STAMFORD HEALTH

BYLAWS OF THE MEDICAL STAFF

STAMFORD HOSPITAL

By: _____

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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, 01/08/2024
Medical Staff	09/2009, 03/2011,07/01/2013, 9/25/15, 10/27/16, 9/27/2018, 1/24/2020, 01/19/2024
Board of Trustees	09/23/2009, 05/18/2011, 07/24/2013, 11/19/15, 11/16/16, 9/26/2018, 1/29/2020, 01/24/2024

STAMFORD HOSPITAL MEDICAL STAFF BYLAWS

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ARTICLE I
DEFINITIONS

1.1 The term "**Accrediting Organization**" or "**Hospital's Accrediting Organization**" means The Joint Commission or one or more other accrediting agenc(ies) approved by the Board from time to time through which the Hospital obtains accreditation.

1.2 The term "**APPs**" or "**APP Staff**" means advanced practice professionals, including but not limited to certified registered nurse anesthetists, nurse practitioners, physician assistants ("**PAs**"), advanced practice registered nurses ("**APRNs**"), certified nurse mid-wives, radiologist assistants, and certain doctoral health professionals who are duly licensed, certified, or otherwise authorized, as applicable, to practice their profession in Connecticut, and for which the Board has approved the establishment of clinical privileges. For clarity, the Board shall determine the categories of APPs who may apply for Medical Staff membership and for whom clinical privileges may be granted.

1.3 The term "**Board"** means the Hospital's Board of Directors that serves as the governing body of the Hospital as described in its bylaws.

1.4 The term "**business day**" means every day except Saturday, Sunday, and a state or federal holiday.

1.5 The term "**CEO"** means the Chief Executive Officer of the Hospital.

1.6 The term "**Committee**" or "**Medical Staff Committee**" means a Standing, Additional Standing, or Special Medical Staff Committee including the MEC, unless otherwise stated**.**

1.7 The term "**CPE**" means the **Chief Physician Executive**, **SVP of Medical Affairs**, or **Chief Medical Officer** of the Hospital, who shall be a member of the Active Medical Staff and a member of Hospital administration, reporting to the CEO.

1.8 The term "**Credentials Manual**" shall mean the document setting forth the Hospital's credentialing and privileging requirements, including all related policies and procedures, for each Medical Staff category described in Article VI of these Bylaws.

1.9 The term "**Department**" or "**Clinical Department**" means a clinical department of the Hospital.

1.10 The term "**Department Rules**" means a written set of rules for the operation of a Hospital Department and/or Division that includes criteria for granting clinical privileges within a Department and its Division(s) and for holding office in a Department. The process for adopting and amending Department Rules is set forth in the Medical Staff Rules.

1.11 The term "**Division"** or "**Clinical Division"** means an organized specialty division of a Department.

1.12 The term "**entitled to vote**" means having the right to vote in a given context.

1.13 The term "**Hospital"** means Stamford Hospital, Inc. and, where applicable, all other health care facilities included on the Connecticut acute care hospital license of Stamford Hospital, including without limitation Hospital service locations in the Tully Health Center and other outpatient Hospital-licensed sites.

1.14 The term "**House Staff"** means an intern, resident, or fellow who has graduated from an accredited medical school and is receiving education and providing clinical care at the Hospital under supervision as required by law and accreditation requirements.

1.15 The term "**MEC"** means the Medical Executive Committee that serves as the governing body of the Medical Staff as described in these Bylaws.

1.16 The term "**Medical Staff"** means all Practitioners who continuously meet the requirements, qualifications and responsibilities set forth in these Bylaws and who are appointed by the Board.

1.17 The term "**Medical Staff Leader(s)**" means the Medical Staff President, applicable Department Chair(s), CPE, and CEO.

1.18 The term "**Medical Staff Member**" means a Practitioner who has been appointed to the Medical Staff by the Board.

1.19 The term "**Medical Staff Policy**" means a policy established by the MEC pursuant to the Medical Staff Rules as described in Article XVI of these Bylaws.

1.20 The term "**Medical Staff Rules**" means the Medical Staff Rules and Regulations that govern the conduct and clinical activities of the Medical Staff.

1.21 The term "**MSO**" means the Medical Staff Office of the Hospital.

1.22 The term "**NPDB**" means the National Practitioner Data Bank.

1.23 The term "**Organized Medical Staff**" means Physician Medical Staff Members who have overall responsibility for the oversight of the care, treatment, and services provided by the Medical Staff as a whole. The Organized Medical Staff is responsible for ensuring that the Hospital provides a uniform standard of care to all patients.

1.24 The term "**20% Petition**" means a petition signed by twenty percent (20%) of the Physician Medical Staff entitled to vote.

1.25 The term "**Physician"** means an individual duly licensed to practice medicine, surgery,

podiatry, dentistry, or oral surgery in the State of Connecticut.

1.26 The term "**Practitioner**" means a Physician or APP.

1.27 The term "**quorum**" means the following:

For a meeting of the Medical Staff, the Physician Medical Staff Members present at the meeting and entitled to vote;

For a meeting of a Medical Staff Committee, a majority of the Medical Staff Members who are members of the Committee and entitled to vote.

1.28 The term "**Reproductive Health Services Exception**" means Connecticut Public Act No. 23-128, which provides, in relevant part, that the Hospital shall not revoke, suspend, reprimand, penalize, refuse to issue, or renew credentials or privileges or take any other adverse action against a Medical Staff Member based on a pending disciplinary action, an unresolved complaint, or the imposition of disciplinary action against them by a duly authorized professional disciplinary agency of another state, the District of Columbia, or a commonwealth, territory, or possession of the United States based ***solely*** on the alleged provision of, receipt of, assistance in the provision or receipt of, material support for, or any theory of vicarious, joint, several, or conspiracy liability derived therefrom, reproductive health services that (i) are permitted under Connecticut law; (ii) were provided in accordance with the applicable standard of care; ***and*** (iii) were provided by the Medical Staff Member (a) before they joined the Hospital's Medical Staff; or (b) outside the scope of the Medical Staff Member's employment or other relationship with the Hospital, regardless of whether the patient receiving such services was a Connecticut resident.

1.29 The term "**restriction**" or "**restrict**" with respect to clinical privileges or Medical Staff membership means an action that results in the inability of a Medical Staff Member to exercise their own independent judgment in a professional setting.

1.30 The term "**Significant Adverse Action**" means the actions described as such in Article XIII of these Bylaws.

1.31 The term "**simple majority**" or "**majority**" means more than fifty percent (50%) of Medical Staff Members (and other individuals if permitted to vote on certain Medical Staff Committees pursuant to Article XI of these Bylaws) entitled vote at any meeting at which a quorum is present. Unless otherwise stated, all action taken by vote referenced in these Bylaws shall require a simple majority, either in person and/or, if specified, electronically, utilizing a secure voting mechanism that is approved by the MEC.

1.32 The term "**SHI**" means Stamford Health, Inc.

1.33 The term **"they/them**" and "**their/theirs**," as used herein means such gender as the context may require and includes references to "s/he," "him/her," "his/hers," and any other gender-identifying term, in both the singular and plural.

1.34 The term "**written notice,**" "**written request**," or "**in writing**" means a notice, request, or other communication transmitted via (i) hand delivery; (ii) certified mail, return receipt requested; (iii) overnight or other trackable, expedited mail or carrier service; or (iv) email or facsimile with confirmation of delivery. A written notice shall be deemed received (i) on the date it is delivered by hand, electronically, or by certified mail; or (iii) on the day following delivery to a carrier service for next day delivery.

1.35 **Titles include authorized designee(s)**. Whenever any title of a person is used in these Bylaws, such title shall refer to the individual holding such title as well as his/her authorized designee(s).

ARTICLE II

NAME

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

ARTICLE III

SCOPE AND PURPOSES

These Medical Staff Bylaws, as well as the Medical Staff Rules, Medical Staff Policies, and all Department Rules, apply to and are binding upon all Medical Staff Members and all Practitioners holding or seeking clinical privileges and/or Medical Staff membership, whether or not expressly stated in a given Section. In the event of a conflict or inconsistency between these Bylaws and any Medical Staff Rules, Medical Staff Policies, or Department Rules, these Bylaws shall govern.

The purposes of the Medical Staff are:

3.1 To create and maintain a set of Bylaws that define its role and responsibilities within the context of the Hospital setting in the oversight of care, treatment, and services, and, together with the Medical Staff Rules, create a framework within which Medical Staff Members may act with a reasonable degree of freedom and confidence.

3.2 To create and maintain the Medical Staff Rules, Medical Staff Policies, and Department Rules.

3.3 To ensure that all patients who receive health care services from the Hospital shall receive quality medical care.

3.4 To ensure a high level of professional performance of all Medical Staff Members through the appropriate exercise of professional judgment and the ongoing review and evaluation of each Medical Staff Member's performance.

3.5 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.

3.6 To provide a means by which the Medical Staff, Board, and Hospital management may hold discussions concerning Medical Staff and Hospital issues.

3.7 To encourage cooperation with other hospitals, educational institutions, medical schools, and health care facilities.

3.8 To set forth the process by which Practitioners may obtain clinical privileges and Medical Staff membership and fulfill the obligations and requirements associated therewith.

ARTICLE IV

MEDICAL STAFF MEMBERSHIP

4.1 GENERAL PRINCIPLES

A. **Medical Staff Membership and/or Clinical Privileges.** Medical Staff membership shall be extended only to Practitioners who meet the qualifications, standards, and requirements set forth in these Bylaws, Medical Staff Rules, and Medical Staff Policies, and are appointed to the Medical Staff by the Board.

B. **Uniform Application of Criteria**. The criteria for Medical Staff membership specified in these Bylaws shall be applied uniformly to all Practitioners and are designed to assure the Board and the Medical Staff that Hospital patients will receive quality medical care. No Practitioner shall be entitled to Medical Staff membership solely by virtue of the fact that they are duly licensed to practice in Connecticut or any other state, that they are a member of any professional organization, or that they had in the past, or currently have, privileges at this or another hospital.

C. **Threshold Appointment Criteria.** Appointment to the Medical Staff shall be contingent upon: (i) the Hospital's ability to provide adequate facilities and supportive services for the applicant and their patients; (ii) the applicant's ability to demonstrate clinical skill and competence; and (iii) the applicant's ability to satisfy such additional criteria as may be established from time to time by the Board.

D. **Dues**. The MEC may set annual dues required to be paid by Medical Staff Members.

E. **Non-Discrimination**. No Practitioner shall be denied Medical Staff membership on the basis of gender, race, age, disability, religion, national origin, color, marital status, sexual orientation, gender identification or expression, ancestry, genetic information, or being identified as a member of any other protected class.

4.2 THRESHOLD QUALIFICATIONS FOR AND OBLIGATIONS OF MEDICAL STAFF MEMBERSHIP.

The specific professional criteria and qualifications that constitute the basis for granting or denying Medical Staff membership are set forth in the Medical Staff Credentials Manual. All Practitioners are subject to, and must comply with, all such requirements. In addition to the requirements set forth in the Medical Staff Credentials Manual, the following requirements for Medical Staff membership are deemed to be of particular importance.

4.3 PHYSICIAN BOARD CERTIFICATION

A. **Basic Requirements**[1]. All Physician Medical Staff Members and all Physicians seeking Medical Staff membership shall:

1. Have successfully completed a residency or fellowship approved by a specialty board recognized by the American Board of Medical Specialties, the American Board of Oral and Maxillofacial Surgery, the American Osteopathic Board of Medical Specialties, the American Board of Podiatric Surgery, or an equivalent specialty board approved by the Board after considering the recommendation of the MEC; and

2. Meet all requirements for attaining and maintaining board certification in their specialty as set forth below. As a general rule, Physician Medical Staff Members must become board certified in the specialty that is appropriate for their clinical practice within (i) the time frame set by the certifying board, or (ii) five years after completing residency or fellowship training, as applicable, whichever is the longer timeframe, such that Physicians shall have at least five years from the completion of their residency or fellowship training in which to become board certified (the "**Required Certification Timeframe**"). The application of this rule with respect to Medical Staff applicants and current Medical Staff Members are set forth below.

B. **Discretionary Certification Extension for New Medical Staff Applicants**

1. Physician Medical Staff Applicants – Required Certification Timeframe Expired. A Physician Medical Staff applicant who has not become board certified within the Required Certification Timeframe may request appointment to the Medical Staff despite not having obtained board certification within the Required Certification Timeframe by requesting additional time to become board certified (a "**Discretionary Certification Extension"**). Such request must be acted upon favorably by the Board before the applicant is permitted to submit an application for appointment to the Medical Staff. If the Board denies the request for a Discretionary Certification Extension, the applicant shall be deemed not to meet the criteria for

[1] Notwithstanding the provisions of Section 4.3, any non-board-certified Physician who was a Medical Staff Member in good standing on May 19, 2004, shall not be disqualified from Medical Staff membership or reappointment by reason of the absence of, or ineligibility for, board certification.

appointment to the Medical Staff and shall not be entitled to apply for Medical Staff membership. If the Board grants a Discretionary Certification Extension and the applicant is ultimately appointed to the Medical Staff, the Medical Staff Member shall sit for the first board certification examination offered following the granting of any Discretionary Certification Extension, and the Discretionary Certification Extension shall expire on the date upon which the Medical Staff Member is notified of their exam results, unless the Board, after conferring with the Department Chair, determines that there are exigent and extenuating circumstances or a critical clinical need that would constitute grounds for extending the Discretionary Certification Extension.

No hearing or other due process rights shall apply with regard to the Board's denial of a request for a Discretionary Certification Extension or any extension thereof.

2. Physician Medical Staff Applicants – Required Certification Timeframe Not Expired. A Physician Medical Staff applicant whose Required Certification Timeframe has not yet expired at the time of appointment shall be held to the Board Certification requirement applicable to current Medical Staff Members set forth below.

C. **Certification Extensions –Current Medical Staff Members**

1. Automatic Certification Extension. If a Physician Medical Staff Member fails to obtain board certification as required herein within the Required Certification Timeframe, such Physician Medical Staff Member shall automatically have one additional year to obtain board certification without their Medical Staff membership being affected ("**Automatic Certification Extension**"). [2]

2. Discretionary Certification Extension. If a Physician Medical Staff Member fails to obtain board certification within the Required Certification Timeframe plus the Automatic Certification Extension, the Board may, one time only and for good cause shown by the Physician Medical Staff Member, grant a Discretionary Certification Extension after considering the recommendations of the appropriate Division Director, Department Chair, Credentials

[2] For clarity, Automatic Certification Extension, as defined below, shall not be available to applicants to the Medical Staff, whether or not they receive a Discretionary Certification Extension with respect to their initial appointment to the Medical Staff. Automatic Certification Extensions shall be available only to current Medical Staff Members who are appointed to the Medical Staff before their Required Certification Timeframe expired and who then fail to obtain certification within the Required Certification Timeframe.

Committee, and MEC. The Board's determination as to whether good cause exists shall take into account the demonstrated competence of the Physician Medical Staff Member and the needs of the Hospital and the community it serves**.** If the Board grants a Discretionary Certification Extension, the Medical Staff Member shall sit for the first board certification examination offered following the granting of any Discretionary Certification Extension, and the Discretionary Certification Extension shall expire on the date upon which the Medical Staff Member is notified of their exam results, unless the Board, after conferring with the Department Chair, determines that there are exigent and extenuating circumstances or a critical clinical need that would constitute grounds for extending the Discretionary Certification Extension. No hearing or other due process rights shall apply with regard to the Board's denial of a request for a Discretionary Certification Extension or any extension thereof.

D. **Failure to Certify**. If (i) a Physician Medical Staff Member fails to request a Discretionary Certification Extension prior to the expiration of the Automatic Certification Extension; (ii) the Board denies such Physician Medical Staff Member's request for a Discretionary Certification Extension; or (iii) such Physician Medical Staff Member fails to obtain board certification prior to the expiration of a Discretionary Certification Extension, then such Physician Medical Staff Member's Medical Staff membership shall terminate as of the last day of the Discretionary Certification Extension. No hearing or other due process rights shall apply.

E. **Maintenance of Physician Board Certification/Board Recertification**

1. Maintenance of Board Certification or Board Recertification Required. All Physician Medical Staff Members except (a) those who have been certified in perpetuity or otherwise grandfathered pursuant to the rules of the applicable certifying board; or (b) those certified by a board that has expressly indicated that no recertification or maintenance of certification is required, shall be required to maintain their board certification[3] or to obtain board recertification in their specialt(ies) (such maintenance of board certification or formal recertification shall be referred to herein as "**Recertification**," or "**Recertify**" regardless of the means by which it is achieved) within the timeframe required by the applicable certifying board (the "**Required Recertification Timeframe**").

[3] Physician Medical Staff Members may maintain their board certification by fulfilling the requirements of the certifying board(s) that offer pathways for certification maintenance, as opposed to formal recertification.

2. Automatic Board Recertification Extension. If a Physician Medical Staff Member fails to Recertify within the Required Recertification Timeframe, the Physician Medical Staff Member shall automatically have one additional year to Recertify without their Medical Staff membership being affected ("**Automatic Recertification Extension**").

3. Discretionary Recertification Extension. If a Physician Medical Staff Member fails to Recertify within the Required Recertification Timeframe plus the Automatic Recertification Extension, such Physician Medical Staff Member must, prior to the expiration of their current certification, request their Department Chair's permission to request an additional specified time within which to obtain recertification ("**Discretionary Recertification Extension"**). If the Department Chair grants such permission, the Board may, one time only and for good cause shown by the Physician Medical Staff Member, grant a Discretionary Recertification Extension after considering the recommendations of the appropriate Division Director, Department Chair, Credentials Committee, and MEC. The Board's determination as to whether good cause exists shall take into account the demonstrated competence of the Physician Medical Staff Member and the needs of the Hospital and the community it serves. If the Board grants a Discretionary Recertification Extension and the Medical Staff Member's board recertification is to be accomplished by a recertification examination, the Medical Staff Member shall sit for the first board recertification examination offered following the granting of any Discretionary Certification Extension. If Recertification is to be accomplished by means other than an examination, the Board shall, in its discretion, determine the length of the Discretionary Recertification Extension Period based upon the circumstances. The Discretionary Certification Extension shall expire on the date upon which the Medical Staff Member is notified of their examination results or, if recertification shall be achieved by means other than an examination, upon the end date set by the Board, all unless the Board, after conferring with the Department Chair, Division Director, Credentials Committee, and MEC, determines that there are exigent and extenuating circumstances or a critical clinical need that would constitute grounds for extending the Discretionary Certification Extension Period. No hearing or other due process rights shall apply with regard to the Board's denial of a request for a Discretionary Recertification Extension or any extension thereof.

F. **Failure to Recertify**. If (i) a Physician Medical Staff Member fails to request a Discretionary Recertification Extension prior to the expiration of the Automatic Certification Extension; (ii) their Department Chair denies the Medical Staff

Member's request for permission to request, and/or the Board denies a Physician Medical Staff Member's request for, a Discretionary Recertification Extension; or (iii) the Physician Medical Staff Member fails to obtain recertification within the Discretionary Recertification Extension including any extension thereof, then the Physician Medical Staff Member's Medical Staff membership shall be terminated as of the last day of the Discretionary Recertification Extension, and no hearing or other due process rights shall apply.

4.4 **APP BOARD CERTIFICATION**. For clarity, APPs in specialties for which board certification is currently, or in the future becomes, required by governmental, licensing, or accreditation bodies, must be board certified in order to join the Medical Staff and must maintain such board certification in order to remain on the Medical Staff in good standing. Failure to do so shall result in the termination of Medical Staff membership and no hearing or other due process rights shall apply.

4.5 **MALPRACTICE INSURANCE.** Medical Staff Members shall maintain and provide documentation of professional liability insurance, with an insurer approved by the Board, that provides insurance coverage for the privileges being exercised in the minimum or greater amount, and in such form, as may be required by the Board. The Board, in consultation with the MEC, shall from time to time review the adequacy of professional liability insurance recommended by the Departments and Divisions to ensure consistency with the Hospital's Risk Management Program.

4.6 **CALL RESPONSE.** Medical Staff Members shall at all times be within such distance from the Hospital as needed to ensure prompt response in accordance with these Bylaws, Medical Staff Rules, and/or any Department Rules, whichever are more stringent. Failure to adhere to these response times may subject the Medical Staff Member to corrective action as set forth in Article XIII of these Bylaws, which may include termination of Medical Staff membership.

4.7 **REPRODUCTIVE HEALTH SERVICES EXCEPTION**. Notwithstanding anything in these Bylaws to the contrary, all Medical Staff appointment, reappointment, privileging, credentialing, and similar processes shall be subject to the Reproductive Health Services Exception.

