider the recommendations of the Department Chair and conduct such further review and investigation as the Committee deems to be appropriate. The Credentials Committee shall make a recommendation to the Medical Executive Committee and if the recommendation is adverse, the practitioner shall be notified in writing of the recommendation and afforded an opportunity to present additional information to the Medical Executive Committee.
- 4.4.3.1.6. The Medical Executive Committee shall consider the recommendations of the Department Chair and Credentials Committee conduct such further review and investigation as the Committee deems to be appropriate. The Medical Executive Committee shall make a recommendation to the Board of Directors and if the recommendation is adverse, the practitioner shall be notified in writing of the recommendation and a summary of the grounds therefore, and provided notice of any right to a hearing under Article XIV of the Bylaws. A recommendation that a

practitioner's provisional status be extended shall not be considered to be a materially adverse action and shall not entitle the practitioner to a hearing.

- 4.4.3.1.7. At the completion of any provisional staff appointment, the Department Chair shall recommend to the Medical Executive Committee through the Credentials Committee whether:
- a.) provisional status should be ended with the member treated as a non-provisional member of the staff in the category approved,
 - b.) the provisional member's appointment should be terminated, or
 - c.) such other action as the Department Chair deems appropriate.
- 4.4.3.1.8. In the event the recommendation of the Medical Executive Committee is materially adverse to the practitioner, the applicant shall be given notice of said Medical Executive Committee recommendation, a summary of the grounds therefore, and notice of any right to a hearing under Article XIV of these Bylaws.

ARTICLE V

APPOINTMENT AND REAPPOINTMENT PROCESS

- 5.1. **APPOINTMENT PROCESS:** The Medical Staff Office shall submit completed applications for staff membership and clinical privileges to the Chair of the department(s) in which the applicant seeks privileges.
- 5.1.1. **Department Procedure:** If s/he has not already done so, within twenty (20) days after receipt of the completed application, the Chair of the applicable department(s) shall meet with the applicant to assess his/her qualifications for the privileges s/he seeks. The Chair may consult with Directors of the clinical divisions and where appropriate, other members of his/her department concerning the applicant. Within thirty (30) days of receipt of the completed application, the Chair of the applicable department(s) shall provide the Credentials Committee with specific, written recommendations for approving, rejecting or approving with modifications the application for the staff category and clinical privileges to be granted; and these recommendations shall be made a part of the Credentials Committee's report to the Medical Executive Committee made pursuant to Section 5.1.2 of these bylaws.
- 5.1.2. **Credentials Committee Procedure:** Within sixty (60) days after receipt of the completed application and all required material, the Credentials Committee shall make a written report of its evaluation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the applicant, his/her peers and other sources available to the

committee, including but not limited to information from the National Practitioner Data Bank and appraisal from the Chair of the department(s) in which privileges are sought, whether the applicant meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him, consistent with the general principles for medical staff membership set forth in Article IV. Any minority views may be submitted, supported by reasons and references, and transmitted with the majority report. With its report, the Credentials Committee shall transmit to the Medical Executive Committee the complete application and a recommendation that the application be accepted or rejected, in whole or in part, or that the application be deferred for further consideration.

5.1.3 **Medical Executive Committee Procedure:**

- a.) At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Board of Directors that the practitioner be provisionally appointed to the medical staff, that s/he be rejected for medical staff membership, that his/her application be deferred for further consideration, or such other action as the Medical Executive Committee deems appropriate. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by applying conditions relating to such clinical privileges. Any minority views may be submitted, supported by reasons and references, and transmitted with the majority report.
- b.) When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it together with all supporting documentation to the Board of Directors.
- c.) When the recommendation of the Medical Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the applicant by regular and certified mail, return receipt requested, and shall advise the practitioner of the practitioner's right to a hearing and that the failure to request a hearing shall constitute a waiver of the right to a hearing.
- d.) The applicant may, by written request delivered to the Hospital President/CEO within thirty (30) calendar days after receipt of the notice of the action proposed by the Medical Executive Committee, request a hearing in accordance with Article XIV.
- e.) If the applicant does not request a hearing within thirty (30) days, the report and recommendations of the Medical Executive Committee, along with the entire file, shall be forwarded to the Board of Directors.

- f.) If the recommendation of the Medical Executive Committee is adverse to the practitioner, no action shall be taken by the Board of Directors until the time for the practitioner to request a hearing has expired, or if a hearing is requested, all procedures related to the hearing have been completed.

5.1.4. **Board of Directors Procedure:**

- a.) Not later than its next regular meeting after receipt of a final recommendation from the Medical Executive Committee concerning an applicant, the Board of Directors shall act in the matter. The Board of Directors may act to accept, reject, or accept with modifications the recommendations of the Medical Executive Committee, or refer the matter back to the Medical Executive Committee for further consideration or information. If the Board of Directors' action is favorable to the applicant in respect to his/her requested appointment and clinical privileges, such action shall be final. All decisions to appoint shall include a delineation of the clinical privileges, which the applicant may exercise. For those applications which meet certain criteria established by the Board of Directors, the Board of Directors may delegate to a committee of the board the right to take action on an application prior to the next regularly scheduled meeting of the board, subject to board ratification.
- b.) When the Board of Directors' decision is final, it shall send notice of such decision through the Chief Executive Officer to the President of the Medical Executive Committee, to the Chair of the department(s) concerned, and to the applicant. Notice of an adverse decision by the Board of Directors shall be sent to the applicant by regular and certified mail, return receipt requested and shall advise the practitioner of any right to a hearing and that the failure to request a hearing, if one is permitted, will result in the waiver of a right to a hearing. The applicant may, within thirty (30) calendar days after receipt of notice of the final action of the Board, request a hearing and further review pursuant to Article XIV by delivering a written request to the Hospital President/CEO. Such a hearing shall be permitted only if the final decision of the Board is more adverse than the recommendations of the Medical Executive Committee and a hearing has not been previously held.

5.1.5. **Deferral of Action:** Neither the Board of Directors nor the Medical Executive Committee shall defer action on, or remand an application for further consideration unless it does not have adequate information by which to evaluate the applicant's qualifications for the staff category and clinical privileges requested. In the event of deferral of action or remand, the applicant shall be promptly notified of the additional information which the Board of Directors or Medical Executive Committee may require of him. Failure of an applicant to provide adequate information by which to evaluate his/her qualifications within said thirty calendar (30) days may result in the application being considered incomplete in which case

it shall not be processed further and shall be deemed to be withdrawn. Any remand shall state the reasons therefore and shall set a time limit within which a subsequent recommendation and supporting documentation shall be forwarded to the Medical Executive Committee or Board of Directors, as applicable. At its next regular meeting after expiration of said time limits, the board that deferred or remanded consideration of the application shall take definitive action on the application.

5.2. **REAPPOINTMENT PROCESS:** Each member of the medical staff and each person who is granted clinical privileges shall apply for reappointment and/or renewal of clinical privileges in accordance with the provisions of Article IV. The process set forth in this Section 5.2 shall be described to each applicant upon application for reappointment or renewal of privileges.

5.2.1. **Reappointment Application:** At least one hundred twenty (120) days prior to the anticipated reappointment date the Chief Executive Officer or his/her designee shall cause a reappointment application form to be sent to each member of the staff. The staff member shall specify on the form the staff category and/or clinical privileges s/he desires, with reasons for any change in current appointment or privileges, evidence of continuing medical education, and such other information as the Medical Executive Committee or Board of Directors may from time to time require, including but not limited to a statement by the staff member attesting to his/her current sound physical and mental health. The reappointment form shall be returned to the Medical Staff Office within thirty (30) days after it is mailed. All members of the staff applying for reappointment shall be considered for the same category of the staff with the same clinical privileges they then hold, unless they specifically request otherwise.

5.2.2. **Factors to be Considered:** Reappointment of a staff member and clinical privileges to be granted upon reappointment shall be based upon:

- a.) Member's current licensure and current controlled substance registration status;
- b.) Member's certificate of insurance, which shall conform to minimum coverage amounts and underwriter status as determined from time to time by the Board of Directors;
- c.) Professional ethics, competence, conduct, skills and clinical judgment in the treatment of patients as indicated by the direct observation of patient care provided, and review of the records of patients treated;
- d.) Results of quality assurance studies and participation in medical staff performance improvement activities;
- e.) Member's demonstrated current professional competence, including his/her ability to perform any specific clinical privileges that may be requested;
- f.) Any past or present suspension, investigation, letters of censure or reprimand, actions by the state including consent orders, revocation, restriction or voluntary

- surrender of the member's professional license to practice medicine or prescribe medication; whether the member has voluntarily relinquished his/her professional license or registration, or whether the member is the subject of any pending investigation or proceeding initiated by such a licensing authority;
- g.) Any voluntary or involuntary termination, suspension, limitation, reduction, loss of, or imposition of conditions on, clinical privileges at another hospital or health care institution;
 - h.) A member's progress toward obtaining board certification in his/her specialty or subspecialty if s/he is not already so certified as required in Bylaws section 4.2.2.; or maintaining board certification in his/her specialty and/or subspecialty, if s/he is already so certified as required in Bylaws section 4.2.2. However, the member may apply to the Board of Directors for a waiver of the recertification requirement, or for an extension of time to meet the recertification requirement, and the member's medical staff membership and clinical privileges shall be extended until such time as the Board of Directors decides whether to approve the waiver or extension request. If the waiver or extension is denied, the member shall not be entitled to a hearing or procedural rights or review with regard either to the denial of the request for a waiver or an extension by the Board or with regard to the denial of the application for reappointment;
 - i.) Member's relevant recent training, scientific publications and professional distinctions;
 - j.) Member's use of the hospital's facilities for his/her patients and utilization of clinical privileges;
 - k.) Member's attendance at staff and departmental meetings, and participation in staff affairs;
 - l.) Member's participation in the Hospital's graduate medical education program;
 - m.) Member's compliance with hospital bylaws, policies, and directives and the medical staff bylaws, rules and regulations, including compliance with Section 4.2.3 of the medical staff bylaws; his/her cooperation with hospital personnel; his/her cooperation and relations with other practitioners; his/her general attitude toward patients, the hospital and the public;
 - n.) Information obtained from the National Practitioner Data Bank and OIG;
 - o.) Information as to convictions or allegations of criminal conduct by the member, whether the member has been found guilty of malpractice or negligence in the practice of his/her profession, whether the member is a defendant in pending civil litigation in which malpractice or negligence in the practice of his/her profession is

- alleged, and whether the member has settled, prior to final judgment, any allegation of malpractice or negligence in the practice of his/her profession;
- p.) Member's completion of the continuing education requirements which, at a minimum:
 - (i) for medical staff shall consist of an average of 25 CME category 1 credit hours per calendar year of the reappointment cycle;
 - (ii) for ancillary staff shall consist of an average of 25 CEU and/or 25 category 1 CME credit hours per calendar year of the reappointment cycle; and
 - q.) Relevant practitioner-specific data as compared to aggregate data, including procedures performed and outcomes, if such data are available for that practitioner;
 - r.) Peer recommendations particularly when physician specific data are not available for the practitioner,
 - s.) Performance measurement data, including morbidity and mortality data if such data are available for that practitioner, as well as the results of any ongoing professional practice evaluation and any focused practice evaluation or external review;
 - t.) Documented health status;
 - u.) Involvement in any professional liability actions, including final judgments and settlements and evidence of any unusual pattern or excessive number of professional liability actions.

5.2.3. **Department Procedure:** At least sixty (60) days prior to the end of the reappointment year, the Medical Staff Office shall transmit to the Chair of each department a list of the members of that department who are being considered for reappointment and/or renewal of privileges together with the information submitted by each applicant and any other pertinent documentation or information. Each Department Chair shall consult with the members of his/her department concerning applicants from his/her department, including, where applicable, the Director of an applicant's clinical division, and shall collect recommendations concerning such applicants from persons who have directly observed such applicants rendering care to patients. At least thirty (30) days prior to the end of the reappointment year, the Department Chair(s) shall submit to the Credentials Committee recommendations concerning the application for reappointment and/or renewal of privileges of each member of his/her department, including the specific clinical privileges to be granted to each reappointee for the appointment term. For those physicians having limited admitting or consulting activity in the Hospital, the Department Chair may request office records of care delivered to patients. These files shall be purged of all patient identifiers. Upon request of the Chair, the applicant shall supply copies of such office

records within ten business days. Failure to comply with the reappointment requirements stated in Section 5.2.2, including the prerequisite CME credits, may result in: imposition of probationary status for a period not to exceed 1 year reappointment for a one-year term, requirement for additional clinical or administrative supervision, or other conditions as recommended by the Department Chair to the Credentials Committee to the Medical Executive Committee and approved by the Board of Directors. Failure by the member to satisfy the condition of his/her probation as of the completion of the probationary period will result in non-reappointment to the Medical Staff.

- 5.2.4. **Medical Executive Committee Procedure:** Prior to the final scheduled meeting of the Board of Directors in the medical staff year, the Medical Executive Committee shall make written recommendations to the Board of Directors, through the Chief Executive Officer, concerning the reappointment of each member of the staff, including the specific clinical privileges to be granted to each reappointment applicant for the ensuing reappointment period. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall have been adequately investigated and documented.
- 5.2.5. **Procedure Thereafter:** Thereafter, the procedure provided in Section 5.1.3 through 5.1.4 of Article V relating to recommendations on applications for initial appointment shall be followed, except that hearing and appellate review rights shall be governed by Section 14.2 of these bylaws.
- 5.3. **ACCEPTANCE OF APPOINTMENT OR REAPPOINTMENT:** Acceptance of an appointment or reappointment shall constitute the applicant's agreement to be governed by the bylaws, rules and regulations of the medical staff and of the hospital. Appointments shall confer on an applicant only such clinical privileges as are specified in the notice of appointment or reappointment.
- 5.4. **WAIVER:** The Hospital Board of Directors may, after considering the recommendations of the Medical Executive Committee and any appropriate department chairs, waive any of the requirements for Medical Staff membership and clinical privileges established pursuant to these Bylaws or the rules and regulations of the Medical Staff or any department or division for good cause shown if the Board determines that such waiver is necessary to meet the needs of the Hospital and the community it serves. The refusal of the Board of Directors to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.
- 5.5. **EXTENSION OF TIME TO ACT:** Any times set forth in these Bylaws for action to be taken may be extended by the individual or body currently considering the matter if necessary to obtain additional information or to allow for the orderly consideration and processing of applications for appointment, reappointment and clinical privileges.

