# BYLAWS OF THE MEDICAL STAFF

**MIDDLESEX HOSPITAL**
**Middletown, Connecticut**

***2025 September***

MIDDLESEX HOSPITAL – MEDICAL STAFF BYLAWS

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# PREAMBLE

WHEREAS – Middlesex Hospital (the "Hospital") is a health care facility that exists to provide patient care, education and research and thereby to contribute to the development of medical knowledge and to enhance the provision of health care services in the community;

WHEREAS – The laws, regulations, customs and generally recognized professional standards that govern hospitals require that all practitioners practicing in a hospital be formally organized into a medical staff that is a collegial body of professionals, providing for, among other things, its members' mutual education and clinical support; and

WHEREAS – The medical staff is the organizational component to which responsibility is delegated, and from which accountability is exacted, by the Hospital's governing body for the quality and appropriateness of medical care rendered to patients in the hospital, subject to the ultimate authority of the Hospital's governing body; and

WHEREAS – The Hospital's board and management require a source of collective advice from the professionals practicing at Hospital to aid in policy formulation and enforcement, planning, coordination of services and governance; and

WHEREAS – A purpose of the Hospital is to establish and maintain a health care facility for persons suffering from illness or disabilities, including persons who require inpatient and outpatient care; and

WHEREAS – Dedication to this purpose requires a cooperative effort among the professional peers practicing in the Hospital and the Hospital's board and management, with well-defined lines of communication, responsibility and authority throughout the Hospital's organizational structure; and

WHEREAS – The Hospital is a teaching institution providing education to family medicine residents, medical students, advanced practice students, and nursing students;

THEREFORE – The practitioners practicing in the Hospital have organized themselves into a single medical staff in conformity with the Bylaws, rules and regulations of the Medical Staff of Middlesex Hospital, and the charters, bylaws, policies, rules and regulations of the Hospital and its health care facilities.

DEFINITIONS

1. ADVANCED PRACTICE PROFESSIONAL or APP shall mean those health care professionals described in Article Four of these Bylaws.

2. ADVANCED PRACTICE PROFESSIONAL STAFF or APP STAFF shall have the meaning set forth in Section 4.12 of these Bylaws.

3. ANNUAL MEETING shall mean the meeting held each year pursuant to Section 12.2.1 of these Bylaws.

4. BOARD OF DIRECTORS or BOARD shall mean the governing body of the Hospital.

5. CHIEF MEDICAL OFFICER OR CMO shall mean the Physician responsible for fulfilling those duties and responsibilities set forth in Article Six-A and elsewhere within these Bylaws.

6. CLINICAL PRIVILEGES or PRIVILEGES shall mean the permission granted to a Practitioner or APP to provide specifically delineated diagnostic, therapeutic, medical, surgical, dental, podiatric or other health care services to patients in the Hospital.

7. CONTINUING MEDICAL EDUCATION OR CME shall mean medical education credits required by licensure statutes or regulations or any applicable certification body.

8. CONTINUING MEDICAL INVOLVEMENT OR CMI shall mean any medical staff activity that is not included as pre-approved Continuing Medical Education (CME) or primarily social; e.g. peer review activities or committee/Department/Section/Medical Staff meeting attendance.

9. CREDENTIALS COMMITTEE shall mean the committee responsible for coordinating the credentialing of Medical Staff and Advanced Practice Professional Staff members in accordance with these Bylaws and all applicable Hospital and Medical Staff policies and procedures.

10. DEPARTMENT shall mean a clinical department of the Medical Staff.

11. DEPARTMENT CHAIR or CHAIR shall mean the elected officer of a particular Department.

12. DIRECTOR OF MEDICAL EDUCATION shall mean the Physician who is a member of the Medical Staff and who is employed to implement, coordinate and oversee programs designed to meet the educational needs of the Medical Staff and to monitor the Medical Staff's participation in CME activities.

13. JOINT CONFERENCE COMMITTEE or JCC shall mean the committee described in Section 9.4 of these Bylaws.

    a. *EX OFFICIO* shall mean service as a member of a body by virtue of an office or position held.

14. HOSPITAL shall mean Middlesex Hospital.

15. LOCUM TENENS shall mean a Practitioner with specific Privileges who is serving within a specifically limited time frame for a member of the Medical Staff.

16. MEDICAL STAFF EXECUTIVE COMMITTEE or MSEC shall mean the executive committee of the Medical Staff Council as described in Section 9.3 of these Bylaws.

17. MEDICAL STAFF COUNCIL or MSC shall mean the committee described in Section 9.2 of these Bylaws.

18. MEDICAL REVIEW COMMITTEE shall mean and include any committee or subcommittee referred to in or authorized under these Bylaws, including, but not limited to, the MSEC or MSC, all committees referred to in or authorized under the provisions of Article Nine of these Bylaws, Departmental and Sectional committees, subcommittees or liaison committees, and meetings of any Department or Section or other entry established under these Bylaws including the entire Medical Staff. All the foregoing are intended to be "Medical Review Committees" within the meaning of that term as set forth in Section 19a-17b of the Connecticut General Statutes, as amended from time to time.

19. MEDICAL STAFF shall mean the formal organization of all Physicians, dentists and appropriately qualified podiatrists who are privileged to attend to patients or to provide other diagnostic, therapeutic, teaching or research services in the Hospital, as provided in these Bylaws.

20. MEDICAL STAFF YEAR shall mean the time period set forth in Section 12.1 of these Bylaws.

21. MEDICO-ADMINISTRATIVE OFFICERS shall mean those Physicians with medical responsibility for a clinical Section who also have administrative responsibility for that same Section.

22. MEMBERSHIP PREROGATIVE shall mean a participatory right granted, by virtue of Medical Staff category or otherwise, to a Medical Staff member and exercised subject to the conditions and limitations imposed in these Bylaws and in Hospital or Medical Staff policies.

23. MIDDLESEX HEALTH SYSTEM shall mean the network of health care facilities and provider organizations affiliated with Middlesex Hospital, including without limitation, Middlesex Hospital, Shoreline Medical Center, Marlborough Medical Center, Middlesex Health Outpatient and Cancer Center, Middlesex Health Primary Care, Middlesex Family Medicine and Middlesex Health Surgical Center.

24. NPDB shall mean the National Practitioner Data Bank established under the Health Care Quality Improvement Act of 1986 (the "HCQIA").

25. PHYSICIAN shall mean an individual with an M.D. or D.O. degree who is licensed to practice medicine in the State of Connecticut.

26. PRACTITIONER shall mean any Physician, dentist, or appropriately licensed and qualified podiatrist applying for or exercising Clinical Privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital.

27. PRESIDENT OF THE MEDICAL STAFF shall mean the officer elected by the Medical Staff to fulfill those duties and responsibilities set forth in Article Six and elsewhere in these Bylaws.

28. PRESIDENT OF THE HOSPITAL shall mean the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

29. RESPONSIBLE PHYSICIAN shall mean the admitting, attending, or consulting Physician making key decisions during that phase of care.

30. RULES AND REGULATIONS shall mean the rules and regulations of the Medical Staff of Middlesex Hospital.

31. SCOPE OF PRACTICE shall mean the permission granted to an APP to provide specifically delineated services to patients under the supervision of or in collaboration with a member of the Medical Staff.

32. SECTION or CLINICAL SECTION shall mean an organized specialty division of a Department of the Medical Staff.

33. SECTION CHIEF or CHIEF shall mean the elected officer of a Section.

34. SPECIAL NOTICE or NOTICE shall mean written notification sent by certified or registered mail, return receipt requested.

## ARTICLE 1. NAME

The name of this organization shall be "The Medical Staff of Middlesex Hospital."

## ARTICLE 2. PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

### 2.1 PURPOSES

The purposes of the Medical Staff shall be to:

2.1.1 Strive to ensure that all patients admitted to, or otherwise treated in or by, the Hospital receive appropriate medical care.

2.1.2 Constitute a professional, collegial body providing for its members' mutual education, consultation, and professional support to the end that patient care provided at the Hospital shall be consistently maintained at that level of quality optimally achievable given the state of the healing arts and the resources locally available and leading to the continuous advancement of professional knowledge and skill.

2.1.3 Serve as the collegial body through which individual Practitioners shall obtain Membership Prerogatives and Clinical Privileges at Hospital.

2.1.4 Promote a high level of professional performance by all Practitioners through an ongoing review and evaluation of each Practitioner's performance.

2.1.5 Develop a self-governing organizational structure, reflected in the Medical Staff's Bylaws, Rules and Regulations, and other related protocols which shall adequately define responsibility and concomitant authority and accountability of each Medical Staff member, officer, and committee and shall be designed to assure that each Medical Staff member, officer, and committee exercises the responsibility and authority commensurate with such individual's or committee's respective contributions to patient care and to the teaching and research needs of the Hospital and shall fulfill like accountability obligations.

2.1.6 Provide the primary mechanism for accountability to the Board, through defined Medical Staff components, for the appropriateness and quality of the patient care services, professional and ethical conduct, and teaching and research activities of each individual Practitioner holding membership on the Medical Staff and/or exercising Clinical Privileges.

2.1.7 Provide a means or method by which members of the Medical Staff shall formulate recommendations for the Hospital's policy-making and planning processes and through which such policies and plans shall be communicated to and observed by each member of the Medical Staff.

2.1.8 Provide a means whereby issues concerning the Medical Staff and the Hospital may be presented to and discussed with the President of the Hospital and the Board by the Medical Staff.

## 2.2 RESPONSIBILITIES

To accomplish the purposes enumerated above, it shall be the obligation and responsibility of the members, officers, and committees of the Medical Staff to:

2.2.1 Provide quality medical care to all patients admitted to, or otherwise treated in or by, the Hospital.

2.2.2 Participate in the Hospital's quality improvement program(s) by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including, without limitation:

(a) Evaluating Practitioner and institutional performance through valid and reliable measurement systems based on objective, clinically-sound criteria.

(b) Engaging in the ongoing monitoring of critical aspects of care and enforcement of Medical Staff and Hospital policies.

(c) Arranging for Medical Staff participation in programs designed to meet the Medical Staff's educational needs and developing, participating in, and monitoring the Medical Staff's education and training programs and clinical research activities.

(d) Assuming a leadership role in the education of patients and families in the coordination of care.

(e) Ensuring that medical and health care services at the Hospital are appropriately employed for meeting patients' medical, social, and emotional needs consistent with sound health care resource utilization practices.

2.2.3 Evaluate Practitioner credentials for initial and continued membership on the Medical Staff and for the delineation of Clinical Privileges for Medical Staff members and APPs and to make recommendations to the Board concerning appointments and reappointments to the Medical Staff, including membership category, Department and Section assignments, Clinical Privileges, specified services for APPs, and corrective action.