ARTICLE V

APPLICATION, APPOINTMENT, AND REAPPOINTMENT

5.1 PRE-APPLICATION

A. **Submission**. All Practitioners seeking an application for Medical Staff membership shall submit a request in writing to the MSO. The MSO will send the applicant a pre-application questionnaire to obtain preliminary information about the applicant, including their qualifications, training, and experience, as well as the Hospital's ability to provide adequate facilities and supportive services for the applicant and their patients. Upon receipt by the MSO, the completed questionnaire will be sent to the CPE, Department Chair, and Division Director. An application for Medical Staff membership will then be provided to the applicant unless the pre-application questionnaire indicates there is a basis for not doing so as described below. All applications for appointment to the Medical Staff shall be submitted in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Board after consultation with the MEC.

B. **Grounds for Not Providing Application Package/Notice**. No application for appointment or reappointment shall be provided to a prospective applicant, nor shall an application be accepted from a prospective applicant, if the MSO determines that any of the following is true:

1. The Hospital does not have the ability to provide adequate facilities or services for the prospective applicant or the patients to be treated by them;
2. The Hospital has contracted with an individual or group to provide the clinical services sought to be provided by the prospective applicant on an exclusive basis and the prospective applicant is not and will not be associated with the individual or group holding the exclusive contract;
3. The prospective applicant is listed in the Healthcare Integrity and Protection Data Bank as a health care provider who is excluded from participation in Medicare or Medicaid, or is sanctioned by Medicare or Medicaid;
4. The prospective applicant does not meet, and shall not be able in the reasonable future to meet, the Hospital's requirements relating to licensure and registration, professional liability insurance, board certification, or other requirements set forth in these Bylaws; or
5. The prospective applicant does not qualify for Medical Staff membership based on their education and/or training.

C. **Notice of Non-Provision of Full Application**. Any Practitioner who is refused an application shall be notified in writing of the reasons for the refusal and may, within twenty (20) business days after receipt of such written notice, submit any additional

information they wish the Hospital to consider. The CEO, in consultation with the Medical Staff President, shall consider any such information and make a final decision concerning whether the individual is entitled to receive an application. No individual shall be entitled to a hearing or other due process rights provided in these Bylaws as a result of a refusal by the Hospital to provide an application to such individual.

5.2 **BURDEN OF PROVIDING INFORMATION**. The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. The applicant also shall have the burden of establishing their qualifications for the specific clinical privileges they request.

5.3 **COMPLETENESS AND VERIFICATION**

A. The MSO shall review for completeness an applicant's completed application for appointment, reappointment, clinical privileges, or change in Medical Staff category or status, as well as their references, licensure, certifications, malpractice insurance, education, training, and Medicare and Medicaid standing, and shall verify other information 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 to which the applicant seeks to be assigned.

B. An application shall be considered incomplete if:

1. The applicant has submitted an application with questions unanswered or incomplete, items left blank, or attachments missing;

2. The applicant has failed to provide additional information, documentation, and/or verification within twenty (20) business days of receipt of a written request for such from the Department Chair(s), Credentials Committee, or MEC, unless such timeframe is waived by the Medical Staff President or CEO; or

3. The applicant has failed to pay any dues, assessments, or fines that are currently due within twenty (20) business days of receipt of a written request to do so from the Department Chair(s), Credentials Committee, or MEC, unless such timeframe is waived by the Medical Staff President or CEO.

C. An incomplete application shall not be accepted by the Hospital and shall be deemed to be withdrawn. No hearing or other due process rights shall apply.

5.4 **RECORDS**. The MSO shall maintain a file for each applicant, which file shall contain all documents pertinent to the applicant's application and the Hospital's consideration thereof.

5.5 **RESTRICTION ON RE-APPLICATION**. A prospective applicant (i) whose application for appointment, reappointment, or clinical privileges has been denied for reasons related to their professional conduct or clinical competence; or (ii) who has resigned or failed to apply for reappointment to the Medical Staff after being notified in writing that they are under investigation or that an investigation is being initiated; shall not be eligible to reapply for Medical Staff membership for five years from the date of such decision or resignation unless the Board expressly decides 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 decision or no longer exists.

5.6 **REQUESTS FOR NEW CLINICAL PRIVILEGES.** Any Medical Staff Member who wishes to request new or additional clinical privileges shall submit to the MSO a request in writing setting forth the privileges requested and the training and experience that qualifies them for such new or additional 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 an FPPE as defined and described below.

5.7 **APPOINTMENT PROCESS**

A. **Department Procedure - Submission of Application/Review by Department Chair.** If they have not already done so, within fourteen (14) business days after receipt of the completed application, the Chair(s) of the applicable Department(s) shall schedule a time to meet with the applicant (in person, remotely, or by telephone if necessary) to interview them and assess their qualifications for Medical Staff membership. The Chair may also consult with Directors of the relevant Clinical Divisions and, where appropriate, other members of their Department concerning the applicant. The Chair shall then forward to the MSO their specific, written recommendations to approve, reject, or approve with modifications the application for Medical Staff membership, including Medical Staff category and any clinical privileges requested. The MSO shall transmit the application and all supporting materials, including the results of the interview and the Chair's recommendations, to the Credentials Committee for evaluation of the applicant's credentials.

B. **Credentials Committee Procedure.** Within sixty (60) business days after receipt of completed application and all accompanying materials, the Credentials Committee shall determine, through information contained in references provided by the applicant, their peers, and other sources, including but not limited to information from the NPDB and the assessment of the Department Chair, whether the applicant meets all of the necessary qualifications for the category of Medical Staff membership and

any clinical privileges requested. Such determination shall include an assessment of the character, professional competence, qualifications, and ethical standing of the applicant, consistent with the general principles set forth in these Bylaws. Within such sixty (60) business day period, the Credentials Committee shall make a written report of its evaluation to the MEC. Such report shall include the recommendations of the Department Chair pursuant to Section 5.7(A) above, 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.

C. **MEC Procedure**

1. At its next regular meeting after receipt of the application, report, and recommendation of the Credentials Committee, or at a special meeting called for the review of the application, the MEC shall determine whether to recommend to the Board that the applicant be appointed to the Medical Staff, that their application be rejected, that their application be remanded for further consideration and additional information, or that such other action be taken as the MEC deems appropriate. All recommendations for Medical Staff appointment must also specifically provide a recommendation as to any clinical privileges to be granted, including any specific restrictions or other conditions that the MEC wishes to place upon such privileges.

2. If the recommendation of the MEC is favorable to the applicant, the CEO shall promptly forward it together with all supporting documentation to the Board.

   If the MEC recommends Significant Adverse Action, the CEO shall promptly so notify the applicant in writing. Such written notice (the "**MEC Significant Adverse Action Notice**") shall advise the applicant of their right to a hearing under Article XIV of these Bylaws and expressly indicate that the failure to request a hearing within thirty (30) business days of receipt of the MEC Significant Adverse Action Notice shall constitute a waiver of the right to a hearing. For clarity, a recommendation to remand the application is not a Significant Adverse Action.

   If the applicant does not request a hearing within thirty (30) business days of receipt of the MEC Significant Adverse Action Notice, the applicant's entire file, including the report and recommendations of the MEC, shall be forwarded to the Board for final action.

If the applicant does request a hearing within thirty (30) business days of receipt of the MEC Significant Adverse Action Notice, the applicant shall be entitled to a hearing in accordance with Article XIV of these Bylaws.

3. Notwithstanding the foregoing, if the MEC recommends a Significant Adverse Action, the Board shall take no action with respect thereto until the time for the applicant to request a hearing has expired, or if a hearing is requested, until the hearing process has been completed.

D. **Board Procedure**

1. Not later than its next regular meeting after receipt of a final recommendation from the MEC concerning an applicant, the Board shall act on the matter. The Board may act to accept, reject, or accept with modifications the recommendations of the MEC, or refer the matter back to the MEC for further consideration or information.

2. If the Board's action is favorable to the applicant, such action shall be final. All decisions to appoint an applicant to the Medical Staff shall include a delineation of any clinical privileges that the applicant may exercise. For applications that meet certain criteria established by the Board, the Board may delegate to the CEO the right to act on an application prior to the next regularly scheduled Board meeting, subject to Board ratification. When the final decision has been made, the Board shall send written notice of its decision through the CEO to the Medical Staff President, the Department Chair, and the applicant.

3. If the Board's action confirms the MEC's recommendation for Significant Adverse Action (whether following a hearing or after the right to a hearing has been waived), such action shall be final and no other hearing or due process rights shall apply. When the final decision has been made, the Board shall send written notice of its decision through the CEO to the Medical Staff President, the Department Chair, and the applicant.

4. If the Board's action is to impose Significant Adverse Action despite the MEC not having made such a recommendation, such decision shall constitute a Significant Adverse Action, and the notice of such decision ("**Board Significant Adverse Action Notice**") shall advise the applicant of their right to a hearing. For clarity, such a determination by the Board shall entitle the Medical Staff Member to a hearing at the Board level ***IF AND ONLY IF the final decision of the Board is to impose a Significant Adverse Action where the MEC has not made such a recommendation and a hearing on the matter has not been held previously.*** In such event, the Board Significant Adverse

Action Notice shall expressly indicate that:

a. A hearing may be requested by delivering a written request to the CEO within thirty (30) business days of delivery of the Board Significant Adverse Action Notice; and
b. The failure to request a hearing within thirty (30) business days of delivery of the Board Significant Adverse Action Notice shall constitute a waiver of the right to a hearing.

E. **Remand for further Information.** Neither the Board nor the MEC shall defer action on, or remand, an application for further consideration unless it determines that it does not have adequate information to evaluate the applicant's qualifications for the Medical Staff category requested. In the event of a remand, the applicant shall be promptly notified of the reason(s) for the remand, the additional information that the Board or MEC requires, and a time frame within which the information must be submitted. Failure of an applicant to provide the information requested within the stated timeframe shall result in the application being considered incomplete, in which case it shall not be processed further and shall be deemed to be withdrawn. If the applicant provides the information within the required timeframe, the MEC or Board, as applicable, shall act on the application at its next regular meeting after the required information has been submitted.

5.8 INITIAL APPOINTMENT PROCESS

A. **Appointment – General**. The clinical privileges granted to a Medical Staff Member shall be consistent with their skill, training, and experience, and based upon the certification in respect thereto by the Chair of their Department. Every Medical Staff Member shall be entitled to exercise only those privileges specifically granted to them by the Board, except as provided in Sections 7.4 and 7.5 of these Bylaws. Practice outside the scope of approved privileges by a Medical Staff Member shall be grounds for corrective action pursuant to Article XIII of these Bylaws.

B. **Duration**. Appointment to the Medical Staff shall be for a period of up to three years. Notwithstanding the foregoing, appointments to the Medical Staff may be for less than three years if the Board, based on the recommendation of the MEC, determines it is necessary to establish an orderly system for appointments. No Practitioner or current Medical Staff Member shall be entitled to a hearing or other due process rights set forth in these Bylaws in connection with a recommendation or decision that a Practitioner be granted clinical privileges, or appointed to the Medical Staff, for a period of less than three years.

C. **Assignment to Department**. The MEC shall assign each Medical Staff Member to a

staff category and to a Department where their performance shall be evaluated by the Department Chair to determine their eligibility for reappointment to the Medical Staff.

D. **Initial FPPE**. Each new Medical Staff Member with clinical privileges shall be subject to a focused professional practice evaluation ("**Initial FPPE**") for a period of six months (the "**Initial FPPE Period**") which may include proctoring and/or chart review.

1. During the Initial FPPE Period, Medical Staff Members:

   a. Shall not have the right to hold office or vote on Medical Staff or Department matters but may serve and vote on Medical Staff Committees other than the MEC. Notwithstanding the foregoing, Department Chairs may serve as voting members on the MEC and vote on Medical Staff Committee and Department matters during their Initial FPPE Period.

   b. May attend Department and Medical Staff meetings.

   c. Shall participate in the on-call coverage of the Emergency Department and other specialty coverage programs as scheduled or required by the MEC and the Hospital.

   d. Must have either (i) admitted and/or treated (as applicable) a sufficient number of patients to enable the Chair to evaluate their clinical skills and conduct; or (ii) for those Medical Staff Members having limited admitting or consulting activity in the Hospital, the Department Chair may request office records of care delivered to patients, which shall be purged of all patient identifiers and supplied by the Medical Staff Member within ten (10) business days of the request.

2. Each newly appointed Medical Staff Member's performance shall be monitored by the Department Chair in such manner as they deem appropriate. At the completion of the Initial FPPE Period, the Department Chair shall review the Medical Staff Member's performance and shall report their findings and recommendation to the Credentials Committee as to whether:

   a. Medical Staff membership should continue, the Initial FPPE should end, and the Medical Staff Member should be put on Ongoing Professional Practice Evaluation ("**OPPE**") status;

   b. Medical Staff membership should continue and the Initial FPPE should be extended and remain in place for a specified period of time, followed by OPPE;

   c. Medical Staff membership should terminate; or

   d. Such other action as the Department Chair deems appropriate should be taken.

3. The recommendation of the Department Chair shall be made after consideration of all performance improvement, quality and patient safety, peer review, utilization review, and outcomes management information relating to the Medical Staff Member, 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. If the Department Chair recommends a Significant Adverse Action, the Medical Staff Member shall be notified in writing of such recommendation and the grounds therefor and provided an opportunity to present to the Credentials Committee any additional information the Medical Staff Member wishes to have considered. The Credentials Committee shall consider the recommendations of the Department Chair and any additional information provided by the Medical Staff Member and conduct such further review and investigation as the Committee deems appropriate. The Credentials Committee shall make a recommendation to the MEC and if the Credentials Committee recommends a Significant Adverse Action, the Medical Staff Member shall be notified in writing of such recommendation and afforded an opportunity to present additional information to the MEC.

5. The MEC shall consider the recommendations of the Department Chair and Credentials Committee and any additional information provided by the Medical Staff Member and conduct such further review and investigation as the MEC deems appropriate. The MEC shall make a recommendation to the Board and if the MEC recommends a Significant Adverse Action, the Medical Staff Member shall be notified in writing of such recommendation and a summary of the grounds therefor and provided written notice of the right to a hearing under Article XIV of these Bylaws.

5.9 **REAPPOINTMENT PROCESS.** Each Medical Staff Member shall apply for reappointment in accordance with the following:

A. **Duration**. Reappointments to the Medical Staff shall be for a period of up to three years following the date of renewal. Notwithstanding the foregoing, reappointments to the Medical Staff may be for less than three years if the Board, based on the recommendation of the MEC, determines it is necessary to establish an orderly system for reappointments. In addition, the Board may, after considering the recommendations of the MEC, establish a shorter term in order to provide for more frequent evaluations of individual Medical Staff Members if determined by the Board, upon the recommendation of the MEC, to be necessary to ensure that the Medical Staff Member's clinical skills and conduct are appropriate. No Practitioner or current Medical Staff Member shall be entitled to a hearing or other due process rights set forth in these Bylaws in connection with a recommendation or decision that a Practitioner be granted clinical privileges, or reappointed to the Medical Staff, for a period of less than three years.

B. **Reappointment Application.** The CEO shall cause a reappointment application form to be sent to each Medical Staff Member at least one hundred twenty (120) calendar days prior to their Medical Staff appointment expiration date. The Medical Staff Member shall specify on such form the Medical Staff category, including any clinical privileges, they desire, with reasons for any change in current appointment or privileges, evidence of continuing medical education, and such other information as the MEC or Board may from time to time require, including but not limited to a statement by the Medical Staff Member attesting to their current sound physical and mental health or otherwise identifying any conditions that may interfere with their ability to practice safely, with or without a reasonable accommodation. The reappointment form shall be returned to the MSO within twenty (20) business days of receipt. All Medical Staff Members applying for reappointment shall be considered for the same Medical Staff category and the same clinical privileges they then hold, unless they specifically request otherwise.

C. **Department Procedure**. On at least a monthly basis, the MSO shall transmit to each Department Chair a list of the Medical Staff Members of that Department being considered for reappointment, together with the information submitted by each applicant and any other pertinent documentation or information. Each Department Chair shall consult with the members of their Department, including the Division Director, concerning applicants from their Department and shall collect recommendations concerning such applicants from persons who have personally observed them rendering patient care. The Department Chair(s) shall submit to the Credentials Committee recommendations concerning the application for

reappointment and/or renewal of privileges of each applicant in the Department, including the specific clinical privileges to be granted to each re-appointee for the reappointment term. For those Medical Staff Members having limited admitting or consulting activity in the Hospital, the Department Chair may request records of care delivered to their office patients. The applicant shall supply copies of such office records, purged of all patient identifiers, within ten (10) business days of the Chair's request. Failure to comply with the reappointment requirements may result in reappointment for less than the full three-year term or the imposition of specific clinical privilege restrictions or other conditions on reappointment as recommended by the Department Chair.

D. **Credentials Committee Procedure**. The Credentials Committee shall consider the recommendations of the Department Chair and conduct such further review and investigation as the Committee deems appropriate. The Credentials Committee shall make a recommendation to the MEC and if the Credentials Committee recommends Significant Adverse Action, the Medical Staff Member shall be notified in writing of recommendation and afforded an opportunity to present additional information to the MEC.

E. **MEC Procedure**. As applications for reappointment, including all recommendations from the Credentials Committee, are received, the MEC shall make written recommendations to the Board, concerning the reappointment of each applicant, including the specific clinical privileges to be granted to each applicant for the ensuing reappointment period. If the MEC recommends Significant Adverse Action, the reasons for such recommendations shall have been adequately investigated and documented.

5.10 **PROCEDURE THEREAFTER**. If the MEC recommends a Significant Adverse Action, the procedure set forth in Sections 5.7(C) and 5.7(D) that relate to a recommendation for Significant Adverse Action on an application for initial appointment shall apply.

5.11 **REPRODUCTIVE HEALTH SERVICES EXCEPTION**. Notwithstanding anything in these Bylaws to the contrary, all Medical Staff appointment, reappointment, privileging, credentialing, and similar processes shall be subject to the Reproductive Health Services Exception.

5.12 **WAIVER**. The Board may, after considering the recommendations of the MEC and the appropriate Department Chair, waive any of the requirements for Medical Staff membership and clinical privileges established pursuant to these Bylaws or the Medical Staff Rules 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 to waive

any requirement shall not entitle any applicant or Medical Staff Member to a hearing or any other due process rights provided under these Bylaws.

5.13 **EXTENSION OF TIME TO ACT**. Any time frames 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/or clinical privileges; provided, however, that any such extension shall be permitted only to the extent permitted by the Hospital's Accrediting Organization and applicable law and regulation.

5.14 **ACCEPTANCE OF APPOINTMENT OR REAPPOINTMENT**. Acceptance of an appointment or reappointment shall constitute the applicant's agreement to be governed by these Bylaws, the Medical Staff Rules, the Medical Staff Policies, all applicable Department Rules, and all Hospital bylaws, policies, and procedures.

ARTICLE VI

CATEGORIES OF THE MEDICAL STAFF

6.1 **CATEGORIES OF THE MEDICAL STAFF**. The Medical Staff shall be divided into the following categories:

Honorary Medical Staff

Physician Medical Staff

- Active Physician Medical Staff
- Courtesy Physician Medical Staff
- Office-Based Physician Medical Staff
- Telemedicine Physician Medical Staff

APP Medical Staff

- Active APP Medical Staff
- Office-Based APP Medical Staff

Clarifying definitions:

"**Medical Staff**" shall refer to all Physician Medical Staff and all APP Medical Staff, in all Medical Staff categories.

"**Active Medical Staff**" shall refer to all Active Physician Medical Staff and all Active APP Medical Staff.

"**Office-Based Medical Staff**" shall refer to all Office-Based Physician Medical Staff and all Office-Based APP Medical Staff.

Physician Medical Staff Members who meet the criteria for both the Active Physician and Office-Based Physician categories will be Active Physician Medical Staff Members.

APP Medical Staff Members who meet the criteria for both the Active APP and Office-Based APP categories will be Active APP Medical Staff Members.

Each Medical Staff Member shall be appointed to one clinical Department and may be appointed to additional Department(s) with the approval of the applicable Department Chair(s).

6.2 HONORARY MEDICAL STAFF

A. Appointment

1. Eligibility Criteria. In order to be eligible for the Honorary Medical Staff, a current or former Medical Staff Member must:

   a. No longer be actively practicing their profession;
   b. Be in good standing and of good repute in the medical community; and
   c. Have been Medical Staff Members (including APPs formerly on the Ancillary Staff) for at least twenty-five (25) years.

2. Considerations. The appropriate Department Chair and Division Director, if any, shall make the initial determination as to whether a former or current Medical Staff Member meeting the above criteria is deserving of Honorary Medical Staff membership. They shall base such recommendation on the former or current Medical Staff Member's dedication and contributions to the Hospital, the medical field, and the community, taking into account their personal circumstances and unique challenges. Further, the Department Chair and Division Director shall have the discretion to determine that a former or current Medical Staff Member not meeting the criteria set forth in Subsection 1(c) above is nonetheless deserving of Honorary Medical Staff membership.