ARTICLE VI
CATEGORIES OF THE STAFF

- 6.1. **CATEGORIES:** The medical staff shall be divided into honorary, office based, active, courtesy, telemedicine and house staff categories. Ancillary staff members are not members of the medical staff, but may be granted clinical privileges in accordance with Section 6.8 of these bylaws.
- 6.2. **THE HONORARY STAFF:** The honorary staff shall consist of (a) members of the medical or ancillary staff who have attained sixty-five (65) years of age, or who have attained sixty (60) years of age with not less than twenty-five (25) years of service to the hospital, and are no longer actively practicing their professions, and (b) other non-practicing physicians who are of outstanding reputation, whether or not they reside in the community. To be eligible for appointment to the honorary staff, the individual must be and remain in good standing and of good repute in the medical community. Honorary staff appointments shall be made by the Medical Executive Committee, subject to approval by the Board of Directors. Honorary staff members shall not have clinical privileges, shall not be permitted to admit, treat or consult on patients in the Hospital., shall not vote or hold office, shall not be required to serve on standing medical staff committees, shall not be required to have malpractice insurance and shall not be required to pay medical staff dues. Honorary staff members shall not be required to comply with the requirements of Section 4.2. relating to Qualifications for Membership or Article V relating to reappointment. Members of the Honorary staff shall be appointed and reappointed to that staff category in accordance with procedures approved by the Medical Executive Committee and Board of Directors.
- 6.3. **THE ACTIVE STAFF:** The active staff shall consist of practitioners who are qualified under these bylaws, whose principal office or offices and principal practice conform to the requirements of Article IV, and who assume all the functions and responsibilities of membership on the active staff, including staff call and consultation assignments. Members of the active staff with minimal hospital activity shall be subject to the same credentialing and peer review procedures as courtesy staff members, and may include the evaluation of peer review information from other health care facilities including but not limited to peer references and a review of patient records. Renewal of active staff privileges shall be determined on a biennial basis. Members of the active staff shall be appointed to a specific department, shall be eligible to vote and hold office, and may serve on medical staff committees. With the approval of the Chairs of the departments concerned and of the Medical Executive Committee, any member may practice in more than one department. Members of the active staff shall have the privilege of admitting patients, except that active staff members appointed to the Emergency Department, shall not have the privilege of admitting patients to inpatient services.
- 6.3.1. **Exemption:** Active staff members who have attained sixty (60) years of age or twenty-five (25) years of service on the active staff of the hospital shall, at the request of the

practitioner, be exempt from serving on the departmental emergency call and coverage rosters and from committee and outpatient responsibilities. The Department Chairs, with the approval of the Medical Executive Committee, may require active staff members otherwise qualified for exemption from call to continue to serve on call lists where there is demonstrated need for such service. Such extensions of service must be approved by the Medical Executive Committee on an annual basis and the extension may not exceed a total of two (2) years. No staff member may be required to serve after attaining the age of 62, but may volunteer to continue to serve after attaining that age.

6.4. **THE COURTESY STAFF.** The courtesy staff shall consist of practitioners who occasionally admit and treat patients at the Hospital or who primarily provide services on a consulting basis rather than as the primary attending physician. Courtesy Staff members may admit or consult on a maximum of twenty four (24) patients (including all inpatients and outpatients) during any consecutive twelve (12) month period unless the Board of Directors grants specific exemption for designated services or procedures. If the number of patients admitted or consulted on by a Courtesy Staff member during the Medical Staff year exceeds this limit, the practitioner shall thirty (30) days after notification be automatically transferred to the Active Staff. If advanced to the Active Staff, the staff member shall remain on the Active Staff, and shall be required to comply with all Active Staff requirements, for a minimum of one (1) year. Members of the Courtesy Staff shall have such admitting and clinical privileges as may be recommended by the Medical Executive Committee and approved by the Board of Directors, except that courtesy staff members appointed to the Emergency Department, shall not have the privilege of admitting patients to inpatient services.

6.4.1. Members of the Courtesy Staff shall be appointed to departments and clinical divisions, where appropriate, and shall be encouraged to attend departmental and medical staff meetings. Courtesy Staff members may vote, hold office and be appointed to medical staff committees. Members of the courtesy staff may be required by the Chair of the Department, with the approval of the Medical Executive Committee and the Hospital President/CEO or designee, to participate in a call system for the provision of care to staff patients when insufficient numbers of specialty physicians are available to provide these services to the community. In such situations, patients assigned to courtesy staff members through the ED call roster or seen through the clinic shall not be counted in connection with the maximum number of patients Courtesy Staff members are permitted to treat.

6.4.2. Members of the courtesy staff shall be subject to the same credentialing and peer review procedures as active staff members, including the evaluation of peer review information from other health care institutions. Renewal of courtesy staff privileges shall be determined on a biennial basis.

6.5. **HOUSE STAFF:** The term house staff means an intern, resident or fellow, who has graduated from an approved medical school, and is receiving education and providing clinical care under the

direction of the Residency Program Director. They shall not have privileges to admit patients to the Hospital. House Staff members shall not vote or hold office or attend medical staff meetings except by invitation but may be appointed to medical staff committees. Applicants to and members of the house staff shall not be entitled to the hearing and appellate review procedures set forth in Articles XIII and XIV of these bylaws. Members of the attending medical staff will be responsible for house staff supervision.

6.6. **ANCILLARY STAFF:** The ancillary staff shall consist of those allied health professionals, including but not limited to certified registered nurse anesthetists, nurse practitioners, physician assistants, advanced practice registered nurses, nurse midwives, radiologist assistants and certain doctoral scientists, and whose services are desired within the hospital, as determined from time to time by the Medical Executive Committee with the approval of the Board of Directors. Ancillary staff members must be licensed, registered or certified under state law to practice their respective professions. The use of the term "practitioner" in these Bylaws shall include ancillary staff.

6.6.1. **Ancillary Staff Application:** Persons desiring appointment to the ancillary staff shall submit a completed application form to the Medical Staff Office. The application form shall request such information as the Medical Executive Committee may from time to time require, subject to the approval of the Board of Directors. Appointments to the ancillary staff shall be made by the Board of Directors in accordance with Section 5.1 of these bylaws. Clinical privileges granted to ancillary staff members shall be based upon their current licensure, registration or certification, individual training, experience, demonstrated competence and judgment, and current physical and mental health, and shall be within the scope of the professional activities they are legally authorized to perform. Members of the ancillary staff are not members of the medical staff and may not vote at any meeting of, or hold office on, the medical staff. They are not obligated to attend medical staff meetings, but may be requested to serve on any medical staff committee by invitation of the President. Members of the ancillary staff shall be subject to biennial reappointment and renewal of privileges in accordance with Section 5.2 of these bylaws. Ancillary staff members shall be entitled to the hearing and appellate review procedures set forth in Article XIV of these bylaws unless the ancillary staff member is employed by the Hospital or a related entity, in which event the personnel policies and procedures of the employing entity shall apply.

6.6.2. **Departmental Assignment:** Members of the ancillary staff shall be assigned by the Medical Executive Committee to an appropriate department for supervision.

6.6.3. **Privileges:** Each profession within the ancillary staff shall be organized as a separate division of the ancillary staff. The department to which each division of the ancillary staff is assigned may promulgate such rules and regulations with respect to such division, as it deems appropriate, subject to review and approval by the Medical Executive Committee and the Board of Directors. The scope and extent of privileges for ancillary staff divisions

shall be delineated separately for each division by the department to which the division is assigned, subject to review and approval by the Medical Executive Committee and Board of Directors.

- 6.6.4. **Physician Responsibility:** A physician member of the medical staff shall be responsible for the admission and hospital care of any patient treated by a member of the ancillary staff. Such responsibility shall include an admitting history and physical, review of all diagnostic examinations, therapeutic interventions and medication prescribing and the general medical care of the patient during hospitalization. The responsible practitioner shall cosign the patient's discharge summary. Dentists shall be responsible for the parts of their patients' histories and physical examinations relating to dentistry respectively. Podiatrists shall be responsible for the parts of the parts of their patients' histories and physical examinations relating to podiatry respectively.
- 6.6.5. **Rules and Regulations:** Members of the ancillary staff shall abide by the rules and regulations of the medical staff and of their respective departments.
- 6.6.6. In the event of the termination, restriction or suspension of the Medical Staff membership or clinical privileges of the sponsoring, supervising or collaborating physician of any member of the dependent Ancillary Staff, the clinical privileges of the Ancillary Staff member shall be immediately and automatically suspended. The Ancillary Staff member shall have thirty (30) days within which to arrange an affiliation with another member of the Medical Staff and provide a copy of the written affiliation agreement. If the Ancillary Staff member does not provide a new affiliation agreement within thirty (30) days, the Ancillary Staff member shall be deemed to no longer be qualified for clinical privileges and the clinical privileges of the Ancillary Staff member shall immediately and automatically terminate. The Ancillary Staff member shall not be entitled to a hearing in accordance with the Fair Hearing and Appellate Review Plan.
- 6.7. **OFFICE-BASED STAFF:** The Office-Based Staff shall consist of those applicants or existing Members who wish to be affiliated with the Hospital and refer patients to members of the Active and Courtesy Staff, but who do not admit or treat patients in the Hospital. Office-Based Staff Members must meet all the requirements set forth in Article IV, except for those requirements related to exercising Hospital clinical privileges. Office-Based members must be involved in the care of outpatients or practice in an office-based setting, and shall not be granted inpatient clinical privileges. Office-Based members may be credentialed to write certain outpatient diagnostic testing orders consistent with Hospital Medical Rules, Regulations.
- Members of the Office-Based Staff:
- 6.7.1. May visit and examine patients in the Hospital, review patient's medical records and receive information concerning patients' medical condition and treatment.
- 6.7.2. May perform histories and physical examinations for patients who are to receive treatment

- as in-patients or out-patients at the hospital.
- 6.7.3. May vote, or be eligible to hold office on the medical staff, department or section.
 - 6.7.4. May serve on and chair committees as appointed by the President, Medical Staff, Medical Executive Committee, Department Chair or Division Director.
 - 6.7.5. May not admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the Hospital, but may order tests and studies to be performed on an outpatient basis.
 - 6.7.6. Shall not be required to meet any activity requirements.
 - 6.7.7. Shall not be required to pay Medical Staff dues, but shall be required to pay such-fees as may be assessed by the Hospital.
 - 6.7.8. May attend meetings of the Medical Staff and the Department/Division to which that person is assigned, including open meetings and educational programs and shall vote at such meetings if they meet medical staff and department eligibility criteria that may be in place (i.e. attendance or other requirements.)
 - 6.7.9. Must provide documentation identifying at least one Active medical staff member or a physician group who shall be responsible for admitting and managing the care of the Office-Based member's patients who present to the Hospital for admission.
 - 6.7.10. Must, at the time of reappointment, provide the name of at least one (1) professional reference who is a current member of the Stamford Hospital medical staff who can attest to their competency, and to the quality and appropriateness of care provided in the office-based setting.
 - 6.7.11. Must comply with the requirements of these Medical Staff Bylaws, including Bylaws 4.3.11 if he/she wishes to apply for a change in category to Active/Courtesy staff with clinical privileges.
- 6.8. **TELEMEDICINE STAFF:** The Telemedicine Staff shall consist of those practitioners who provide medical diagnosis, management, evaluation, treatment or monitoring of injuries or diseases through the use of communication technology. Shall not be members of the Medical Staff but shall only have such clinical privileges as are approved in accordance with these Bylaws Members of the Telemedicine Staff:
- 6.8.1. May not admit patients but may diagnose, treat and consult on patients by telemedicine link.
 - 6.8.2. May not vote, or hold medical staff, department or section office.
 - 6.8.3. May serve on but not chair committees.
 - 6.8.4. Shall not be required to meet any activity requirements.
 - 6.8.5. Shall not be entitled to a hearing or other review procedures pursuant to these Bylaws unless action is taken with regard to a practitioner who is required to be reported to the National Practitioner Data Bank or a state licensing or disciplinary agency.
 - 6.8.6. Shall not be required to pay dues.

- 6.9. **REVIEW REQUIREMENTS:** All staff members shall be subject to such preceptorship or concurrent review requirements as may be imposed on them, or any one of them, from time to time by the Medical Executive Committee upon recommendation by their Department Chair, and the imposition of such requirements shall not give rise to any rights under Article XIV of these bylaws. Such review shall include ongoing professional practice evaluation or focused professional practice evaluation in accordance with policies and procedures adopted by the Medical Staff and the Hospital. The Medical Executive Committee shall require periodic reporting of the performance of any staff member who is subject to preceptorship or concurrent review requirements.
- 6.10. **LEAVE OF ABSENCE:**
- 6.10.1. **Voluntary Leave:** A practitioner may take voluntary leave of absence by submitting a written notice of leave to the President of the Medical Staff, with a copy to the Department Chair and the Medical Staff Office. The written notice shall include the reason for the request and length of leave time requested, including a start date and estimated return date. Such request for leave of absence shall take effect at such time the practitioner designates unless the President of the Medical Staff, the Department Chair and/or the Chief Executive Officer recommends to the Medical Executive Committee that the Leave of Absence not be approved. In that event, the Medical Executive Committee shall review the matter, conduct such investigation as it deems appropriate, and make recommendation to the Board of Directors which shall make the final decision concerning whether the leave of absence shall be granted. The practitioner shall not be entitled to a hearing with regard to any recommendation or action to deny request for a leave of absence. While a practitioner is on a leave of absence, the practitioner shall not have clinical privileges and all the rights and obligations of the practitioner, including meeting attendance, voting, and payment of dues, shall be suspended.
- 6.10.2. **Medical Leave:** Any practitioner may at any time be placed on medical leave of absence at their own request. Processing of practitioner initiated leave of absences is considered voluntary and will adhere to the provisions delineated in Section 6.10.1. In addition, whenever the President of the Medical Staff or the Chief Executive Officer, after consultation with the Chair of the appropriate department determines that an individual is or may be suffering from a physical or mental condition which could impair the ability to treat patients, the President of the Medical Staff or the Chief Executive Officer may place the person on medical leave without a request from, or the consent of the individual. While on medical leave all admitting and clinical privileges of the individual, and all the medical staff obligations, shall be suspended.
- 6.10.3. **Return from Non-Medical Leave:** At such time as a practitioner wishes to return from a leave of absence (not medically related), the practitioner shall give reasonable advance

notice to the Department Chair, the Chief Executive Officer, the President of the Medical Staff and the Credentials Committee. The Department Chair and/or the credentials committee may require that the practitioner submit information concerning the practitioner's activities while on leave. The practitioner's leave of absence shall end at such time as the practitioner states unless the Department Chair, Chief Executive Officer, President of the Medical Staff or Credentials Committee notifies the practitioner of his/her or its recommendation to the Medical Executive Committee that the practitioner's clinical privileges not be reinstated subject to certain conditions. In that event, the Medical Executive Committee, after considering the recommendation of the Department Chair, Chief Executive Officer, President of the Medical Staff and/or the Credentials Committee, shall make the recommendation to the Board of Directors concerning the reinstatement of the practitioner's privileges. The Board of Directors will take the final action on the request for reinstatement and provide for notice of the action to be sent to the practitioner. If the Board of Directors determines the practitioner should not be reinstated, or should be reinstated subject to conditions, the Board of Directors shall notify the practitioner of the reasons for the action and the practitioner shall be entitled to the hearing and appellate review rights set forth in Section 14.2 of these Bylaws

6.10.4. **Return from Medical Leave:** Medical Leave shall terminate when the individual's attending physician provides a written statement to the President of the Medical Staff that the individual's condition will not interfere with his/her treatment of patients unless the President of the Medical Staff, the Department Chair, or the hospital Chief Executive Officer recommends that the individual should remain on medical leave, should be reinstated subject to certain conditions, or that additional information is required before the medical leave is terminated. The President of the Medical Staff or the Chief Executive Officer, or designee, may require that the individual member be examined by an independent physician or physicians designated by the President of the Medical Staff or the Chief Executive Officer or designee. If the Department Chair, President of the Medical Staff or Hospital Chief Executive Officer recommends against reinstatement as requested, the Medical Executive Committee shall, after considering the recommendations of the Department Chair, President of the Medical Staff or the Chief Executive Officer, make a recommendation to the Board of Directors concerning the reinstatement of the practitioner's privileges. The Board of Directors shall take final action on the reinstatement and provide for notice of action to be sent to the practitioner. Copies of all communication relating to the practitioner's return to active status shall be kept in the practitioner's credentials files. The terms of this section are applicable to all medical leaves of absence of one month or more.