2.2.4 Maintain sound evidence-based professional practices and an atmosphere conducive to the diagnosis and treatment of illness, teaching, and research.

2.2.5 Develop, administer, and recommend amendments to these Bylaws and the Rules and Regulations of the Medical Staff and its various components.

2.2.6 Enforce compliance with the Bylaws and Rules and Regulations of the Medical Staff and of its administrative and clinical components and with Hospital bylaws and policies.

2.2.7 Participate actively in the Board's short- and long-term planning processes, assist in identifying community health needs, and suggest to the Board appropriate institutional policies and programs to meet those needs.

2.2.8 Comply with federal and state laws and regulations as may from time to time be enacted that pertain to credentials and Medical Staff membership. The provisions of such laws and regulations, as they may be amended from time to time, are hereby incorporated into these Bylaws. To the extent possible, they shall be construed as being consistent with the provisions of these Bylaws and the Rules and Regulations of the Medical Staff.

2.2.9 Exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

## ARTICLE 3. MEMBERSHIP

### 3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that is granted by the Board after considering the recommendations of the Medical Staff, and that shall be extended only to professionally competent Practitioners who continuously comply with and meet the qualifications, standards, and requirements set forth in these Bylaws, the Rules and Regulations of the Medical Staff, and other Medical Staff policies, including the directives and policies of the MSC and the other Medical Staff committees. Appointment to and membership on the Medical Staff shall confer on the Medical Staff member only such Clinical Privileges as have been specifically granted by the Board in accordance with these Bylaws. The Medical Staff shall consist of not less than five (5) Physicians at all times.

An individual who fails to satisfy the membership qualifications (as described in these Bylaws, including without limitation Section 3.2), standards and requirements is ineligible to apply. A determination of ineligibility does not entitle the individual to the provisions of Article Eleven of these Bylaws.

### 3.2 GENERAL QUALIFICATIONS

Each Practitioner who seeks or enjoys Medical Staff membership shall, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, through documentation and other evidence, the following qualifications:

#### 3.2.1 LICENSURE

A currently valid unrestricted license issued by the State of Connecticut to practice medicine, osteopathy, dentistry, or podiatry and a currently valid federal and state registrations to prescribe controlled substances except where the Practitioner demonstrates that such registration is not required in order to exercise the Practitioner's current or requested Clinical Privileges.

3.2.2 PERFORMANCE

(a) Professional education, training, experience, current competence, and clinical results documenting a continuing ability to provide optimally achievable patient care services given the resources locally available.

(b) With regard to board certification, all applicants to the Medical Staff, with the exception of general dentists, at the time of being granted Privileges, shall:

(i) Have completed a residency accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the American Dental Association, or the Council on Podiatric Medical Education, or by a program with a reciprocity agreement with the American Board of Medical Specialties or American Osteopathic Association; and

(ii) If not certified by a board that is a member of the American Board of Medical Specialties, by a board recognized by the American Board of Medical Specialties, by the American Osteopathic Association, by a board recognized by the American Osteopathic Association, by the American Podiatric Medical Association, or by the American Dental Association (limited to the American Board of Oral and Maxillofacial Surgery), be admissible for certification and become certified within) five (5) years after initial appointment to the Medical Staff.

The requirement to obtain board certification is not made retroactive for the Medical Staff members who held an appointment continuously since 1991, or for those members of the Courtesy and Consulting Staff as of December 31, 2007.

3.2.3 ATTITUDE

A willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Medical Staff members, members of other health disciplines, the Hospital's management, and employees, visitors, and the community in general, in a cooperative, professional manner conducive to the maintenance of an environment appropriate to quality patient care. The behavior of members of and applicants for membership on the Medical Staff and APPs constitutes an essential component of professional activity and personal relationships within the Hospital. Civil deportment fosters an environment conducive to excellent patient care. Accordingly, in addition to the other qualifications set forth in this Article Three, all members of the Medical Staff and APPs at all times shall demonstrate an ability to interact on a professional basis with members of the Medical Staff, patients, and others and to behave in a professional and civil manner. This requirement is not in any way intended to interfere with a Medical Staff member's or APP's privileges: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Medical Staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) to engage in the good faith criticism of

others. The following types of behavior, however, which constitute some examples of an inability to interact on a professional basis with others or to behave in a professional and civil manner, are deemed unacceptable for members of the Medical Staff and APPs:

- Conduct that reasonably could be characterized as sexual and/or racial harassment, including any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or witness it;
- Threats of physical assault or actual physical assault or inappropriate physical contact with another individual, harassment, or the placing of others in fear by engaging in threatening behavior;
- Comply with all applicable Medical Staff and Code of Conduct policies;
- Inappropriate medical record entries concerning the quality of care being provided by the Hospital or any other individual or otherwise critical of the Hospital, other Medical Staff members or personnel;
- Refusal to abide by Medical Staff requirements as delineated in these Bylaws, the Rules and Regulations and Medical Staff policies (including, but not limited to, emergency call issues, response times, medical record keeping and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital staff); and/or
- Written or oral statements that constitute the intentional expression of falsehoods or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of patients, visitors, Practitioners, APPs, Hospital personnel, the Hospital, or others.

Furthermore, all members of the Medical Staff shall demonstrate a willingness and capability, based on current attitude and evidence of performance, to:

(a) Participate equitably in the discharge of Medical Staff obligations appropriate to their Medical Staff membership category; and
(b) Adhere to generally recognized standards of professional ethics.

Failure to follow the established professional and ethical conduct and behaviors may result in corrective action as defined in Article Ten.

### 3.2.4 DISABILITY

To be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a significant possibility of interfering with, the Practitioner's ability to perform the Privileges requested or granted.

### 3.2.5 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance in not less than the minimum amount, if any, as determined from time to time by resolution of the Board after consultation with the MSC or such other evidence of financial responsibility as the Board may from time to time establish.

## 3.3 HOSPITAL AND COMMUNITY NEED AND ABILITY TO ACCOMMODATE

In acting on new applications for Medical Staff membership and Clinical Privileges, consideration shall be given to and an explicit finding made by the Board concerning the Hospital's current and projected patient care, teaching and research needs, and the Hospital's ability to provide the facilities, beds, and support services that will be required if the application is acted upon favorably. In making these required need/ability determinations, consideration shall be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial, and human resources to general and specialized clinical and support services, and the Medical Staff's general and specific goals and objectives as reflected in the Hospital's short- and long-term plans.

## 3.4 EFFECT OF OTHER AFFILIATIONS

No Practitioner shall automatically be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the Practitioner (i) is licensed to practice in Connecticut or in any other state; (ii) is a member of any professional organization; (iii) is certified by any clinical board; (iv) is a member of the faculty of a medical school; or (v) had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Furthermore, no Practitioner shall automatically be entitled to reappointment or particular Privileges merely because the Practitioner had, or presently has, Medical Staff membership, those particular Privileges, or other Privileges at the Hospital.

## 3.5 NONDISCRIMINATION

All provisions of these Bylaws and the accompanying Rules and Regulations, including the granting or denying of Medical Staff membership or Clinical Privileges, shall be interpreted and applied so that no person, member of the Medical Staff, APP, applicant for membership, patient, or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination, such as on the basis of gender, race, creed, national origin, sexual orientation or any other protected class.

## 3.6 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each member of the Medical Staff, regardless of assigned Medical Staff category, and each Practitioner exercising Privileges under these Bylaws, shall:

3.6.1. Provide patients with continuous care at the generally recognized professional level of quality and efficiency within the Privileges granted to that Practitioner;

3.6.2. Abide by the Medical Staff Bylaws, the Rules and Regulations, and the policies, directives, protocols and procedures established by the MSC and the other Medical Staff committees and all other standards, policies, and rules of the Hospital;

3.6.3. Discharge such Medical Staff, committee, Department, Section, and Hospital functions for which the Practitioner shall be responsible by Medical Staff category assignment, appointment, election, or otherwise;

3.6.4. Prepare and complete in a timely fashion the medical and other required records for all patients that the Practitioner admits, or in any way provides care to, in Hospital;

3.6.5. Abide and be governed by generally recognized standards of professional ethics;

3.6.6. During each two-year reappointment period, accrue CME credits as specified in the Rules and Regulations (of which a portion should support the Privileges granted) that shall be referred to the Credentials Committee for consideration at the time of reappointment to the Medical Staff and/or renewal or revision of individual Clinical Privileges;

3.6.7. Support the quality improvement standards established by nationally recognized accreditation agencies and comply with the Hospital's quality improvement plan(s);

3.6.8. Maintain the confidentiality of and not disseminate to any person other than as permitted or required by law, any health information submitted, collected, prepared or obtained by any member of the Medical Staff while (i) treating patients at the Hospital, (ii) obtaining payment for services rendered at the Hospital, or (iii) assisting with health care operations of the Hospital;

3.6.9 Comply with the Hospital's Notice of Privacy Practices and privacy policies as well as with all applicable state and federal laws and regulations while providing services at the Hospital;

3.6.10 Comply with the following ongoing reporting requirements: Each member of the Medical Staff has an ongoing duty to fully inform the President of the Medical Staff of any of the following events. (a) the entering into of any agreement or understanding (e.g., consent decree, consent agreement, or any similar arrangement) arising out of matters relating to the member's license to practice or permit or registration to prescribe; (b) any restriction, suspension, termination, voluntarily relinquishment, or agreement not to exercise any license to practice or permit or registration to prescribe; (c) any restriction, suspension, termination, or voluntarily relinquishment of privileges or medical staff membership at another hospital; (d) any loss of professional liability (malpractice) insurance or restriction on coverage; (e) any involvement, settlement or adverse judgment in a professional liability action; (f) any suspension, exclusion, termination, voluntary relinquishment or other type of ineligibility from or restriction related to participation in the Medicare or Medicaid Programs or any other federal or state health insurance program; (g) any conviction of any felony, or of any misdemeanor crime involving insurance fraud, health care fraud or abuse, the practice of medicine, or relating to controlled substances, illegal drugs, elder abuse, child abuse, or violence, or any indictment or charge alleging the commission of such a crime; (h) any entry by the member into Health Assistance InterVention Education Network for Connecticut Health Professionals, Inc. (HAVEN) or any similar program for impaired physicians. The President of the Medical Staff may request and the

member shall provide the President of the Medical Staff with any further information or documents;

3.6.11 Agree to personally fulfill patient care responsibilities regarding emergency service call coverage for their specialty without regard to payor status, or to obtain appropriate coverage by another member of the Medical Staff in accordance with the Medical Staff policy on call coverage, these Bylaws and the Medical Staff Rules and Regulations;

3.6.12 Comply with all applicable medical records and requirements for completing and documenting medical histories and physical examinations as required by law and as further set forth in Section 3.6A, and in the Rules and Regulations, which are incorporated herein.