3. Process

   In order to be appointed to the Honorary Medical Staff, a Practitioner must first be recommended for appointment by the appropriate Department Chair and Division Director, if any, and then approved by the Credentials Committee, the MEC, the Quality and Clinical Affairs Committee ("**QCAC**"), and the Board. If the Credentials Committee, MEC, QCAC, or Board fail to vote in favor of the appointment, the approval process shall terminate.

   No due process or other hearing rights shall apply to a decision to deny Honorary Medical Staff membership.

B. Revocation of Honorary Staff Status.

If, after a Practitioner has been granted Honorary Medical Staff status, any good faith concern regarding the appropriateness of such status is brought to the attention of the Department Chair, Division Director, Medical Staff President, or CPE, such individuals shall confer and come to a consensus as to whether Honorary status should be continued or revoked. Such determination shall be final, and the Practitioner shall not be entitled to any hearing or other due process rights set forth in these Bylaws with respect thereto.

C. **Prerogatives and Restrictions**. Honorary Medical Staff Members shall have the following prerogatives and restrictions:

1. Privileges. Shall not have clinical privileges

2. Admission of Patients. May not admit, treat, or consult on patients in the Hospital

3. Medical Staff Meetings. May attend, without vote, all Medical Staff and applicable Department and Division meetings

4. Medical Staff Committees. May serve, without vote, on Medical Staff Committees in the discretion of the Committee Chair

5. Medical Staff Office. May not hold Medical Staff Office such as Medical Staff President, or any other office such as Committee Chair, Department Chair, or Division Director

6. Malpractice Insurance. Shall not be required to have malpractice insurance other than any such coverage required for teaching or other similar activity approved by the Department Chair

7. Dues, Fees, and Assessments. Shall be exempt from paying Medical Staff dues, fees, and assessments

Honorary Medical Staff membership shall automatically terminate upon the death of the Medical Staff Member.

6.3 PHYSICIAN STAFF

A. Active Physician Staff

1. Qualifications. Active Physician Medical Staff Members shall consist of Physicians involved in the care of at least twenty four (24) Hospital inpatients and/or Hospital outpatients during any consecutive twelve (12) month period, or must have demonstrated a commitment to the Medical Staff and Hospital through service on committees, participation in professional practice evaluation

functions and/or performance improvement activities, serving in educational or leadership roles, or as otherwise determined by the Department Chair.[4]

2. Prerogatives and Restrictions**.** Active Physician Medical Staff Members shall have the following prerogatives and restrictions:

   a. Privileges. May exercise such clinical privileges as are granted to them

   b. Admission of Patients. May admit patients except as otherwise provided in the Bylaws or Medical Staff Rules or as limited by the Board, provided, however, that Active Physician Medical Staff Members in Emergency Medicine shall not have the privilege of admitting patients to inpatient services.

   c. Medical Staff Meetings. May vote at all Medical Staff and applicable Department and Division meetings

   d. Medical Staff Committees. May serve as a voting member of Medical Staff Committees

   e. Medical Staff Office. May hold Medical Staff Office such as Medical Staff President, or other office such as Committee Chair, Department Chair, or Division Director

3. Responsibilities. Active Physician Medical Staff Members shall have the following responsibilities:

   a. *Committee Service*. Serve on committees as requested

   b. *Meeting Attendance*. Attend quarterly and annual Medical Staff meetings

   c. *On-Call Coverage*. Provide on-call coverage for the Hospital, including its Emergency Department, in accordance with these Bylaws, applicable Medical Staff Rules, Medical Staff Policies, Department Rules, and Hospital requirements

   d. *Consultations*. Accept inpatient consultations when requested

[4] Active Physician Medical Staff Members with minimal Hospital activity shall be subject to the same credentialing and peer review procedures as Courtesy Physician Medical Staff Members, which procedures may include the evaluation of peer review information from other health care facilities.

e. *Quality Assurance*. Participate in the professional practice evaluation and performance improvement process, including the development of clinical practice protocols and guidelines pertinent to their specialties

f. *Staff Evaluation*. Participate in the evaluation of new Medical Staff Members

g. *Dues, Fees, and Assessments*. Pay dues, fees, and assessments as applicable to their Medical Staff category

B. **Courtesy Physician Staff**

1. Qualifications. Courtesy Physician Medical Staff Members shall consist of Physicians involved in the care of fewer than twenty-four (24) Hospital inpatients and/or Hospital outpatients during any consecutive twelve (12) month period, or as otherwise determined by the applicable Department Chair.[5]

2. Prerogatives and Restrictions**.** Courtesy Physician Medical Staff Members shall have the following prerogatives and restrictions:

a. *Privileges*. May exercise such clinical privileges as are granted to them

b. *Admission of Patients*. May admit or consult on a maximum of twenty-three (23) patients (including all inpatients and outpatients) during any consecutive twelve (12) month period unless the Board grants specific exemption for designated services or procedures (any patients seen on call pursuant to Section 3(c) below shall not be counted toward this maximum number)

c. *Medical Staff Meetings*. May vote at all Medical Staff and applicable Department and Division meetings

d. *Medical Staff Committees*. May serve as a voting member of Medical Staff Committees

e. *Medical Staff Office*. May serve as Committee Chair, but not hold a Medical Staff Office

[5] *Please note*: If the number of patients admitted or consulted on by a Courtesy Physician Medical Staff Member exceeds twenty-three (23) patients in any consecutive 12-month period, they shall be transferred automatically to the Active Physician Medical Staff thirty (30) business days after receipt of notification by the MSO or Department Chair. If advanced to the Active Physician Medical Staff, they shall remain on the Active Physician Medical Staff, and shall be required to comply with all Active Physician Medical Staff requirements, for a minimum of one year.

3. Responsibilities. Courtesy Physician Medical Staff Members shall have the following responsibilities:

a. *Committee Service*. Serve on committees as requested

b. *Meeting Attendance*. Use best efforts to attend quarterly and annual Medical Staff meetings

c. *On-Call Coverage*. Provide on-call coverage for Hospital, including its Emergency Department, if required by the Chair and approved by the MEC and CEO, when an insufficient number of specialty physicians are available, in accordance with applicable Medical Staff Rules, Department Rules, Medical Staff Policies, and Hospital requirements

d. *Consultations*. Accept inpatient consultations when requested

e. *Quality Assurance*. Participate in the professional practice evaluation and performance improvement process, including the development of clinical practice protocols and guidelines pertinent to their medical specialties

f. *Staff Evaluation*. Participate in the evaluation of new Medical Staff Members

g. *Dues, Fees, and Assessments*. Pay dues, fees, and assessments as applicable to their Medical Staff category

C. **Office-Based Physician Staff**

1. Qualifications. The Office-Based Physician Medical Staff shall consist of Physicians who wish to be affiliated with the Hospital and refer patients to Active and Courtesy Physician Medical Staff Members, but who do not admit or treat Hospital inpatients or outpatients.

2. Prerogatives and Restrictions. Office-Based Physician Medical Staff Members shall have the following prerogatives and restrictions:

a. *Privileges*. May not obtain Hospital clinical privileges

b. *Admission of Patients*. May not admit patients to the Hospital

c. *Hospital Patient Care*. May visit and examine patients in the Hospital, review patients' medical records, and receive information concerning patients' medical condition and treatment, but may not write orders for

inpatient care, perform surgical or invasive procedures, or otherwise treat Hospital inpatients or outpatients

d. *Ordering Hospital Outpatient Diagnostic Tests, Studies, Transfusions, and Infusions*. May order diagnostic tests, imaging studies, and transfusions and infusions to be performed on a Hospital outpatient basis

e. *Medical Staff Meetings*. May serve as a voting member of the Medical Staff and applicable Department and Division meetings

f. *Medical Staff Committees*. May vote on all Medical Staff Committees

g. *Medical Staff Office*. May serve as Committee Chair but not hold a Medical Staff Office

3. Responsibilities. Office-Based Physician Medical Staff Members shall have the following responsibilities:

a. *Committee Service*. Serve on Medical Staff Committees as requested

b. *Meeting Attendance*. Use best efforts to attend quarterly and annual Medical Staff meetings

c. *Patient Care*. Be involved in the care of patients in an office-based setting, including the performance of histories and physical examinations for patients who are to receive treatment as Hospital inpatients or outpatients

d. *Quality Assurance*. Participate in the professional practice evaluation and performance improvement process, including participating in the development of clinical practice protocols and guidelines pertinent to their medical specialties

e. *Identification of Admitting Physician*. Provide documentation identifying at least one Active Physician Medical Staff Member or a physician group who shall be responsible for admitting and managing the care of their patients who present to the Hospital for admission

f. *Professional Reference*. At the time of reappointment, provide the name of at least one reference who is a current Physician Medical Staff Member who can attest to the Physician's competency and to the quality and appropriateness of care provided in the office-based setting

g. *Dues, Fees, and Assessments*. Pay dues, fees, and assessments as applicable to their Medical Staff category

h. *Meet All Other Medical Staff Membership Requirements.* Meet all requirements set forth in Section 6.3 (A) above except for those requirements related to exercising Hospital clinical privileges

D. **Telemedicine Physician Medical Staff**

Telemedicine is the medical diagnosis, management, evaluation, treatment, or monitoring of injury or disease through the use of electronic communication technology. Physician Medical Staff Members who exclusively diagnose and treat Hospital patients via telemedicine link shall be Telemedicine Physician Medical Staff Members and shall be privileged and credentialed in accordance with these Bylaws. If permitted by law, regulation, and any applicable accreditation standards, the Hospital may obtain and rely on information and documentation related to the Physician's qualifications and competence provided by the primary organization with which the Physician is affiliated if that organization is accredited by Hospital's Accrediting Organization and is either accredited by Medicare as a participating hospital or is an entity that complies with the Medicare Conditions of Participation ("**Other Accredited Organization**"). The Hospital may conduct credentialing/privileging by proxy and rely on the decision of the Other Accredited Organization with which the Physician is affiliated or may directly verify all information through original sources and make such independent decision as the Hospital deems appropriate.

1. Qualifications. The Telemedicine Physician Staff shall consist of Physicians who diagnose and treat Hospital patients exclusively via telemedicine link.

2. Prerogatives and Restrictions. Telemedicine Physician Medical Staff Members shall have the following prerogatives and restrictions:

   a. *Privileges*. May exercise such privileges as are granted to them

   b. *Admission of Patients*. May not admit patients to the Hospital

   c. *Hospital Patient Care*. May diagnose, treat, and consult on patients by telemedicine link, and provide medical diagnosis, management, evaluation, treatment, and monitoring of injuries or diseases through the use of electronic communication technology

   d. *Medical Staff Meetings*. May attend, without vote, all Medical Staff and applicable Department and Division meetings

   e. *Medical Staff Committees*. May serve as a non-voting member of all Medical Staff Committees

f. *Medical Staff Office*. May not hold Medical Staff Office such as Medical Staff President, or any other office such as Committee Chair, Department Chair, or Division Director

g. *Fees, Dues, and Assessments*. Shall be exempt from paying Medical Staff dues

3. Responsibilities. Telemedicine Physician Medical Staff Members have the following responsibilities:

a. *Quality Assurance*. Participate in the professional practice evaluation and performance improvement process, including participating in the development of clinical practice protocols and guidelines pertinent to their medical specialties

b. *Staff Evaluation*. Participate in the evaluation of new Medical Staff Members

c. *Dues, Fees, and Assessments*. Pay fees and assessments (but not dues, as noted above) as applicable to their Medical Staff category

6.4 APP MEDICAL STAFF

A. Active APP Medical Staff

1. Qualifications. The Active APP Medical Staff shall consist of APPs who are involved in the care of Hospital inpatients and/or outpatients or have demonstrated a commitment to the Medical Staff and Hospital through service on committees, participation in professional practice evaluation functions and/or performance improvement activities, serving in educational or leadership roles, or as otherwise determined by the applicable Department Chair.

2. Prerogatives and Restrictions**.** Active APP Medical Staff Members shall have the following prerogatives and restrictions:

a. *Privileges*. May exercise such clinical privileges as are granted to them

b. *Admission of Patients*. May not admit patients to the Hospital

c. *Medical Staff Meetings*. May attend, without vote, all Medical Staff and applicable Department and Division meetings

d. *Medical Staff Committees*. May serve as a non-voting member on Medical Staff Committees or as otherwise provided in Article XI of these Bylaws

e. *Medical Staff Office*. May not hold a Medical Staff Office such as Medical Staff President, or any other office such as Committee Chair, Department Chair, or Division Director

3. Responsibilities. Active APP Medical Staff Members shall have the following responsibilities:

a. *Collaboration and Supervision Agreements*. Maintain a valid collaboration or supervision agreement with a Physician Medical Staff Member to the extent required by applicable law, regulation, or regulatory agency

b. *Collaboration with Physician Medical Staff Members*. Collaborate and cooperate with Physician Medical Staff Members, as applicable, who shall be responsible for the admission and Hospital care of any patient treated by an APP Medical Staff Member

c. *Committee Service*. Serve on committees as requested

d. *Meeting Attendance*. Use best efforts to attend quarterly and annual Medical Staff meetings

e. *On-Call Coverage*. Provide APP on-call coverage for the Hospital, including its Emergency Department, in accordance with applicable Medical Staff Rules, Department Rules, Medical Staff Policies, and Hospital requirements

f. *Consultations*. Accept inpatient consultations when requested

g. *Quality Assurance*. Participate in the professional practice evaluation and performance improvement process, including the development of clinical practice protocols and guidelines pertinent to their medical specialties

h. *Staff Evaluation*. Participate in the evaluation of new Medical Staff Members

i. *Dues, Fees, and Assessments*. Pay dues, fees, and assessments as applicable to their Medical Staff category

B. **Office-Based APP Medical Staff**

1. Qualifications. The Office-Based APP Medical Staff shall be comprised of APPs who wish to be affiliated with the Hospital and refer patients to Active and Courtesy Physician Medical Staff Members, but who do not treat Hospital inpatients or outpatients.

2. Prerogatives and Restrictions. Office-Based APP Medical Staff Members shall have the following prerogatives and restrictions:

   a. *Privileges*. May not obtain Hospital clinical privileges

   b. *Admission of Patients*. May not admit patients to the Hospital

   c. *Hospital Patient Care*. May visit and examine patients in the Hospital, review patients' medical records, and receive information concerning patients' medical condition and treatment, but may not write orders for inpatient care, perform surgical or invasive procedures, or otherwise treat Hospital inpatients or outpatients.

   d. *Ordering Hospital Outpatient Diagnostic Tests, Studies, Transfusions, and Infusions*. May order diagnostic tests, imaging studies, transfusions, and infusions, to be performed on a Hospital outpatient basis

   e. *Medical Staff Meetings*. May attend, without vote, all Medical Staff and applicable Department and Division meetings

   f. *Medical Staff Committees*. May serve as non-voting members on Medical Staff Committees as requested

   g. *Medical Staff Office*. May not hold a Medical Staff Office such as Medical Staff President, or any other office such as Committee Chair, Department Chair, or Division Director

3. Responsibilities. Office-Based APP Medical Staff Members shall have the following responsibilities:

   a. *Collaboration and Supervision Agreements*. Maintain a valid collaboration or supervision agreement with a Physician Medical Staff Member to the extent required by applicable law, regulation, or a regulatory agency

   b. *Committee Service*. Serve on committees as requested

   c. *Meeting Attendance*. Use best efforts to attend quarterly and annual Medical Staff meetings

   d. *Quality Assurance*. Participate in professional practice evaluation and performance improvement process, including participating in the

development of clinical practice protocols and guidelines pertinent to their medical specialties

e. *Patient Care*. Be involved in the care of patients in an office-based setting, including the performance of histories and physical examinations for patients who are to receive treatment as Hospital inpatients or outpatients

f. *Identification of Admitting Physician*. Provide documentation identifying at least one Active Medical Physician Staff Member or a physician group who shall be responsible for admitting and managing the care of their patients who present to the Hospital for admission

g. *Professional Reference*. At the time of reappointment, provide a reference from their supervising or collaborating Physician, or, if the APP is not required to have a supervising or collaborating Physician arrangement in place, from another current Physician Medical Staff Member who can attest to the Practitioner's competency and to the quality and appropriateness of care provided in the office-based setting

h. *Dues, Fees, and Assessments*. Pay dues, fees, and assessments as applicable to their Medical Staff category

i. *Meet All other Medical Staff Membership Requirements*. Meet all requirements set forth in Section 6.4(A) above except for those requirements related to exercising Hospital clinical privileges

6.5 REVIEW REQUIREMENTS

All Medical Staff Members shall be subject to such preceptorship or concurrent review requirements as may be imposed on them from time to time by the MEC upon recommendation by their Department Chair, including ongoing FPPE or OPPE in accordance with these Bylaws and Medical Staff Rules. The imposition of such requirements shall not give rise to any hearing or other due process rights under Article XIV of these Bylaws. The MEC shall require periodic reporting of the performance of any Medical Staff Member who is subject to preceptorship or concurrent review requirements.

ARTICLE VII

PRIVILEGES

7.1 **SCOPE OF PRIVILEGES.** The privileges granted to a Medical Staff Member shall be consistent with their skill, training, and experience and based upon a certification with respect thereto by the Chair of their Department. Every Medical Staff Member shall be entitled to exercise only those privileges specifically granted to them, except as provided otherwise in these Bylaws. The scope of privileges available in each Department shall be specified in Department Rules. Practice outside the scope of approved privileges by a Medical Staff Member shall be grounds for corrective action pursuant to Article XIII of these Bylaws. 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 result in the automatic termination of their clinical privileges at the Hospital.

7.2 **LIMITED RIGHTS.** Practitioners with only temporary, emergency, or disaster privileges shall not be considered Medical Staff Members. They shall have only such rights and privileges as are necessary to exercise the clinical privileges that are granted to them and all rights appurtenant thereto but shall have no other rights. Notwithstanding the foregoing, they shall be bound by all applicable Medical Staff Bylaws, Medical Staff Rules, Medical Staff Policies, Department Rules and all Hospital bylaws, policies, and procedures.

7.3 **TEMPORARY PRIVILEGES**. All temporary privileges shall be specifically delineated by the Chair of the Department and shall be granted by the CEO subject to the processes and approvals described below. In exercising temporary privileges, the Practitioner shall act under the supervision of the Chair of their Department. Temporary privileges granted hereunder shall expire on the earlier of (i) 120 calendar days from the granting of temporary privileges; or (ii) resolution of the particular circumstances giving rise to the temporary privileges; provided, however, that the CEO may revoke temporary privileges at any time for any reason. Termination of temporary privileges shall be effective upon written or verbal notice to the Practitioner from the Department Chair. The granting, denial, or revocation of temporary privileges shall not give rise to any hearing or other due process provided in these Bylaws.

A. **Temporary privileges may be granted under the following circumstances:**

1. To meet an important care need (in a particular clinical area or for a specific patient, as described below); or
2. For applicants who are requesting initial or additional privileges and are awaiting review and approval by the Board

B. **Requirements for Granting Temporary Privileges**

1. For an important care need:

a. *Important Care Need in a Specific Clinical Area*. For temporary privileges to fulfill an important care need in a particular clinical area, the following shall be required:

i. A complete application for Medical Staff membership; and
ii. Approval by the Department Chair, Medical Staff President, and CPE

b. *Urgent Clinical Need for Specific Patient*. For temporary privileges to fulfill an important patient-specific clinical need, the following shall be required:

i. Verification of licensure and current competence; and
ii. Approval of the Department Chair, the Medical Staff President, and the CPE

2. For applicants awaiting action by the Board. For temporary privileges for Practitioners who have applied for Medical Staff membership and are awaiting review and approval by the Board, the following shall be required:

a. A complete application for Medical Staff membership; and
b. Approval of the Department Chair, the Medical Staff President, and the CPE

C. **Special Requirements Applicable to all Temporary Privileges/Due Process Inapplicable.** Special requirements of supervision and reporting may be imposed by the Department Chair on any Practitioner granted temporary privileges. The receipt of temporary privileges does not guarantee that the Practitioner shall be granted full privileges. A Practitioner shall not be entitled to a hearing or any other due process rights set forth in these Bylaws as a result of their being denied temporary privileges or the termination of their temporary privileges.

7.4 **EMERGENCY PRIVILEGES**. For purposes of this Section, an "**emergency**" is defined as a condition where a patient's life or health is in immediate danger, or a patient is at risk of serious harm and any delay in treatment would exacerbate that danger. In the case of an emergency, any Practitioner, to the degree permitted by their license and regardless of Department affiliation or lack thereof, shall be permitted and assisted to do everything possible to save the life of a patient or any other person on Hospital grounds, using every

resource of the Hospital necessary, including calling for any consultation necessary or desirable. In such event the Practitioner shall be deemed to have emergency privileges. When an emergency situation no longer exists, the Practitioner must request the privileges necessary in order to continue to treat the patient if they wish to do so and the patient so requests. In the event the Practitioner does not request such privileges or such privileges are denied, the patient shall be assigned to an appropriate Medical Staff Member. If the Practitioner does apply for such privileges and is denied, no hearing or other due process rights shall apply.