- 6.10.5. **Leave of Absence-Hearing Rights:** In the event that the practitioner disagrees with the recommendation of the Medical Executive Committee regarding being placed or continued on medical leave, or reinstated with conditions, the practitioner may request a hearing concerning the decision in accordance with the fair hearing and appellate review plan set forth in Article XIV.
- 6.10.6. **Leave of Absence-Reappointment:** If the practitioner's current term of appointment expires while on leave, the practitioner shall be required to apply for reappointment pursuant to Article V, Section 5.2 of these Bylaws. In addition, any practitioner whose leave of absence extends beyond a 12-month period must be recredentialed pursuant to section 5.2 of these Bylaws in order to be reinstated as a member of the Medical Staff.

ARTICLE VII

PRIVILEGES

- 7.1. **SCOPE OF PRIVILEGES:** Every member of the medical staff and ancillary staff shall be entitled to exercise only those privileges specifically granted to him/her by the Board of Directors, except as provided in Sections 7.2 and 7.3 of these bylaws. The scope of privileges available in each department of the hospital for medical staff and ancillary staff members shall be specified in the rules and regulations of the various departments.
- 7.2. **TEMPORARY PRIVILEGES:** The granting of temporary privileges is a courtesy on the part of the hospital and the granting, denial or termination of temporary privileges shall not give rise to any hearing or appellate review rights under Article XIV of these bylaws. Specific clinical privileges shall be delineated by the appropriate Department Chair prior to granting temporary privileges to any practitioner hereunder. All temporary privileges are granted by the CEO or authorized designee upon the recommendation of the President of the Medical Staff or authorized designee.
- 7.2.1. **Medical Staff Applicants:** The Chief Executive Officer may grant temporary admitting and clinical privileges to a new practitioner upon receipt of a completed application that meets the medical staff membership criteria established in the Medical Staff Bylaws section Article IV and has been reviewed and recommended for approval by the Chief Physician Executive, or designee, Chair of the Credentials Committee and the President of the Medical Staff, or designee, upon receipt of a National Practitioner Data Bank and OIG report and verification that the applicant shall
- (1) Have submitted a completed application, including all information and documentation required for appointment to the Medical Staff and/or for clinical privileges (including current license, relevant training or experience, current competence and ability to perform privileges requested), has been received, reviewed and verified by the Medical Staff Office;

- (2) Have no current or previously successful challenge to licensure or registration;
- (3) Not be subject to involuntary termination of medical staff membership at another organization;
- (4) Not be subject to involuntary limitation, reduction, denial or loss of clinical privileges at any other healthcare organization.

In exercising such temporary privileges, the applicant shall act under the supervision of the Chair of the department to which s/he is assigned. Temporary privileges granted hereunder shall be effective for a period not to exceed one hundred and twenty (120) days. The practitioner must provide proof of current unrestricted, unconditional Connecticut licensure or otherwise be authorized to practice pursuant to Connecticut law.

7.2.2. **Locum Tenens:** The Chief Executive Officer or designee may permit a practitioner serving as a locum tenens for a member of the medical staff to attend to patients without applying for membership on the medical staff for a period not to exceed one hundred and twenty (120) days providing that all of his/her credentials have first been approved by the Department Chair concerned, the Chief Physician Executive, the President of the Medical Staff or designee, and the Chair of the Credentials Committee. In exercising such privileges, the physician shall act under the supervision of the Chair of the department to which s/he is assigned.

7.2.3 **Urgent Care Needs Physicians:** To fulfill an important patient care, treatment, and service need, temporary privileges may be awarded to a physician on a specific patient basis to meet an important patient care or service need after current licensure and current competence are verified. After consultation with the Chair of the clinical department concerned, the Chief Physician Executive, the President of the Medical Staff or designee, and the Chair of the Credentials Committee may recommend temporary clinical privileges be granted by the Chief Executive Officer or designee of the hospital for the care of a specific patient to a practitioner who is not an applicant for medical staff membership. In exercising such privileges, the practitioner shall act under the supervision of the Chair of the Department to which s/he is assigned. Temporary privileges granted hereunder shall be effective for a period not to exceed 120 days and shall automatically expire at such time as the particular circumstances giving rise to the temporary privileges have been resolved.

7.2.4 **Temporary Consulting Privileges:** At the request of the physician of record, and after consultation with the appropriate Department Chair, temporary consultation privileges to physicians not previously appointed as hospital consultants may be awarded by the Chief Executive Officer or his/her designee. The Chief Executive Officer or his/her designee shall advise the nursing department of such temporary consultative privileges.

7.2.5 **Special Requirements:** Special requirements of supervision and reporting may be imposed by the Department Chair concerned on any practitioner granted temporary

privileges. Temporary privileges may be immediately terminated at any time and for any reason by the Chief Executive Officer upon written notice from the Department Chair and the practitioner shall not be entitled to a hearing in accordance with these bylaws.

- 7.3. **EMERGENCY PRIVILEGES:** In the case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department affiliation or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request such privileges, the patient shall be assigned to an appropriate member of the medical staff. For the purpose of this section, an "emergency" is defined as a condition in which serious harm might result to a patient or in which the life or health of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- 7.4. **DISASTER PRIVILEGES:** Disaster privileges during activation of the emergency preparedness plan: Disaster privileges may be granted by the Chief Executive Officer or his/her designee and the President, Medical Staff 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". This policy shall be kept in the Medical Staff Credentialing Manual.
- 7.5. **NEW PROCEDURES OR SERVICES:** New procedures or services which are not currently being provided at the Hospital shall be subject to review and approval in accordance with policies and procedures adopted by the Medical Staff and the Hospital.

ARTICLE VIII

THE MEDICAL EXECUTIVE COMMITTEE

- 8.1. **RESPONSIBILITIES AND DUTIES:** The Medical Executive Committee shall be principally responsible for the quality of all medical care provided to patients of the hospital and for the ethical conduct and professional practices of members of the medical staff. It shall be responsible to the Board of Directors for the establishment and maintenance of professional standards, policies and practices in the hospital. It shall make recommendations to the Board of Directors with respect to any matter the medical staff, through its elected officers, may present to it. The Medical Executive Committee may, on its own initiative, recommend action by the Board of Directors on any matter. Without limiting the foregoing, the duties of the Medical Executive Committee shall include the following:

- a.) To represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws.
- b.) To coordinate the activities and general policies of the various clinical departments.
- c.) To receive and act upon the reports and recommendations of medical staff committees, departments, divisions and other assigned activity groups; and to respond promptly in writing to recommendations submitted to it.
- d.) To make policy recommendations to the Board of Directors with respect to the medical staff structure, Bylaws and Rules and Regulations, and to implement and enforce such medical staff policies as may be approved by the Board of Directors, which policies are not otherwise the responsibility of the departments or divisions to implement and enforce.
- e.) To provide liaison between the medical staff, Chief Executive Officer and the Board of Directors.
- f.) To recommend action to the Chief Executive Officer on matters of a medico-administrative nature.
- g.) To fulfill the medical staff's accountability to the Board of Directors for the quality of medical care rendered to patients in the hospital.
- h.) To ensure that the medical staff is informed of the accreditation program of the Joint Commission or other accreditation organization approved by the Board of Directors, that medical staff members participate in the accreditation process, including participation in the hospital survey and summation conference, and that the medical staff is informed of the hospital's accreditation status.
- i.) To ensure that the medical staff participates in a program of continuing education for all staff members designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh them in various aspects of their basic medical education.
- j.) To review the credentials of all applicants and to make recommendations to the Board of Directors on all matters relating to applications for staff appointment, assignment to departments and divisions, and delineation of clinical privileges.
- k.) To review all information available regarding the performance and clinical competence of medical staff members, and other practitioners with clinical privileges, and as a result of such reviews, to make recommendations to the Board of Directors on all matters relating to reappointments and renewal or changes in clinical privileges.
- l.) To ensure regular periodic thorough evaluations of each staff member and of staff practices and functions.
- m.) To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical and ancillary staff corrective or review measures when warranted.

- n.) To monitor all functions relating to the provision of patient care, including, but not limited to: performance improvement activities, surgical case review, tissue review, review of pharmacy and therapeutic activities, review of medical records, review of blood utilization, review of the clinical use of antibiotics, review of infection control, internal and external disaster plans, hospital safety matters, utilization of procedures, quality assurance functions, and other patient related professional activities.
- o.) To report at each general medical staff meeting and otherwise as required by the medical staff and Board of Directors.
- p.) To require medical staff attendance at special meetings as may be deemed necessary from time to time by the Medical Executive Committee.
- q.) To develop a mechanism by which medical staff membership may be terminated in accordance with the fair hearing procedures of the medical staff set forth in these bylaws.
- r.) Assess and recommend to the Hospital CEO approval of sources of patient care provided outside the Hospital.
- s.) Make recommendations to the Board of Directors regarding clinical services to be provided by telemedicine.

8.2. **COMPOSITION OF THE MEDICAL EXECUTIVE COMMITTEE:**

The Medical Executive Committee shall consist of voting members and non-voting members as designated below.

8.2.1. The voting members shall be:

- a) the President, Vice President and Secretary/Treasurer of the Medical Staff;
- b) one (1) Chair from each clinical department,
- c) the number of members at-large shall equal the total number of departments, with one member from each department,
- d) the Chief Physician Executive
- e) the Director of Hospitalists Program

8.2.2. The non-voting members shall be:

- a) the immediate past President of the Medical Staff (for a period of 1 year),
- b) the President/Chief Executive Officer,
- c) the Vice President for Patient Services,
- d) Executive Vice President and Chief Operating Officer,
- e) the Chair of the Credentials Committee,
- f) the Vice President for Quality

8.2.3. The President, Vice President and Secretary/Treasurer of the Medical Staff shall be nominated by the nominating committee and elected by the medical staff. At-large members will be nominated and elected by their respective department (see section 8.5.2).

8.3. **QUALIFICATIONS OF MEDICAL EXECUTIVE COMMITTEE MEMBERS:** Physician members of the Medical Executive Committee must be members of the active medical staff in good standing during their term of office. Physician members shall be qualified by training, adequate hospital experience, dedicated interest and demonstrated ability to serve as Medical Executive Committee members. In addition, Medical Executive Committee members who are medical staff officers or Department Chairs must retain their respective positions during their terms as members of the Medical Executive Committee. Failure of Medical Executive Committee members to maintain their required qualifications shall immediately create a vacancy in the Medical Executive Committee which shall be filled by the successor medical staff officer, Department Chair or newly elected departmental representative, as the case may be.

8.4. **APPOINTMENT OF MEDICAL EXECUTIVE COMMITTEE MEMBERS:**

8.4.1. **Officers and At-Large members:** Medical staff officers and at-large members shall become members of the Medical Executive Committee on the first day of January following their election. Refer to Section 9.3 for election details. Elections to fill a vacancy on the Medical Executive Committee shall be held within thirty (30) days after the creation of such a vacancy.

8.4.2. **Departmental Chairs:** Departmental Chairs shall be members of the Medical Executive Committee.

8.4.3. **Ex-Officio Members:** Ex-officio members shall assume membership on the Medical Executive Committee by virtue of their position. A vacancy in any of these positions will be filled by the successor in that office.

8.5. **TERM OF OFFICE:**

8.5.1. **Officers:** Medical staff officers shall serve as members of the Medical Executive Committee for their elected two-year term of office. The immediate past President shall be appointed as a one-year term of office as a member of the Medical Executive Committee.

8.5.2. **At-large members:** Elected at-large members shall serve as members of the Medical Executive Committee for two-year terms, or until their successors are duly elected and qualified. Elected at-large members shall begin to serve on the first day of January immediately following their election. Each at-large member may serve up to two consecutive terms. The member will be eligible for re-nomination after a two-year period of ineligibility. In October, if applicable, due to representative term limits, each department's nominating committee is responsible for soliciting all department members for election candidates. A department election of an at-large member as defined in section 8.2 shall be a secure voting mechanism approved on an annual or as needed basis by the Medical Executive Committee all eligible members of the active staff of the respective department by November 1st with a return date no-later than November 15th. Ballots will

be counted and the elected member's name shall be submitted to the Medical Executive Committee Chair by December 1st..

- 8.6. **REMOVAL OF ELECTED MEDICAL EXECUTIVE COMMITTEE MEMBERS:** Elected Medical Staff Officers may be removed from office as described in Bylaws Section 9.5. An elected Medical Executive Committee member may be removed by a vote of two-thirds of the active medical staff members of their respective constituency at a duly called and held medical staff meeting, or by a vote of two-thirds of the members of the Medical Executive Committee. Any vacancy in a Medical Executive Committee position shall be filled by an election by their respective constituencies within thirty (30) days after creation of such vacancy. Criteria for removal from office may include but not be limited to:
- a.) Resignation from the active medical staff;
 - b.) Failure to maintain, voluntarily or involuntarily, a license to practice medicine;
 - c.) Conviction of a felony or a misdemeanor related to suitability to practice of medicine;
 - d.) Failure to comply with medical staff bylaws or rules and regulations;
 - e.) Suspension of the medical staff member, as defined in bylaws sections 13.2 and 13.3, or
 - f.) Failure to perform the duties of membership defined in Bylaws Section 8.1.
- 8.7. **OFFICERS:** The officers of the Medical Executive Committee shall be the officers of the medical staff elected pursuant to Article IX of these bylaws.
- 8.8. **CHAIR:** The Chair of the Medical Executive Committee shall exercise professional leadership in all medical care matters in the hospital, subject to the direction of the Medical Executive Committee. S/he shall be an ex-officio member with a vote on all medical staff committees provided for or authorized pursuant to Article XI of these bylaws. The Chair shall hold office for a two-year term but shall not be eligible for that office again until after an absence from it for three (3) years. S/he shall report to the medical staff and the Board of Directors at each of their regular meetings on the state of medical care in the hospital and on any matters recommended for action by the medical staff, Medical Executive Committee, or Board of Directors.
- 8.9. **MEETINGS:** The Medical Executive Committee shall meet at least 10 (ten) times per year, or more often as necessary, at the hospital at such time and place as may be designated by the Chair. Special meetings shall be held upon the call of the Chair or at the request of three (3) or more members of the Medical Executive Committee. The Chair, or his/her designee, shall preside at all meetings of the Medical Executive Committee, and a permanent record of its proceedings and actions shall be maintained. A permanent file for Medical Executive Committee records shall be preserved in the office of the Chief Executive Officer of the hospital.