## 3.6A MEDICAL HISTORY AND PHYSICAL EXAMINATION

A complete medical history and physical examination (H&P) must be completed and documented for each patient at the time of admission to the inpatient service, or within thirty (30) days before the admission provided that the patient's condition has not significantly changed since the H&P was performed. All H&P reports must be included in the medical record within twenty-four (24) hours of the admission, but prior to any surgery except in cases of emergency.

A medical history and appropriate physical examination is required for outpatients when an outpatient procedure is to be performed with the use of sedation. Sedation is defined to include procedural sedation and analgesia and monitored anesthesia care. The H&P must be completed within thirty (30) days prior to the procedure provided the patient's condition has not significantly changed since the H&P was performed.

When the H&P is conducted within thirty (30) days before admission or registration, an update must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services. The examination must be conducted by a licensed practitioner who is credentialed and privileged to perform an H&P. The update note must document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment.

The required H&P content shall always include sufficient information necessary to provide the care and services required to address the patient's conditions and needs and thus may vary with the setting and type of care delivered. The H&P report shall include reason for admission, pertinent past history, pertinent physical findings, diagnosis, and plan of treatment or operative procedure. For appropriate non-sedated, invasive procedures performed outside the operating room, the H&P shall indicate significant medical history, other significant physical findings, and diagnosis.

The H&P must be completed and documented by a physician, an oral maxillofacial surgeon, or a podiatrist, with specific privileges in accordance with state law and hospital policy. Members of the Advanced Practice Professional Staff may perform H&Ps if granted the appropriate privileges; the H&P must then be validated and countersigned, timed and dated, by the attending physician. The attending physician shall countersign all H&Ps recorded by a member of the House Staff.

## 3.7 TERM OF APPOINTMENT

Appointments to the Medical Staff shall be for a period not to exceed three (3) years, or two (2) years for Practitioners with surgical privileges, except that upon the recommendation of the MSC, or in order to comply with law, regulation, interpretive guidelines, or accreditation standards, the Board may set a more frequent reappraisal period for exercise of particular Privileges.

## 3.8 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

The Board shall act on appointments, reappointments, or revocation of appointments following a recommendation from the MSC acting in accordance with these Bylaws.

### 3.8.1 APPLICATION FOR APPOINTMENT

Applications for Medical Staff membership shall be issued by the President of the Hospital and signed by the applicant.

By applying for appointment to the Medical Staff and/or for Clinical Privileges, each applicant, whether or not the application is accepted, thereby agrees to the provisions of this Article Three, specifically including:

(a) The applicant shall provide detailed information concerning professional qualifications, including the names of at least four (4) peer references (i.e., appropriate providers in the same professional discipline as the applicant) who have extensive firsthand experience in observing and working with the applicant. The peer recommendations must refer, as appropriate, to relevant training or experience, current competence, ethical conduct, fulfillment of obligations as a medical staff member, and any effects of health status on the privileges being recommended. Where feasible, two (2) of these references shall have served in a chief or supervisory capacity.

(b) The applicant shall disclose whether the applicant's (i) membership status and/or clinical privileges in any hospital or other institution; (ii) membership in any local, state, or national medical society or college; (iii) license to practice any profession; (iv) state or federal registrations or permits to dispense controlled substances are subject to any pending or previously successful challenge or have ever been voluntarily or involuntarily penalized, reprimanded, investigated, reduced, limited, denied, suspended, revoked, placed on probation, not renewed, voluntarily relinquished or any other type of action not listed in these Bylaws or (v) the applicant is listed as debarred, excluded, or otherwise ineligible for participation in federally funded health care programs. The applicant shall provide detailed information with respect to the circumstances of any of the foregoing.

(c) The applicant shall disclose their involvement in any malpractice or professional liability claim or claims against the applicant are pending and

whether any previous claims have been settled or have resulted in a judgment. The applicant shall provide detailed information with respect to the circumstances of any of the foregoing.

(d) The applicant shall submit a medical evaluation form completed by a licensed healthcare provider attesting to the fact that the applicant has no physical or mental health problems or conditions that would affect such applicant's ability to perform the Clinical Privileges requested.

(e) In addition to the signed acknowledgment required from each applicant evidencing such agreement, the applicant, by their application, agrees to abide by (i) these Bylaws, Rules and Regulations, and the policies of the Medical Staff; (ii) any Hospital policies that apply to activities as a Medical Staff member, and (iii) generally recognized standards of professional ethics as well as the following:

(1) To provide for continuous patient care, and appropriate practice coverage;

(2) To delegate during absence(s) the responsibility for diagnosis or care of patients only to a Practitioner who is a member of the Medical Staff who is qualified and has appropriate Privileges;

(3) To seek and accept requests for consultation whenever necessary and within the Practitioner's professional capabilities;

(4) To obtain the patient's informed consent where appropriate; and

(5) To refrain from illegal fee splitting or other illegal inducements relating to patient referrals.

(f) The applicant authorizes the release to the Hospital of all information deemed pertinent by the person or committee reviewing the application, consents to communications with any individual or organization who may have information desired by the person or committee reviewing the application, releases from any liability and agrees not to make any claims against any and all persons and organizations providing or receiving any information, including but not limited to the Medical Staff, the Hospital administration and the Board, and agrees to a personal interview or interviews if requested.

(g) The applicant understands that it is the applicant's burden to produce adequate and convincing evidence for the proper evaluation of the application, to comply with all requests for additional information, including reasonable evidence of current ability to perform the requested Clinical Privileges, and to resolve all doubts raised about qualifications or fitness for membership on the Medical Staff or for requested Clinical Privileges. The Credentials Committee shall make a reasonable inquiry into, and may require the applicant to submit reasonable evidence of, ability to perform the Clinical Privileges requested.

(h) The application shall be submitted to the Medical Staff Services office for processing, including appropriate primary source verification of licensure, board certification (if applicable under Section 3.2.2(b)), relevant training, experience, current competence, ability to perform privileges requested, professional liability insurance, identity (through verification of a driver's license, passport, Hospital identification card, or similar means) and any other information deemed appropriate as identified in this Article. The application and verified information shall be reviewed by the Section Chief, if appropriate, and Department Chair for recommendation to the Credentials Committee. The Credentials Committee shall review and evaluate the application and if complete, shall forward a recommendation to the MSC who shall then forward a recommendation to the Board. If additional information is required, the application shall be deemed incomplete until such information is provided within a specified period of time but not more than sixty (60) days of the request. If the requested information is not provided within the specified period of time, the application shall be deemed abandoned by the applicant. In the event that the application is deemed abandoned because it was incomplete and the applicant desires appointment to the Medical Staff and/or Privileges, the applicant must reapply for appointment to the Medical Staff and/or for Privileges. Once the required information is received, a determination shall be made by the Credentials Committee regarding the application's completeness. Once an application is deemed complete, the application will be promptly reviewed as set forth above, and a final decision shall be made by the Board in writing regarding the application within one hundred twenty (120) days of the determination of completeness. If the recommendation of the MSC to the Board regarding an application is adverse to the applicant, the provisions of Article Eleven shall apply.

(i) Individuals in administrative positions who desire Medical Staff membership or Clinical Privileges shall be subject to the same procedures as all other applicants for membership or Privileges.

(j) Upon appointment to the Medical Staff, the MSC may impose any condition on the applicant's Medical Staff membership and/or Clinical Privileges and such condition shall not entitle the applicant to due process, including a hearing or appellate review pursuant to Article Eleven, or any rights pursuant to these Medical Staff Bylaws unless such condition is considered an adverse action pursuant to Section 11.2.2.

### 3.8.2 REAPPOINTMENT PROCESS

The provisions of Section 3.8.1 of these Bylaws shall apply to the reappointment process, in addition to the following:

(a) Each recommendation concerning the reappointment of a Medical Staff member and the Clinical Privileges to be granted upon reappointment shall be based upon the same standards used for the evaluation of initial

appointments and such additional standards relating to current competence as have been deemed relevant. The Credentials Committee shall make a reasonable inquiry into, and may require the applicant to submit reasonable evidence of, the ability to perform the Clinical Privileges requested. If additional information is required, the application shall be deemed incomplete until such information is provided within a specified period of time, but not more than sixty (60) days of a request therefore. If the request for information is not provided within the specified period of time, the application shall be deemed abandoned by the applicant. In the event that the application is deemed withdrawn because it was incomplete and the applicant desires appointment to the Medical Staff and/or Privileges, the applicant must reapply for appointment to the Medical Staff and/or for Privileges. Once the required information is received, a determination shall be made by the Credentials Committee regarding the application's completeness. Once an application is deemed complete, the application will be promptly reviewed as set forth in Section 3.8.1(h) above, and a final decision regarding the application shall be made by the Board in writing within one hundred twenty (120) days of the determination of completeness. If the recommendation of the MSC to the Board regarding an application is adverse to the applicant, the provisions of Article Eleven shall apply.

(b) The Credentials Committee and then the MSC shall review all pertinent information available on each applicant for the purpose of determining its recommendations for reappointment to the Medical Staff and for granting Clinical Privileges for the ensuing period. This information shall include a recommendation from the appropriate Department Chair or Section Chief or a reference by another peer for members not known to the Department Chair or Section Chief, and may also include a review of: professional competence, physical ability to perform Clinical Privileges requested and documented health status; clinical judgment; ethics and conduct; cooperation with Hospital personnel; compliance with the Medical Staff Bylaws, Rules and Regulations, the Code of Conduct, and Medical Staff and Hospital policies; participation on Medical Staff committees; participation in CME; information acquired from the National Practitioner Data Bank query and OIG Exclusions List query; information provided by the Medical Staff member regarding voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; information provided by the Medical Staff member regarding previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration; or Practitioner-specific performance management data relative to service quality, technical quality, resource utilization, patient safety/rights (if such data are available for that Practitioner). When insufficient Practitioner-specific data is available to evaluate a Practitioner's application for reappointment, Practitioners shall submit two (2) peer references upon request by the Credentials Committee.

(c) The MSC shall make recommendations to the Board concerning the reappointment and/or Clinical Privileges of each applicant scheduled for periodic appraisal. In the event that reappointment is recommended for a period of less than three years, the applicant shall not have the right to a hearing or appellate review in accordance with the provisions of Article Eleven of these Bylaws unless the reappointment is for a period of less than six (6) months.

(d) Whenever failure to apply for reappointment results in the lapse of a Practitioner's appointment to the Medical Staff, the Practitioner shall be required to apply for Medical Staff membership in the same manner as one applying for initial appointment in order to reinstate their Medical Staff membership.