7.5 **DISASTER PRIVILEGES.** The CEO and/or the Medical Staff President may grant disaster privileges during activation of the Hospital's Emergency Preparedness Plan. The granting of such privileges shall be consistent with the standards of the Hospital's Accrediting Organization and pursuant to the Medical Staff Policy for "Disaster Privileges During Activation of the Emergency Preparedness Plan." Disaster privileges shall automatically terminate when the Emergency Preparedness Plan is deactivated, and no hearing or other due process rights shall apply to such termination.

7.6 **TELEMEDICINE PRIVILEGES**

Members of the Telemedicine Physician Medical Staff shall obtain telemedicine privileges. Members of any other category of the Medical Staff may be required to obtain telemedicine privileges in the future to the extent required by the Hospital's Accrediting Organization or applicable law, or to the extent the Board determines that telemedicine privileges should be required in other contexts.

The Board will determine what clinical services may be provided through telemedicine after considering the recommendations of the appropriate Department Chair, the Credentials Committee, and the MEC.

7.7 **NEW PROCEDURES OR SERVICES.** Privileges for procedures or services that 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

LEAVE OF ABSENCE FROM THE MEDICAL STAFF

8.1 VOLUNTARY NON-MEDICAL LEAVE

A. **Taking Voluntary Non-Medical LOA**. A Medical Staff Member may take a voluntary non-medical leave of absence ("**Voluntary Non-Medical LOA**") by submitting a written request for a Voluntary Non-Medical LOA to their Department Chair and the MSO with a copy to the Medical Staff President and the CPE.[6] The written request shall include the reason for the request and length of Voluntary Non-Medical LOA requested, including the start date and estimated return date. Such Voluntary Non-Medical LOA shall take effect at such time as the Medical Staff Member requests unless the Department Chair determines in their discretion that the request should be modified or denied due to clinical need. The Medical Staff Member shall not be entitled to a hearing or any other due process rights with regard to any decision by the Department Chair with regard to a request for Voluntary Non-Medical LOA. While a Medical Staff member is on Voluntary Non-Medical LOA, they shall not have clinical privileges and all of their rights, duties, and obligations as a Medical Staff Member, including meeting attendance, voting, and payment of dues, shall be suspended.

B. **Return from Voluntary Non-Medical LOA**. At such time as a Medical Staff Member wishes to return from a Voluntary Non-Medical LOA, the Medical Staff Member shall give at least fifteen (15) business days' written notice to their Department Chair and the MSO with a copy to the Medical Staff President and CPE. The Department Chair, Medical Staff President, and/or CPE may require that the Medical Staff Member submit information concerning the Medical Staff Member's activities while on Voluntary Non-Medical LOA. The Medical Staff Member's Voluntary Non-Medical LOA shall end at such time as the Medical Staff Member requests, with no change in Medical Staff category or in clinical privileges, unless the Department Chair, Medical Staff President, or CPE recommends (i) Significant Adverse Action such as denial of reinstatement or restriction of privileges; or (ii) imposition of other conditions that must be met in order for the Medical Staff Member to be reinstated and notifies the Medical Staff Member in writing of such recommendation. In such event, the matter shall be brought before the Credentials Committee, which shall consider the matter and make a recommendation to the MEC. If the Credentials Committee recommends (i) Significant Adverse Action such as denial of reinstatement or restriction of privileges;

[6]For clarity, there is no "Involuntary Non-Medical LOA," as any such involuntary leave is included in other leave categories that may be taken by a Medical Staff Member, as described in these Bylaws.

or (ii) imposition of other conditions that must be met in order for the Medical Staff Member to be reinstated, any such recommendation shall be deemed to constitute an Investigative Report under Article XIII of these Bylaws and shall be handled in accordance with the process set forth therein.

8.2 MEDICAL LEAVE OF ABSENCE – VOLUNTARY OR INVOLUNTARY

A. **Taking Medical Leave of Absence**. A Medical Staff Member may at any time be placed on medical leave of absence ("**Medical LOA**") at their own request. Medical Staff Member-initiated Medical LOA is considered voluntary. In addition, whenever the CPE, Medical Staff President, and Department Chair, after conferring, determine that a Medical Staff Member is or may be suffering from a physical or mental condition that could impair their ability to treat patients, the CPE, Medical Staff President, or Department Chair may place the Medical Staff Member on involuntary Medical LOA immediately without a request from, or the consent of, the Medical Staff Member. While on Medical LOA (voluntary or involuntary), the Medical Staff Member shall not have clinical privileges and all of their rights, duties, and obligations as a Medical Staff Member, including meeting attendance, voting, and payment of dues, shall be suspended.

B. **Return from Medical Leave of Absence.** Medical LOA (voluntary or involuntary) shall terminate when the Medical Staff Member's treating physician provides a written statement to the Medical Staff President that the Medical Staff Member's condition will not interfere with their treatment of patients, unless the CPE, Medical Staff President, and Department Chair determine that additional information is required and/or that a clinical evaluation by a Hospital-designated provider shall be conducted. If such determination is made, the Medical Staff Member shall provide the required information and/or submit to the requested independent clinical evaluation and shall provide their written consent for the results of such evaluation to be shared with Hospital personnel. The CPE, Medical Staff President, and Department Chair shall (after reviewing any additional information provided and/or the results of the independent clinical evaluation, as and if applicable), then make a recommendation to the Credentials Committee as to whether (i) the Medical Staff Member should be reinstated unconditionally; (ii) the Medical Staff Member should not be reinstated; (ii) specific restrictions should be imposed on the Medical Staff Member's privileges; or (iii) other conditions must be met in order for the Medical Staff Member to be reinstated, and shall notify the Medical Staff Member in writing of such recommendation. In that event, the Credentials Committee shall, after considering the recommendation of the CPE, Medical Staff President, and Department Chair, make a recommendation to the MEC. If the Credentials Committee recommends (i) Significant Adverse Action such as denial of reinstatement or restriction of privileges; or (ii) the imposition of other conditions that must be met in

order for the Medical Staff Member to be reinstated, such recommendation shall be deemed to constitute an Investigative Report under Article XIII and shall be handled in accordance with the process set forth therein.

8.3 VOLUNTARY AND MEDICAL LOA – REAPPOINTMENT

A. **Voluntary or Medical LOA Over One Year**. Any Medical Staff Member whose Voluntary or Medical LOA extends beyond a twelve (12)-month period must be recredentialed and reappointed to the Medical Staff in accordance with Article V of these Bylaws.

B. **Expiration of Medical Staff Membership While on Voluntary or Medical LOA.** If a Medical Staff Member's current term of appointment expires while on Voluntary or Medical LOA, the Practitioner shall be required to apply for reappointment pursuant to Article V of these Bylaws.

ARTICLE IX

MEDICAL STAFF OFFICERS

9.1 **MEDICAL STAFF OFFICERS.** The Officers of the Medical Staff shall be the President, Vice President, and Secretary/Treasurer (each, a "**Medical Staff Officer**").

9.2 **QUALIFICATIONS OF OFFICERS**

A. Medical Staff Officers must be members of the Active Physician Medical Staff at the time of nomination and election and must remain such in good standing during their term of Office.

B. Only Active Physician Medical Staff Members who are qualified by training, adequate hospital experience, dedicated interest, and demonstrated ability shall be eligible to be Medical Staff Officers.

C. No individual Medical Staff Member may hold more than one of the following positions simultaneously: Medical Staff President, Medical Staff Vice-President, Medical Staff Secretary/Treasurer, Department Chair, and At-Large MEC Member.

9.3 **ELECTION OF MEDICAL STAFF OFFICERS**. At the annual Medical Staff meeting (the "**Annual Meeting**"), the Medical Staff Nominating Committee 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 be a nominee. Medical Staff Officers shall be elected by vote of the Physician Medical Staff Members entitled to vote following distribution of ballots after the Annual Meeting. Physician Medical Staff Members entitled to vote shall have fourteen (14) business days to submit their votes after the ballots are distributed. Where there are three or more candidates for an Office and no candidate receives a simple majority of votes cast, there shall be a runoff election between the two candidates who received the most votes. The candidate who then receives a simple majority vote shall be declared elected.

9.4 **TERM OF OFFICE**. Medical Staff Officers shall be elected to serve one two-year term commencing on January 1 of the year immediately following their election, or until their successor is duly elected and qualified. However, if the Medical Staff Vice President has been in Office for one year or less at the time the two-year term of the Medical Staff President expires, the MEC may elect to extend the term of the current Medical Staff President for one additional year. No Medical Staff Officer may serve consecutive terms in a single Office, and no Medical Staff Officer shall be eligible for election to the same Office until after a three-year period of ineligibility.

9.5 **REMOVAL OF MEDICAL STAFF OFFICERS**

A. **Automatic Suspension from Office**. A Medical Staff Officer shall be automatically suspended from Office upon the commencement of an investigation (as described in Article XIII of these Bylaws). Upon completion of the investigation, provided the Medical Staff Officer remains a Medical Staff Member in good standing, the MEC shall vote to decide whether the subject individual should be reinstated as a Medical Staff Officer or removed from such position.

B. **Removal of a Medical Staff Officer by Medical Staff/MEC**. Removal of a Medical Staff Officer from Office may also be initiated by a 20% Petition or by a two-thirds (2/3) vote of the MEC. Following either such act, the vote of two thirds (2/3) of the Physician Medical Staff Members entitled to vote who are present at a special Medical Staff meeting duly called for such purpose and at which a quorum is present is required to remove a Medical Staff Officer.

9.6 **VACANCIES IN OFFICE.** Vacancies in any Medical Staff Office except for the President shall be filled within thirty (30) business days by the MEC. If there is a vacancy in the Office of Medical Staff President, the Medical Staff Vice President shall serve the remainder of the Medical Staff President's term. With regard to any Medical Staff Officer other than the Medical Staff President, the Medical Staff President shall determine whether a vacancy, as opposed to a temporary absence, exists. With regard to the Office of Medical Staff President, the CPE shall make such determination in consultation with the CEO.

9.7 **DUTIES OF MEDICAL STAFF OFFICERS**

A. **President.** The Medical Staff President shall:

1. Serve as Chair of the MEC, call and preside at all meetings of the MEC, and be responsible for the agenda of MEC meetings
2. Call and preside at all meetings of the Medical Staff, and be responsible for the agenda of such meetings
3. Serve as a member of any Joint Conference Committee
4. Serve as a voting ex-officio member of all Medical Staff Committees except as otherwise provided in these Bylaws
5. Act in cooperation and coordination with the CEO in all matters relating to patient care at the Hospital

6. Support the philosophy of continuous quality improvement and communicate with the CPE and the CEO regarding opportunities for improvement identified by the Medical Staff
7. Bring to the attention of the MEC matters that the Medical Staff may wish the MEC to consider
8. Bring to the attention of the Board matters that the Medical Staff may wish the Board to consider
9. Be responsible, in conjunction with the CPE, for the enforcement of these Bylaws, the Medical Staff Rules, and the Medical Staff Policies, for implementation of sanctions when indicated, and for Medical Staff compliance with procedural safeguards, including those described in Articles XIII and XIV of these Bylaws
10. Appoint Medical Staff Members to all Special Committees in consultation with the CPE or Department Chair, as applicable
11. Communicate the views, policies, needs, and grievances of the Medical Staff to the MEC, CPE, CEO, and Board
12. Report to the Board on the performance and quality of clinical care provided by the Medical Staff
13. Be responsible for the educational activities of the Medical Staff
14. Be the spokesperson for the Medical Staff in its external professional and public relations
15. 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 hearing and other due process proceedings as specified in these Bylaws
16. Perform any of the duties of any Department or Medical Staff Committee Chair if such individual is unavailable or otherwise fails to perform their duties
17. Have and exercise such other authority and powers as are provided by these Bylaws.

B. **Vice President.** The Vice President shall automatically serve in the role of President if the President resigns, is removed, or is temporarily unable to perform the duties of that Office. They also shall be a member of the MEC and any Joint Conference Committee and shall serve as Co-Chair of the Peer Review Oversight Committee.

C. **Secretary/Treasurer.** The Secretary/Treasurer of the Medical Staff shall:

1. Serve as the Secretary and Treasurer of the MEC

2. Be responsible for all correspondence to and from the MEC
3. Keep a complete written record of the transactions of all Medical Staff financial business, including payment and receipt of all Medical Staff fees and dues, and make disbursements as authorized by the MEC
4. Serve in the role of Vice President when the latter fails to serve the remainder of their term for any reason, including a circumstance where the Vice-President is required to serve in the role of President; in such event, the Secretary /Treasurer position shall remain vacant until the next election
5. Serve on the Peer Review Oversight Committee
6. Serve on the Credentials Committee

D. **Chief Physician Executive.** The CPE shall possess recognized clinical expertise and shall be a member of the MEC and of Hospital administration, reporting to and appointed by the CEO. They shall assist the Department Chairs and the MEC in maintaining high quality patient care, review Medical Staff appointments and reappointments, and serve as a medical liaison between and among Hospital administration, the Medical Staff, the Department Chairs, and Medical Staff search committees. They shall participate at all levels in the Hospital and Medical Staff quality assessment and improvement functions.

ARTICLE X

CLINICAL DEPARTMENTS

10.1 CATEGORIES OF SERVICES

A. **Departments.** The Medical Staff shall be divided into clinical departments ("**Departments**"), which may be further divided into divisions based on subspecialty ("**Divisions**"). Each Medical Staff Member shall be assigned to a Department. Where appropriate, a Medical Staff Member may be assigned to more than one Department. The MEC shall determine what Medical Staff Departments and Divisions the Medical Staff shall have, subject to the approval of the Board. The Departments of the Medical Staff are currently as follows:

- Anesthesiology
- Family Medicine
- Medicine
- Obstetrics and Gynecology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Psychiatry
- Radiology
- Surgery

B. **Clinical Divisions.** Each Department may be organized into Divisions for any subspecialties. Divisions shall be established and/or eliminated based upon recommendation of the Department Chair made to and approved by the MEC and the Board. Each Division shall have a Division Director. Where appropriate, a Medical Staff Member may be assigned to more than one Division within one or more Departments. Also, where appropriate, Divisions within different Departments may, with the approval of the respective Division Directors and Department Chairs, affiliate for administrative purposes. Departments and Divisions may be combined or restructured by the MEC subject to the approval of the Board.

10.2 DEPARTMENT CHAIRS AND DIVISION DIRECTORS

A. Department Chairs

1. Qualifications. Each Department shall have a Chair, who shall be a Physician responsible for the overall supervision of the clinical work within the Department, except as may otherwise be specified in Department Rules. Each Chair shall be an Active Physician Medical Staff Member, and shall be qualified by training, experience, and demonstrated ability for the position. A Department Chair must restrict their professional work exclusively to the Department(s) to which their appointment is made and, consistent with Accrediting Organization requirements, must meet all board certification requirements hereunder.

2. Appointment/Removal. The CEO shall appoint a multi-disciplinary search committee to select a Department Chair. Upon selection of a recommended candidate by the search committee, the candidate's name shall be presented to the MEC for its recommendation to the CEO. The Chair of each Department shall be appointed by the CEO after consultation with the Medical Staff President. A Chair may be removed by the CEO in their sole discretion after consultation with the Medical Staff President and CPE.

3. Responsibilities. Each Chair shall (except as may be otherwise specified in Department Rules):

   a. Be responsible for all professional and administrative activities within their Department, including Divisions thereof, and report on such activities regularly to the MEC

   b. Be a voting MEC member who shall provide guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding their own Department in order to ensure quality patient care

   c. Monitor and review the professional performance of all Medical Staff Members in their Department through the maintenance of quality control programs

   d. Report regularly to the MEC with respect to the activities of their Department Committee(s) and with respect to the Department's performance improvement activities

   e. Be responsible for the enforcement, within their Department, of the Hospital bylaws, these Bylaws, Medical Staff Rules, Medical Staff

Policies, and Department Rules

f. Be responsible for the implementation, within their Department, of actions taken by the Board, the Medical Staff, and the MEC

g. Transmit to the Credentials Committee and the MEC their Department's recommendations concerning Medical Staff classification, appointments and reappointments, Department and Divisional assignments, and delineation of clinical privileges for all Department members

h. Be responsible for the orientation, teaching, education, and research programs in their Department, including determining the continuing education requirements for the professional and non-professional staff in their Department

i. Promote the integration of their Department into the mission of the Hospital and participate in the coordination of interdepartmental and intradepartmental services for the facilitation of quality patient care

j. Develop and implement policies and procedures for the provision of clinical services in coordination with the Hospital's nursing service and Hospital administration

k. Assist in the preparation of such annual reports, including budgetary planning reports, pertaining to their Department and Divisions thereof as may be required by the MEC, CEO, or Board

l. Recommend to the CEO individuals to serve as Division Directors within their Department

m. Ensure that appropriate Department members participate in Medical Staff Peer Review Committees (of the Department or multiple Departments) pursuant to these Bylaws and their Department Rules

n. Assess and recommend to the MEC external sources for any needed patient care services not provided by the Hospital

o. Recommend to the MEC a sufficient number of qualified and competent Medical Staff Members to provide care or services in the Department

p. Determine the qualifications and competence of Medical Staff Members in their Department

q. Make recommendations to the MEC regarding space and other resource needs of the Department

r. Perform such other duties as the Board or MEC may require

B. **Division Directors**

1. Qualifications. Each Division shall have a Division Director, who shall be a

Physician responsible for the overall supervision of the clinical work within the Division, except as may otherwise be specified in Department Rules. Each Division Director shall be an Active Physician Medical Staff Member, and shall be qualified by training, experience, and demonstrated ability for the position.

2. Appointment/Removal. The CEO shall appoint Division Directors after considering any recommendations of the applicable Department Chair. A Division Director may be removed by the CEO after consultation with the Department Chair.

3. Responsibilities. Each Division Director shall (except as may be otherwise specified in Department Rules):

   a. Make recommendations to the Department Chair regarding Medical Staff and other staff appointments, reappointments, and assignments to their Division;
   b. Work together with the Department Chair to:
      i. Direct and supervise the work performed in their Division;
      ii. Conduct clinical conferences and employ such other methods as they deem necessary or appropriate to ensure quality care within their Division.
   c. Provide consultation on all Medical Staff appointments, reappointments, assignments, and promotions within their Division.
   d. Perform such other duties as may be required by Department Rules, the Department Chair, the MEC, and the Board.

10.3 DEPARTMENTAL ORGANIZATION AND FUNCTIONS

A. Each Department shall maintain a written set of Department Rules regarding the Department's 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. Department Rules shall not conflict with each other or these Bylaws, the Medical Staff Rules, the Medical Staff Policies, or Hospital policy. All Department Rules shall be subject to review and approval by the MEC.

B. Each Department shall conduct appropriate quality improvement and risk management activities.

C. Each Department shall meet as needed to review and analyze on a peer-group basis the clinical work of the Department and shall render periodic reports to the MEC.

D. Each Department shall conduct educational meetings and establish such requirements as are deemed necessary or appropriate by the Department to ensure an adequate program of continuing education for its members.

E. 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.

F. Each Department may, at the Department Chair's discretion, have an Associate Chair whose duty it shall be to assist and act as Chair when necessary. If the Department Chair wishes to have an Associate Chair, the CEO shall appoint an Associate Chair after considering any recommendations of the Department Chair. An Associate Chair may be removed by the CEO after consultation with the Department Chair.

G. Action taken at Departmental meetings shall be by vote when a quorum is present. A quorum for a Departmental meeting shall be defined by each Department's Rules.

H. Each Department and Division thereof shall maintain accurate written records of all of its proceedings and actions. A permanent file of such written records shall be maintained by each Department.

10.4 Each Department shall participate in one or more Multi-Specialty Peer Review Committee(s), each of which shall be a subcommittee of the MEC, all as described in Article XI of these Bylaws.

ARTICLE XI

MEDICAL STAFF COMMITTEES

11.1 **ESTABLISHMENT OF COMMITTEES**. There shall be such Standing Committees, Additional Standing Committees, and Special Committees of the Medical Staff (all as defined below) as are established pursuant to these Bylaws or by action of the MEC, subject to the approval of the CEO, to perform necessary functions on an ongoing basis. The Standing Committees established pursuant to these Bylaws shall be the MEC, Peer Review Oversight, Medical Staff Peer Review, Credentials, APP Credentials, Cancer, Nominating, Bylaws, and Joint Conference.

11.2 **PROCEDURES**

A. **Committee Meetings**. Medical Staff Committee meetings may be called by the Committee Chair, any three committee members, the MEC, or the Board. The Committee Chair shall give written notice of committee meetings at least two business days in advance. Committee appointments are a privilege and responsibility of each Medical Staff Member. Attendance at committee meetings is encouraged and expected for all committee members.

B. **Committee Rules and Records**. Committees may adopt such rules, regulations, and procedures for their governance as are consistent with the Hospital bylaws, these Bylaws, and the Medical Staff Rules. Each committee shall maintain records of its actions and proceedings, and a permanent file for committee records shall be maintained by the MSO.