ARTICLE IX
MEDICAL STAFF OFFICERS

- 9.1. **OFFICERS OF THE MEDICAL STAFF:** The elected officers of the medical staff shall be:
- a.) President
 - b.) Vice President
 - c.) Secretary/Treasurer
- 9.2. **QUALIFICATIONS OF OFFICERS:** Officers of the medical staff must be members of the active medical staff at the time of nomination and election, and must remain members in good standing during their term of office. Only active medical staff members who are qualified by training, adequate hospital experience, dedicated interest and demonstrated ability shall be eligible to be officers. Failure to maintain the foregoing qualifications shall immediately create a vacancy in the applicable office.
- 9.3. **ELECTION OF OFFICERS:** At the annual meeting, the nominating committee, refer to Article XI, 11.3.5, shall submit to the medical staff one or more nominees for each office. Nominations may also be made from the floor at the annual meeting, provided the prospective nominee has been notified and agrees to have his/her name in nomination. Officers shall be elected by simple majority vote utilizing a secure voting mechanism that is approved on an annual or as needed basis by the Medical Executive Committee at the conclusion of the medical staff meeting. Voting members should have fourteen (14) calendar days to submit their votes after the ballots are distributed. Where there are three (3) or more candidates for an office and no candidate receives a majority vote, there shall be successive balloting, each time eliminating the name of the candidate receiving the fewest votes until a majority vote is obtained by one candidate, who shall be declared elected.
- 9.4. **TERM OF OFFICE:** All medical staff officers shall serve a two-year term commencing on January 1 of the year immediately succeeding their election, or until their successor is duly elected and qualified. However, if the Vice President of the Medical Staff has been in office for less than one (1) year at the time the two year term of the President of the Medical Staff expires, the Medical Executive Committee may elect to extend the term of the current President of the Medical Staff for one (1) additional year. No officer of the medical staff may serve consecutive terms in a single office, and any officer shall not again be eligible for election to the same office again until an absence from it for three (3) consecutive years. Provided however, any Medical Staff officer then in office who has not served three (3) consecutive one year terms in a single office as of the December, 2004 election of Medical Staff officers may, at that election, be elected to serve a single one year term.
- 9.5. **REMOVAL OF OFFICERS:** Except as otherwise provided in these bylaws, removal of a medical staff officer may be initiated by a petition signed by 25% of the active medical staff or by a two-

thirds vote of the Medical Executive Committee. A two-thirds vote at a duly called and held medical staff meeting is required to remove a medical staff officer. Criteria for removal from office shall include:

- a.) Failure to maintain, voluntarily or involuntarily, a license to practice medicine;
- b.) Conviction of a felony or a misdemeanor related to suitability to practice medicine;
- c.) Failure to comply with medical staff bylaws or rules and regulations;
- d.) Suspension of the medical staff member, as defined in bylaws sections 13.2 and 13.3;
- e.) Failure to perform the duties of the job specified in Bylaws section 9.7,
- f.) Mental or physical impairment or incapacity which prevents an officer from fulfilling his/her duties and responsibilities for an extended period of time,
- g.) Any action or conduct which would be grounds for corrective action pursuant to Article XIII even if corrective action is not taken,
- h.) Conduct which is detrimental to, or reflects adversely on, the Medical Staff or the Hospital.

9.6. **VACANCIES IN OFFICE:** Vacancies in any medical staff office during the medical staff year, except for the President, shall be filled within thirty (30) days by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the Vice President shall serve out the President's remaining term.

9.7. **DUTIES OF OFFICERS:**

9.7.1. **President:** The President of the medical staff shall:

- a.) Call and preside at all meetings of the medical staff, and be responsible for the agenda of such meetings;
- b.) Serve as a President of the Medical Executive Committee and call and preside at all meetings of the Medical Executive Committee, and be responsible for the agenda of such meetings;
- c.) Serve as a member of the joint conference committee;
- d.) Serve as an ex-officio member of all other medical staff committees with a vote;
- e.) Act in cooperation and coordination with the Chief Executive Officer in all matters relating to patient care within the hospital;
- f.) Support the philosophy of continuous quality improvement and communicate with the Chief Physician Executive and the Chief Executive Officer regarding opportunities for improvement identified by the medical staff;
- g.) Bring to the attention of the Medical Executive Committee matters which the medical staff may wish the Medical Executive Committee to consider;
- h.) Bring to the attention of the Board of Directors at meetings of the joint conference committee matters which the medical staff may wish the Board of Directors to consider;
- i.) Be responsible, in conjunction with the Chief Physician Executive, for the enforcement of medical staff bylaws, rules and regulations, for implementation of sanctions where these

are indicated, and for medical staff compliance with procedural safeguards in instances where corrective action has been requested against a practitioner;

- j.) Appoint members to all ad hoc committees;
 - k.) Represent the views, policies, needs and grievances of the medical staff to the Medical Executive Committee, Chief Physician Executive, Chief Executive Officer, and Board of Directors;
 - l.) Receive and interpret the policies of the Board of Directors to the medical staff and report to the Board of Directors on the performance and improvement of quality of medical care provided by the medical staff;
 - m.) Be responsible for the educational activities of the medical staff; and
 - n.) Be the spokesman for the medical staff in its external professional and public relations.
 - o.) Investigate matters relating to the conduct or actions of Medical Staff members, counsel members of the Medical Staff regarding unacceptable or disruptive conduct or inappropriate clinical practices, and initiate and participate in corrective actions as otherwise specified in these Bylaws,
 - p.) Perform any of the duties of any department chair, or chair of any Medical Staff committee, if such individual is unavailable or otherwise fails to perform his/her necessary duties.
 - q.) Have and exercise such other authority and powers as are provided by these Bylaws.
- 9.7.2. **Vice President:** The Vice President shall, in the absence or incapacity of the President, perform the duties of that office. S/he shall also be a member of the Medical Executive Committee, and the joint conference committee. The Vice President shall automatically succeed the President when the latter fails to serve for any reason.
- 9.7.3 **Secretary/Treasurer:** The Secretary/Treasurer shall automatically succeed the Vice President when the latter fails to serve for any reason.
- The Secretary of the medical staff shall:
- a.) Shall serve as the secretary of the Medical Executive Committee
 - b.) Be responsible for all correspondence from the Medical Executive Committee and will serve as the medical staff communication officer
 - c.) The Secretary shall keep a complete and legible record of the transactions of all financial business of the Medical Staff, including payment and receipt of all Medical Staff fees and dues and make disbursements as authorized by the Medical Executive Committee or its designees
- 9.8. **CHIEF PHYSICIAN EXECUTIVE:** The Chief Physician Executive shall be a member of the medical staff with recognized clinical expertise and a member of the hospital administration, reporting to the Chief Executive Officer. S/he shall assist the department chairmen and executive committee in maintaining high quality patient care; review medical staff appointments and reappointments; serve as a medical liaison between the hospital administration, medical staff and community; chairs

medical staff search committees; and participate at all levels in the quality assessment and quality improvement functions of the hospital and medical staff. S/he is a member of the Medical Executive Committee.

ARTICLE X

CLINICAL DEPARTMENTS

10.1. CATEGORIES OF SERVICES:

10.1.1. **Departments:** The medical staff shall be divided into departments which shall be organized as separate divisions of the medical staff. Each member of the medical staff shall be assigned to a department in accordance with Section 4.4.3 of these bylaws. Where appropriate, a staff member may be assigned to more than one department. The Medical Executive Committee shall determine what Medical Staff departments and divisions the Medical Staff shall have, subject to the approval of the Board of Directors. The departments of the medical staff shall initially be as follows:

- a.) Medicine
- b.) Surgery
- c.) Obstetrics and Gynecology
- d.) Family Medicine
- e.) Pediatrics
- f.) Psychiatry
- g.) Anesthesiology
- h.) Pathology
- i.) Radiology
- j.) Emergency Medicine
- k.) Orthopedic Surgery

10.1.2. **Clinical Divisions:** Each of the departments may be organized into divisions for any of their subspecialties. Establishment of divisions shall be upon recommendation of the department Chair made to and approved by the Medical Executive Committee and approved by the Board of Directors. Elimination of a division likewise shall be upon recommendation of the department Chair made to and approved by the Medical Executive Committee and approved by the Board of Directors. Each division shall have a Director. Members of clinical divisions shall be board certified in the applicable subspecialty area by a physician certifying Board or organization recognized and approved by the department as required in Bylaws section 4.2.5. Where appropriate, a staff member may be assigned to more than one clinical division within one or more departments. Also, where appropriate,

clinical divisions within different departments may, with the approval of the respective Clinical Division Director and Department Chairs, affiliate for administrative purposes.

10.1.3. Departments and divisions may be eliminated, combined, created, or restructured by the Medical Executive Committee subject to the approval of the Board of Directors.

10.2. **QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRS AND DIVISION DIRECTORS:**

10.2.1. **Chairs:** Each department shall have a Chair, who shall be responsible for the overall supervision of the clinical work within his/her department, except as may otherwise be specified in departmental rules and regulations. Each Chair shall be a member of the active medical staff, qualified by training, experience and demonstrated ability for the position. A Department Chair must restrict his/her professional work exclusively to the particular department to which his/her appointment is made, and be certified by the physician certifying Board or organization governing his/her field recognized and approved by the hospital, or document and demonstrate that s/he has comparable training, knowledge, experience and qualifications.

a.) The Chair of each department shall be appointed by the Hospital CEO or designee after consultation with the Medical Staff President. The appointment process for Chairs shall be as set forth in Section 10.6 of these bylaws. Each Chair may be removed by the CEO after consultation with the Medical Staff President.

10.2.2. **Directors:** A Director of a division shall be a member of the active medical staff, qualified by training, experience and ability for the position. A Division Director shall be certified by the physician certifying Board or organization governing his/her sub-specialty field recognized and approved by the department, or shall document and demonstrate that s/he has comparable training, knowledge, experience and qualifications.

a.) The Hospital CEO shall appoint Directors after considering any recommendations of the applicable Department Chair.

b.) Each Director may be removed by the Hospital CEO after consultation with the Department Chair.

10.3. **DUTIES OF DEPARTMENT CHAIRS AND DIVISION DIRECTORS:**

10.3.1. Each Chair shall (except as specified in departmental rules and regulations):

a.) Be responsible for all professional and administrative activities within his/her department including divisions thereof. S/he shall report on such activities regularly to the Medical Executive Committee;

- b.) Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his/her own department, in order to assure quality patient care;
- c.) Monitor and review the professional performance of all practitioners with clinical privileges in the department through the maintenance of quality control programs;
- d.) Report regularly to the Medical Executive Committee with respect to the activities of his/her departmental and medical care evaluation committee and with respect to the department's performance improvement activities;
- e.) Be responsible for the enforcement within his/her department of the hospital bylaws, the medical staff bylaws, rules and regulations, and departmental rules and regulations;
- f.) Be responsible for the implementation within his/her department of actions taken by the Board of Directors, the medical staff, the Medical Executive Committee;
- g.) Be responsible for recommending to the Medical Executive Committee criteria for privileges within his/her department and divisions thereof;
- h.) Transmit to the Credentials Committee and the Medical Executive Committee his/her department's recommendations concerning staff classification, appointment and reappointments, departmental assignments and assignments to divisions within his/her department, and delineation of clinical privileges for all members of his/her department;
- i.) Be responsible for the orientation, teaching, education and research programs in his/her department including determining the continuing education requirements for the professional and non-professional staff members in his/her department;
- j.) Promote the integration of his/her department into the mission of the organization and participate in the coordination of interdepartmental and intradepartmental services for the facilitation of optimal patient care;
- k.) Develop and implement policies and procedures for the provision of clinical services in cooperation with the nursing service and the hospital administration;
- l.) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department and divisions thereof as may be required by the Medical Executive Committee, the Chief Executive Officer or the Board of Directors;
- m.) Recommend appointment of an associate President to the Medical Executive Committee and the Board of Directors;
- n.) Recommend to the Medical Executive Committee and Board of Directors appointment of Division Director;

- o.) Appoint a medical care evaluation committee for his/her department (which may be a committee of the whole), pursuant to these bylaws and rules and regulations of his/her department;
- p.) Perform such other duties as the Board of Directors or Medical Executive Committee may require;
- q.) Assess and recommend to the Medical Executive Committee offsite sources for needed patient care services, if any, not provided by the department or the hospital;
- r.) Be responsible for recommending to the Medical Executive Committee a sufficient number of qualified and competent persons to provide care or service in the department;
- s.) Be responsible for determining the qualifications and competence of department personnel who provide patient care services, but are not licensed independent practitioners; and
- t.) Be responsible for making recommendations to the Medical Executive Committee regarding space and other resource needs of the departments.

10.3.2. **Directors:** Each Director of a division shall (except as specified in departmental rules and regulations):

- a.) Make recommendations to the Chair of his/her department regarding staff appointments and reappointments, and assignments to his/her division;
- b.) Work together with the Chair of his/her department to:
 - (i) Direct and supervise the work performed in his/her division;
 - (ii) Be responsible for the completion of medical records by staff members in his/her division;
 - (iii) Conduct clinical conferences and employ such other methods as s/he deems necessary or appropriate to ensure quality care within his/her division;
- c.) Provide consultation on all staff appointments, reappointments, assignments or promotions within his/her division.
- d.) Perform such other duties as may be required by departmental rules and regulations, the Department Chair, the Medical Executive Committee and/or the Board of Directors.

10.4. **DEPARTMENTAL ORGANIZATION AND FUNCTIONS:**

10.4.1. Each department shall maintain a written set of current rules and regulations for its operation which shall include criteria for granting of clinical privileges within the department and its division(s) and for the holding of office in the department. The rules and regulations of departments shall not conflict with each other or with the bylaws, rules, regulations or

policies of the medical staff or of the hospital. All departmental rules and regulations shall be subject to review and approval by the Medical Executive Committee and Board of Directors.