(e) Upon reappointment to the Medical Staff, the MSC may impose any condition on the applicant's Medical Staff membership and/or privileges and such condition shall not entitle the applicant to due process, including a hearing or appellate review pursuant to Article Eleven, or any rights pursuant to these Medical Staff Bylaws unless such condition is considered an adverse action pursuant to Section 11.2.2.

## 3.9 MEDICO-ADMINISTRATIVE OFFICERS

Notwithstanding any other provision of these Bylaws or of the Rules and Regulations, the provisions of Article Nine of these Bylaws and the contract between the Medico-Administrative Officer and the Hospital shall control matters relating to the removal of such Medico-Administrative Officer from office and the effect of removal on membership status and Clinical Privileges. Furthermore, the Hospital may provide by agreement with a Medico-Administrative Officer that membership on the Medical Staff and Clinical Privileges are contingent on, and shall expire simultaneously with, the agreement or understanding with such Medico-Administrative Officer. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws, the Rules and Regulations, and the policies of the Medical Staff and of the Hospital with respect to hearings, appellate review, etc., shall not apply. Notwithstanding the existence of a contract between a Medico-Administrative Officer and the Hospital, a Medico-Administrative Officer seeking Medical Staff membership or Clinical Privileges must be appointed and, thereafter, reappointed to the Medical Staff and granted Clinical Privileges in accordance with these Bylaws.

## 3.10 EXPEDITED PROCESS

An application for Medical Staff appointment or reappointment and/or Clinical Privileges may receive an expedited review by a committee of at least two (2) voting members of the Board following a favorable recommendation from the MSC. A favorable decision by the Board committee will result in approval of the Medical Staff appointment and/or Clinical Privileges requested. The full Board shall consider and, if appropriate, ratify all favorable Board committee decisions at its next regularly scheduled meeting. If the Board committee's decision is adverse to an applicant, the matter shall be referred back to the MSC for further evaluation.

An applicant is ineligible for the expedited process if any of the following has occurred:

(a) Applicant submits an incomplete application;

(b) MSC makes a recommendation that is adverse or with limitation;

(c) There is a current challenge or a previously successful challenge to licensure or controlled substance registration;

(d) Applicant has received involuntary termination of Medical Staff membership at another organization or voluntarily resigned to avoid disciplinary action;

(e) Applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges or voluntarily surrendered privileges to avoid disciplinary action at the Hospital or at another health care facility; or

(f) There has been an unusual pattern of or an excessive number of final judgments adverse to the applicant in professional liability actions.

## 3.11 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

The Hospital and a Practitioner or a group of Practitioners may provide by agreement that Medical Staff membership and Clinical Privileges are contingent upon such agreement. In the event that an agreement has such a provision, then Medical Staff membership and Privileges shall expire simultaneously with termination of the agreement and shall not be subject to the provisions of these Bylaws concerning hearings, appellate review, or other procedural rights. Notwithstanding the existence of a contract between an individual or group and the Hospital, such individual or group must be appointed and thereafter, reappointed to the Medical Staff and granted Clinical Privileges in accordance with these Bylaws.

## 3.12 RESIGNATION

Resignation from Medical Staff appointment and/or voluntary relinquishment of Clinical Privileges shall be presented in writing to the President of the Medical Staff and brought before the Credentials Committee and then the MSC for presentation to the Board for informational purposes.

# ARTICLE 4. MEDICAL STAFF CATEGORIES AND ADVANCED PRACTICE PROVIDERS

## 4.1 CATEGORIES

There shall be six (6) categories of membership on the Medical Staff: Active, Courtesy, Telemedicine, Consulting, Honorary, and House. APPs, may be selected and participate in the Medical Staff organization as members of the Advanced Practice Professional Staff in accordance with Section 4.11.

## 4.2 ACTIVE STAFF

### 4.2.1 QUALIFICATIONS FOR ACTIVE STAFF

Excepting members of the Department of Emergency Medicine, an Active Staff member shall:

(a) Be located (office and residence) closely enough to the Hospital where Clinical Privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Medical Staff member having at least equivalent Clinical Privileges.

(b) Regularly admit patients to Hospital as a principal site of clinical activity or be involved in the care of patients within the Middlesex Health System.

### 4.2.2 MEMBERSHIP PREROGATIVES OF ACTIVE STAFF

Active Staff members may:

(a) Admit patients without limitation, except as otherwise provided in the Medical Staff Rules and Regulations or delineation of Privileges.

(b) Vote on all matters presented at general and special meetings of the Medical Staff and of the Department, Section, and committees of which they are members, except as provided by resolution of the MSC (or MSEC acting on behalf of the MSC) and approved by the Board.

(c) Hold office at any level in the Medical Staff organization and sit on, or be chairs of, any committee, except as otherwise provided in these Bylaws or pursuant to a resolution of the MSC (or MSEC acting on behalf of the MSC).

(d) Exercise only such specific Clinical Privileges as are granted to them in accordance with the processes set forth in these Bylaws.

### 4.2.3 OBLIGATIONS OF ACTIVE STAFF

Active Staff members, in addition to meeting the basic obligations set forth in Article Three, shall:

(a) Contribute to the organizational and administrative affairs of the Medical Staff, including service in Medical Staff, Department, and Section offices and on Hospital and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed.

(b) Participate in the quality improvement activities required of the Medical Staff.

(c) Discharge the recognized functions of Medical Staff membership by engaging in the Medical Staff's teaching and continuing education programs, providing

specialty coverage in the Emergency Department, attending unassigned patients as required, giving consultation to other Medical Staff members consistent with their delineated Privileges, supervising Practitioners during their provisional period, and fulfilling such other Medical Staff functions as may reasonably be required of Medical Staff members.

(d) Participate in Continuing Medical Involvement ("CMI") activities set forth in Section 12.4 of these Bylaws, as demonstrated by an ongoing commitment to the clinical, educational and/or community service mission of the Hospital, through participation in formal Hospital and Medical Staff committees or administrative functions that support patient care when asked to participate.

(e) Comply with MSC, other Medical Staff committee, Department, Section, and Hospital policies, procedures, and directives.

(f) Be willing to have their patients participate in the Hospital's teaching programs.

(g) Arrange coverage for the member's patients by a member of their Department who holds Clinical Privileges that are appropriate to provide such coverage in the event of the member's absence.

(h) Comply with the provisions of Section 4.7 regarding the provisional period of appointment.

(i) Present any information and opinions that they may have in connection with the process by which Practitioners are appointed or reappointed to the Medical Staff or by which corrective or investigative action is taken with respect thereof.

4.2.4 ACTIVE/ATTENDING STAFF

The Active/Attending Staff shall consist of Physicians who regularly admit and attend to patients at the Hospital. Active/Attending Staff are required to demonstrate an ongoing commitment to the Medical Staff, the Hospital, and the residents of the Hospital's service area by continuously meeting the following clinical requirements during each reappointment period:

(a) Minimum of forty (40) clinical activities defined as follows:

- Admissions
- Attending and discharge of patients
- Pre-surgical assessments
- Consultations
- Conjoint post-surgical care
- Emergency Department visits
- Operative procedures
- Diagnostic testing
- Therapeutic procedures
- Teaching of Family Medicine residents
- Other activities as approved by the Department Chair and MSC

Failure to meet the requirements of Active Attending Medical Staff will automatically result in re-assignment to the Active Affiliate Medical Staff on recommendation of the Department Chair and the MSC.

#### 4.2.5 ACTIVE/AFFILIATE ATTENDING STAFF

The Active/Affiliate Attending Staff shall consist of Physicians who are regularly involved in the care of patients within the Middlesex Health System and who may hold admitting privileges but do not meet the criteria for clinical activities required for Active/Attending as described in Section 4.2.4 hereof. The Active/Affiliate Attending Staff are required to demonstrate an ongoing commitment to the Medical Staff, the Hospital, and the residents of the Hospital's service area by continuously meeting the obligations of Active Staff set forth in Section 4.2.3 during each reappointment period.

Failure to meet the requirements of Active Affiliate Attending Medical Staff will automatically result in re-assignment to the Courtesy Medical Staff on recommendation of the Department Chair and the MSC.

The Affiliate Attending Staff shall submit the names of two (2) peer references at the time of recredentialing. These references shall be contacted to obtain information regarding the applicant's professional competence and ethical character.

#### 4.2.6 ACTIVE/SENIOR ATTENDING/SENIOR AFFILIATE ATTENDING STAFF

The Active/Senior Attending/Senior Affiliate Attending Staff shall consist of Practitioners with a minimum of five (5) years of Active Medical Staff service. Elevation to Senior Attending/Senior Affiliate Attending status will be considered based on the recommendation of the member's Department Chair and, if applicable, the member's Section Chief once five (5) years of Active Medical Staff service has been achieved.

### 4.3 COURTESY STAFF

#### 4.3.1 QUALIFICATIONS FOR COURTESY STAFF

Courtesy Staff members shall:

(a) Be located (office and residence) closely enough to the Hospital where Clinical Privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Medical Staff member having at least equivalent Clinical Privileges.

(b) Have fewer than the number of patient contacts (admissions, consultations, procedures, etc.) per year specified in Section 4.2 Active Staff.

(c) Submit the names of two (2) peer references. If the member holds an active hospital affiliation with another organization, at least one of the references should be from an individual in a supervisory/leadership role at that facility where the member holds privileges.

#### 4.3.2 MEMBERSHIP PREROGATIVES OF COURTESY STAFF

A Courtesy Staff member shall admit patients in the same manner as an Active Staff member, subject to the limitations in Section 4.3.1(b), and exercise such specific Clinical Privileges as are granted. Courtesy Staff members shall not be eligible to hold office in the Medical Staff organization or vote at meetings of the Medical Staff, Departments, Sections, or committees.

#### 4.3.3 OBLIGATIONS OF COURTESY STAFF

Courtesy Medical Staff members who wish to transfer to the Active Medical Staff category are required to apply for such Medical Staff membership in the same manner as any other Practitioner seeking appointment in accordance with the provisions of these Bylaws.

### 4.4 CONSULTING STAFF

#### 4.4.1 QUALIFICATIONS FOR CONSULTING STAFF

Consulting Staff members shall:

(a) Possess specialized skills needed at Hospital in a specific project or on an occasional basis when requested by a Department Chair or Section Chief, other authorized Medical Staff officer or a member of the Medical Staff.

(b) If the patient care contacts (consultation, procedures, etc.) of Consulting Staff members over any twelve (12) month period are more than occasional (as defined by the Department or Section to which they are assigned and approved by the MSC), they shall be required to apply for Active Staff status.

(c) Submit the names of two (2) peer references. If the member holds an active hospital affiliation with another organization, at least one of the references should be from an individual in a supervisory/leadership role at that facility where the member holds privileges.