C. **Automatic Suspension from Committee**. In addition to any other removal mechanisms described in this Article, a Medical Staff Member shall be automatically suspended from a Medical Staff Committee upon the commencement of an investigation as described in Article XIII of these Bylaws. Upon completion of the investigation, if the individual remains a Medical Staff Member in good standing, the MEC shall vote to decide whether the subject individual should be reinstated as a Medical Staff Committee member or removed from such position.

D. **Committee Reports**. All Standing and Special Committees shall report directly to the MEC, which shall report on their activities to the Medical Staff, Hospital administration, and the Board as appropriate. Committees shall report in writing to the MEC at least annually unless a committee does not meet during any year, and otherwise as may be required under these Bylaws or by the MEC.

11.3 **STANDING COMMITTEES**

A.` **MEC**

1. Composition. The MEC shall consist of voting members and non-voting members as specified below.

   a. *Voting Ex-Officio MEC Members.* The following shall be voting ex-officio MEC Members **(" Voting Ex Officio MEC Members")**:

   - President, Vice President, and Secretary/Treasurer of the Medical Staff
   - Chair of each Department
   - CPE
   - Director of Hospitalists Program

   i. *Appointment.* Voting Ex-Officio Members, including Department Chairs, shall assume membership on the MEC as of the start date of their position.

   ii. *Term/Term Limits*. Voting Ex Officio MEC Members shall remain MEC Members as long as they hold the position that entitles them to ex officio membership on the MEC.

   iii. *Vacancy*. A vacancy in any of these positions will be filled by the successor to that position.

   b. *Non-Voting Ex-Officio MEC Members*. The following shall be non-voting ex officio MEC Members ("**Non-Voting Ex Officio MEC Members**"):

   - Immediate past Medical Staff President for a period of one year following their term as President
   - CEO
   - Chief Nurse Executive
   - Chief Operating Officer
   - Chair of the Credentials Committee
   - Chief Clinical and Quality Officer

   i. *Appointment*. Non-Voting Ex-Officio Members shall assume membership on the MEC as of the start date of their position.

ii. *Term/Term Limits*. Non-Voting Ex Officio MEC Members shall remain MEC Members as long as they hold the position that entitles them to ex officio membership on the MEC.

iii. *Vacancy*. A vacancy in any of these positions will be filled by the successor to that position.

c. *At-Large MEC Members.*

i. *Composition*. At-Large MEC Members shall be comprised of one Physician representative from each Department (in addition to the Chairs, unless otherwise approved by the Medical Staff President) ("**At-Large MEC Members**").

ii. *Voting*. All At-Large MEC Members shall have the right to vote.

iii. *Appointment.* Each October, each Department Chair shall solicit Department candidates for election as At- Large MEC Members to the extent there will be one or more vacancies in such Department's MEC representative seat. Voting shall begin November 1, with a ballot return date no-later than November 15. The elected At-Large MEC Members' names shall be submitted to the Medical Staff President by December 1 and their MEC membership shall begin on January 1 following their election.

iv. *Term/Term Limits*. At-Large MEC Members may be appointed to up to two two-year terms, or until their successors are duly elected and qualified. At-Large MEC Members who have served two consecutive two-year terms shall be eligible for nomination and election after a two-year period of ineligibility.

v. *Suspension/Removal***.** In addition to automatic suspension as described in Section 11.2C above, an At-Large MEC Member may be removed from the MEC by (a) a two-thirds vote of the Physician Medical Staff entitled to vote who are present at a Medical Staff Meeting duly called for such purpose and at which a quorum is present; or (b) by a two-thirds vote of MEC Members present at a meeting duly called for such purpose and at which a quorum is present.

vi. *Vacancy*. The applicable Department Chair shall appoint qualified individuals to fill any vacancy that occurs prior to the

end of an At-Large MEC Member's term.

d. *APP MEC Members*.

i. *Composition*. One APRN and one PA shall serve on the MEC ("**APP MEC Members**").

ii. *Voting*. APP MEC Members shall be non-voting.

iii. *Appointment*. Each October, the APP Nominating Committee shall solicit and approve a slate of APRNs (the "**Approved APRN Slate**") and a slate of PAs (the "**Approved PA Slate**"). The APRNs shall vote to elect one APRN representative from the Approved APRN Slate to serve as a non-voting APP MEC Member. The PAs shall vote to elect one PA representative from the Approved PA Slate to serve as a non-voting APP MEC Member. Voting shall begin November 1st and with a ballot return date no-later than November 15th. The elected APP MEC Members' names shall be submitted to the Medical Staff President by December 1. Their MEC membership shall begin on January 1 following their election.

iv. *Term/Term Limits*. APP MEC Members may be appointed to up to two two- year terms, or until their successors are duly elected and qualified. APP MEC Members who have served two consecutive two-year terms shall be eligible for election after a two-year period of ineligibility.

v. *Suspension/Removal*. In addition to automatic suspension as described in Section 11.2C above, an APP MEC Member shall be suspended from the MEC by (a) a two-thirds (2/3) vote of the Physician Medical Staff Members entitled to vote who are present at a meeting duly called and held for such purpose and at which a quorum is present; or (b) by a two-thirds (2/3) vote of MEC Members present at a meeting duly called for such purpose and at which a quorum is present.

vi. *Vacancy*. The Medical Staff President, in consultation with the CPE, shall appoint a qualified APP Medical Staff Member to fill any vacancy that may occur prior to the end of an APP MEC Member's term.

2. Medical Staff Officers – Nomination and Election/Responsibilities**.** The Officers of the Medical Staff described in Article IX of these Bylaws shall be the Officers of the MEC. The Physician Medical Staff Members entitled to vote shall elect such Medical Staff Officers as set forth in Article IX of these Bylaws. Medical Staff Officers may be removed from office, and their vacancies filled, as provided in Article IX. No Medical Staff Member may hold more than one of the following positions simultaneously: Medical Staff President, Medical Staff Vice-President, Medical Staff Secretary/Treasurer, Department Chair, and At-Large MEC Member.

3. Meetings. The MEC shall meet at least ten (10) times per year 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 or more voting MEC Members. The Medical Staff President, as MEC Chair, shall preside at all MEC meetings, and a permanent record of its proceedings and actions shall be maintained by the MSO.

4. Responsibilities. The MEC shall be principally responsible for fostering the provision of quality medical care to Hospital patients and for the ethical conduct and professional practices of Medical Staff Members. It shall be responsible to the Board for the establishment and maintenance of professional standards, policies, and practices in the Hospital. The MEC may, on its own initiative, recommend action by the Board on any matter, and it shall make recommendations to the Board with respect to any matter that the Medical Staff, through its elected Medical Staff Officers, may present to it. Without limiting the foregoing, the duties of the MEC shall include the following:

   a. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws
   b. Coordinate the activities and general policies of the various clinical Departments
   c. Receive and act upon the reports and recommendations of Medical Staff Committees, Departments, Divisions, and other groups, and respond promptly in writing to recommendations submitted to it
   d. Make policy recommendations to the Board with respect to Medical Staff structure, as well as these Bylaws, Medical Staff Rules, and Medical Staff Policies, and implement and enforce such Medical Staff Rules and Medical Staff Policies as may be approved by the Board
   e. Serve as a liaison between and among the Medical Staff, Hospital administration, and the Board
   f. Recommend to Hospital administration action on medico-

administrative matters

g. Fulfill the Medical Staff's duty of accountability to the Board for the quality of medical care rendered to Hospital patients

h. Ensure that the Medical Staff is informed of the Hospital's accreditation status and the accreditation program of the Accrediting Organization, and that Medical Staff Members participate in the accreditation process, including participation in the Hospital survey and summation conference

i. Ensure that the Medical Staff participates in a program of continuing education designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and refresh their knowledge in various aspects of their basic medical education

j. Review the credentials of all applicants for appointment and/or reappointment to the Medical Staff, Departments, and Divisions, determine delineation of privileges, and make recommendations to the Board with respect thereto

k. Ensure regular, periodic, thorough evaluations of each Medical Staff Member and of staff practices and functions

l. Take steps to ensure professionally ethical conduct and competent clinical performance on the part of all Medical Staff Members, including the initiation of and/or participation in corrective action or peer review measures when warranted

m. Monitor functions relating to the provision of patient care, including, but not limited to performance improvement, quality, and utilization review activities, as well as review of surgical cases, pharmacy and therapeutic activities, medical records, blood and tissue utilization, antibiotic stewardship, infection control, internal and external disaster plans, Hospital safety matters, and other patient related professional activities

n. Report at each Medical Staff meeting and otherwise as required by the Medical Staff President and Board

o. Require Medical Staff attendance at annual meetings and at special meetings as the MEC may deem necessary from time to time

p. Develop a mechanism by which Medical Staff membership may be terminated in accordance with the due process procedures set forth in these Bylaws

q. Assess and recommend to Hospital administration potential outside sources of patient care or other relevant services provided under contract or otherwise

r. Make recommendations to the Board regarding clinical services to be provided at the Hospital

B. **Peer Review Oversight Committee ("PROC")**

1. Composition/Appointment. The Committee shall be comprised of the following:

   a. *Voting Ex-Officio Members*. The six Multi-Specialty Peer Review Committee (MPRC) Chairs (defined below), Medical Staff Vice-President, and Medical Staff Secretary/Treasurer

   b. *Non-Voting Ex Officio Members*. CPE, Chief Clinical and Quality Officer, Chief Nursing Executive, Director of Medical Staff Services, Peer Review Manager, and Peer Review Coordinator

   c. *Chair*. A Chair appointed by the Medical Staff President and approved by the MEC. The Medical Staff Vice-President shall serve as Co-Chair

   d. *Department Representatives*. A Physician Medical Staff Member representative from each of the following Departments, selected by the Medical Staff President after taking into consideration the recommendation of the applicable Department Chair: Emergency Medicine, Family Medicine, Pediatrics, Anesthesiology, Radiology, and Psychiatry. If a Committee member from one of the above Departments is selected to Chair an MPRC, an alternative Committee member shall be selected pursuant to the same process.

2. Voting. All Physician Committee members except the Non-Voting Ex Officio Committee members shall have the right to vote. Non-Physician Committee members shall be non-voting.

3. Term/Term Limits. The Committee Chair may be appointed to up to three consecutive two-year terms and shall again be eligible for appointment after a two-year period of ineligibility. The six MPRC Chairs will serve for the duration of their terms as MPRC Chair. The additional voting Committee members may be appointed to up to three consecutive two-year terms.

4. Meetings. The Committee shall meet at least quarterly.

5. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

6. Vacancy. Except with respect to ex officio Committee members, the Medical Staff President, in consultation with the appropriate Department Chair, shall appoint a qualified individual to fill any vacancy that may occur prior to the end of a Committee member's term.

7. Responsibilities. The responsibilities of the Committee shall include the following:

a. Create a performance improvement-focused peer review culture that helps Medical Staff Members provide high quality patient care

b. Provide ongoing oversight for the structure, policies, procedures, and results of Medical Staff Member performance improvement as performed by Medical Staff Peer Review Committees

c. Ensure that the peer review process provides appropriate data to evaluate the current competency of Medical Staff Members

C. **Multi-Specialty Peer Review Committees**. The MEC, in consultation with the Department Chairs and the PROC Chair, shall establish and conduct one or more Multi-Specialty Peer Review Committees, each of which shall be a subcommittee of the Peer Review Oversight Committee (each, a "**Multi-Specialty Peer Review Committee**" or "**MPRC**").

1. Composition. The Committee shall be comprised of Physicians and non-Physicians as needed for the specialties reviewed by the Committee. The Committee Chair shall be a Physician. The Medical Staff President, in consultation with the CPE, shall decide the number of Physician and non-Physician Committee members.

2. Voting. Physician Committee members shall have the right to vote. Non-Physician Committee members shall be non-voting.

3. Appointment. The Medical Staff President shall appoint the Committee Chair from among the current voting Committee members, in consultation with the applicable Department Chairs and subject to MEC approval. The Medical Staff President shall appoint all other Physician Committee members based on the recommendations from the Department Chairs and the Committee Chair,

subject to MEC approval. The Chair shall be a Physician. The Medical Staff President will appoint a Vice Chair from the MPRC voting members to serve if the Committee Chair is not available or has a conflict of interest. Any non-Physician Committee members shall be appointed by the Committee Chair.

4. Term/Term Limits. All Committee members may be appointed to up to three two-year terms. Members shall again be eligible for appointment after a two-year period of ineligibility.

5. Meetings. Each Medical Staff Peer Review Committee shall meet ten (10) times per year and shall maintain an accurate record of its proceedings. Voting Committee members will be expected to attend at least two-thirds (2/3) of the scheduled meetings over a 12-month period and perform assigned case reviews according to Peer Review Oversight Committee policies.

6. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a Committee member may be removed by the Medical Staff President or by vote of the MEC.

7. Vacancy. The Medical Staff President, in consultation with the appropriate Department Chair, shall appoint a qualified individual to fill any vacancy that may occur prior to the end of a Committee member's term.

8. Responsibilities

   a. Each Medical Staff Peer Review Committee shall have the following functions and responsibilities as related to the applicable Department(s):

      i. 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 Hospital Departments
      ii. Review, study, and report as to whether procedures and patient care were appropriate, medically necessary, and justified in all cases in which a major discrepancy exists between preoperative and postoperative (including pathologic) diagnoses; such review shall include peer review activities and other mechanisms
      iii. Develop standards and criteria to ensure optimal patient care and that will be used to create additional screening mechanisms

to identify cases for presentation at monthly Department meetings

b. Each MPRC Chair shall have responsibilities including the following:

i. Conduct case reviews of clinical care as described in the peer review policies
ii. Request the PROC to obtain external reviews as needed
iii. Review Medical Staff case review criteria and methods at least biennially in collaboration with the Department Chairs and recommend changes to the PROC
iv. When individual Medical Staff Member improvement opportunities are identified, ensure that the appropriate individuals are notified and a reasonable improvement plan is developed
v. Monitor and evaluate Medical Staff Member improvement plans initiated by the MPRC
vi. Identify potential issues related to Hospital systems affecting Medical Staff Member practice and communicate concerns to the appropriate Hospital Department
vii. Communicate to the Medical Staff CME potential program topics based on case reviews

9. Medical Staff Peer Review Committees Constitute Medical Review Committees. Each Medical Staff Peer Review Committee shall constitute a Medical Review Committee as described below.

D. **Credentials Committee**

1. Composition/Appointment/Voting. The Chair and all other Committee members shall be Physicians. The Credentials Committee shall consist of the following individuals:

a. The Medical Staff President, CPE, and Medical Staff Secretary/Treasurer, ex officio, with vote; the Medical Staff President shall appoint the Chair and Vice-Chair, if any

b. One Active Physician Medical Staff Member, with vote, from each of the Departments of Anesthesiology, Emergency Medicine, Family Medicine, Pediatrics, Orthopedics, Obstetrics & Gynecology, Psychiatry, and Radiology, each appointed by the applicable Department Chair

c. Two Active Physician Medical Staff Members, with vote, from the

Department of Medicine, one of whom shall be from the Hospitalist Division, both appointed by the Chair of the Department of Medicine

d. Two Active Physician Medical Staff Members, with vote, from the Department of Surgery, one of whom shall be a surgical subspecialist, both appointed by the Chair of the Department of Surgery;

e. One additional Active Physician Medical Staff Member, with vote, from the Department of which the Credentials Committee Chair is a member, appointed by the applicable Department Chair;

f. One Active Physician Medical Staff Member from the Department of Pathology, without vote, who shall serve in an advisory capacity, as needed, appointed by the Chair of the Department of Pathology

g. Active Physician Medical Staff Members of other clinical Departments, without vote, if called upon to serve in an advisory capacity as needed, appointed by the applicable Department Chair(s)

2. Term/Term Limits. Committee members shall be appointed to three-year terms. There shall be no limit on the number of terms a Committee member can serve.

3. Meetings. The Credentials Committee shall meet at least ten (10) times per year.

4. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

5. Vacancy. Except with respect to ex officio Committee members, the Medical Staff President, in consultation with the CPE, the Credentials Committee Chair (unless the Committee Chair position is vacant), and the appropriate Department Chair shall appoint a qualified individual to fill any vacancy that may occur prior to the end of a Committee member's term.

6. Responsibilities. The Credentials Committee shall:

a. Review, investigate, and consider fully the credentials and qualifications of all applicants for all credentialing actions described in these Bylaws including but not limited to: Medical Staff appointments and reappointments, recommendations for Medical Staff membership, assignment to clinical Departments, and delineation of clinical privileges, all in accordance with the provisions of these Bylaws

b. Issue a report to the MEC on each applicant for Medical Staff

membership, including specific consideration of the recommendations from the Department or Departments to which the applicant seeks to be assigned

c. Review requests for new clinical procedures and issue a report on such to the MEC

E. **APP Credentials Committee.** The APP Credentials Committee shall be a subcommittee, and shall be subject to the oversight, of the Credentials Committee.

1. Composition. The Medical Staff President and the CPE shall be ex-officio voting members of the Committee. The APP Credentials Committee shall be comprised of APPs (the Medical Staff President, in consultation with the CPE, shall determine the number), the Chief Nurse Executive, and one Physician who is a member of the Credentials Committee and who shall serve as Committee Chair.

2. Voting. All Committee members shall have the right to vote.

3. Appointment. The Medical Staff President shall appoint the Committee Chair and, in consultation with Chief Nurse Executive, all other Committee members.

4. Term/Term Limits. Once appointed, Committee members shall remain Committee members until they resign or are removed or are no longer in the office that entitled them to an ex officio appointment.

5. Meetings. The Committee shall meet at least ten (10) times per year.

6. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

7. Vacancy. The Medical Staff President shall appoint a qualified individual to serve as Committee Chair if that position becomes vacant and, in consultation with the Chief Nurse Executive, shall appoint a qualified individual to fill any other non ex officio vacancy that may occur.

8. Responsibilities. The APP Credentials Committee shall provide guidance and expertise to the Credentials Committee in the area of APP Medical Staff credentialing and privileging.

F. **Cancer Committee**

1. Composition. The Medical Staff President and the CPE shall be ex officio Committee members. The Medical Staff President, in consultation with CPE, shall determine the number of other Committee members. The Cancer Committee shall be multidisciplinary, representing Physician Medical Staff Members 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. Physician members will include a general surgeon or surgical specialist, medical oncologist, radiation oncologist, diagnostic radiologist, pathologist, palliative care physician, and the Cancer Liaison Physician.

   Non-Physician members shall include a cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar, quality management professional, clinical research data manager or nurse, and palliative care specialist. One coordinator shall be designated for each of the six areas of Cancer Committee activity: Cancer Conference Coordinator, Quality Improvement Coordinator, Cancer Registry Quality Coordinator, Clinical Research Coordinator, Psychosocial Services Coordinator, and Survivorship Program Coordinator. Additional members may be included at the discretion of the Committee Chair.

   As permitted by the Commission on Cancer, appointed alternates may attend Cancer Committee meetings as designees of both physician and non-physician Committee members.

2. Appointment. The Medical Staff President shall appoint all Committee members, taking into account the recommendations of the Division Director of Hematology and Medical Oncology.

3. Voting. All Committee members shall have the right to vote.

4. Term/Term Limits. Once appointed, Committee members shall remain Committee members until they resign or are removed or no longer serve in one of the positions listed above.

5. Meetings. The Cancer Committee shall meet at least quarterly.

6. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

7. Vacancy. Except with respect to ex officio Committee members, the Medical Staff President, in consultation with the Division Director of Hematology and Medical Oncology, shall appoint a qualified individual to fill any vacancy that may occur.

8. Responsibilities**.** The Cancer Committee is responsible for supporting patient-centered care, including goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities within the Hospital. The Cancer Committee may establish subcommittees (e.g., Breast Leadership, Lung Committee, etc.) to carry out its responsibilities. Such subcommittees shall report to the Cancer Committee and ultimately to the MEC.

G. **Nominating Committee**

1. Composition**.** The President of the Medical Staff and the CPE shall be ex officio voting members of the Committee. The Nominating Committee shall consist of one Active Physician Medical Staff Member from each Department.

2. Voting. All Committee members shall have the right to vote.

3. Appointment. The Medical Staff President shall appoint the Committee Chair. The Chair of each Department shall appoint the Committee members representing their Departments, all of whom shall be Physicians.

4. Term Limits. Nominating Committee members may be appointed to up to two consecutive three-year terms. Members shall again be eligible for appointment after a three-year period of ineligibility.

5. Meetings. The Nominating Committee shall meet at least three times during any year in which nominations are required and elections are held for Medical Staff Officers, as follows:

   a. An initial meeting on about September 1 of each year to review the Nominating Committee charge to consider potential candidates for Medical Staff Officer positions, and schedule additional meetings;
   b. An open meeting on about October 15 of each year, announced at least two weeks in advance, to allow additional nominations (who meet all eligibility criteria) and input from all Active Physician Medical Staff Members; and
   c. A meeting on or about November 15 of each year to prepare a final

slate of Medical Staff Officer candidates for presentation at the December Medical Staff Meeting.

6. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non- ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

7. Vacancy. Except with respect to ex officio Committee members, the applicable Department Chair shall appoint a qualified individual to fill any vacancy that may occur prior to the end of a Committee member's term; the Medical Staff President shall fill a vacancy in the position of Committee Chair.

8. Responsibilities**.** The Nominating Committee shall be responsible for preparing and presenting a slate of Medical Staff Officer candidates to the Physician Medical Staff Members entitled to vote for election in accordance with these Bylaws.

H. **Bylaws Committee**

1. Composition. The President of the Medical Staff and the CPE shall be ex officio members of the Committee. The Bylaws Committee shall consist of at least five members of the Active Physician Medical Staff including the Medical Staff President, Medical Staff Vice President, Medical Staff Secretary/Treasurer, and Credentials Committee Chair. The Committee may also include APPs, provided that at all times Physician Medical Staff Members shall constitute a majority of the membership of the Bylaws Committee.

2**.** Voting. Physician Committee members shall have the right to vote. APP Committee members shall be non-voting.

3. Appointment. The Medical Staff President, in consultation with the CPE, shall appoint the Committee Chair and all Physician and APP Committee members.

4. Term/Term Limits. Once appointed, Committee members shall remain Committee members until they resign or are removed or no longer serve in the position that entitled them to an ex officio appointment.

5. Meetings. The Committee shall meet at least annually and otherwise as needed.

6. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC.

7. Vacancy. Except with respect to ex officio Committee members, the Medical Staff President, in consultation with the CPE, shall appoint a qualified individual to fill any vacancy that may occur.

8. Responsibilities. The Bylaws Committee shall review these Bylaws and the Medical Staff Rules at least every two years and propose amendments thereto as it deems appropriate or as presented to it as provided in Article XVII of these Bylaws.

I. **Joint Conference Committee**. The Medical Staff President, CPE, CEO, MEC, or the Board may at any time request that a Joint Conference Committee be convened to discuss any issue involving the Board and Medical Staff.

1. Composition/Appointment. The Medical Staff President and CPE shall be ex officio members of any Joint Conference Committee. Any Joint Conference Committee shall consist of an equal number of members appointed by each of the Board Chair and the Medical Staff President in consultation with the CPE, with such number to be mutually agreed upon. All Committee members shall be Physicians.
2. Voting. All Committee members shall have the right to vote.

3. Suspension/Removal. In addition to automatic suspension as described in Section 11.2C above, a non-ex officio Committee member may be removed by the Medical Staff President or by vote of the MEC, as to Committee members appointed by the Medical Staff President, or by the Board Chair as to Committee members appointed by the Board Chair.

4. Responsibilities. The Joint Conference Committee facilitates communication between and among the leadership of the Board, Hospital administration, and the Medical Staff in addressing issues and/or concerns through communication and collaboration. A 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 and the MEC. A Joint Conference Committee shall be automatically dissolved upon completion of its consideration and resolution of the issues presented to it.

11.6 **ADDITIONAL STANDING COMMITTEES**. There shall be established such other standing committees as the MEC and the 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 the Hospital's Accrediting Organization or otherwise (in any instance, "**Additional Standing Committees**"). Except as otherwise required pursuant to applicable law or accreditation requirements, the MEC, subject to the approval of the CEO, shall determine the membership (including the Chair), voting rights, meeting frequency, responsibilities, and all other aspects of the establishment and operation of Additional Standing Committees.

11.7 **SPECIAL COMMITTEES**

A. **Composition/Appointment**. The Medical Staff President may from time to time establish other special committees for a particular purpose. The Medical Staff President and the CPE shall be ex officio voting members of any Special Committee. The Committee shall remain in existence until the purpose for which it was formed has been satisfied. The Medical Staff President, in consultation with the CPE and CEO, shall appoint the Committee Chair and all Committee members, and shall determine the number of Committee members. The Chair shall be a Physician.

B. **Voting**. The Medical Staff President, in consultation with the CPE and CEO, shall determine the voting rights of Committee members, other than the ex officio members designated above.

C. **Terms/Term Limits**. The Medical Staff President, in consultation with the CPE, shall determine the terms and/or term limits of Committee members.

D. **Meetings**. A Special Committee shall meet as frequently as is necessary to discharge its responsibilities and shall make reports and recommendations to the MEC, the CEO, or others in such manner as the Medical Staff President and the CEO shall direct.

E. **Suspension/Removal**. In addition to automatic suspension as described in Section 11.2C above, a Committee member may be removed by the Medical Staff President or by vote of the MEC.

F. **Vacancy**. If Committee members have set terms, the Committee Chair shall appoint qualified individuals to fill any vacancies that arise prior to the end of a Committee member's term; the Medical Staff President shall appoint a qualified individual to serve as Chair if a vacancy occurs in that office. If Committee members have no set terms, The Medical Staff President, in consultation with the CPE and CEO, shall appoint qualified individuals to fill any vacancies that may occur.

G. **Responsibilities**. The specific duties of any Special Committee shall be established by the MEC subject to the approval of the CEO.

11.8 MEDICAL REVIEW COMMITTEES

A. Medical Review Committees are established for the purpose of conducting peer review activities in accordance with Connecticut General Statutes Section 19a-17b, as amended from time to time, 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. All Medical Staff Committees, and 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. For clarity, the MEC, all other Medical Staff Committees, and all standing, ad hoc, special, and any other committees or groups that engage in peer review or other 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.

B. The Hospital's Accrediting Organization, 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, the Hospital's Accrediting Organization shall be bound to protect the confidentiality of information of the Medical Review Committee, pursuant to applicable law and the contract between the Hospital and its Accrediting Organization.

C. It is intended and understood that in order to properly and effectively carry out their peer review activities, Medical Review Committees may from time to time require the assistance of others, including subcommittees, Department Chairs, Division Directors, committee and subcommittee Chairs, the Medical Staff President and other Medical Staff Officers, the CPE, other Hospital-affiliated 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 groups and individuals are part of the proceedings of such Medical Review Committees for the purpose of performing peer review.

D. It is intended and understood that 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 and mortality, and establishing guidelines to control health care costs. The proceedings of all Medical Review Committees, including data and information

gathering and analysis and reporting by authorized individuals for the 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.

E. The MEC shall from time to time review the functions of all Medical Staff Committees established pursuant to these Bylaws, to determine which of said Committees are performing peer review activities within the meaning of Connecticut General Statutes Section 19a-17b, as amended from time to time. Such committees shall be identified as Medical Review Committees in policies and procedures to be promulgated by the Hospital; provided, however, that the foregoing shall not invalidate or waive peer review protection in a Medical Staff Committee or other committee or group that has engaged in peer review before being officially identified as a Medical Review Committee in Hospital policies or procedures.

ARTICLE XII

MEETINGS OF THE MEDICAL STAFF

12.1 **ANNUAL MEETING.** The annual meeting of the Medical Staff shall be held during the month of December. At the annual meeting, the MEC, other Medical Staff Committees, and Medical Staff Officers shall make such reports as may be desirable or appropriate. Medical Staff 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, and September.

12.3 **SPECIAL MEETINGS.** Special meetings of the Medical Staff may be called at any time by the Medical Staff President and shall be called at the written request of the Board Chair, the Medical Staff President, or any twenty (20) Physician Medical Staff Members entitled to vote, which written request must state the purpose for such a meeting and, if a vote will be taken, indicating that a vote shall occur. The Medical Staff President shall then designate the time and location for the special meeting. Written notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered by the Secretary/Treasurer to each Medical Staff Member not less than ten (10) business days before the day of such meeting. Attendance 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 written notice of the meeting.

12.4 **ACTION AT MEETINGS**

A. **Quorum**. A quorum at any Medical Staff Meeting shall meeting shall be the Physician Medical Staff Members present and entitled to vote.

B. **Action**. Except as otherwise provided in these Bylaws, any action taken or to be taken by the Medical Staff may be approved at any annual, regular, or special Medical Staff meeting when a quorum is present.

C. **Voting**. While all Medical Staff Members are permitted and encouraged to attend Medical Staff meetings, only Physician Medical Staff Members entitled to vote may vote and be counted for a quorum at such meetings.

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

A. Call to order
B. Vote on the adoption of the minutes of the last regular or special meeting

C. Unfinished business
D. Communications
E. Reports of Standing and Special Committees
F. Report of the MEC
G. Report of the CEO
H. New Business
I. Adjournment

12.6 **ATTENDANCE AT MEETINGS**

A. All Medical Staff Members shall register on the attendance roster.

B. Attendance at a Departmental meeting shall not count as attendance at a Medical Staff meeting.

C. A Medical Staff Member who has attended at a case that is to be presented for discussion at any Medical Staff meeting shall be notified and shall be obliged to be present.

D. Members of the Active Medical Staff are expected to attend all annual, regular, and special Medical Staff meetings and all meetings of the Department to which the Medical Staff Member is assigned, unless they have a valid excuse, as determined by the MEC.

12.7 **DEPARTMENT MEETINGS.** Department 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, Medical Staff Committees, Departments, and Divisions, unless otherwise provided in these Bylaws.

ARTICLE XIII
MEDICAL STAFF MEMBER COMPETENCE AND CONDUCT

13.1 **APPLICABILITY/SCOPE - CLINICAL CONDUCT AND/OR PROFESSIONAL CONDUCT**. This Article describes the process pursuant to which the following types of Medical Staff issues shall be addressed:

A. The clinical competence of any Medical Staff Member, including concerns regarding the care, treatment, management, or safety of patients and issues related to possible Medical Staff Member impairment; provided however, that issues related to possible impairment may be handled in accordance with the Medical Staff Impaired Medical Staff Member Policy in lieu of under these Bylaws as noted below.

B. The known or suspected violation by any Medical Staff Member of applicable ethical standards, these Bylaws, Medical Staff Rules, Medical Staff Policies, Department Rules, and/or Hospital bylaws or policies; and

C. Conduct by any Medical Staff Member that is considered below Hospital standards or disruptive to the orderly operation of the Hospital or the Medical Staff, including the inability of a Medical Staff Member to work harmoniously with others; provided, however, that as noted below, such issues may be handled in accordance with the Disruptive Medical Staff Member Policy or Code of Conduct if deemed appropriate by any two Medical Staff Leaders.

13.2 **COLLEGIAL INTERVENTION**

A. **Possible Medical Staff Member Impairment**. If any Medical Staff Member has reason to suspect that another Medical Staff Member is impaired in their behavior, judgment, or performance, they shall immediately report such concern to a Medical Staff Leader. Such report will be kept in strict confidence and to the extent any two Medical Staff Leaders agree that impairment is a concern, the matter shall be handled pursuant to the Impaired Medical Staff Member Policy.

B. **Initial Approach Unless Medical Staff Leaders Decide Otherwise**. Except in the case of an impaired Medical Staff Member, who will be subject to the Impaired Medical Staff Member Policy, resolution of issues covered by this Article shall begin with collegial and educational efforts by an individual designated by any two Medical Staff Leaders unless they determine that:

1. Such approach is not appropriate under the circumstances, in which case the process described in Section 13.3 shall be followed;

2. Summary Action or Automatic Administrative Action (as described in Sections 13.5 and 13.6 below) is warranted; or

3. The Disruptive Medical Staff Member Policy or Code of Conduct, as applicable, should be followed.

The goal of these efforts is to arrive at voluntary, responsive actions by the Medical Staff Member to resolve concerns that have been raised. Collegial intervention efforts are part of confidential, routine, peer review activity and may precede or result in ongoing and focused professional practice evaluation ("**OPPE**" and "**FPPE**," respectively).

C. **Examples of Collegial Intervention**. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff Members and pursuing counseling, education, and related steps, including but not limited to the following:

1. Advising Medical Staff Members of all applicable Hospital policies, Medical Staff Policies, Medical Staff Rules, Medical Record Rules, Department Rules, and the Code of Conduct, including those regarding appropriate behavior, communication, call obligations, and the timely and adequate completion of medical records; and

2. Sharing blinded, comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist Medical Staff Members to conform their practices to appropriate norms.

D. **Documentation of Collegial Intervention**. The relevant Medical Staff Leaders shall document collegial intervention efforts and/or institute an FPPE plan if appropriate; such documentation shall be kept in the Medical Staff Member's confidential MSO file. The Medical Staff Member shall have an opportunity to review any formal documentation that is prepared by the Medical Staff Leaders and respond in writing. The response shall be maintained in the Medical Staff Member's MSO file along with the original documentation.

13.3 **Determine Whether an Investigation is Warranted or Required.** If any two Medical Staff Leaders determine that:

A. Collegial intervention is not appropriate under the circumstances; or

B. Collegial intervention has failed in the reasonable determination of the Medical Staff Leaders,

then the two Medical Staff Leaders shall determine whether:

A. The matter should be handled pursuant to the Disruptive Medical Staff Member Policy or Code of Conduct, in which case the process set forth therein shall be followed; or

B. An investigation pursuant to Section 13.4 hereof is warranted.

Please note: An investigation shall be required if Summary Action has been taken.

13.4 **INVESTIGATION**. If collegial intervention fails or is determined to be inappropriate under the circumstances and any two Medical Staff Leaders have determined that an investigation is warranted, or if Summary Action has been taken, an investigation shall be conducted.

A. **Investigative Committee**. Once a determination has been made that an investigation is warranted or required as described above, the Medical Staff President shall (i) notify the Medical Staff Member in writing that an investigation will be conducted and that they shall be entitled to an interview as described below; and (ii) shall appoint an investigative committee comprised of at least three MEC Members to conduct the investigation (the "**Investigative Committee**"). To preserve impartiality, the Investigative Committee shall not include any individual who: (i) is in direct economic competition with the Medical Staff Member under investigation; (ii) is professionally associated with or a relative of, the Medical Staff Member under investigation; or (iii) has actively participated in the matter at any previous level. If practicable, at least one Investigative Committee member shall be a clinician in the same specialty as the Medical Staff Member under investigation.

B. **Medical Staff Member Interview**. As part of the investigation, the Medical Staff Member under investigation shall be provided with the opportunity for an interview with the Investigative Committee. Any such interview shall take place as soon as practicable following receipt by the Medical Staff President of a written request for an interview from the Medical Staff Member. At such interview, the Investigative Committee shall inform the Medical Staff Member of the general nature of the matters being investigated, and shall invite them to discuss, explain, or refute the allegations. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the hearing or other due process rights otherwise provided in these Bylaws shall apply thereto. The Medical Staff Member shall not be entitled to have counsel present, and neither party shall have the right to record the interview other than in written notes. A written summary of the interview shall be made and included with the Investigative Committee's report to the MEC described below (the "**Investigative Report**").

C. **Investigative Report**. The Investigative Report shall be made and submitted to the MEC within thirty (30) business days after the investigation begins, or as soon as practicable thereafter. The Investigative Report shall include the summary of the interview and a recommendation for action, including but not limited to the following (collectively, "**Possible Action**"):

1. Take no further action

2. Issue a letter of admonition or reprimand

3. Impose a requirement for consultation or additional medical education or other specific conditions on the Medical Staff Member's practice that do not rise to the level of a Significant Adverse Action as defined below

5. Recommend an action that is required to be reported to the NPDB or the State of Connecticut[7] (the "**State**"), including the following (collectively, "**Significant Adverse Action**"):

    a. Denial or revocation (as applicable) of Medical Staff appointment, Medical Staff reappointment, or clinical privileges for reasons related to clinical competence or professional conduct
    b. Suspension or restriction of Medical Staff membership (including Summary Action but not including *Automatic Administrative Action)* or suspension or restriction of clinical privileges for reasons related to the Medical Staff Member's clinical competence or professional conduct, any of which lasts for more than thirty (30) days
    c. Imposition of Involuntary Medical LOA
    d. Denial of reinstatement from an LOA if the reasons relate to clinical competence or professional conduct, or the placement of conditions on such reinstatement that would be required to be reported to the NPDB or the State

The Investigative Report shall state the reasons for the recommended action.

D. **MEC Review of Investigative Report – Determination of Potential for Significant Adverse Action**. The MEC shall review the Investigative Report to determine whether (i) adoption of the recommendation(s) contained therein would result in Significant Adverse Action against the Medical Staff Member under investigation; or (ii) the MEC otherwise wishes to consider taking Significant Adverse Action.

[7] For clarity, although NPDB reporting is mandatory with respect to Physicians and voluntary with respect to APPs, APPs shall be entitled to the hearing and other due process rights set forth in these Bylaws if they are the subject of any of the listed Significant Adverse Actions.

E. **MEC Vote on Investigative Report – Recommendation to the Board for Possible Action**

1. If Significant Adverse Action Is Not Under Consideration. If acceptance of the recommendation(s) made in the Investigative Report *would not* result in Significant Adverse Action and the MEC does not believe that it would otherwise take Significant Adverse Action under the circumstances,[8] then the MEC shall vote within thirty (30) business days following the receipt of the Investigative Report to recommend to the Board the Possible Action the MEC recommends be taken.

2. If Significant Adverse Action Is Under Consideration. If acceptance of the recommendations made in the Investigative Report *would* result in Significant Adverse Action or the continuation thereof or if the MEC believes that it otherwise may take or continue Significant Adverse Action, the Medical Staff President shall notify the affected Medical Staff Member in writing that the MEC is considering Significant Adverse Action and that the Medical Staff Member shall be permitted to make an appearance before the MEC prior to the MEC vote. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the hearing or other due process rights otherwise provided in these Bylaws shall apply thereto. The Medical Staff Member shall not be entitled to have counsel present, and neither party shall have the right to record the proceeding. The MEC shall make a written summary of such appearance and shall vote as soon as reasonably possible thereafter whether to recommend that the Board take Significant Adverse Action.

3. Notification of MEC Recommendation(s). Following its vote, the MEC shall submit to the Board the MEC's written recommendation(s) for Possible Action, which recommendation shall set forth the reasons for its recommendation(s). The CEO shall simultaneously notify the affected Medical Staff Member in writing of the Possible Action the MEC is recommending to the Board. If the Possible Action being recommended is Significant Adverse Action, the notice shall contain the information required pursuant to Section 14.2 of these Bylaws, including advising the affected Medical Staff Member that they are entitled to a hearing on the matter prior to the Board's vote by following the process set forth in Article XIV of these Bylaws.

F. **Medical Staff Member's Right to a Hearing Only on MEC's or Board's Recommendation for Significant Adverse Action**. Any recommendation by the MEC for Significant Adverse Action shall entitle the affected Medical Staff Member

[8] The MEC shall not be limited by the Investigative Report in terms of the Possible Action it may recommend.

to the hearing and other procedural rights provided in Article XIV of these Bylaws prior to any action by the Board. If the MEC has not recommended Significant Adverse Action, no hearing or other due process rights set forth in these Bylaws shall apply to the MEC's recommendation or to the Board's final action, unless the Board votes to take Significant Adverse Action notwithstanding the MEC's contrary recommendation.[9]

G. **Board Action**. The Board shall review and vote upon the recommendation of the MEC as follows:

1. If the MEC does not recommend Significant Adverse Action or the Medical Staff Member has not requested a hearing on any Significant Adverse Action recommendation within the requisite timeframe set forth in Article XIV of these Bylaws, the Board shall vote at its next regular meeting; or

2. If the MEC does recommend Significant Adverse Action and the Medical Staff Member has requested a hearing on such Significant Adverse Action recommendation within the requisite timeframe as described in Article XIV of these Bylaws, the Board shall not vote until after the hearing has occurred and the Board has received the recommendation of the Hearing Panel.

H. **Notification of CEO**. The Medical Staff President shall promptly notify the CEO in writing of all questions involving clinical competence or professional conduct referred to or raised by the MEC and shall continue to keep the CEO fully informed of all action taken in connection therewith.