- 10.4.2. Each department shall conduct appropriate quality improvement and risk management activities.
- 10.4.3. Each department shall meet separately as needed to review and analyze on a peer-group basis the clinical work of the department and shall render periodic reports to the Medical Executive Committee.
- 10.4.4. Each department shall conduct educational meetings and establish such requirements as are deemed necessary or appropriate by the department to assure an adequate program of continuing education for its members.
- 10.4.5. At the annual meeting of the medical staff, each department shall report in writing to the medical staff as a whole as to the performance of the department and its divisions and shall make recommendations with respect thereto.
- 10.4.6. Each department shall have an Associate Chair whose duty it shall be to assist the Chair and act as Chair when necessary.
- 10.4.7. Action taken at departmental meetings shall be by majority vote when a quorum is present. A quorum for a departmental meeting shall be defined by each department's Rules and Regulations.
- 10.4.8. Each department and division thereof shall maintain accurate records of all of its proceedings and actions. A permanent file of such records shall be maintained by each department.
- 10.5. **MEDICAL CARE EVALUATION/PEER REVIEW COMMITTEES:** Each department shall establish a medical care evaluation/peer review committee. Each medical care evaluation/peer review committee shall also be a subcommittee of the Medical Executive Committee referred to in Section 11.2.1 of these bylaws and shall render reports concurrently to its department and to the Medical Executive Committee.
 - 10.5.1. **Duties:** Each medical care evaluation committee shall develop mechanisms to measure, assess and improve the quality of patient care provided within the department and, when appropriate, within other clinical and non-clinical departments of the hospital. Each medical care evaluation committee shall review, study and report whether procedures and patient care were appropriate, medically necessary and justified. All cases in which a major discrepancy exists between preoperative and postoperative (including pathologic) diagnoses shall be evaluated. In addition, each medical care evaluation committee shall develop standards and criteria to assure optimal patient care. Additional screening mechanisms based on such standards and criteria shall be used to identify cases for presentation at monthly departmental meetings.

- 10.5.2. **Meetings:** The medical care evaluation committees shall meet as needed and shall maintain an accurate record of their proceedings. These meetings may be attended in lieu of attending regular departmental meetings for purposes of compliance with bylaws requirements, Section 12.6.
- 10.6. **SELECTION OF DEPARTMENT CHAIR:** As part of the Chair selection process the CEO shall appoint a multi-disciplinary search committee after consideration of any recommendations by the medical staff executive committee. Upon selection of a recommended candidate by a search committee, the candidate's name shall be presented to the Medical Executive Committee for its recommendation to the Hospital CEO.

ARTICLE XI

COMMITTEES

- 11.1. **MEMBERSHIP:** Committee appointments are a privilege and responsibility of each member of the staff. Attendance at committee meetings is encouraged for all members of the active staff. Absence of a member from more than 50% of committee meetings in any medical staff year without an excuse acceptable to the Medical Executive Committee shall constitute grounds for forfeiture of committee membership.
- 11.1.1. **Appointments:** There shall be such standing committees and special committees of the medical staff as are established by these Bylaws or are established by the Medical Executive Committee, by resolution, subject to the approval of the Hospital President/CEO to perform necessary functions on an ongoing basis. The committees established by these bylaws shall consist of the Bylaws, Executive, Credentials, Nominating, Cancer and Joint Conference Committees.
- Except as otherwise provided in these bylaws, physician members of all committees shall be appointed by the Chair of the Medical Executive Committee. Except as otherwise provided in these bylaws, where the committee includes non-physicians, the Chief Executive Officer shall appoint representatives or employees of the Hospital to serve as non-voting members, subject to the approval of the Medical Staff President. Except as otherwise provided in these bylaws, committee members shall be appointed annually, but once appointed shall remain as a member of the committee until replaced or removed. Except as otherwise provided in these bylaws, any appointed member of a committee may be removed with or without cause by the Chair of the Medical Executive Committee or by vote of the Medical Executive Committee.
- 11.1.2. **Officers:** The Chair of each committee shall be appointed by the Chair of the Medical Executive Committee. The Chair of each committee shall be appointed at the time the committee is appointed, unless otherwise provided in these bylaws. The Chair or his/her

designee shall preside at all committee meetings. Each committee shall maintain records of its actions and proceedings, and a permanent file for committee records shall be preserved in the office of the Chief Executive Officer.

11.1.3. **Procedures:** Except as otherwise provided in these bylaws, committees shall meet as may be necessary or appropriate to accomplish their respective purposes and duties. Meetings may be called by the committee Chair, any three members of the committee, the Medical Executive Committee, or the Board of Directors. The secretary of the committee shall give notice of committee meetings at least two (2) days in advance in person or by telephone or fax, or at least five (5) days in advance by mail. Unless otherwise specified, a quorum at a committee meeting shall be the physician members present. When a quorum is present, the vote of a majority of the committee members present and voting may decide any question brought before the meeting. Committees may adopt such rules, regulations and procedures for their governance as are consistent with the hospital bylaws and the bylaws, rules and regulations of the medical staff, subject to approval by the Medical Executive Committee.

11.1.4. **Reports:** All standing and special committees shall report directly to the Medical Executive Committee, which shall report on the activities of the standing and special committees to the medical staff, Hospital administration and the Board of Directors as appropriate. Committees shall report in writing to the executive committee at least annually, and otherwise as may be required by these bylaws or by the executive committee.

11.1.5. **Ex-Officio Members:** The Chair of the Medical Executive Committee and the Chief Physician Executive shall be ex-officio members of all committees with vote.

11.2. **MEDICAL REVIEW COMMITTEES:**

11.2.1. All committees that engage in peer review or any activities related to peer review or quality improvement are hereby established as Medical Review Committees within the meaning of Connecticut General Statutes Section 19a-17b, as amended from time to time. The Joint Commission or such other accreditation agency as may be designated by the Board of Directors, while performing accreditation services for the Hospital, shall be acting as part of a medical review committee engaged in peer review as an agent of the Hospital. In its capacity as agent, any accreditation agency shall be bound to protect the confidentiality of information of the medical review committee engaged in peer review, pursuant to state law and the contract between the accreditation agency and the Hospital.

11.2.2. The Medical Executive Committee shall from time to time review the functions of committees, and all other standing and special committees of the Medical Staff appointed pursuant the provisions of these bylaws, to determine which of said committees are performing peer review activities within the meaning of Connecticut General Statutes

Section 19a-17b. Such committees shall be identified in policies and procedures to be promulgated by the Hospital.

11.2.3. These committees and groups are established as medical review committees for the purpose of conducting peer review activities in accordance with Connecticut General Statutes Section 19a-17b, which shall include evaluating the quality and efficiency of services ordered or performed by health care professionals, performing practice analyses, conducting inpatient hospital and extended care facility utilization reviews, conducting medical audits, and performing ambulatory care reviews and claims reviews. It is intended and understood that when performing these activities, these medical review committees will, among other things, gather and review information relating to the care and treatment of patients for purposes of evaluating and improving the quality of health care rendered, reducing morbidity or mortality, or establishing guidelines to keep within reasonable bounds the cost of health care. It is also intended and understood that in order to properly and effectively carry out their peer review activities, these medical review committees may from time to time require the assistance of others, including subcommittees, Department Chairs, Division Directors, committee and subcommittee chairs, the President and other officers of the Medical Staff, the Chief Physician Executive, and other individuals, and outside experts or consultants, and it is expressly intended that when such other groups and individuals are engaged by a medical review committee to assist in a peer review function, such others are part of the proceedings of such medical review committees for the purpose of performing peer review.

11.2.4. The proceedings of all these medical review committees, including data and information gathering and analysis and reporting by authorized individuals for the primary purpose of peer review activities, as well as minutes and other documents from meetings, shall be kept strictly confidential. All medical review committees shall comply with the Hospital's Peer Review Policy and Procedure Statement.

11.3. **STANDING COMMITTEES:**

11.3.1 **The Bylaws Committee:**

- a.) Composition: The Bylaws Committee shall consist of at least four (4) members of the active medical staff including the Medical Staff President, Vice President, and Credentials Committee Chair and appropriate representatives of the Board of Directors and administration, all of whom shall be voting members of the committee. At all times physicians shall constitute a majority of the membership of the Bylaws Committee.
- b.) Duties: The committee shall, at least annually, review the bylaws and rules and regulations of the staff and propose amendments thereof.

11.3.2 **Cancer Committee:**

- a.) Composition: The cancer committee shall be multidisciplinary, representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services as outlined by the standards of the Commission on Cancer of the American College of Surgeons. Members of the Cancer Committee shall be appointed by the Chair of the Medical Executive Committee after considering the recommendations of the Director of Oncology Services. Membership will include a general surgeon, medical oncologist, radiation oncologist, diagnostic radiologist and pathologist. Non-physician members include a cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar, quality management professional, clinical research data manager or nurse, palliative care physician or specialist, a rehabilitation medicine representative, and a genetics counselor. The Cancer Liaison Physician must also be a member of the committee. One coordinator is designated for each of the six areas of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, community outreach, clinical research coordinator, and psychosocial services coordinator. Additional members may be included at the discretion of the committee chair.
- b.) Duties and responsibilities: The cancer committee is responsible for ensuring patient centered care including goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities within Stamford Hospital.
- c.) Meetings: The committee shall meet at least four (4) times per year.

11.3.3 **The Credentials Committee:**

- a.) Composition: The Credentials Committee shall consist of one active staff representative appointed by the Chair of the Medical Executive Committee, after consultation with the appropriate Department Chairs and the Chief Physician Executive, one member from the departments of anesthesiology, emergency medicine, family medicine, pediatrics, orthopedics, obstetrics & gynecology, psychiatry, and radiology, and two members from the department of medicine, one of whom should be from the Hospitalist division, and the department of surgery, one of whom should be a surgical subspecialist. A representative from the department of pathology shall be appointed to serve in an advisory capacity, as needed. Members of other clinical departments may be called upon to service in an advisory capacity as needed. In addition, the Committee shall include the Chief Physician Executive and an additional representative from the department of the committee Chair. Each member of the Credentials Committee, or his/her designee from within his/her department, shall attend all Credentials Committee meetings. A Chair and vice-Chair shall be appointed by the Chair of the Medical

Executive Committee. A quorum shall consist of 50% of the membership. Members of the Credentials Committee shall serve three (3) year terms, except the initial members of the Credentials Committee shall serve staggered terms so that approximately one-third of the members of the committee will be elected each year after its initial members are elected. There shall be no limit on the number of terms a member can serve.

b.) **Duties:**

- (i) To review, investigate and consider fully the credentials and qualifications of all applicants for all credentialing actions described in these bylaws specific to but not limited to: medical staff appointments and reappointments, and recommendations for medical staff membership, assignment to clinical departments, and delineation of clinical privileges in compliance with the provisions of these bylaws. To provide guidance and expertise in the area of ancillary staff credentialing and privileging, to be called on as needed, the Credentials Committee shall establish an Ad Hoc Committee on Ancillary Staff Credentialing. The composition of the committee shall include representatives from mid-level extenders such as nurse practitioners, physician assistants and other similar type practitioners as approved by the Board of Directors.
- (ii) To issue a report to the Medical Executive Committee on each applicant for medical staff membership or clinical privileges, including specific consideration of the recommendations from the department or departments in which the applicant requests privileges.
- (iii) To seek advice from the departments and divisions in which the applicant requests privileges.
- (iv) To review requests for new procedures and issue a report to the Medical Executive Committee.

c.) **Meetings:** The Committee shall meet at least quarterly.

11.3.4. **Medical Executive Committee:** The duties, membership and other provisions regarding the Medical Executive Committee are set forth in Article VIII of these Bylaws.

11.3.5. **The Nominating Committee:**

- a.) **Composition:** The nominating committee shall consist of one member from each of the departments of the hospital. Members of the nominating committee shall be nominated by the nominating committee of their respective departments and elected by majority vote of the eligible active medical staff members of each department by a voting mechanism that is approved on an annual or as needed basis by the Medical Executive Committee. Members of the nominating committee

shall serve three (3) year terms, except the initial members of the nominating committee shall serve staggered terms so that approximately one-third of the members of the committee will be elected each year after its initial members are elected. No member of the nominating committee shall serve more than two consecutive three-year terms, but shall thereafter be eligible for election to the nominating committee after an absence of three years there from.

- b.) Duties: The nominating committee shall be responsible for preparing and presenting a slate of candidates to the medical staff for election to each medical staff and Medical Executive Committee officer position in accordance with these bylaws.
- c.) Meetings: Open positions shall be filled by the respective departments no later than July 1st of the membership year. The nominating committee shall meet at least three times annually:
 - (i) an initial meeting on about September 1st to review the committee charge, elect a chairperson, consider potential candidates and schedule additional meetings;
 - (ii) on about October 15th which shall be an open meeting, announced at least two weeks in advance, to allow additional nominations and input from all members of the active medical staff;
 - (iii) on or about November 15th to prepare a final slate for presentation at the December Medical Staff Meeting.

11.3.6. **Joint Conference Committee:** The President of the Medical Staff, the Chief Physician Executive, the President/CEO, the Medical Executive Committee or the Board of Directors may at any time request that a Joint Conference Committee be convened to discuss any issues. Any Joint Conference Committee shall consist of an equal number of members appointed by the Chair of the Board of Directors and the President of the Medical Staff. The Joint Conference Committee shall consider such matters as are referred to it by the person or entity requesting appointment of the Committee and the Committee shall make its report and recommendations on such issues to the Board of Directors and the Medical Executive Committee. Any Committee which is appointed shall be automatically dissolved upon completion of the consideration of the issues presented to the Committee.

11.3.7. **Other Standing Committees:** There shall be established such other standing committees as the Medical Executive Committee and the Hospital CEO shall agree upon to address such issues as infection control, performance improvement, utilization review, pharmacy and therapeutics, and other administrative and clinical issues as may be required by an accrediting agency or otherwise.

- 11.3.7.1. Members of standing committees shall be those practitioners appointed by the President of the Medical Staff subject to the approval of the Hospital CEO and those representatives or employees of the Hospital appointed by the Hospital CEO of the Hospital with the approval of the President of the Medical Staff.
- 11.3.7.2. All physician and non-physician members of committees shall be voting members. Except as otherwise provided herein, a majority of the members of each standing committee shall be members of the Medical Staff, and the chair of each standing committee shall be a member of the Medical Staff.
- 11.3.7.3. The chair of each committee shall be appointed from the membership of the committee by the President of the Medical Staff with the approval of the Hospital CEO, unless otherwise provided by these Bylaws.
- 11.3.7.4. The specific membership and duties of the standing committees shall be established by the Medical Executive Committee subject to the approval of the Hospital CEO.
- 11.3.7.5. The standing committees shall meet as frequently as is necessary to discharge the duties of such committees and shall make reports and recommendations to the Medical Executive Committee, the Hospital CEO, or others in such manner as the President of the Medical Staff and the Hospital CEO of the Hospital shall direct.

11.4. **SPECIAL COMMITTEES**: The President of the Medical Executive Committee shall from time to time appoint such other special committees as in the President's judgment are required. They shall serve during the President's term of office.

ARTICLE XII

MEETINGS

- 12.1. **ANNUAL MEETING**: The annual meeting of the medical staff shall be held during the month of December each year. At the annual meeting, the Medical Executive Committee, medical staff committees and retiring medical staff officers shall make such reports as may be desirable or appropriate. Officers for the ensuing year shall be elected.
- 12.2. **REGULAR MEETINGS**: The regular meetings of the medical staff shall be held during the months of March, June, September, and December.
- 12.3. **SPECIAL MEETINGS**: Special meetings of the medical staff may be called at any time by the President of the medical staff, and shall be called at the written request of the Chair of the Board of Directors, the Medical Executive Committee, or any ten (10) members of the active medical staff stating the purpose for such a meeting. The President shall designate the time and place of any special meeting. Written or printed notice stating the place, day, and hour of any special meeting of the medical staff shall be delivered by the secretary either personally or by mail to each member of

the active staff not less than ten (10) days before the day of such meeting. If mailed, the date of the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice of the meeting.