#### 4.4.2 MEMBERSHIP PREROGATIVES OF CONSULTING STAFF

A Consulting Staff member may exercise the Clinical Privileges granted. Consulting Staff members shall not be eligible to admit patients to Hospital, hold office in the Medical Staff organization or vote at meetings of the Medical Staff, Departments, Sections, or committees.

### 4.4.3 OBLIGATIONS OF CONSULTING STAFF

Consulting Medical Staff members who wish to transfer to the Active Medical Staff are required to apply for such Medical Staff membership in the same manner as any other Practitioner seeking initial appointment in accordance with the provisions of these Bylaws.

## 4.5 TELEMEDICINE STAFF

### 4.5.1 QUALIFICATIONS FOR TELEMEDICINE STAFF

Telemedicine Staff shall:

(a) meet all of the qualifications for Medical Staff appointment hereunder, except for those requirements relating to geographic location, coverage arrangements, and emergency call responsibilities;

(b) have a written agreement with the Hospital to provide telemedicine services to patients of the Hospital, provided that telemedicine Clinical Privileges that are granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement. Such written agreement may be in their individual capacity or between Hospital and the Telemedicine Staff Member's employer, or associated entity;

(c) not physically provide services to patients at any Hospital location and never be primarily responsible for a patient.

### 4.5.2 MEMBERSHIP PREROGATIVES OF TELEMEDICINE STAFF

A Telemedicine Staff Member may consult, within the scope of Clinical Privileges granted, with respect to patients for whom the Practitioner's services have been requested and may be invited to serve on committees. A Telemedicine Staff Member shall not admit patients to, or attend to patients in, the Hospital; vote at general or special meetings of the Medical Staff; hold Medical Staff office; and is not entitled to any rights or prerogatives of these Bylaws, including, without limitation, the right to hearings, appellate review, or other procedural or due process rights.

### 4.5.3 TELEMEDICINE STAFF OBLIGATIONS

A Telemedicine Staff member shall apply for such telemedicine Clinical Privileges, and shall abide by all applicable provisions of the Clinical Privileges granted, the agreement by and between the Practitioner and the Hospital, and the applicable provisions of these Bylaws, the Rules and Regulations and other Medical Staff policies and procedures, including, without limitation, carrying professional liability insurance in an amount required by these Bylaws.

## 4.6 HONORARY STAFF

The Honorary Staff shall consist of: (a) distinguished members of Active Medical Staff who have attained twenty (20) years of Medical Staff service, who, for reasons acceptable to the MSC, wish to surrender their duties and privileges as Active Staff members; and (b) those practitioners who no longer actively practice, who have been members of the Medical Staff, and whom the Medical Staff wishes to honor for their services, ability, or other reason. Honorary Staff members shall not have the privilege of admitting patients, holding office, or serving on standing Medical Staff committees. Honorary Staff appointments shall be made by the MSC, subject to approval by the Board. Members of the Honorary Staff will not be required to apply for reappointment. Membership on the Honorary Staff shall be at the pleasure of the Board, and may be rescinded at any time by the Board with or without cause. The various provisions of these Bylaws shall apply to members of the Honorary Staff only as specifically provided. Provisions relating to hearings and appellate review shall not apply to the Honorary Staff, nor shall the Honorary Staff be eligible to vote, hold Medical Staff office, or attend Medical Staff meetings, except by invitation.

## 4.7 HOUSE STAFF

The House Staff shall consist of residents appointed for one-year terms to Medical Staff membership in this category by the MSC upon recommendation of the Director of the Family Medicine Residency Program. Such appointments are subject to approval by the Board. Membership in the House Staff category is coterminous with the member's status as a resident in good standing.

The various provisions of these Bylaws shall apply to members of the House Staff only as specifically provided. Provisions relating to hearings and appellate review shall not apply to the House Staff, nor shall the House Staff be eligible to vote, hold Medical Staff office, or attend Medical Staff meetings, except by invitation.

A member of the House Staff who successfully completes the residency program may not become a member of any other category of the Medical Staff without applying for initial appointment in the same manner as any other Physician seeking initial appointment in accordance with the provisions of these Bylaws.

## 4.8 PROVISIONAL PERIOD

### 4.8.1 APPLICABILITY AND DURATION

All new appointments to the Active Medical Staff shall be on a provisional basis. The provisional period shall run concurrently with the Practitioner's initial appointment period. However, all individuals within the same Department or Section will be treated equally with respect to the length of provisional appointment unless there is justification to extend the provisional period.

During their provisional period, Medical Staff members shall not be eligible to hold office in the Medical Staff organization, vote at general and special meetings of the Medical Staff or for Medical Staff-wide office, chair any committee, or serve on the

MSC or Credentials Committee, unless the MSC in its discretion makes an exception for a Medical Staff member. During their provisional period, such Medical Staff members shall not be eligible to vote on matters presented at meetings of the Department or Section, as applicable, or any committees of which they are a member unless the MSC in its discretion makes an exception for a Medical Staff member.

4.8.2 PURPOSE

During the provisional period, a Practitioner's performance shall be specifically observed and evaluated by the Department Chair or the Section Chief with which the Practitioner has a primary affiliation and by the Chair of each other Department or Chief of each other Section in which the Practitioner exercises initial Privileges, or by such other Active Staff member specifically delegated these tasks by such Chair or Chief. Such observation and evaluation shall focus on the Practitioner's demonstrated professional ability, interest in the affairs of the Hospital, and willingness to participate in quality improvement program(s).

## 4.9 LEAVE OF ABSENCE

For adequate cause, a member of the Medical Staff may apply for a leave of absence of no more than one (1) calendar year without loss of Membership Prerogatives on the Medical Staff, contingent upon favorable review by the Credentials Committee. During the leave of absence period, Membership Prerogatives shall not be exercised. A leave of absence request must be submitted to and approved by the MSEC prior to the initiation of the leave of absence. Decisions in regard to the granting or denial of leave of absence shall not be subject to the provisions of Article Eleven of these Bylaws or any other review and shall be final. It is the obligation of the Medical Staff member on leave of absence to apply for reinstatement on a timely basis, in accordance with the approved terms of the member's leave of absence. If the leave of absence was due to health or welfare reasons that affect the member's ability to exercise Clinical Privileges or otherwise practice in a safe manner, a medical clearance from a treating healthcare provider must be included with the application for reinstatement or reappointment that includes any limitations related to performing the Practitioner's Clinical Privileges. If the Medical Staff member fails to apply for reinstatement prior to the end of the approved leave of absence, the Medical Staff appointment shall lapse and the member must apply for Medical Staff membership in the same manner as one applying for initial appointment. Medical Staff members whose leave of absence coincides with their reappointment cycle are obligated to fulfill the process in its entirety, in the same manner as any other practitioner seeking reappointment in accordance with the provisions of these Bylaws.

## 4.10 GENERAL QUALIFICATIONS

Each Practitioner who seeks or holds Medical Staff membership shall satisfy, at the time of appointment and continuously thereafter, all of the basic qualifications set forth in these Bylaws as well as any additional qualifications that attach to the Medical Staff category to which such Practitioner seeks appointment or in which membership exists. Under exceptional circumstances, the Board (upon recommendation of the MSC) may waive any

qualification when in its discretion, such waiver will serve the best interests of patient care in Hospital except where requirements are established by law.

## 4.11 LIMITATION OF MEMBERSHIP PREROGATIVES

4.11.1 The Membership Prerogatives set forth under each Medical Staff category are general in nature and may be subject to limitation by special conditions attached to a Practitioner's Medical Staff membership by other Section of these Bylaws, and by other policies of the Hospital. The Membership Prerogatives of dentist and podiatrist members of the Medical Staff shall be limited to those for which they have demonstrated the requisite level of medical education, training, experience, and ability.

4.11.2 Any Medical Staff category change requires filing a written request and providing information as directed. The request must meet all the requirements for initial appointment to the category requested.

## 4.12 ADVANCED PRACTICE PROFESSIONAL STAFF (APP)

### 4.12.1 DEFINED

APPs shall be individuals, other than Physicians, dentists, and podiatrists, who are licensed and qualified to render advanced practice patient care services within their areas of professional competence. APPs shall serve patients who are the primary responsibility of members of the Medical Staff but shall not have the privilege to admit patients independently. APPs include, but may not be limited to, physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives who are permitted by law and by the Hospital to provide advanced practice patient care services in accordance with their Clinical Privileges in collaboration with or under the supervision of a Medical Staff member.

### 4.12.2 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Only an APP holding a license, certificate, or such other credentials as may be required by applicable state law and satisfying the basic qualifications as generally set forth in Article Three and other Sections of these Bylaws, shall be eligible to provide advanced practice patient care services in the Hospital. The MSC may establish additional qualifications required of members of any particular APP discipline. All APPs shall participate in continuing education as needed to maintain certification by the applicable certifying specialty organization and the applicable state licensing requirements.

### 4.12.3 GENERAL PROVISIONS

(a) APPs shall be appointed and reappointed to one of the several Departments of the Medical Staff for periods not to exceed three (3) years. They shall be appointed and reappointed by the Board after submission of an application to the President of the Medical Staff and recommendation by the appropriate Chair, the Credentials Committee, and the MSC.

(b) Clinical Privileges granted shall be based upon current licensure, registration or certification, individual training, experience, demonstrated competence and judgment, and current physical and mental health, and shall be within the Scope of Practice activities they are legally authorized to perform. Members of the Advanced Practice Professional Staff shall be assigned by the MSC to an appropriate Department for supervision and assessment. Protocols for the supervision of supervised APPs shall be described in Departmental policy and the individual APP shall enter into a collaboration or supervision agreement with the collaborating or supervising Medical Staff member, with approval by the Department Chair and the MSC.

(c) At all times a Physician member of the Medical Staff must be jointly responsible for the admission and medical care of any patient treated by a member of the Advanced Practice Provider Staff. Each person desiring appointment to the Advanced Practice Provider Staff must specify on the application form the Physician member of the Active Medical Staff who will assume this joint responsibility. Such responsibility shall include supervision for the general medical care of the patient. In the event the responsible physician becomes unavailable to fulfill the duties of supervision, it is the responsibility of the Advanced Practice Professional Staff Member to locate a new responsible physician. APPs shall retain appropriate responsibility within their area of professional competence for each patient in the Hospital for whom the APP is providing services, or arrange a suitable alternative for such care and supervision, which arrangements for alternate coverage must be made by or through the supervising or collaborating Medical Staff member who has ultimate responsibility for the patient's medical care.