13.5 SUMMARY ACTION

A. **Grounds for Summary Action**. Notwithstanding the foregoing or anything herein to the contrary, in any one or more of the following circumstances, the CEO, with the approval of any two Medical Staff Leaders, shall have the right, upon written notice to the affected Medical Staff Member, to summarily suspend or restrict a Medical Staff Member's Medical Staff membership and any clinical privileges (collectively, "**Summary Action"**):

1. The failure to take such action may result in an imminent danger to the health of any individual
2. The Medical Staff Member is charged with commission of a felony
3. The Medical Staff Member is charged with commission of a misdemeanor of a nature that makes them unsuitable for Medical Staff membership
4. The Medical Staff Member has engaged in unethical activity relating to the

[9] If (i) the MEC does not vote to recommend Significant Adverse Action and therefore no hearing takes place; or (ii) if, following a hearing, the Hearing Panel does not vote to recommend Significant Adverse Action but the Board nonetheless votes to take Significant Adverse Action, then the affected Medical Staff Member shall be entitled to the hearing and other due process rights set forth in Article XIV with regard to the Board's action.

practice of medicine, including such conduct as is described in the Stamford Hospital Medical Staff Code of Conduct or the AMA Principles of Medical Ethics

5. The Medical Staff Member has or is reasonably believed to have made a material misstatement or omission on any pre-application or application for appointment or reappointment, or has otherwise deceived the Medical Staff and/or Hospital
6. The Medical Staff Member has falsified or inappropriately destroyed or deliberately altered any medical record
7. The Medical Staff Member has deliberately abandoned a patient or has wrongfully refused to provide care to a patient based on gender, race, age, disability, religion, national origin, color, marital status, sexual orientation, gender identification or expression, ancestry, genetic information or being identified as a member of any other protected class
8. The Medical Staff Member engages in clinical activities outside the scope of their clinical privileges
9. The Medical Staff Member engages in unprofessional, abusive, or inappropriate conduct that is or may be disruptive to Hospital operations
10. The Medical Staff Member refuses to submit to immediate evaluation relating to their mental or physical status if such evaluation is needed as determined by any Medical Staff Leader
11. The Medical Staff Member has had their licensure or other professional status terminated, suspended, restricted, conditioned, or limited in any way in any state other than Connecticut, has had their medical staff membership at any other health care facility in any state (including Connecticut) terminated, suspended, restricted, conditioned or limited in any way, has resigned from any other medical staff in any state (including Connecticut) while under, or 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 at any other facility in any state (including Connecticut) during or following an investigation, or to avoid such an investigation or disciplinary action, subject, however, to the Reproductive Health Services Exception.

C. **Arrangement of Clinical Coverage**. Immediately upon the imposition of Summary Action, the appropriate Department Chair or Medical Staff President shall have the authority, as and if necessary, to arrange for alternative medical coverage for the patients of the suspended Medical Staff Member who are in the Hospital at the time of such Summary Action. The wishes of the patient shall be considered in the selection of such alternative Medical Staff Member.

D. **Investigation Required**. An investigation shall be conducted following the imposition of any Summary Action in accordance with Section 13.4 hereof.

13.6 **AUTOMATIC[10] ADMINISTRATIVE ACTION.** The terms "Automatic Administrative Suspension" and "**Automatic Administrative Termination**" shall be collectively referred to herein as "**Automatic Administrative Action**."

A. **Automatic Administrative Suspension**

1. Medical Record Noncompliance. Notwithstanding the foregoing or anything herein to the contrary, the Medical Staff membership and any clinical privileges of a Medical Staff Member may, upon written notice to the Medical Staff Member, be automatically suspended if the Medical Staff Member fails to timely complete medical records in accordance with the Medical Staff Policy governing the maintenance and completion of medical records ("**Medical Record Policy**"). Any such Automatic Administrative Suspension shall remain in effect for as long as the Medical Staff Member is in violation of the Medical Record Policy. The process for determining whether a Medical Staff Member's non-compliance with the Medical Record Policy warrants suspension of their Medical Staff Membership and clinical privileges, including the process for notification of the Medical Staff Member and all other aspects of such a suspension, shall be as set forth in the Credentials Manual.

2. Conflict of Interest Disclosure Noncompliance. Notwithstanding the foregoing or anything in these Bylaws to the contrary, the Medical Staff membership and any clinical privileges of a Medical Staff Member may, upon written notice to the Medical Staff Member, be automatically suspended if the Medical Staff Member fails to timely complete and submit the Conflict-of-Interest Form distributed on a yearly basis pursuant to the Hospital's Medical Staff Conflict of Interest Disclosure Policy ("**COI Policy**"). Any such Automatic Administrative Suspension shall remain in effect for as long as the Medical Staff Member is in violation of the COI Policy. The process for determining whether a Medical Staff Member's non-compliance with the COI Policy warrants suspension of their Medical Staff Membership and clinical privileges, including the process for notification of the Medical Staff Member and all other aspects of such a suspension, shall be as set forth in the Credentials Manual.

3. Other Grounds for Automatic Administrative Suspension**.** The Medical Staff membership and clinical privileges of a Medical Staff Member shall be

[10] The term "automatic" as used in this Section 13.6 refers to the fact that no hearing or other due process rights set forth in these Bylaws shall apply to any Medical Staff membership suspension imposed under such Section.

automatically suspended immediately upon the occurrence of any of the following:

a. Failure to maintain appropriate malpractice insurance for the privileges being exercised

b. Failure to maintain a current, active, unrestricted Connecticut license to practice their profession

c. Exclusion or suspension from participation in Medicare or Medicaid

d. Failure to maintain a current, active DEA certification or Department of Consumer Protection registration (if required for practice)

e. With respect to APP Medical Staff, the restriction, suspension, or termination of the Medical Staff membership of the Physician Medical Staff Member (the "**Collaborating Physician**") with whom the Medical Staff Member has a written collaboration, supervision, delegation, or other similar type of agreement (a "**Collaboration Agreement**")

4. **Practitioner Notification and Right to Present Evidence**. The Medical Staff President shall notify the Medical Staff Member verbally and then in writing of the Automatic Administrative Suspension and the basis therefor. The notice shall indicate that the Medical Staff member shall have twenty (20) business days within which to produce clear and convincing evidence that the facts relied upon by the Hospital in instituting the Automatic Administrative Suspension were incorrect or are no longer correct.

a. If the Medical Staff Member does not provide the MSO with such evidence within such twenty (20) business day period[11], the individual's Medical Staff membership (including all clinical privileges) shall automatically terminate.

b. If the Medical Staff Member does provide the MSO with such evidence that is satisfactory in the judgment of the Medical Staff President and CPE within such twenty (20) business day period, the Medical Staff President shall reverse the Automatic Administrative Suspension.

B. **Automatic Administrative Termination.** The Medical Staff membership and clinical privileges of a Medical Staff Member shall be automatically terminated and the

[11] With respect to an APP Medical Staff Member whose Collaborating Physician is suspended or removed from the Medical Staff, such evidence would consist of the submission of a new Collaboration Agreement with another Collaborating Physician within such twenty (20) business day period.

Medical Staff member shall be deemed to have relinquished their Medical Staff membership and clinical privileges, immediately upon the occurrence of any of the following:

1. Termination of employment of a Medical Staff Member by the Hospital, Stamford Health Medical Group, or other provider entity owned, operated, or controlled by SHI, where the Medical Staff Member's employment agreement, offer letter, or other document governing terms of employment provides that their Medical Staff membership is coterminous with their employment

2. Where a third party provides services to Hospital, SHMG, and/or any other provider entity owned, operated, or controlled by SHI pursuant to a services agreement (a "**Services Agreement**") that provides that the Medical Staff membership of any providers rendering services thereunder is coterminous with the Services Agreement and/or that the Medical Staff membership of any individual provider providing services under such a Services Agreement shall automatically terminate when such individual ceases to provide services thereunder for any reason, even if the Services Agreement remains in effect

C. **Arrangement for Clinical Coverage**. Immediately upon the imposition of an Automatic Administrative Action, the appropriate Department Chair or Medical Staff President shall have the authority to arrange for alternative medical coverage for the patients of the suspended Medical Staff Member who are in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Medical Staff Member.

D. **No Due Process Applies**. The hearing and other due process rights set forth in Article XIV of these Bylaws shall not apply to Automatic Administrative Action.

ARTICLE XIV
HEARING AND APPEALS PROCEDURES

14.1 **GROUNDS FOR HEARING**. A Medical Staff Member is entitled to a hearing and other due process rights whenever the MEC or the Board[12], following an investigation conducted pursuant to Article XIII of these Bylaws, recommends or has taken Significant Adverse Action. No recommendation, decision, or action other than the forgoing shall entitle a Medical Staff Member to a hearing or other due process rights pursuant to these Bylaws, regardless of whether the inapplicability of such hearing or due process is expressly stated herein.[13]

14.2 **NOTICE OF RECOMMENDATION FOR SIGNIFICANT ADVERSE ACTION AND RIGHT TO A HEARING**. The CEO shall promptly give written notice to the affected Medical Staff Member of a recommendation for Significant Adverse Action by the MEC or the Board. This notice shall contain:

A. A statement of the Significant Adverse Action recommendation and the general reasons for it;

[12] If the Board votes to take any Significant Adverse Action absent an initial Significant Adverse Action recommendation by the MEC, a Medical Staff Member is entitled to a hearing. Although this Article refers to Significant Adverse Action recommendations of the MEC, when a hearing is triggered by a proposed Significant Adverse Action by the Board, any reference in this Article to the "MEC" will be interpreted as a reference to the "Board."

[13] Actions Not Grounds for Hearing. The following are examples, but not an exhaustive list, of actions that do not constitute Significant Adverse Actions and therefore do not entitle a Medical Staff Member to a hearing or other due process rights. A Medical Staff Member is, however, entitled to submit a written statement regarding the following types of actions for inclusion in his or her MSO file: (1) Automatic Administrative Action; (2) voluntary acceptance of an FPPE; (3) imposition of conditions, monitoring, or proctoring that does not rise to the level of a "restriction" as defined in Article I of these Bylaws and does not last more than thirty (30) days; (4) imposition of a requirement for additional training or continuing education; (5) issuance of a letter of guidance, counsel, warning, or reprimand; (6) lapse, withdrawal of, or decision not to grant or not to renew temporary privileges; (7) denial of a request for Voluntary LOA or for an extension of Voluntary LOA; (8) removal from the on-call roster or any reading or rotational panel; (9) determination that an application for Medical Staff Membership is incomplete; (10) determination that an application for Medical Staff Membership will not be processed due to a misstatement or omission; or (11) determination of ineligibility for Medical Staff Membership based on a failure to meet threshold eligibility criteria, a lack of resources, or the existence of an exclusive provider services contract.

B. A statement that the Medical Staff Member has the right to a hearing as provided in Section 14.3 and shall be deemed to have waived such right if the written request for a hearing is not submitted within thirty (30) days following receipt of the notice; and

C. A copy of this Article XIV.

14.3 REQUEST FOR HEARING

If a Medical Staff Member wishes to have a hearing regarding a Significant Adverse Action recommendation, they must submit to the Medical Staff President a written request for a hearing within thirty (30) business days following receipt of written notice from the CEO of a Significant Adverse Action recommendation. The request for a hearing shall include the name, address, and telephone number of the Medical Staff Member's counsel, if any. Failure to request a hearing within the stated timeframe will constitute waiver of the right to a hearing, and the MEC's Significant Adverse Action recommendation will be transmitted to the Board for final action.

14.4 INITIAL NOTICE OF HEARING/INITIAL PROVISION OF INFORMATION TO MEDICAL STAFF MEMBER

A. **Initial Notice**. If the Medical Staff Member submits a written request for a hearing within the required timeframe, the Medical Staff President, after consulting with the CEO, shall send a written notice to the Medical Staff Member that shall (a) confirm receipt of the request and the Medical Staff Member's right to a hearing; (b) advise the Medical Staff Member that the hearing shall be held not less than thirty (30) business days following receipt of the CEO's written notice; (c) summarize the reasons for the Significant Adverse Action recommendation; and (d) remind the Medical Staff Member that they are bound by these Bylaws, including but not limited to Section 14.4 B(1) below with respect to the confidentiality requirements applicable to all information provided to them as part of the hearing process (the "**Initial Notice**").

B. **Initial Provision of Information to Medical Staff Member/Discovery**

1. Confidentiality Obligation. In requesting a hearing, the Medical Staff Member represents and warrants that they shall maintain all documents and information provided to them, in written or other format (collectively, "**Confidential Information**"), whether or not containing Protected Health Information as defined under the Health Insurance Portability Act of 1996 and accompanying regulations ("**HIPPA**"), in strict confidence and will not use Confidential Information for any purpose outside of the hearing, or disclose Confidential Information to any third party including counsel and expert witnesses, without first ensuring that such third party shall have executed a binding written confidentiality agreement or Business Associate Agreement, as applicable, in connection with any such Confidential Information.

2. As soon as practicable following receipt of the request for a hearing the Medical Staff Member will be provided with the following:

   a. Copies of, or reasonable access to, all patient medical records supporting the reasons for the recommended Significant Adverse Action, at the Medical Staff Member's expense;

   b. Reports of experts relied upon by the MEC;

   c. Copies of relevant Medical Staff committee minutes (with portions regarding other Medical Staff Members and unrelated matters redacted); and

   d. Copies of any other documents relied upon by the MEC.

The provision of this information is not intended to and shall not waive any privilege.

14.5 HEARING OFFICER AND HEARING PANEL

A. **Hearing Officer**. The Medical Staff President, after consultation with the CEO, will appoint an attorney to serve as Hearing Officer, and shall notify the Medical Staff Member of the name of the Hearing Officer selected within five business days following their appointment. The Hearing Officer shall not act as an advocate for either side at the hearing.

1. The Hearing Officer shall:

   a. Schedule and conduct a pre-hearing conference

   b. Allow the hearing participants to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination

   c. Rule on matters of procedure and the admissibility of evidence

   d. Maintain decorum throughout the hearing

   e. Determine the order in which the components of the hearing shall be presented

   f. Hear argument by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Officer determines that it is beneficial for the Hearing Panel to be present

2. The Hearing Officer may participate in the private deliberations of the Hearing Panel, be a legal advisor to it, and draft the report of the Hearing Panel's

decision based upon the findings and discussions of the Hearing Panel but shall not vote on its recommendations.

3. Hospital's legal counsel may advise the Hearing Officer with regard to the hearing process.

B. **Objections to Hearing Officer**. The Medical Staff Member shall present in writing to the Medical Staff President any objections to the selection of the Hearing Officer within five business days of receipt of notice of the selection. The Medical Staff President shall then work with the other Medical Staff Leaders to address the issue. The Medical Staff President in consultation with the CEO may, but shall not be obligated to, propose one or more alternate Hearing Officer(s). If the Medical Staff President proposes one or more alternate Hearing Officer(s), the Medical Staff Member shall respond with their acceptance of or objections to such alternates within five business days following receipt of the names of the proposed alternates, and this process shall continue until the selection of the Hearing Officer is final as determined by the Hospital. Notwithstanding anything herein to the contrary, the selection of the Hearing Officer shall be in the sole discretion of the Hospital.

C. **Hearing Panel**. Once the selection of the Hearing Officer has been finalized, the Hearing Officer, in consultation with the Medical Staff President and CEO, shall appoint a Hearing Panel and shall notify the Medical Staff Member of the names of the Hearing Panel members within five business days following their selection. The Hearing Panel shall be selected in accordance with the following rules:

1. The Hearing Panel shall consist of at least three members all of whom shall be Medical Staff Members and one of whom will be designated by the Medical Staff President as Chair. The Hearing Panel may also include one or more alternates to serve if one or more members of the Hearing Panel are unable to continue; such alternates shall not be counted toward the three-member minimum.

3. Knowledge of the underlying peer review matter, in and of itself, shall not preclude an individual from serving on the Hearing Panel.

4. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Hearing Panel.

5. Notwithstanding the foregoing, the Hearing Panel shall not include any individual who:

   a. Is in direct economic competition with the Medical Staff Member;

b. Is professionally associated with or a relative of the Medical Staff Member;

c. In the reasonable judgment of the Hearing Officer, has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

d. Actively participated in the matter at any earlier stage.

D. **Objections to Hearing Panel**. The Medical Staff Member shall present in writing to the Medical Staff President and the Hearing Officer any objections to the selection of those proposed to be appointed to the Hearing Panel within five business days following receipt of the names of the individuals designated as the Hearing Panel. The Hearing Officer shall provide the Medical Staff President an opportunity to be heard regarding any objections raised and then shall work with the Medical Staff Leaders to address any issue raised. The Hearing Officer may, but shall not be obligated to, propose one or more alternate Hearing Panel members. If the Hearing Officer proposes one or more alternate Hearing Panel members, the Medical Staff Member and the Medical Staff President shall respond to the Hearing Officer with their acceptance of or objections to any such alternates within five business days following receipt of the names of the proposed alternates, and this process shall continue until the selection of the Hearing Panel is final as determined by the Hearing Officer. Notwithstanding anything herein to the contrary, the selection of the Hearing Panel shall be in the sole discretion of the Hearing Officer.

E. **Compensation**. The Hospital may compensate the Hearing Panel members and/or the Hearing Officer for their service. Compensation shall not constitute grounds for challenging the impartiality of the Hearing Officer or the Hearing Panel members.

F. **Counsel**. The Hearing Officer and counsel for both parties shall be attorneys at law licensed to practice in Connecticut.

14.6 PRE-HEARING PROCEDURES

A. **Scheduling the Hearing - Notice**. The Medical Staff President, in consultation with the other Medical Staff Leaders, the Hearing Officer, and the Hearing Panel, shall select a date, time, and place for the hearing to be held as soon as practicable but no earlier than thirty (30) business days after the Medical Staff Member's receipt of the Initial Notice, unless the parties have agreed in writing to an earlier hearing date. The Medical Staff President shall then provide, by written notice to the Medical Staff Member, the date, time, and place of the hearing.

B. **Objections to Hearing Date, Time, or Place**. The Medical Staff Member shall provide to the Medical Staff President and Hearing Officer, in writing, any objections to the hearing date, time, or place within five business days following receipt of the information. The Medical Staff President shall then work with the Hearing Officer, and the Hearing Panel members to address the issue. The Hearing Officer may, but shall not be obligated to, propose one or more alternate date(s), time(s) and/or location(s). If the Hearing Officer proposes an alternative date, time, or place for the hearing, the Medical Staff President and the Medical Staff Member shall respond with their acceptance of or objections to such alternatives within five business days following receipt of notice, and this process shall continue until the hearing date, time and place are finalized as determined by the Hearing Officer. Notwithstanding anything herein to the contrary, the selection of the hearing date, time, and place shall be in the sole discretion of the Hearing Officer.

C. **Exchange of Witness Lists and Evidence**. At least ten (10) business days prior to the pre-hearing conference described in Section 14.6 E below, each party shall provide to the other party and the Hearing Officer a proposed list of witnesses who will give testimony at the hearing and a brief summary of their anticipated testimony, as well as any documentary evidence such party wishes to present at the hearing.

D. **Objections to Witnesses or Evidence**. Any objection to witnesses or evidence submitted by a party shall be submitted to the other party and the Hearing Officer at least five business days prior to the pre-hearing conference. Any objection must include reasons to support it. The Hearing Officer will rule on the objections and give notice to the parties. The Hearing Officer shall make evidentiary determinations based on the guiding principle that the record should contain information sufficient to allow the Board to decide whether the Medical Staff Member is qualified for Medical Staff Membership and clinical privileges. Evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay, as well as evidence unrelated to the MEC recommendation or to the Medical Staff Member's qualifications for appointment or clinical privileges will be excluded. Notwithstanding anything herein to the contrary, although the Hearing Officer shall work with the parties to accommodate reasonable concerns, the admissibility of witness testimony and other evidence shall be in the sole discretion of the Hearing Officer. Further, notwithstanding the foregoing, the witness list and/or documentary evidence of either party may, in the discretion of the Hearing Officer, be amended at any time during the course of the hearing.

E. **Limited Discovery Permitted**. The Medical Staff Member will have no right to discovery beyond obtaining the information provided under these Bylaws and Hospital shall have no obligation to provide information regarding other Medical Staff Members. Except as provided in the following Subsection, neither party shall have the right to depose, interrogate, or interview the other party's witnesses prior to the hearing. Neither the Medical Staff Member nor any other person acting on their behalf,

may contact Hospital employees or other Medical Staff Members whose names appear on the MEC's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, unless and until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the Medical Staff Member once it has contacted such employees and other Medical Staff Members and determined their willingness to meet. Any employee or Medical Staff Member may agree or decline to be interviewed by or on behalf of the Medical Staff Member who requested a hearing.

F. **Pre-Hearing Conference**

1. At least ten (10) business days prior to the hearing, the Hearing Officer shall hold a pre-hearing conference with the Medical Staff Member and the Medical Staff President (or a representative of each, who may be counsel).

2. At the pre-hearing conference:

   a. The Hearing Officer will resolve all procedural questions, including any still outstanding objections to exhibits or witnesses, establish the time to be allotted to each witness's testimony and cross-examination (or if no other determination is made, such time allotment shall be in accordance with Section 14.8(E) below), and resolve any other outstanding issues relevant to the conduct of the hearing.

   b. The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

G. **Provision of Information to the Hearing Panel**. The Hearing Officer shall provide the following documents to the Hearing Panel in advance of the hearing:

1. A pre-hearing statement that either or both parties may choose to submit;

2. Witness list and documentary evidence to be presented by each party (without the need for authentication); and

3. Stipulations agreed to by the parties.

14.8 THE HEARING

A. **Persons to Be Present**. Attendance at the hearing will be restricted to those individuals involved in the proceeding, including administrative personnel and any alternate Hearing Panel members.