12.4. **ACTION AT MEETINGS:** Except as otherwise provided in these bylaws, action at any annual, regular or special meeting of the medical staff shall be taken by a simple majority vote when a quorum of the active medical staff is present. A quorum at any meeting of the medical staff shall be the active staff members present. While all members of the medical staff are privileged to attend staff meetings, only members of the active staff may vote and be counted for a quorum at such meetings.

12.5. **AGENDA OF REGULAR MEETINGS:** The agenda at any regular meeting shall be:

- a.) Call to order.
- b.) Reading of the minutes of the last regular meeting and of all special meetings.
- c.) Unfinished business.
- d.) Communications.
- e.) Reports of standing and of special committees.
- f.) Report from the Medical Executive Committee.
- g.) Report of the Chief Executive Officer.
- h.) New business.
- i.) Adjournment.

12.6. **ATTENDANCE AT MEETINGS:**

- a.) All members of the active staff are obligated to register on the attendance roster.
- b.) An elective attendance at another departmental meeting shall not be credited on the attendance roster of the member's department.
- c.) Only members of the department whose names are carried on the attendance roster shall be privileged to vote in that department.
- d.) A member of any department of the staff who has attended a case which is to be presented for discussion at any meeting shall be notified and shall be obliged to be present.
- e.) Members of the active staff are expected to attend all annual, regular and special meetings of the medical staff, and all meetings of the department to which the member is assigned, unless the member has a valid excuse, as determined by the Medical Executive Committee.

12.7. **DEPARTMENTAL MEETINGS:** Departmental meetings shall be held at least quarterly. Minutes and a record of the attendance shall be kept.

- 12.8. **CONDUCT OF MEETINGS:** Roberts Rules of Order Revised, most recent edition, shall prevail in the conduct of meetings of the medical staff, departments, divisions and committees, unless otherwise provided in these bylaws.

ARTICLE XIII

CORRECTIVE ACTION

13.1. **CORRECTIVE ACTION PROCEDURES:**

- 13.1.1. **Impaired Physician Policy:** If a member of the hospital staff or medical staff has reason to suspect that a practitioner is impaired in his/her behavior, judgment or performance, it must be reported immediately to the President of the Medical Staff, the Department Chair, or the Chief Physician Executive. Such report will be kept in strict confidence and handled under the provisions of the medical staff's Impaired Practitioner Policy.
- 13.1.2. **Grounds for Action:** Corrective action may be taken against any practitioner whenever
- a.) the activities or professional conduct of the practitioner fails to comply with the bylaws, policies and directives of the hospital or the bylaws, rules, regulations or policies of the Hospital, the medical staff or its departments,
 - b.) whenever such activity or conduct is not consistent with accepted ethical and professional standards of practice and care, or
 - c.) whenever such activity or conduct is or may be disruptive of hospital operations.
- 13.1.3. **Initial Investigation:** An investigation regarding the activities, professional conduct, qualifications or competence of any practitioner may be initiated by any Department Chair, the Credentials Committee, the Medical Executive Committee, the Hospital President/CEO or the Board of Directors. Such investigation may include referral of the matter to an existing committee of the Medical Staff, the appointment of an ad hoc committee, the use of external reviewers, or such other procedures as are deemed to be appropriate. A practitioner shall be deemed to be "under investigation" for purposes of this Article XIII and for purposes of reporting to the National Practitioner Data Bank when the practitioner has been notified in writing of the commencement of an investigation. Routine review and evaluation during the reappointment process or any routine peer review process shall not be considered to be an investigation.
- 13.1.4. **Departmental Procedure:** The Medical Executive Committee may refer the matter to the Chair of the appropriate department wherein the practitioner has privileges or, if the request is directed against the Chair, to the Chief Physician Executive. The Department Chair or the Chief Physician Executive, as appropriate, shall review the matter and may conduct such investigation as is deemed appropriate, including appointing an ad hoc committee of members of the subject department to investigate the matter.

- 13.1.5. **Ad Hoc Investigation Committee:** If the Department Chair or Chief Physician Executive appoints an ad hoc committee to investigate the matter, the ad hoc committee shall provide to the Department Chair or Chief Physician Executive a written report of its findings and recommendations. Prior to making such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc committee. A report of such interview shall be included in the report to the Department Chair or the Chief Physician Executive.
- 13.1.6. **Department Chair:** Upon completion of any investigation, the Department Chair or Chief Physician Executive shall report the results of the investigation to the Medical Executive Committee. Prior to making such report, the practitioner against whom corrective action has been recommended shall have an opportunity for an interview with the Department Chair, Chief Physician Executive or other committee or individuals reviewing the matter. A report of such interview shall be included with the report to the Medical Executive Committee. The practitioner concerned shall be entitled to receive a copy of any report made to the Medical Executive Committee and shall be permitted, or may be required, to submit a response or additional information for consideration by the Medical Executive Committee.
- 13.1.7. **Interview:** The interviews referred to in Sections 13.1.5 and 13.1.6 of these bylaws shall not constitute a hearing, shall be preliminary in nature, and none of the procedures specified in Article XIV of these bylaws shall apply thereto. At such interview, the practitioner against whom corrective action has been requested shall be informed of the specific nature of the issues under investigation, and shall be invited to discuss, explain or refute them. There will be no audio or video recording of the interview without the agreement of all participants. The practitioner shall be provided a copy of any written summary or report of the interview and provided an opportunity to give a response.
- 13.1.8. **Medical Executive Committee Procedure:** After receipt of the report from the Department Chair, any committee or the Chief Physician Executive following review or investigation of any matter which may be grounds for corrective action involving reduction or suspension of clinical privileges, or a suspension or expulsion from the medical staff; the affected practitioner shall be afforded the opportunity to meet informally with the Medical Executive Committee, which meeting shall not itself constitute a formal hearing.
- 13.1.9. **Medical Executive Committee Action:** The Medical Executive Committee may:
- a.) Issue a written warning or a letter of reprimand;
 - b.) Recommend probation or a requirement for consultation;
 - c.) Recommend reduction or suspension of clinical privileges;
 - d.) Recommend that the practitioner's staff membership be suspended or revoked, or
 - e.) Take summary action in accordance with section 13.2.

- f.) Recommend any other action that the Committee considers appropriate.
- A report of the action taken or recommended and the reasons therefore, shall be made to the Board of Directors, through the Chief Executive Officer, and to the affected practitioner. If the action of the Medical Executive Committee constitutes grounds for a hearing under Article XIV of these Bylaws, further action by the Board of Directors shall be held in abeyance until the time for the practitioner to request a hearing has expired, or, if the practitioner requests a hearing, the hearing and all post-hearing procedures have been completed.

13.1.10 **Attorney Representation:** A practitioner may be accompanied by an attorney at any hearing or in connection with any appearance before the Medical Executive Committee or the Board of Directors, provided that the practitioner shall be required to respond personally to any questions directed to the practitioner, unless directed by counsel not to answer. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the Medical Staff of the name of the attorney or other representative at least ten calendar (10) days prior to the hearing or appearance. Failure to do so may result in the hearing being postponed. If the practitioner fails to provide the name of any attorney or other representative at least ten (10) calendar days before any rescheduled hearing, the practitioner may not be permitted to be accompanied by counsel.

13.2. **SUMMARY ACTION:**

13.2.1. **Grounds for Action:** The Chief Executive Officer of the hospital or his/her designee, with the approval of a minimum of 2 of the following individuals - the President of the Medical Staff, the Vice President of the Medical Staff, the Chair of the Credentials Committee, or the Chair of the department in which the affected practitioner has clinical privileges, shall have the right to summarily suspend, restrict or place conditions on all or any portion of the clinical privileges of a practitioner whenever:

- a.) The failure to take such action may result in an imminent danger to the health of any individual;
- b.) The practitioner is charged with of a felony;
- c.) The practitioner is charged with of a misdemeanor which may be related to the practitioner's suitability for medical staff membership;
- d.) The practitioner has engaged in unethical activity relating to the practice of medicine; including such conduct as is defined in the Stamford Hospital Medical Staff Code of Conduct or the AMA Principles of Medical Ethics;
- e.) The practitioner has been placed on the OIG list of health care providers excluded from participation in Medicare or Medicaid;

- f.) The practitioner has had his/her medical staff membership at any other health care facility, licensure or other professional status terminated, suspended, restricted, conditioned or limited in any way or has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges following an investigation, while under investigation or to avoid an investigation or disciplinary action;
- g.) The practitioner made a material misstatement or omission on any pre-application or application for appointment or reappointment, or otherwise deceived the Medical Staff and/or Stamford Hospital;
- h.) The practitioner has falsified or inappropriately destroyed or deliberately altered any medical record;
- i.) The practitioner deliberately abandons a patient or wrongfully refuses to provide care to a patient based on sexual orientation, religion, national origin, disease or ability to pay;
- j.) The practitioner engages in clinical activities outside the scope of the practitioner's approved clinical privileges.
- k.) A practitioner engages in unprofessional, abusive or inappropriate conduct which is or may be disruptive of Hospital operations and procedures,
- l.) A practitioner refuses to submit to immediate evaluation relating to the practitioner's mental or physical status.

13.2.2. Any such suspension, restrictions or conditions shall be effective immediately and shall remain in effect until terminated by the Chief Executive Officer or the Board of Directors. Upon request made in writing by the concerned practitioner to the Chief Executive Officer within thirty (30) calendar days after being notified of the summary action by the Chief Executive Officer, the Medical Executive Committee shall within ten (10) business days of such request review the case and recommend to the Board of Directors modification, continuation, or termination of the suspension. The Medical Executive Committee may conduct such investigation as it deems appropriate and may require the practitioner to appear before the Medical Executive Committee, or designated members of the Medical Executive Committee, for an interview. Any appearance before the Medical Executive Committee shall not be considered to be a hearing and the practitioner shall not be entitled to be represented by counsel before the Committee.

13.2.3. If the practitioner requests review of the suspension by the Medical Executive Committee, upon completion of such review the President of the Medical Staff shall prepare a report to the Board of Directors setting forth the recommendations of the Medical Executive Committee and the reasons for the recommendations. A copy of the report of the Medical

Executive Committee shall be sent to the practitioner, who may, within five (5) business days after the date of the report, provide to the Board of Directors, any written comments or information the practitioner wishes the Board to consider.

13.2.4. Within fifteen (15) business days after the date of the report of the President of the Medical Staff, the Board of Directors shall act to continue, terminate, or modify the summary action and shall immediately notify the practitioner of the action taken. The terms of the summary action as sustained or modified by the Board of Directors shall remain in effect pending further action by the Board.

13.2.5. Any matter giving rise to a summary action shall be referred to the appropriate department chief in accordance with section 13.1. for investigation and recommendation concerning what action, if any, should be taken with regard to the practitioner's Medical Staff membership and clinical privileges. Upon completion of such investigation the matter shall be considered by the Medical Executive Committee and Board of Directors in accordance with these bylaws. Unless any summary action is terminated by the Stamford Hospital Chief Executive Officer or the Board of Directors, the suspension, restriction or conditions shall remain in effect while such investigation and review takes place.

13.3. **AUTOMATIC SUSPENSION:**

13.3.1. **Failure to Maintain Medical Records:** The Medical Executive Committee, with the approval of the Hospital CEO or Board of Directors may adopt rules, regulations, policies, and procedures relating to the completion of medical records. If any practitioner fails to complete medical records in accordance with the policies and procedures adopted by the Hospital, the clinical privileges of the practitioner may be suspended pursuant to the policy as long as the practitioner is in violation of the Hospital's policies and procedures.

13.3.2 **Other Grounds for Action:** A practitioner's clinical privileges shall be automatically suspended in the event the practitioner fails to (i) maintain appropriate malpractice insurance for the privileges being exercised, (ii) maintain a current, active, unrestricted Connecticut license to practice medicine, (iii) is excluded from participation in Medicare or Medicaid, or (iv) maintain a current, active DEA certification (if required for practice). The practitioner shall be notified of the suspension and the basis of the suspension by regular and certified mail, and given thirty (30) calendar days to produce clear and convincing evidence that the facts relied upon by the Hospital in instituting automatic suspension are not correct. If the Hospital does not receive such evidence from the member within thirty (30) calendar days, the individual shall no longer be qualified for Medical Staff membership and clinical privileges and the individual's Medical Staff membership and clinical privileges shall automatically terminate, and the individual shall not be entitled to a hearing as set forth elsewhere in these Bylaws.

- 13.3.3 **Procedures:** The hearing and appellate review procedures set forth in Article XIV of these bylaws shall not apply to automatic suspensions or dismissals implemented pursuant to Section 13.3 of these bylaws. The Chief Executive Officer, his/her designee, or Board of Directors shall have the authority to reverse an automatic suspension or dismissal implemented pursuant to this Section 13.3 if at any time the affected practitioner establishes, to the satisfaction of the Chief Executive Officer, his/her designee, or the Board of Directors that there did not exist, or no longer exists, grounds for such automatic suspension or dismissal.
- 13.4. **PROVISIONS FOR PATIENT CARE:** Immediately upon the imposition of a summary or automatic suspension, the appropriate Department Chair or the Chair of the Medical Executive Committee shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the hospital at the time of such suspension. The wishes of the patient may be considered in the selection of such alternative practitioner.

ARTICLE XIV

HEARING AND REVIEW PROCEDURES

- 14.1. **HEARING RIGHTS:** Each practitioner appointed to the Medical Staff and each applicant for medical staff membership and/or clinical privileges shall have a right to a hearing in the event of a proposed recommendation of the Medical Executive Committee or a proposed decision of the Board of Directors (not based on a prior adverse recommendation of the Medical Executive Committee) that, if final, would result in:
- a.) Denial of initial appointment to the medical staff or requested clinical privileges
 - b.) Denial of advancement or a requested change in medical staff category;
 - c.) Denial of medical staff reappointment;
 - d.) Revocation of medical staff membership;
 - e.) Denial of a requested increase in clinical privileges;
 - f.) Involuntary medical leave;
 - g.) Decrease or restriction of clinical privileges but not including a probation;
 - h.) Suspension (other than automatic suspension pursuant to Section 13.3) of clinical privileges, or
 - i.) Denial of request for reinstatement from voluntary leave of absence or approval of reinstatement subject to conditions pursuant to Section 6.9.2 of these Bylaws.
- 14.1.1. No other matter or action other than those enumerated in Sections 14.1 shall constitute grounds for a hearing with respect to a practitioner. No practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not related to the practitioner's medical qualifications, competence or conduct and is not reportable to

the State of Connecticut or the National Practitioner Data Bank, including, but not limited to, the following:

- a.) Letters of warning, reprimand, or admonition;
- b.) Imposition of monitoring, proctoring, review, or consultation requirements;
- c.) Requiring provision of information or documents, such as office records, or notice of events or actions;
- d.) Imposition of educational or training requirements;
- e.) Placement on probationary or other conditional status;
- f.) Appointment or reappointment for less than two (2) years; and,
- g.) Refusal to place a practitioner on any on-call or interpretation roster, removal of any practitioner from any such roster, or a requirement that a practitioner serve on an on-call roster.