(d) Provisions in Article Eleven of these Bylaws relating to hearings and appellate review shall not in any circumstance apply to APPs. The fair hearing and appellate review mechanism for APPs shall be as follows: adverse decisions related to appointment, reappointment, and/or Clinical Privileges may be appealed by the APP to the Department Chair. The Chair shall review the APP's appeal, and shall issue a written decision containing the basis for the decision. Upon request of the APP, the Chair's decision shall be reviewed by the MSEC. The MSEC, at its discretion, shall determine the process to be followed, provided that the APP shall be permitted to appear at a regular or special meeting of the MSEC and shall have the right to file a written statement, but shall not have the right to be represented by counsel at the meeting. The MSEC shall then review and issue a decision. The MSEC's decision shall be in writing and shall explain the reasons for the decision. The APP subsequently shall have the right to appeal the MSEC's decision to the Board or a committee of the Board. The Board or its committee, at its discretion, shall establish the process to be followed, provided that the APP shall be permitted either to make an oral statement or to file a written statement. The decision of the Board or its committee shall be in writing and shall be final. The MSEC and the Board shall establish reasonable time frames within which their respective reviews shall take place and their respective decisions shall be rendered. Notwithstanding the

foregoing, the appointment and Clinical Privileges of an APP shall automatically terminate in the event the APP's employment by the Hospital terminates or the APP is no longer supervised by a Medical Staff member, and such termination shall be without right of hearing or appellate review.

(e) APPs are not deemed to be members of the Medical Staff. The various provisions of these Bylaws and the accompanying Rules and Regulations shall apply to them only where specifically provided, or where the context requires application.

(f) APPs shall not have the right to admit patients to the Hospital, nor shall they have the right to vote on any matters that come before the Medical Staff.

(g) Each APP shall maintain the confidentiality of and shall not disseminate to any person other than as permitted or required by law, any health information submitted, collected, prepared or obtained while (i) treating patients at Hospital, (ii) obtaining payment for services rendered at Hospital, or (iii) assisting with health care operations of Hospital. Each APP shall comply with the Hospital's Notice of Privacy Practices and privacy policies as well as with all applicable state and federal laws and regulations while providing services at Hospital. In the event that an APP fails to comply with this Section 4.11.3(g), the President of the Medical Staff, Department Chair or Section Chief shall issue a written warning to the APP. If after receipt of a written warning, the APP fails to comply with this Section 4.11.3(g), the APP's (a) Clinical Privileges and (b) right to treat patients and to consult with respect to patients shall be suspended by the President of the Medical Staff, Department Chair, or Section Chief effective immediately and continuing until the earlier of thirty (30) days from the effective date of the suspension or such date on which the APP agrees in writing to comply with the confidentiality of health information requirements. Except as set forth below, the provisions of these Bylaws regarding due process applicable to APPs, including but not limited to Section 4.11.3(d), shall not apply to actions taken against an APP due to violations of this Section 4.11.3(g). In the event that an APP fails to agree in writing to comply with the confidentiality of health information requirements of Sections 3.6.8 and 3.6.9 within ten (10) days from the effective date of a suspension permitted by this Section 4.11.3(g) or concurrent with the second suspension of an APP pursuant to this Section 4.11.3(g), the Department Chair shall take all appropriate corrective action necessary to resolve the APP's failure to comply with this Section 4.11.3(g). Thereafter, the procedures of Section 4.11.3(d), if applicable, shall apply.

(h) An APP's Clinical Privileges and membership on the Advanced Practice Professional Staff shall be subject to the provisions addressing summary suspension and automatic sanctions set forth in Sections 10.2 and 10.3 of these Bylaws, provided that APPs shall not be eligible for any procedural rights afforded to Practitioners thereunder, in accordance with Section 4.11.3(d) above.

#### 4.12.4 AVAILABILITY OF PRIVILEGING INFORMATION

The list of Privileges granted to APPs shall be available to authorized staff by print or electronic means.

### 4.13 DUES

Members of the Medical Staff are required to pay membership dues and assessments as may be recommended by the MSEC. In the event the MSEC determines that a member is delinquent in the payment of dues or assessments and has not provided a satisfactory excuse for such delinquency, the MSEC may impose appropriate sanctions, including but not limited to the imposition of a fine or suspension or limitation of Membership Prerogatives or Clinical Privileges. A Medical Staff member shall not be entitled to the procedural rights set forth in Article Eleven in connection with any action taken by the Medical Staff due to a violation of this Section 4.13.

## ARTICLE 5. DELINEATION OF CLINICAL PRIVILEGES

### 5.1 EXERCISE OF PRIVILEGES

A Practitioner providing clinical services at Hospital by virtue of Medical Staff membership or otherwise may, in connection with such practice and, except as otherwise provided in Sections 5.6 and 5.7, exercise only those Clinical Privileges specifically granted to such Practitioner by the Board. Regardless of the level of Privileges granted, each Practitioner shall obtain consultation when necessary for the safety of patients or when required by the Rules and Regulations and other policies of the Medical Staff, any of its Departments or Sections, or the Hospital.

### 5.2 BASES FOR DETERMINATION OF PRIVILEGES

Privileges governing clinical practice shall be granted in accordance with prior and continuing education, training, experience, demonstrated current competence, judgment, and ability to perform the Clinical Privileges requested as documented and verified in each Practitioner's credentials file and in accordance with the general qualifications set forth in Article Three. The bases for determination of Privileges for current Medical Staff members in connection with reappointment or a requested change in Privileges shall also include observed clinical performance and documented results of the Medical Staff's quality improvement program activities.

### 5.3 SYSTEM AND PROCEDURE FOR DELINEATING PRIVILEGES

Clinical privileging is performed in conjunction with the appointment and reappointment process. Additional Privileges may be requested through the same procedure as prescribed for obtaining the original Privileges. A request for additional Privileges must be supported by documentation of training and/or experience supportive of the request. Additional information to be reviewed by the Department Chair and the Credentials Committee includes data from the Practitioner's professional practice evaluation.

Limitations to Privileges will be explicitly stated in the Practitioner's credentials file.

## 5.4 SPECIAL CONDITIONS FOR ADVANCED PRACTICE PROFESSIONAL SERVICES

Requests to perform specified patient care services from APPs shall be processed in the manner specified in Section 4.11.

## 5.5 EMERGENCY AND DISASTER PRIVILEGES

### 5.5.1 EMERGENCY PRIVILEGES

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any Medical Staff member or APP shall be authorized and shall be assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the member or APP's license but regardless of Department or Section affiliation, Medical Staff category, or level of Privileges. A Medical Staff member or APP exercising emergency Privileges shall be obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

### 5.5.2 DISASTER PRIVILEGES

Practitioners or APPs who are not currently members of the Middlesex Hospital Medical Staff may volunteer to furnish services and be granted disaster privileges during an "emergency" situation, where an "emergency" is defined as an activation of the Emergency Management Plan. The Middlesex Command Center, in consultation with the President of the Medical Staff or their designee, will reasonably exhaust the resources of current members of the Medical Staff before accepting or soliciting support from outside Physicians and APPs. Disaster privileges will be granted by the President of the Hospital or the President of the Medical Staff or their respective designees, on a case-by-case basis, and volunteers granted disaster privileges will be identified as such at all times on Hospital premises. The granting of disaster privileges will be in accordance with the Hospital's and Medical Staff's policies and procedures.

Prior to granting any disaster privileges to a volunteer practitioner, the Hospital will obtain a valid government-issued identification from the practitioner, as well as at least one of the following: (i) a current picture identification card from a health care organization that clearly identifies professional designation; (ii) a current license to practice medicine in the state of Connecticut; (iii) primary source verification of licensure; (iv) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group, if applicable; (v) identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or (vi) confirmation by a Practitioner having Clinical Privileges with

personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

The activities of all volunteer practitioners granted limited disaster privileges shall be overseen by members of the Medical Staff. The Hospital shall verify primary sources of licensure as soon as the immediate emergency situation is under control, or within seventy-two (72) hours of granting such privileges to the extent practicable, and based on oversight of the volunteer practitioner the Medical Staff shall make a determination within seventy-two (72) hours as to whether a particular volunteer practitioner's disaster privileges should be continued.

## 5.6 TEMPORARY PRIVILEGES

### 5.6.1 CONDITIONS

Temporary Privileges may be granted only in the circumstances described in Section 5.7.2: (i) only to appropriately licensed Practitioners and APPs, (ii) only when the information available shall support a favorable determination regarding the requesting Practitioner/APP qualifications, ability, and judgment to exercise the Privileges requested, and (iii) only after verification that the Practitioner/APP has satisfied the professional liability insurance requirement, if any, of these Bylaws, and applicable licensure requirements, and demonstrates current competence and ability to perform the clinical privileges requested. Special requirements of consultation and reporting shall be imposed by the Department Chair or Section Chief responsible for the Practitioner. Temporary Privileges shall not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital in all matters relating to the temporary Privileges granted. Said Bylaws, Rules and Regulations, and policies shall control in all matters relating to the exercise of temporary Privileges. All temporary Privileges of applicants shall be specifically delineated.

### 5.6.2 CIRCUMSTANCES

Upon the written concurrence of the Department Chair where the Privileges will be exercised, or the President of the Medical Staff if the Chair is unavailable, the President of the Hospital or his designee, after appropriate verification, may grant temporary Privileges in the following circumstances:

(a) Pendency of Application: After receipt of a completed and verified application for Medical Staff appointment and a written request for specific temporary Privileges for a period of up to one hundred twenty (120) days, subject to the recommendation of the Department Chair. The completed application must indicate that the applicant has (1) no current or previously successful challenge to licensure or registration; (2) not been subject to involuntary termination of medical staff membership at another organization; and (3) not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges. This shall be done only when appointment without undue restriction is anticipated.

(b) Care of Specific Patients: Upon receipt of a written request for specific temporary Privileges for the care of one (1) or more specific patients from a practitioner who is not an applicant for Medical Staff membership. Such privileges shall be granted for a defined period not to exceed sixty (60) days consecutively, with one (1) renewal of an additional period of sixty (60) days.

(c) Locum Tenens: Upon receipt of a written request for specific temporary Privileges, to a practitioner who is not an applicant for Medical Staff membership and who is serving as a Locum Tenens for a member of the Medical Staff or for the Hospital to satisfy a patient care need. Locum Tenens Privileges may be granted to fulfill an important patient care need for a defined period not to exceed sixty (60) days consecutively, with one (1) renewal of an additional period of sixty (60) days.

#### 5.6.3 TERMINATION OF TEMPORARY PRIVILEGES

The President of the Hospital or his designee shall, on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise all or any of the temporary Privileges granted, and may at any other time after consultation with the Chair or Chief responsible for supervision, terminate all or any of a Practitioner's temporary Privileges, provided that where the life or well-being of a patient is determined to be endangered, the termination may be affected by any person entitled to impose summary suspensions under these Bylaws. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chair or Chief responsible for the Practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

#### 5.6.4 RIGHTS OF THE PRACTITIONER

A Practitioner shall not be entitled to the procedural rights afforded by the Bylaws in the event that the Practitioner's request for temporary Privileges is refused or such granted temporary privileges are subsequently terminated pursuant to Section 5.7.3 hereof.