B. **Presence of Hearing Panel Members**. All members of the Hearing Panel must be present throughout the hearing. In unusual circumstances when a Hearing Panel

member must be absent from any part of the hearing, that Hearing Panel member must certify upon their return that they have read the entire transcript or reviewed the electronic recording of the portion of the hearing from which they were absent. In the alternative, the Hearing Officer may select an alternate Hearing Panel member to act in the place of the absent Hearing Panel member.

C. **Failure to Appear**. If the Medical Staff Member for whom the hearing has been scheduled fails, without good cause, to appear and proceed at the hearing, they shall be deemed to have waived their right to a hearing and the matter will be forwarded to the Board for final action with no further right to a hearing or appeal.

D. **Postponements and Extensions**. Postponements and extensions of time may be requested by either party but will be permitted by the Hearing Officer only upon a showing of good cause.

E. **Time Allotted for Hearing**. Unless otherwise determined by the Hearing Officer, the hearing will last no more than ten (10) hours, with each side being afforded no more than five hours to present its case, including direct and cross-examination of witnesses. The Hearing Officer may, after considering any objections, grant limited extensions of time upon a demonstration of good cause.

F. **Record of Hearing**. An accurate record of the hearing shall be kept. The Hearing Officer shall determine the mechanism for such record-keeping, which may be accomplished by use of a court reporter, electronic recording, or transcription. The affected Medical Staff Member shall be entitled, upon payment of reasonable charges associated with preparing the record, to obtain a copy of the record of the proceedings. Oral testimony will be taken on oath or affirmation administered by the Hearing Officer.

G. **Rights of Both Sides and the Hearing Panel at the Hearing**. At the hearing, both parties will have the following rights, subject to reasonable limits determined by the Hearing Officer:

1. To call and examine witnesses, to the extent they are available and willing to testify. Whether or not the Medical Staff Member testifies on their own behalf, they may be called and questioned by the MEC or the Hearing Panel. The Hearing Panel may question witnesses or request the presence of additional witnesses or documentary evidence

2. To introduce evidence (through exhibits or testimony), provided, however, that the Hearing Officer shall make all decisions as to the admissibility of evidence

3. To cross-examine any witness

4. To submit a written statement at the close of the hearing

5. To submit proposed findings, conclusions, and recommendations to the Hearing Panel

6. To have representation by counsel, who may perform all of the tasks described above

H. **Order of Presentation**. The MEC will first present evidence in support of its recommendation. Thereafter, the Medical Staff Member who requested the hearing shall present evidence.

I. **Rules of Evidence Inapplicable**. The hearing shall be conducted in an informal manner. Formal rules of evidence and procedure shall not apply.

14.9 HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

A. **Basis of Hearing Panel Recommendation**. Consistent with the burden on the Medical Staff Member to demonstrate that they satisfy, on a continuing basis, all criteria for Medical Staff appointment, reappointment, and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the Medical Staff Member has proved by clear and convincing evidence that the MEC's recommendations were arbitrary, capricious, or not supported by credible evidence.

B. **Deliberations and Recommendation of the Hearing Panel.** Within twenty (20) business days after final adjournment of the hearing, the Hearing Panel will conduct its deliberations outside the presence of any other person except the Hearing Officer and will render a written report containing its recommendation and a statement of the basis therefor.

C. **Disposition of Hearing Panel Report.** The Hearing Panel will deliver its report to the Medical Staff President, who shall send a copy of the report to the affected Medical Staff Member, the Medical Staff Leaders, and the Board. The copy of the report sent to the Medical Staff Member shall notify them of the right to appeal the Hearing Panel's decision and the timeframe within which such request must be made, as described below.

14.10 APPEAL PROCEDURE

A. **Time for Appeal**

1. If the Medical Staff Member wishes to appeal the Hearing Panel's recommendation, they must do so within ten (10) business days following receipt of notice of the Hearing Panel's recommendation. The request must be in writing, delivered to the Medical Staff President in person or by written

notice, and will include a statement of the reasons for appeal and the specific facts or circumstances that justify further review.

2. If an appeal is not requested within such ten (10) business day period, the right to an appeal shall be deemed to have been waived and the Hearing Panel's report and recommendation will be presented to the Board for final action.

B. **Grounds for Appeal**. The grounds for appeal will be limited to the following:

1. There was substantial failure by the Hearing Panel to comply with the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

2. The recommendations of the Hearing Panel were arbitrary or capricious or not supported by credible evidence.

C. **Appeal Process**

1. Appeal Panel. The Board may serve as the Appeal Panel or the Board Chair may appoint an Appeal Panel composed of Board members.

2. Written Statement. Whenever an appeal is requested within the required time frame, each party will have the right to present a written statement in support of its position on appeal. The Medical Staff Member will submit their statement first and the MEC will then have ten (10) business days to respond in writing to the Appeal Panel and the Medical Staff Member.

3. Evidence Presented. In addition, when requested by either party, the Appeal Panel may, in its discretion, accept oral testimony from both parties not to exceed thirty (30) minutes each, and written evidence in addition to the evidence presented at the Hearing, subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Appeal Panel determines that the party seeking to admit it can demonstrate that it is new and relevant or that any request to admit it at the hearing was improperly denied. Any oral testimony and/or presentation of written evidence shall be scheduled within thirty (30) days of either party's request.

4. Other Considerations. The Appeal Panel may consider the record upon which the Hearing Panel's recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings, and recommendations of the MEC and Hearing Panel, the statements of the parties, any evidence provided in the preceding Subsections, and any other information that it deems relevant.

5. Appeal Decision. Upon completion of the process set forth above, the Appeal Panel shall submit its written recommendation for final action to the MEC, Board and the Medical Staff Member, unless the Board has acted as the Appeal Panel; in either case, the Board shall then render its final decision as set forth below.

14.11 BOARD ACTION – FINAL DECISION

A. If practicable, the Board will take final action within thirty (30) business days after it (i) considers the appeal as the Appeal Panel, (ii) receives a recommendation from a separate Appeal Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

B. The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Appeal Panel (if applicable).

C. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care it provides, the Board may adopt, modify, or reverse any Appeal Panel recommendation that it receives (unless the Board serves as the Appeal Panel) or refer the matter for further review or information before making a final decision.

D. The Board will render its final decision in writing, including the basis for its decision, and will send notice to the Medical Staff Member. A copy also will be provided to the Medical Staff Leaders.

E. Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

ARTICLE XV

CONFIDENTIALITY AND IMMUNITY FROM LIABILITY

As a condition of any application for, or the maintenance of, Medical Staff membership and/or clinical privileges, all Medical Staff Members agree as follows:

15.1 CONFIDENTIALITY

A. **Patient-Identifiable Information**. All Medical Staff Members shall be bound to protect and maintain the confidentiality of all patient-identifiable information in accordance with all applicable federal and state law, accreditation requirements, these Bylaws, the Medical Staff Rules, Medical Staff Policies, Hospital bylaws, policies and procedures, and Department Rules.

B. **Peer Review Information**. Except as required by law or permitted pursuant to a written release signed by the Medical Staff Member to whom the information relates, all Medical Staff Members shall (i) be bound to protect and maintain the confidentiality of all information with respect to any Medical Staff Member submitted, collected, or prepared by any representative of the Hospital or the Medical Staff or any other health care facility, organization, or individual for the purposes of achieving and maintaining quality patient care, engaging in peer review, conducting risk management and utilization review, or contributing to clinical research, in accordance with and to the fullest extent permitted by law and with any agreement between the Hospital and such individuals; (ii) shall not disseminate or release any such information to anyone other than an authorized representative of the Hospital or Medical Staff; and (iii) shall not use such information for any purpose except as authorized by these Bylaws or by the Hospital bylaws, policies, rules or regulations. 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 DEFENSE AND INDEMNIFICATION

A. **Peer Review**. When individuals are participating in, or providing information to, a Medical Review Committee in good faith and without malice, and in compliance with the confidentiality requirements set forth herein, the Hospital shall defend and indemnify such individuals from personal liability to the full extent permitted by the Hospital's bylaws and certificate of incorporation.

B. **Medical Staff Leadership**. The Hospital shall defend and indemnify from personal liability all Medical Staff Officers, Department Chairs, and Vice-Chairs, Division Directors, Committee Chairs, Committee Members, and their authorized representatives when acting in those capacities in good faith and without malice, to the full extent permitted by the Hospital's bylaws and certificate of incorporation.

ARTICLE XVI

MEDICAL STAFF RULES AND REGULATIONS

16.1 **ADOPTION AUTHORITY**. The MEC, with the approval of the Board, may amend and adopt such Medical Staff Rules as are consistent with the Hospital's certificate of incorporation and bylaws, as well as these Medical Staff Bylaws.

16.2 **PROPOSAL OF NEW OR AMENDED MEDICAL STAFF RULES.** Any proposed new or amended Medical Staff Rule (a "**New Medical Staff Rule**") may be brought forward in the following ways and shall be subject to the following processes; in any event, no New Medical Staff Rule shall be effective unless and until adopted by the Board.

A. **By the MEC to the Medical Staff**. Any New Medical Staff Rule proposed by the MEC shall be distributed to the Medical Staff for review and comment before it is voted upon by the MEC and submitted to the Board for final action.

1. Opportunity for Medical Staff to Object Prior to MEC Approval. Any Medical Staff Member may submit written comments to the MEC within ten (10) business days after a proposed New Medical Staff Rule is distributed to the Medical Staff. The MEC shall not vote on such new Medical Staff Rule until the expiration of such ten (10) business day period and shall consider any such written comments before it votes on a proposed New Medical Staff Rule and submits it to the Board for final action.

2. Opportunity for Medical Staff to Object Following MEC Approval but Before Board Action. Following approval by the MEC, Physician Medical Staff Members entitled to vote shall have twenty (20) business days within which to file a 20% Petition (as defined in Article I) with the Board, that shall detail their objections to a proposed New Medical Staff Rule. The Board shall not act until such twenty (20) business day period has expired and shall consider the objections raised in any such 20% Petition before voting on a proposed New Medical Staff Rule.

3. Opportunity for Conflict Management Following Board Action. If, following consideration of any 20% Petition filed within the above-referenced twenty (20) business day period, the Board votes to adopt a proposed New Medical Staff Rule, the Physician Medical Staff Members entitled to vote shall have the right, upon the submission of a *second* 20% Petition filed within twenty (20) business days after such Board vote, to submit the matter to the Conflict Management Process set forth in Article XVIII of these Bylaws. The Board will take final action following such Conflict Management Process described therein.

B. **By the Medical Staff to the Board by 20% Petition**. The Physician Medical Staff Members entitled to vote may propose a New Medical Staff Rule upon the filing of a 20% Petition with the MEC. The proposed New Medical Staff Rule shall be sent to the MEC and the Board The MEC shall have thirty (30) business days within which to submit its comments to the Board. The Board shall not act until such thirty (30) business day period has expired and shall consider any comments of the MEC before taking final action.

C. **Special Circumstances/Provisional Adoption**. If any two Medical Staff Leaders determine that a special or urgent need exists for a New Medical Staff Rule in order to comply with applicable law, regulation, or accreditation requirements, or due to other exigent circumstances, the MEC may provisionally propose, and the Board may provisionally adopt, such New Medical Staff Rule without prior notification to the Medical Staff (a "**Provisional New Medical Staff Rule**"). In such event the Medical Staff shall be advised promptly of the Provisional New Medical Staff Rule and Medical Staff Members may, within ten (10) business days of such notice, submit to the Board any objections thereto. The Board shall consider any such objections before taking final action on the proposed New Medical Staff Rule.

D. **Adoption**. Medical Staff Rules and any amendments thereto shall become effective and replace any previous Medical Staff Rules after they have been adopted by the Board. Except as otherwise provided herein, Medical Staff Rules and all amendments hereto shall be effective at such time as is specified by the Board. If the Board does not specify when any Medical Staff Rule or amendment shall be effective, such Medical Staff Rule or amendment shall be effective upon Board adoption and shall apply to all matters currently pending to the extent practicable.

16.3 **MEDICAL STAFF POLICIES**. New or amended Medical Staff Policies may be proposed as described in Subsections 16.2 A, B, and C above, but the MEC shall have the authority to adopt Medical Staff Policies without Board action and shall communicate such Medical Staff policies to the Medical Staff following such adoption. Within twenty (20) business days following receipt of such notice, the Physician Medical Staff Members entitled to vote may initiate the Conflict Management Process pursuant to Article XVIII upon the submission of a 20% Petition to the MEC. Medical Staff Policies are not subject to Board approval unless stated otherwise in the policy or as required by law or accreditation requirements.

16.4 **DEPARTMENT RULES.** Department Rules may be proposed and amended pursuant to the process set forth in the Medical Staff Rules.

ARTICLE XVII

BYLAW AMENDMENTS

17.1 **BIENNIAL REVIEW**. The Bylaws Committee shall review these Bylaws not less frequently than every two years to ensure compliance with legal requirements and standards and medical practice in the Hospital's community.

17.2 **PROPOSAL OF NEW OR AMENDED BYLAWS**. Unless otherwise provided herein, all proposed new and amended Medical Staff Bylaws ("**New Bylaw**,") must be submitted to the Bylaws Committee by (i) the MEC; (ii) a Department Chair; (iii) the Physician Medical Staff Members entitled to vote by simple majority vote following submission of a 20% Petition, or (iv) the Board.

17.3 **BYLAWS COMMITTEE RECOMMENDATION TO MEC/MEC VOTE**. The Bylaws Committee shall make a recommendation to the MEC on whether to approve any New Bylaw. Approval by the Bylaws Committee and the MEC shall require a simple majority vote.

17.4 **PRESENTATION TO THE MEDICAL STAFF**. Any New Bylaw approved by the MEC shall be presented at the next regular meeting of the Medical Staff or may be distributed electronically to the Physician Medical Staff entitled to vote in the absence of a Medical Staff meeting. Electronic ballots shall be prepared and validated in such manner as the MEC shall approve. Only ballots received in the MSO within fourteen (14) calendar days after the ballots are distributed shall be counted. A simple majority of votes cast by Physician Medical Staff Members entitled to vote shall be required for Medical Staff approval of a New Bylaw.

17.5 **ALTERNATIVE – MEDICAL STAFF PRESENTATION DIRECTLY TO THE BOARD BY 20% PETITION**. Any proposed New Bylaw may be sent directly to the Board by the Physician Medical Staff Members entitled to vote upon a 20% Petition and shall be sent simultaneously to the MEC, which shall have thirty (30) business days within which to submit its comments to the Board. The Board shall not act until such thirty (30) business day period has expired and shall consider the comments of the MEC before taking final action.

17.6. **ADOPTION OF TECHNICAL AMENDMENTS AND AMENDMENTS REQUIRED BY LAW**. Notwithstanding anything herein to the contrary, the MEC shall have the authority to propose to the Board a New Bylaw without Medical Staff approval if (a) such New Bylaw does not substantively change any current Bylaw and is comprised solely of technical modifications or clarifications, reorganization or renumbering, or corrections of grammatical, spelling, or punctuation errors; or (b) if such New Bylaw is required to comply with any statutory, regulatory, or accreditation requirements, or with interpretive guidance issued by

governmental or accreditation agencies.

17.7 **NO UNILATERAL AMENDMENT/BOARD APPROVAL OF PROPOSED AMENDMENT**. Neither the Medical Staff nor the Board may unilaterally amend these Bylaws. Except as provided in Sections 17.5 and 17.6 above, regardless of how a New Bylaw is proposed, a New Bylaw must be approved by the MEC and a simple majority of votes cast by Physician Medical Staff Members entitled to vote before being submitted to the Board for final action. If the Board does not initially adopt a New Bylaw approved by the MEC and the Physician Medical Staff Members entitled to vote as described above, the MEC or the Board may refer the matter for consideration by a Joint Conference Committee in accordance with Article XI of these Bylaws. After considering the Joint Conference Committee's recommendation as described in Article XI of these Bylaws, the New Bylaw will again be presented to the Board for final action.

17.8 **ADOPTION**. These Bylaws and any amendments hereto shall become effective and replace any previous Bylaws after they have been adopted by the Board. Except as otherwise provided herein, these Bylaws and all amendments hereto shall be effective at such time as is specified by the Board. If the Board does not specify when any Bylaw amendment shall be effective, such amendment shall be effective upon Board adoption and shall apply to all matters currently pending to the extent practicable.

ARTICLE XVIII

CONFLICT MANAGEMENT

18.1 **APPLICABILITY AND SCOPE.** The conflict management process set forth herein (the "**CM Process**") is to be applied in the event of a conflict between the Medical Staff and the MEC regarding any matter, including but not limited to the adoption of any new Medical Staff Rule or any new Medical Staff Policy. This process is not applicable to (i) conflicts related to proposed New Medical Staff Bylaws; or (ii) conflicts involving the Board. Any such conflicts are to be submitted to a Joint Conference Committee for resolution.

18.2 **INITIATION OF CM PROCESS**. The CM Process may be initiated by the Medical Staff upon submission to the MEC of a 20% Petition, or by vote of the MEC.

18.3 **CONFLICTS MANAGEMENT COMMITTEE**. Regardless of the party initiating the process, a Conflict Management Committee (the "**CM Committee**") shall be formed consisting of the following:

A. The CEO and CPE as ex officio, non-voting members; and

B. An equal number of representatives of (i) the Medical Staff (who shall not be MEC members) ("**Medical Staff Reps**"); and (ii) the MEC ("**MEC Reps**"). The Medical Staff President shall appoint the MEC Reps and the Medical Staff shall appoint the Medical Staff Reps at a special meeting duly called for such purpose. The Medical Staff President shall determine the number of MEC and Medical Staff Reps, provided that there shall be an equal number of each.

18.4 **CM COMMITTEE PROCESS**

A. **Good Faith Negotiation**. The CM Committee shall meet to discuss the disputed matter and work in good faith to resolve the differences between the parties within twenty (20) business days of its first meeting.

B. **CM Committee Vote and Presentation of Recommendation to the Board**. Any recommendation approved by vote of the CM Committee shall be submitted to the Board for consideration and final action. If the CM Committee members do not reach agreement within the twenty (20) business day negotiation period, the CM Committee members shall individually or collectively report to the Board regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute. In the case of a dispute regarding a Medical Staff Rule

or Medical Staff Policy, the Board shall vote to take final action following the conclusion of the CM Process.

18.5 **OUTSIDE FACILITATOR**. If deemed appropriate by the Medical Staff President and CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any dispute.

ARTICLE XIX

HISTORY AND PHYSICAL REQUIREMENTS

19.1 **HISTORY AND PHYSICAL EXAMINATION (H&P) – BASIC REQUIREMENTS**. Except as provided herein, an H & P shall include the following in order to be considered complete: chief complaint, reason for admission and/or planned procedure, details of present condition and/or illness, past medical and surgical history, medication and allergies list, relevant social and family histories appropriate to the patient's age, system review, complete 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. The H&P must be performed by Medical Staff members with appropriate privileges to do so.

19.2 **H&P – TIMING**. The H&P must be performed for all patients, regardless of whether surgery or a procedure will be performed, no more than thirty (30) calendar days prior to, or within twenty-four (24) hours after, registration or inpatient admission; provided, however that, except in an emergency, if a patient is undergoing surgery or a procedure requiring anesthesia services, the H&P must be performed prior thereto. If the H&P was performed within thirty (30) days prior to registration or inpatient admission, it must be reviewed, and any updates must be entered into the medical record, within twenty-four (24) hours after registration or inpatient admission but in any event prior to surgery or a procedure requiring anesthesia services. All pertinent findings must be confirmed the day of the procedure and prior to surgery.

19.3 **SHORT H&P IN LIMITED CIRCUMSTANCES**. When a patient is scheduled for ambulatory surgery or a procedure with local anesthesia, the H & P 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, medication and allergies list, 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 H & P, and a statement on the course of action planned for the patient for that episode of care.

19.4 **H & P – PLACEMENT IN THE MEDICAL RECORD**

A. **Written (By Hand or Electronic)**. Written documentation of the completed H & P must be entered into the patient's medical record within twenty-four (24) hours after

registration or inpatient admission, and in any event, except in emergencies, prior to any surgery or procedure. All entries into the medical record must be dated and signed; this requirement applies to all documentation, whether handwritten or entered electronically.

B. **Dictated**. If the H&P is dictated, the admitting Physician Medical Staff Member 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.

19.5 **OBSTETRICAL ADMISSION H&P**. Any admission of a pregnant patient shall be considered an obstetrical admission regardless of the reason for the admission. In the case of an obstetrical admission, the patient's medical record shall include a complete and timely H & P and a complete prenatal record. The referring OB Physician shall be responsible for ensuring that the prenatal record is transferred to the Hospital prior to admission except in an emergency, and in any event, that it is *legible*, signed and dated. This requirement shall apply even when such prenatal record is a copy of the referring OB Physician's office record. If applicable, the referring OB Physician is also responsible for entering a *legible* interval admission note that includes pertinent additions to the H & P and any subsequent changes. A complete H & P will be required if there is no prenatal record for the patient.