14.1.2. **Conduct of Hearing:** Any hearing hereunder shall be conducted in accordance with Section 14.4 of these bylaws. There shall be no more than two (2) hearing dates, and hearings shall be conducted for no more than five (5) hours on any hearing date. If more than one hearing date is scheduled, the additional date(s) shall be within fourteen (14) days of the initial hearing date. Extension beyond these time limits may be authorized by the hearing officer only in exceptional circumstances.

14.1.3. **Appellate Review:** Appellate review of a hearing to which a practitioner is entitled pursuant to these bylaws shall be conducted in accordance with Section 14.5 of these bylaws

14.2. **HEARING PROCEDURES:** The following procedures shall apply to hearings to which practitioners are entitled under this Article XIV.

14.2.1. **Notice:** The Chief Executive Officer shall be responsible for giving prompt notice of each proposed recommendation or decision to any affected practitioner who is entitled to a hearing pursuant to these bylaws as a result of such proposed recommendation or decision. For purposes of this Article, "notice" shall mean a letter delivered in hand or mailed by certified mail, return receipt requested to the affected practitioner's address of record with the Hospital. Refusal of mail delivery by the affected practitioner shall constitute delivery. The notice shall include a statement of the proposed recommendation or decision, the reason or reasons therefore, a summary of the practitioner's rights in connection with any hearing and that the affected practitioner has the right to a hearing on the proposed recommendation or decision if requested within the time period stated in Section 14.1.2. A copy of the applicable sections of these bylaws and a summary of the hearing rights set forth in his/her Article XIV shall be mailed to the affected practitioner with such notice.

14.2.2. **Request for Hearing:** Any practitioner entitled to a hearing under these bylaws may request a hearing by delivering a written request for hearing to the President executive

office within thirty (30) days after receipt of the notice described in Section 14.2.1 of these bylaws.

14.2.3 **Waiver of Hearing:** The failure of a practitioner to request a hearing to which s/he is entitled by these bylaws in the manner herein provided within thirty (30) days after receipt of notice thereof, shall be deemed a waiver of his/her right to such hearing and such appellate review to which s/he might otherwise have been entitled. When the hearing and appellate review waived relates to a recommendation of the Medical Executive Committee, such waiver shall also apply to any final action pertaining to such recommendation by the Board of Directors and any appellate review thereof. Where the hearing and appellate review waived relates to a proposed decision by the Board of Directors, the same shall apply to any appellate review thereof. In either of such events, the Chief Executive Officer shall promptly give notice to the affected practitioner of the final decision of the Board of Directors.

14.2.4. **Composition of Hearing Committee:** All hearings relating to a proposed recommendation of the Medical Executive Committee shall be conducted by an ad hoc committee of not less than three (3) members and up to (2) alternates, all of whom shall be active members of the medical staff appointed by the Chair of the Medical Executive Committee. The ad hoc committee shall be established for the purpose of conducting peer review activities in accordance with Connecticut General Statutes Section 19a-17b and, specifically, to evaluate the quality and efficiency of services ordered or performed by the affected practitioner, including the performance of practice analysis, conducting medical audit, and performing review of cases, among other functions. The ad hoc committee shall be a medical review committee within the meaning of Section 11.2 of these bylaws. At least three (3) of the persons so appointed shall be members of the active medical staff, two of whom shall, where possible and appropriate, practice in the affected practitioner's field of expertise. All hearings relating to a proposed decision of the board of directors shall be conducted by an ad hoc committee of not less than three (3) members and up to (2) alternates appointed by the Chair of the Board of Directors. No person who has previously participated in the consideration of the proposed recommendation or decision applicable to the affected practitioner or who is in direct economic competition with the affected practitioner shall be appointed as a member of the hearing committee. All members of the hearing panel, including alternates, may participate in the deliberations and vote on the final decision and recommendations of the hearing panel if they have been present throughout the hearing or have reviewed the transcript of any portions of the hearing for which the panel member was not in personal attendance.

14.2.5. **Hearing Officer:** The Medical Staff President and the CEO of the Hospital shall select a

hearing officer to preside at the hearing. The hearing officer shall be an attorney or other individual familiar with procedures relating to peer review hearings.

14.2.5.1. The practitioner shall be notified of the proposed hearing officer and if the practitioner has any objection to the hearing officer, the practitioner shall, within ten calendar (10) days after notification, state the objection in writing and the reasons for the objection. The Medical Staff President and the Hospital CEO shall, after considering such objections, decide in their discretion whether to replace any hearing officer objected to and the practitioner shall be notified of the decision.

14.2.5.2. The hearing officer shall rule on all procedural matters at the hearing, rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

14.2.5.3. The hearing officer shall conduct a pre-hearing conference unless the parties all agree to waive the pre-hearing conference. At the pre-hearing conference the hearing officer may:

- i. require that all documentary evidence and exhibits be exchanged and shall resolve any objections to proposed documentary evidence and exhibits.
- ii. insure that the names of all proposed witnesses have been provided and that report or summaries of opinions of any experts have been provided.
- iii. establish the amount of time that shall be allotted to each side for the examination and cross-examination of witnesses, unless agreed upon by the parties.
- iv. address any other issues relating to the conduct of the hearing.

14.2.5.4. The hearing officer shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, to limit the number of witnesses to be called by the Medical Staff or practitioner and to advise the members of the hearing panel concerning legal and procedural issues.

14.2.5.5. The hearing officer shall be available to the members of the hearing panel after the conclusion of the hearing to advise them on any procedural or legal matters and to assist the panel with the preparation of their report and recommendations, but shall not vote on any recommendations.

14.2.6 **Notification of Prospective Panel Members and Hearing Officer:** The practitioner shall be notified of the prospective members of the hearing panel and the prospective hearing officer and if the practitioner has any objection to any proposed panel member or the hearing officer, the practitioner shall, within ten calendar (10) days after notification, state the objection in writing and

the reasons for the objection. The individual who appointed the panel members and hearing officer shall, after considering such objections, decide in their discretion whether to replace any person objected to and the practitioner shall be notified of the final hearing officer and members of the hearing panel.

14.2.7. **Hearing Schedule:** The Chief Executive Officer or his/her designee shall schedule and arrange for such hearing as soon as possible after the members of the hearing panel have been selected. The practitioner shall be provided written notice of the date, time and place of the hearing at least thirty (30) calendar days in advance of the initial hearing date, provided that a hearing regarding the summary suspension of a practitioner may be, but is not required to be, held with less than thirty (30) days notice at the request of the affected practitioner.

14.2.8. **Notification of Reasons for Proposed Action, Witnesses and Summary of Hearing Rights:**

14.2.8.1. At least fifteen (15) business days prior to the hearing, the practitioner involved shall be sent by certified and regular mail a statement:

- a.) identifying any witnesses expected to testify before the panel in support of the recommendation under consideration, and
- b.) identifying all medical records or documents expected to be submitted to the panel for consideration.

14.2.8.2. If any expert witness is to be called as a witness in support of the recommendations of the Medical Staff at the hearing, the practitioner shall be told the identity of the experts to be called, provided a copy of the expert's curriculum vitae, provided copies of any reports from the experts on which the Medical Staff intends to rely, or a written description of the substance of the expert's testimony, and provided copies of all documents or materials provided to the expert for review. No witness may be called on behalf of the Medical Staff, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section unless the hearing officer determines that any failure to disclose was unavoidable.

14.2.8.3. At least seven (7) business days prior to the hearing the practitioner shall provide to the Medical Staff the following:

- a.) a list of any witnesses the practitioner will call to testify and a summary of the subject matter of the witnesses' testimony,
- b.) a copy of all documents the practitioner intends to introduce at the hearing,
- c.) if the practitioner intends to call any expert witnesses at the hearing, the member shall identify the experts to be called, provide copies of any reports from the experts on which the practitioner intends to rely or a written description of the substance of the expert's testimony, provide a copy of the witnesses curriculum vitae, and provide a copy of any documents or materials submitted to the expert for review. No witness may be called on behalf of the practitioner, nor any documents submitted for consideration by the panel,

which are not disclosed in accordance with this section unless the hearing officer determines that any failure to disclose was unavoidable, and.

- d.) a statement setting forth the reasons why the practitioner contends that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis

14.2.9. **Conduct of Hearing:**

- a.) **Action:** There shall be at least a majority of the members of the hearing committee present when each hearing session takes place. Any member of the hearing panel, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the panel member was not in personal attendance, shall be permitted to participate in the deliberations and to vote on the recommendations of the hearing panel.
- b.) **Hearing Record:** An accurate record of the hearing must be kept. The mechanism to be used to make a record of the hearing shall be established by the hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. A copy of the record of the hearing shall be made available to the affected practitioner upon payment of a reasonable charge.
- c.) **Mandatory Presence:** No hearing shall be conducted without the personal presence of the practitioner for whom the hearing has been scheduled unless s/he waives such appearance or fails without good cause to appear for the hearing after appropriate notice. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her hearing and appellate review rights hereunder and to have voluntarily accepted the proposed recommendation or decision involved.
- d.) **Representation:** The affected practitioner and Medical Executive Committee or Board of Directors each shall be entitled to be accompanied and/or represented at the hearing by an attorney, a member of the medical staff in good standing or by one other person of the affected practitioner's and Medical Executive Committee or board of director's choice.
- e.) **Evidence:** The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in a civil or criminal action. The practitioner for whom the hearing is being held and Medical Executive Committee or Board of Directors each shall, prior to, during and at the close of the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The hearing committee or hearing officer may also require each party, where practicable, to submit all direct examination testimony through affidavits or other proper documentation. Any such statements shall indicate clearly those matters of which the witness has direct personal knowledge and those matters of which

the witness' knowledge is based on hearsay or information and belief. Such statements shall also indicate the complete basis of any opinions expressed by the witness.

- f.) **Hospital Representative:** The Chair of the Medical Executive Committee or the Chair of the Board of Directors, whichever has appointed the hearing committee, shall appoint a member of the medical staff or Board of Directors, respectively, to present facts in support of the proposed recommendation or decision, and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his/her challenge to the proposed recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that any recommendation or decision based thereon would be either arbitrary, unreasonable or capricious.
- g.) **Examination of Witnesses:** The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence, but neither the practitioner, the Medical Executive Committee, nor the Board of Directors may compel any person to appear at the hearing as a witness. If the practitioner does not testify on his/her own behalf, s/he may be called and examined as if under cross-examination.
- h.) **Deliberations:** The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.
- i.) **Hearing Report:** Within fifteen (15) business days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation, including a statement of the basis for the recommendation, and shall forward the same together with the hearing record and all other documentation through the Chief Executive Officer to the Medical Executive Committee, if the hearing committee was appointed by the Chair of the Medical Executive Committee, or to the Board of Directors, if the hearing committee was appointed by the Chair of the Board of Directors. The report may recommend affirmation, modification, or rejection of the original proposed recommendation of the Medical Executive Committee or decision of the Board of Directors. The Chief Executive Officer shall notify the affected practitioner of the recommendation of the hearing committee, and shall provide the practitioner with a copy of the hearing committee's report and recommendation including a statement of the basis for the recommendation.

- j.) **Consideration of Report by Medical Executive Committee:** Within fifteen (15) business days after the report and recommendations of the Hearing Panel are delivered to the Medical Staff Executive Committee, the practitioner shall submit a written statement to the Medical Staff Executive Committee specifying any findings of fact, conclusions and procedural matters with which the practitioner disagrees and the reasons for such disagreement. Failure to identify any findings of fact, conclusions or procedural matter with which the practitioner disagrees shall constitute a waiver of those issues. The practitioner may not submit new information or evidence not previously considered by the Hearing Panel except as may be requested by the Executive Committee
- k.) **Procedure Thereafter:** Within thirty calendar (30) days after receipt of the hearing committee's report, the Medical Executive Committee shall review the report and recommend to the Board of Directors a final action on the matter. The Medical Staff Executive Committee may, in its sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Staff Executive Committee to present oral argument or respond to inquiries. The Medical Executive Committee may remand the case to the hearing panel for any further proceedings the Medical Executive Committee deems appropriate. Any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. The Chief Executive Officer shall notify the affected practitioner of the final action recommended to the Board of Directors and provide the practitioner with a copy of the report and recommendations of the Medical Executive Committee.
- l.) **Timely Objections to Actions:** In the event any applicant or member of the Medical Staff has any objection to any action taken or procedures followed by the Hospital, the Medical Staff, or any individual, hearing panel or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the Hospital to address the objection and take any corrective action the Hospital deems necessary. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.
- m.) **Discovery:** Except as specifically provided in this Fair Hearing Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any actions taken or not taken with regard to any other practitioner(s). The individual requesting a hearing shall, however, be entitled to any documents relied on by the Medical Staff Credentials or Executive Committees or Board

of Directors in making any recommendation or decision, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the hearing, so long as the individual agrees in writing to keep all such documents confidential. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

14.3. **APPEAL TO THE BOARD OF DIRECTORS:** The following procedures shall apply to appellate reviews to which practitioners are entitled under these bylaws.

14.3.1. **Appeal Request:** Within (10) calendar days after receipt of a notice by an affected practitioner of an adverse recommendation after a hearing as above provided, a practitioner may, by written notice to the Board of Directors, delivered through the Chief Executive Officer, request an opportunity to appear before the Board of Directors or any Committee of the Board designated by the Board (collectively referred to as the "Board"), to present oral argument. Such a request must be submitted in writing to the Hospital CEO. Such appellate review shall be limited to the hearing record and the written statements described below, unless otherwise permitted by the Board of Directors. The record of the hearing and the report of the hearing committee shall be presented to the Board of Directors at the appellate review by the Chair of the hearing committee or his/her designee.

14.3.2 **Waiver of Appeal:** If such appellate review is not requested within such ten calendar (10) day period, the affected practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision.

14.3.3 **Appeal Statements:**

a.) The affected practitioner shall have access to the report and record of the hearing committee and all other materials, favorable or unfavorable, that were considered by the hearing committee in making its recommendation. s/he shall have twenty (20) calendar days after the date of his/her request for appellate review to submit a written statement to the Board of Directors, describing those factual and procedural matters with which s/he disagrees, and his/her reasons for such disagreement. This written statement shall cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Directors through the Chief Executive Officer by certified mail, return receipt requested, and shall supply a copy to the person representing the Medical Executive Committee or Board of Directors at the hearing. The failure to identify any objection to any action taken or procedure followed shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken. A similar statement may be submitted within twenty (20)

calendar days of receipt of the affected practitioner's written statement by or on behalf of the person representing the Medical Executive Committee or board of directors at the hearing, and if submitted, the Chief Executive Officer shall promptly provide a copy thereof to the practitioner by certified mail, return receipt requested.