## ARTICLE 6. STAFF OFFICERS

### 6.1 GENERAL OFFICERS OF THE STAFF

#### 6.1.1 IDENTIFICATION

The general officers of the Staff shall be a president, a vice president, and a secretary/treasurer.

### 6.1.2 QUALIFICATIONS

Each general officer shall be either a physician or dentist member of the Active/Senior Attending Staff or of the Active/Senior Affiliate Attending Staff at the time of nomination and election, shall remain a member in good standing continuously during the term of office, and shall be willing and able to discharge the duties of the particular office faithfully. They shall have demonstrated executive ability and be recognized for their high level of clinical competence. No individual may hold two (2) general Medical Staff offices concurrently. General officers of the Staff shall be and must remain board certified during the term of office.

## 6.2 TERM OF THE OFFICE

The term of office of general Medical Staff officers shall be two (2) Medical Staff Years. Medical Staff officers may serve up to two consecutive two (2) year terms and shall not be limited in the number of times they can pursue office so long as it would not lead to more than two consecutive two (2) year terms. Officers shall assume office on the first day of the month following their election or appointment except that an officer elected to fill a vacancy shall assume office immediately upon election. Each officer shall serve until the end of the term and until a successor is elected, unless the officer sooner resigns or is removed from office.

## 6.3 ELECTION OF OFFICERS

Officers shall be chosen by election by majority vote cast by those members of the Medical Staff eligible and qualified to vote for general officers. Notice and a solicitation of nominations for each election shall be sent to all Medical Staff members who are eligible and qualified to vote for general officers, at least sixty (60) days prior to such election. Nominations for officers may be submitted to the Nominating Committee by any member of the Medical Staff eligible and qualified to vote for general officers at least twenty-one (21) days prior to the election. The Nominating Committee shall consist of members of the MSEC designated to act as a nominating committee and shall offer to all Medical Staff members who are eligible and qualified to vote for general officers one (1) or more nominees for each office. Nominations for officers shall be distributed to all Medical Staff members who are eligible and qualified to vote for general officers fourteen (14) days prior to election. Voting shall be by use of electronic ballot.

## 6.4 VACANCIES

Vacancies in the office of Secretary/Treasurer during the Medical Staff Year shall be filled by the MSEC within ninety (90) days. If the President of the Medical Staff fails to serve for any reason, the Vice-President shall serve as President of the Medical Staff. If the Vice-President fails to serve for any reason, the Secretary/Treasurer shall serve as Vice-President.

## 6.5 RESIGNATION AND REMOVAL FROM OFFICE

### 6.5.1 RESIGNATION

Any general Medical Staff officer may resign at any time by giving written notice to the MSEC. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in it.

### 6.5.2 REMOVAL

In the event that an officer's Privileges have been suspended or terminated, such officer shall be automatically removed from office.

Removal of a general Medical Staff officer for good cause may be effected by a two-thirds (2/3) vote by electronic ballot of the members of the Medical Staff eligible and qualified to vote for Medical Staff officers, such vote being taken with a special election called for that purpose. Permissible grounds for removal shall include, without limitation: (a) failure to perform the duties of the position held in a timely and appropriate manner; and (b) failure to continuously satisfy the qualifications for the position. No such removal shall be effective unless and until ratified by the Board. In the event that the officer under consideration for removal is the President, the Vice-President shall act as the chair for meetings of the Medical Staff, the MSEC and the MSC while the action for removal is being considered.

## 6.6 DUTIES OF THE OFFICERS

The responsibilities and authority including specific functions and tasks of general Medical Staff officers and other Medical Staff members elected or appointed as officers of Departments and/or Sections and committees are set forth in these Bylaws. The overall duties of general Medical Staff officers shall be as provided in this Section 6.6.

### 6.6.1 DUTIES OF THE PRESIDENT

The President of the Medical Staff shall be the senior elected Medical Staff officer. The President of the Medical Staff shall serve as the Chair, and shall be a voting member, of the Medical Staff Executive Committee, Medical Staff Council, and Joint Conference Committee. The President of the Medical Staff's specific functions and tasks in each of these roles are detailed in these Bylaws. The President of the Medical Staff shall:

(a) Act in consultation with the President of the Hospital in all matters of concern to the Hospital and the Medical Staff.

(b) Call, preside at, and prepare the agenda of all general meetings of the Medical Staff.

(c) Oversee the enforcement of Medical Staff Bylaws, Rules and Regulations, and policies; implementation of sanctions where indicated; and Medical Staff compliance with procedural safeguards in all instances where

corrective action has been requested against a Practitioner.

(d) Appoint committee members to all standing, special and multidisciplinary Medical Staff committees, except the Medical Staff Executive Committee and Medical Staff Council.

(e) Represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the President of the Hospital.

(f) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's responsibility to provide medical care.

(g) Oversee the educational activities of the Medical Staff.

(h) Be a spokesperson for the Medical Staff in its external professional and public relations.

(i) Execute, in cooperation with the President of the Hospital, the granting of temporary privileges and summary suspension of privileges as outlined in these Bylaws.

### 6.6.2 DUTIES OF THE VICE PRESIDENT

Whenever the President of the Medical Staff is unable to fulfill the duties of office by reason of illness, absence or other temporary or permanent incapacity, the Vice President shall exercise all the responsibilities and authority of the President of the Medical Staff. The Vice President shall be a member of the Medical Staff Executive Committee, the Medical Staff Council, the Joint Conference Committee and the Quality Improvement Patient Safety Committee.

### 6.6.3 DUTIES OF THE SECRETARY/TREASURER

Whenever the Vice President of the Medical Staff is unable to fulfill the duties of office by reason of illness, absence or other temporary or permanent incapacity, the Secretary/Treasurer shall exercise all the responsibilities and authority of the Vice President. The Secretary/Treasurer shall be a member of the Medical Staff Executive Committee, the Medical Staff Council, the Joint Conference Committee, and the Credentials Committee. The Secretary/Treasurer shall record and report on the meetings of the Medical Staff, the MSEC, and MSC. The Secretary/Treasurer shall keep an accurate and complete account of financial transactions of the Medical Staff, and shall collect and disburse funds upon the order of the President of the Medical Staff. The Secretary/Treasurer shall serve as chair of the Bylaws Committee.

## ARTICLE 6A. CHIEF MEDICAL OFFICER

### 6A.1 CHIEF MEDICAL OFFICER QUALIFICATIONS AND APPOINTMENT

The Chief Medical Officer (CMO) shall be appointed by the President of the Hospital, following consultation with the MSEC/MSC. The MSEC/MSC will identify individuals who possess the abilities and interests required to discharge successfully the responsibilities of the CMO. Suitable candidates will be those Physician members of the Medical staff who have demonstrated outstanding clinical skills, competent administrative performance, and an ability to work successfully with Practitioners, APPs and administrators.

### 6A.2 DUTIES AND RESPONSIBILITIES OF CHIEF MEDICAL OFFICER

The CMO shall act as the senior administrative officer of the Medical Staff. Successful performance of this key position will help assure effective Medical Staff functioning. This will be accomplished by maintaining broad participation in Medical Staff affairs, by frequent interaction with all elements of the Medical Staff, especially those in leadership positions, i.e., chairs, chiefs and elected officers, and by closely monitoring areas of special sensitivity. The CMO functions both as a liaison for the Medical Staff to the administrators of the Hospital and as a communicator for such administrators to the Medical Staff.

### 6A.3 REPORTING

The CMO reports to the President of the Hospital, and is also responsible for reporting to the Board regarding clinical practice. The CMO's performance will be reviewed annually by the President of the Hospital, with consultation from the MSEC/MSC and the Board.

## ARTICLE 7. CLINICAL DEPARTMENTS

### 7.1 CLINICAL DEPARTMENTS AND SECTIONS

The clinical Departments are: Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, and Surgery. Each Department includes such Sections as the Department shall determine to be necessary for proper patient care.

#### 7.1.1 DEPARTMENT OF MEDICINE

The Department of Medicine includes the Sections of cardiology, endocrinology, gastroenterology, hematology/oncology, infectious disease, hospital medicine, nephrology, neurology, occupational medicine, pulmonary medicine, and rheumatology.

#### 7.1.2 DEPARTMENT OF SURGERY

The Department of Surgery includes the Sections of general surgery, neurosurgery, ophthalmology, oral maxillofacial surgery and dental medicine, orthopedics, otolaryngology, plastic surgery, podiatry, urology, and vascular surgery.

## 7.2 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Department shall be a separate organizational component of the Medical Staff, and all Medical Staff members shall be a member of the Department and Section (if applicable) which most closely reflects their professional training and experience and the clinical area in which their practices are concentrated. A Practitioner may be granted Clinical Privileges in one or more of the other Departments or Sections. The exercise of Clinical Privileges within the jurisdiction of any Department or Section shall always be subject to the rules and regulations of that Department and Section, and the authority of the Department Chair and Section Chief, which authority shall be exercised in a manner consistent with these Bylaws, Rules and Regulations, policies of the Hospital and Medical Staff, and applicable law.

## 7.3 FUNCTIONS OF DEPARTMENTS

### 7.3.1 MEETING AND GENERAL FUNCTIONS

Departments shall each hold meetings of the Department not less than quarterly. Departments fulfill administrative, collegial and quality-of-care maintenance and improvement functions. Through election to Medical Staff-wide offices and Departmental representation on committees, the Medical Staff members affiliated with each Department shall perform these same functions on a multidisciplinary, Medical Staff- and Hospital-wide basis.

### 7.3.2 ADMINISTRATIVE FUNCTIONS

Each Department shall assure that its members are given the opportunity to contribute their professional views and insights to the formulation of Medical Staff and Hospital policies and plans, shall communicate formulated policies and plans back to its members for implementation, and shall coordinate the professional services of its members with those of other Departments and Sections and with Hospital and Medical Staff support services.

### 7.3.3 QUALITY IMPROVEMENT/PROFESSIONAL PRACTICE REVIEW FUNCTIONS

Each Department shall discharge the following quality improvement/professional practice review and accountability functions, either alone or in concert with other organizational components of the Medical Staff and the Hospital:

(a) Conduct special studies of the inputs, processes and outcomes of care and specified monitoring activities, including mortality and invasive procedure reviews, for the purpose of evaluating the clinical work performed under its jurisdiction.

(b) Establish minimum requirements for the Clinical Privileges that may be exercised by its members and others exercising Clinical Privileges within its jurisdiction, review the demonstrated results of Privileges so exercised, and frame recommendations for future Privileges.