- b.) New or additional matters not raised during the original hearing or in the hearing committee report, not otherwise reflected in the record, shall only be introduced at the appellate review under extraordinary circumstances, and the Board of Directors shall in its sole discretion determine whether such new matters shall be accepted.

14.3.4. **Board of Directors Procedure:**

- a.) Not later than its next regular meeting after the affected practitioner and Medical Executive Committee or Board of Directors have exercised or waived their rights to submit a written statement pursuant to these bylaws, the Board of Directors shall review the record created in the proceedings, and shall consider the written statements, if any, submitted pursuant to these bylaws, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not unreasonable, arbitrary, or capricious. The Board of Directors may, in its sole discretion, invite the affected practitioner and the representative of the Medical Executive Committee or Board of Directors to be present at such appellate review to answer any questions that may be put to them by any member of the board. In that event, the affected practitioner and the representative of the Medical Executive Committee or Board of Directors may be represented by counsel.
- b.) The Board of Directors, may affirm, modify, or reverse the decision being reviewed, or, in its discretion, refer the matter back to the Medical Executive Committee for further review, with further recommendations from the Medical Executive Committee.
- c.) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 14.5 have been completed or waived. Where permitted by the hospital bylaws, all action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to so act.

14.3.5. **Standard of Appellate Review:** Appellate review by the Board of Directors, or any Committee of the Board designated by the Board, shall be limited determining whether the practitioner has established by clear and convincing evidence that:

1. There has been a substantial failure to comply with the bylaws during the course

of the corrective action which has materially prejudiced the practitioner;

2. The recommendation is arbitrary or unreasonable; or,

3. The recommendation is not supported by any reliable evidence.

14.3.6. **Final Decision by the Board of Directors:**

- a.) Within thirty calendar (30) days after the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee, and through the Chief Executive Officer to the affected practitioner, by certified mail, return receipt requested. The notice to the affected practitioner shall include a statement of the basis for the decision.
- b.) Notwithstanding any other provision of these bylaws, no practitioner shall be entitled to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee, the Board of Directors or a duly authorized committee of the Board of Directors or Medical Executive Committee.
- c.) The decision of the Board of Directors upon any matter subject to the Hearing and Review Procedures of this Article XV shall be final and binding and shall not be subject to any further review under these Bylaws or in any judicial or administrative proceeding.

ARTICLE XV

CONFIDENTIALITY AND IMMUNITY FROM LIABILITY

15.1. **CONDITIONS:** The following shall be express conditions to any application for, or exercise of, staff membership or clinical privileges at this hospital:

15.1.1. Except as otherwise provided in section 4.3.6.(m), the practitioner agrees that there shall be absolute and unconditional immunity from liability for (and shall release any person or entity from liability for) any act, communication, report, recommendation or disclosure for the purpose of achieving and maintaining patient care of high quality in this or in any other health care facility, and all peer review, credentialing, and quality improvement actions shall be privileged to the fullest extent permitted by law. Such immunity and release shall apply to acts, communications, reports, recommendations, or disclosures performed or made in connection with this hospital or any other health care institution's related activities, including but not limited to:

- a.) applications for appointment, reappointment and granting or continuation of clinical privileges;

- b.) periodic reappraisals for reappointment or for increase or decrease in clinical privileges;
- c.) proceedings for suspension of clinical privileges or revocation of staff membership;
- d.) summary or automatic suspension, dismissal or other summary action;
- e.) hearings and appellate review;
- f.) medical care evaluations;
- g.) utilization management reviews;
- h.) other hospital, Medical Executive Committee, medical staff, department, division or committee activities related to the quality of patient care and professional conduct of a practitioner.
- i.) reports or information provided to the National Practitioner Data Bank, any licensing or regulatory agency or any other hospital or healthcare facility or entity.

15.1.2. To the fullest extent permitted by law, there shall be absolute and unconditional immunity for Stamford Hospital, the members of the medical staff, the ancillary staff, the Board of Directors, and all officers, agents and employees of the Hospital, for any and all civil liability arising from any act, communication, report, recommendation, or disclosure involving an initial application for medical staff applicant or medical or ancillary staff member.

15.1.3. That such immunity from liability shall extend to members of the medical staff, the Board of Directors, and the Chief Executive Officer or their designees ("authorized persons"), and to third parties, who supply information to any of the foregoing authorized persons and such persons who are hereby authorized to receive, release or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized person.

15.1.4. That the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an applicant's or a medical or ancillary staff member's professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care at this or any other hospital or health care institution, or the practitioner's suitability for medical staff membership or clinical privileges.

15.1.5. That in furtherance of the foregoing, each applicant and each medical and ancillary staff member shall upon request of the hospital execute releases in accordance with the tenor and import of this Article in favor of the authorized persons and third

parties specified in Paragraph 15.1.2 hereof, subject to such requirements, including those of good faith, absence of malice as may be applicable under the laws of this State.

15.1.6. Provisions in these bylaws and in application or reappointment forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections and immunities provided by law and not in limitation thereof.

15.1.7. Stamford Hospital shall indemnify and defend each practitioner serving as an officer of the Medical Staff or on any committee or department or section of the Medical Staff, or otherwise participating in any Medical Staff activity conducted pursuant to the Medical Staff Bylaws, against any claims made against any practitioner as a result of actions taken on behalf of the Hospital, as long as there is no evidence of overt misconduct on the part of the practitioner and the practitioner maintains appropriate confidentiality and follows all Hospital approved procedures in connection with any peer review, credentialing or other activities.

15.2. **Confidentiality of Information:**

15.2.1. Information with respect to any practitioner which is submitted, collected or prepared by any representative of Stamford Hospital or the Medical Staff or any other health care facility, organization, or individual for the purposes of achieving and maintaining quality patient care, reviewing the conduct or activities of any practitioner, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated or released to anyone other than an authorized representative of Stamford Hospital or Medical Staff and shall not be used in any way except as authorized by these Bylaws or Stamford Hospital. Such information shall not be made a part of any patient's record or of any general Hospital records except those relating to peer-review and performance improvement and evaluation.

15.2.2. Each member of the Medical Staff and each Allied Health Professional agrees to maintain as confidential all information related to patients' condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care or actions or conduct of health care providers at facilities of Stamford Hospital.

ARTICLE XVI
RULES AND REGULATIONS

- 16.1. The Medical Executive Committee, with the approval of the Board of Directors, may adopt such rules, regulations and policies for the governance of the medical staff as are consistent with the articles of organization and bylaws of the hospital and these bylaws.
- 16.2. Any rule or regulation proposed by the Medical Executive Committee shall be distributed to the members of the Medical Staff for review and comment before the proposed rule or regulation is approved by the Medical Executive Committee. Any member of the Medical Staff may submit written comments to the Medical Executive Committee within ten (10) business days after the rule or regulation is distributed. The Medical Executive Committee shall consider any written comments before it acts to approve the proposed rule or regulation. Following approval by the Medical Executive Committee the proposed rule or regulation shall be forwarded to the Board of Directors for consideration. No rule or regulation shall be effective unless and until approved by the Board of Directors. Any policy adopted by the Medical Executive Committee shall be communicated to the members of the Medical Staff after the policy is approved by the Medical Executive Committee.
- 16.3. In the event there is a documented need for an urgent amendment to rules and regulations, or the adoption of a new rule or regulation, to comply with a law or regulation, the Medical Executive Committee may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the rules and regulations without prior notification to the Medical Staff. In such event the members of the Medical Staff shall be advised of the amendment and members of the Medical Staff may within ten (10) business days submit to the Medical Executive committee any comments regarding the provisional amendment.
- 16.4. If members of the Organized Medical Staff disagree with a rule, regulation or policy proposed or adopted by the Medical Executive Committee, upon petition signed by twenty percent (20%) of the voting members of the Organized Medical Staff and submitted to the Medical Executive Committee within thirty [30] calendar days after a rule, regulation or policy is distributed to the Medical Staff, any provisional amendment adopted pursuant to section, or any rule, regulation, or policy proposed or adopted by the Medical Executive Committee, shall be submitted to conflict management process set forth in Article XVIII.
- 16.5. In addition to the provisions of Sections 16.1 and 16.2, rules, regulations, and policies may also be proposed directly to the Board by majority vote of the members of the Organized Medical Staff entitled to vote. Proposed rules, regulations, or policies may be brought before the voting members of the Medical Staff by petition signed by twenty percent (20%) of the members of the Organized Medical Staff entitled to vote. Any such rules, regulations, or policies proposed by a majority members of the Organized Medical Staff entitled to vote shall

be submitted to Board of Directors for approval. Any proposed rule, regulation or policy shall also be provided to the the Medical Executive Committee for review and comment. All proposed Medical Staff, department, or section rules, regulations, and policies procedures shall become effective only after approval by the Board.

- 16.6. Duly adopted medical staff rules and regulations shall have the same force and effect as these bylaws and shall be appended hereto.

ARTICLE XVII

BYLAWS AMENDMENTS

- 17.1. The Bylaws Committee shall review these bylaws of the medical staff not less frequently than every two (2) years to assure compliance with legal requirements and standards or medical practice in the relevant community. Proposals to amend repeal or supplement these bylaws, or the medical staff or departmental rules and regulations, may be made by a Department Chair, the Bylaws Committee, the voting members of the Organized Medical Staff, Medical Executive Committee or Board of Directors as set forth in these Bylaws. All proposed changes to these bylaws shall be transmitted to the Bylaws Committee for review and recommendation to the Medical Executive Committee.
- 17.2. All proposed amendments approved by the Medical Executive Committee shall be presented at the next regular meeting of the medical staff, or may be mailed or sent electronically to the voting members of the Organized Medical Staff for approval by written or electronic ballot via a secure voting mechanism approved on an annual or as needed basis by the Medical Executive Committee. The Medical Executive Committee shall determine whether to submit the proposed amendments for approval by mail or electronic ballot or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail or electronic ballot shall be subject to approval by a majority of the members of the Active and Courtesy Staff submitting ballots via a secure voting mechanism approved on an annual or as needed basis by the Medical Executive Committee written ballots. Written or electronic ballots shall be prepared and validated in such manner as the Medical Executive Committee shall approve and only ballots received in the Medical Staff Office within fourteen (14) calendar days after the ballots are mailed or sent electronically shall be counted. Voting members should have fourteen (14) calendar days to submit their votes after the ballots are distributed.
- 17.3. Bylaw amendments may also be proposed directly to the Board by vote of the majority of the voting members of the Organized Medical Staff. Proposed Bylaws may be brought before the voting members of the Organized Medical Staff by petition signed by twenty percent (20%) of the voting members of the Organized Medical Staff. Any such proposed bylaw

amendment approved by majority vote of the Organized Medical Staff shall also be submitted to the Medical Executive Committee for review and comment.

- 17.4. All Bylaw amendments approved by the MEC and the voting members of the Organized Medical Staff shall be subject to approval by the Board of Directors. If the Board of Directors has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC or the Board of Directors may refer the matter for consideration by a Joint Conference Committee in accordance with section 11.3.6.
- 17.5. The Medical Executive Committee shall have the authority to adopt amendments to the Medical Staff Bylaws without approval of the Organized Medical Staff if such amendments do not substantively change any bylaw provision and are solely for technical modifications or clarifications, reorganization or renumbering, or to correct grammatical, spelling, or punctuation errors. Such technical amendments shall be effective when approved by the Board of Directors. In addition, the Medical Executive Committee may adopt any amendments required for legal reasons or to comply with any regulatory or accreditation requirements. Such amendments shall be effective when approved and shall remain in effect unless disapproved by the Board of Directors or any committee designated by the Board within sixty (60) days or by the Medical Staff at its next general meeting.

ARTICLE XVIII

CONFLICT MANAGEMENT

- 18.1. In the event of a conflict between the voting members of the Medical Staff and the Medical Executive Committee regarding the adoption of any bylaw, rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by twenty percent (20%) of the members of the Medical Staff entitled to vote, or by majority vote of the Medical Executive Committee, the matter shall be submitted to the following conflict resolution process.
- 18.2. A Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the Active Staff designated by the Medical Staff members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the President of the Medical Staff. However, if the conflict resolution process is initiated by vote of the Medical Executive Committee, representatives of the Medical Staff shall be invited to participate on the Conflict Resolution Committee and the President of the Medical Staff shall select five (5) medical staff representatives from those individuals wishing to participate. The Hospital President/CEO and the Chief Physician Executive shall be ex-officio non-voting members of any Conflict Resolution Committee.
- 18.3. The members of the Conflict Resolution Committee shall meet to discuss the disputed matter and work in good faith to resolve the differences between the parties.

- 18.4. Any recommendation which is approved by a majority of the members of the Conflict Resolution Committee shall be submitted to the Board of Directors for consideration and be subject to final approval by the Board. If agreement cannot be reached by a majority of the Committee members, the members of the Conflict Resolution Committee shall individually or collectively report to the Board of Directors regarding the unresolved differences for consideration by the Board of Directors in making its final decisions regarding the matter in dispute.
- 18.5. In the event of a dispute between the Board of Directors and the Medical Staff or the Medical Executive Committee, the matter in dispute shall be submitted to a Joint Conference Committee pursuant to section 11.3.6.
- 18.6. In the event of a dispute between leaders or segments of the Medical Staff, the matter in dispute shall be Conflict Resolution Committee composed of an equal number of members representing opposing viewpoints who are appointed by the Medical Staff President or the Medical Executive Committee. The members of the Conflict Resolution Committee shall proceed in accordance with Sections 18.2. and 18.3. above.
- 18.7. If deemed appropriate by the President of the Medical Staff and the Hospital President/CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

ARTICLE XXIV

ADOPTION

- 19.1. These bylaws, together with the appended rules and regulations, shall become effective and replace any previous bylaws, rules and regulations, after they have been adopted by the medical staff and approved by the Board of Directors which approval shall not be unreasonably withheld. Except as otherwise provided herein, these Bylaws, and all amendments to these Bylaws, shall be effective at such time as is specified by the Medical Executive Committee and approved by the Board of Directors. If the Medical Executive Committee and the Board of Directors do not otherwise specify when any bylaw amendments shall be effective, such amendments shall be effective at such time as they are finally approved by the Board of Directors and the Medical Staff and shall apply to all matters currently pending to the extent practical.

APPROVED BY:

MEC 08/31/2009, 01/03/2011, 06/03/2013, 9/8/15, 9/5/16, 10/4/16, 9/10/2018, 1/6/2020
 Medical Staff 09/2009, 03/2011, 07/01/2013, 9/25/15, 10/27/16, 9/11/2018, 1/24/2020
 Board of Trustees 09/23/2009, 05/18/2011, 07/24/2013, 11/19/15, 11/16/16, 9/26/2018, 1/29/2020