(c) Monitor its members' performance, on a continuing and concurrent basis, for adherence to Medical Staff, Hospital, and Department policies and procedures, including requirements for alternate coverage and for obtaining consultation; for adherence to sound principles of clinical practice; for appropriate surgical and other procedures; for unexpected clinical occurrences; and for patient safety.

(d) Establish such committees or other mechanisms as are necessary and desirable to properly perform the quality improvement functions assigned to it.

#### 7.3.4 PROFESSIONAL FUNCTIONS

Each Department (or Section as applicable) shall serve as the most immediate peer group for providing clinical support among and between peers, for teaching, continuing education, research and sharing of new knowledge, and for providing consultation within the Department and throughout the Hospital in its specialty area. Each Department will provide appropriate coverage to the Emergency Department.

### 7.4 FUNCTIONS OF SECTIONS

Each Section shall perform the functions assigned to it by the MSC. Such functions may include, without limitation, any of the functions described above for Departments. A Section shall transmit regular reports on the conduct of its assigned functions to the Department Chair.

### 7.5 DEPARTMENT BYLAWS

Each Department shall have Department Bylaws which, when approved by the MSC and the Board, shall be incorporated into and become a part of these Bylaws. Department Chairs shall regularly review their Department Bylaws and shall inform the MSEC of required updates.

## ARTICLE 8. OFFICERS OF DEPARTMENTS

### 8.1 QUALIFICATIONS FOR OFFICERS

#### 8.1.1 DEPARTMENT CHAIRS

Each Department shall have a Chair, who shall be a member of the Active Staff and of such Department and remain in good standing throughout the term of office, shall have demonstrated ability in at least one of the clinical areas covered by the Department, and shall be willing and able to discharge the functions of the Chair faithfully. A Department Chair may serve either under contract with the Hospital or on a voluntary basis. The Chair shall be and must remain board certified during the term of office.

### 8.1.2 SECTION CHIEFS

Each Section shall have a Chief who shall be a member of the Active Staff and of the respective Section and remain in good standing throughout the term of office, shall be qualified by training, experience and current demonstrated ability in the clinical area covered by the Section, and shall be willing and able to discharge the functions of the Section Chief faithfully. The Chief shall be and must remain board certified in the clinical area covered by the Section during the term of office.

## 8.2 SELECTION

A Department Chair or Section Chief shall be elected by majority vote of those members of the Department who are eligible and qualified to vote for officers at the regular Department or Section meeting prior to the Annual Medical Staff meeting. Nominations may be made and seconded at the meeting by any Active Staff member of the Department or Section in good standing, provided that evidence shall be presented to the meeting of the qualifications of the nominee and that the nominee shall accept the nomination.

## 8.3 TERM OF OFFICE

Each Department Chair and Section Chief shall be elected by the members of the Department or Section as frequently as determined by the bylaws or rules and regulations of the Department. A member of the Medical Staff shall be eligible for election as Department Chair or Section Chief if the member is on the Active/Senior Attending or Active/Senior Affiliate Attending Staff. This requirement may be waived by the MSC.

## 8.4 ANNUAL APPOINTMENT

Each Department Chair and Section Chief shall be approved annually by the MSC. The appointment is subject to approval by the Board of Directors.

## 8.5 RESIGNATION AND REMOVAL

A Chair or Chief may resign at any time by giving written notice to the MSC. Such resignation shall take effect on the date of receipt or at any later time specified in it. Removal of a Chair or Chief for good cause may be effected by a two-thirds (2/3) vote of the MSC, or by a two-thirds (2/3) vote of the applicable constituent group eligible to vote. Permissible grounds for removal shall include, without limitation: (a) failure to perform the duties of the position held in a timely and appropriate manner; and (b) failure to continuously satisfy the qualifications for the position.

## 8.6 VACANCIES

An unexpected vacancy in a Chair or Section Chief position shall be filled from the members of the Department or Section concerned through appointment of an acting officer by the President of the Medical Staff. The acting officer shall serve pending a special election conducted in the same manner as provided in Section 8.2.

## 8.7 RESPONSIBILITY, AUTHORITY AND REPORTING OBLIGATIONS OF OFFICERS

### 8.7.1 RESPONSIBILITY AND AUTHORITY

A Department Chair shall have the responsibility and authority to carry out the functions assigned by the Department, by the Board, by the MSC, by these Bylaws and, where applicable, by contract with the Hospital.

A Section Chief shall have the responsibility and authority to carry out whatever functions are assigned by the Section, by the Board, by the Department Chair, by the MSC, by these Bylaws and, where applicable, by contract with the Hospital.

During temporary absences, each Department Chair and Section Chief shall appoint a qualified temporary Chair or Chief to exercise all appropriate and customary responsibilities.

### 8.7.2 REPORTING OBLIGATIONS

Department Chairs shall each report:

(a) At regularly scheduled MSC and Medical Staff meetings on their Department's activities.

(b) When necessary or requested, to the President of the Medical Staff on matters of immediacy, especially where action to coordinate clinical services to maintain quality or to assure patient safety are at issue.

(c) To the President of the Hospital on issues relating to the Chair's administrative duties for coordination of the Hospital's personnel, proper functioning of equipment, efficient scheduling and similar matters.

Section Chiefs shall report at regularly scheduled Department meetings on their Section's activities, to the Department Chair as well as the President of the Medical Staff or other appropriate Practitioner for matters described in Section 8.7.2(b), and to the President of the Hospital for matters described in Section 8.7.2(c).

### 8.7.3 SPECIFIC DUTIES AND OBLIGATIONS OF DEPARTMENT CHAIRS

To assure that the functions of the Departments as provided in these Bylaws are accomplished and to meet their responsibility for all professional and administrative activities within the Departments and their Sections, Department Chairs shall have these specific duties and obligations:

(a) Preside over and prepare the agenda for all Department meetings.

(b) Submit a written report of meetings and Department activities to the MSC.

(c) Participate on a continuous basis in managing the Department through

cooperation and coordination with the nursing and other patient care services and Hospital management on all matters affecting patient care.

(d) Participate in planning with respect to the Department's personnel, equipment, facilities, services, and budget.

(e) Communicate and implement within the Department actions taken by the committees and the Board.

(f) Unless otherwise provided, serve on the MSC, give guidance on the overall medical policies of the Hospital, recommend to the Medical Staff criteria for Clinical Privileges that are relevant to the care provided in the Department, and make specific recommendations and suggestions regarding the Department to the MSC, Hospital management and the Board.

(g) Assist in developing and implementing relevant Medical Staff components of the quality improvement program(s), as required in these Bylaws.

(h) Assist in developing, implementing, supervising, coordinating and evaluating, in conjunction with other appropriate officials, committees, Departments and/or Sections of the Medical Staff, orientation, education, training and research programs for the members of the Department.

(i) Maintain continuing review of the quality of patient care and the professional performance of all Practitioners and others with Clinical Privileges or performing specified services in the Department, including performing or overseeing ongoing and focused professional practice evaluations (OPPE and FPPE), and present regular written reports to the MSC and other Medical Staff and Hospital committees when appropriate.

(j) Prepare and transmit to the appropriate authorities as required by these Bylaws recommendations concerning appointment, reappointment, delineation of Clinical Privileges, and corrective action with respect to Practitioners in the Department.

(k) Enforce Hospital, Medical Staff and Department bylaws, the Rules and Regulations, and policies and procedures within the Department, including initiating corrective action and evaluating clinical performance and requiring consultation to be provided or sought when necessary.

(l) Unless otherwise provided in these Bylaws, appoint Department committees as necessary to perform the functions of the Department and designate a chair of each such committee.

(m) Perform such other duties as commensurate with the office as are set forth in these Bylaws and, where applicable, in a contract with the Hospital and as may from time to time be reasonably requested by the President of the Medical Staff, the MSC, or the President of the Hospital.

(n) Perform an appraisal for the Credentials Committee of each Medical Staff and APP applicant and a reappraisal of each member of the Department at the time of reappointment. Such reappraisal shall include information relative to the individual's professional performance, judgment, and when appropriate, technical skill. This reappraisal shall also include determination of the individual's health status in the perspective of the Practitioner's ability to perform the Clinical Privileges requested.

(o) Oversee the development of Departmental bylaws and ensure that these bylaws are reviewed and updated as necessary.

### 8.7.4 SPECIFIC DUTIES AND OBLIGATIONS OF SECTION CHIEFS

To assure that the functions of the Sections as provided in these Bylaws are accomplished and to meet their responsibility for all professional and administrative activities within the Sections, Section Chiefs shall each have these specific duties and obligations:

(a) Implement and supervise, in cooperation with the Department Chair, CMO and other appropriate officials of the Medical Staff and the Hospital, systems to carry out the quality improvement functions assigned to the Section.

(b) Implement, maintain and update the list of on-call Physicians at the Hospital from within the Section, and oversee the scheduling of call coverage to assure continuous coverage at the Hospital (and elsewhere within Middlesex Health System if necessary) by Physicians from within the Section.

(c) Participate, as applicable, in planning with respect to the Section's personnel, equipment, facilities, services and budget.

(d) Maintain continuing review of patient care and of the professional performance of Practitioners and APPs with Clinical Privileges in the Section, including performing focused and ongoing professional practice evaluation delegated by Department Chairs, as outlined in applicable Medical Staff policies.

(e) Conduct investigations and submit reports and recommendations as required by the Medical Staff's credentialing procedures to the Department Chair and the credentials committee regarding appointment, reappointment, delineating of Clinical Privileges and corrective action with respect to Practitioners and APPs holding membership or exercising Privileges or services in or applying to the Section.

(f) Assist in developing, implementing, supervising and evaluating, in conjunction with other appropriate officials, committees, Departments and/or Sections of the Medical Staff, education, research and training programs for members of the Section.

(g) Recommend to the Medical Staff criteria for Clinical Privileges in the Section.

(h) Preside over and prepare the agenda for all Section meetings.

(i) Submit written reports at least quarterly to the Department Chair on the activities of the Section.

(j) Perform such other duties commensurate with the office as are set forth in these Bylaws and as may from time to time be reasonably requested by the President of the Medical Staff, the Department Chair, the MSC, or the President of the Hospital.

## ARTICLE 9. COMMITTEES

### 9.1 GENERAL PURPOSES AND PRINCIPLES GOVERNING COMMITTEES

As the Medical Staff must be concerned with meeting the community's medical needs, it must look toward a broad, integrated approach to service through various committees which shall either be standing or special. The standing committees described in this are established for the purposes of (a) evaluating and improving the quality of health care rendered in Hospital, (b) reducing morbidity and mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications and activities of the Medical Staff and APPs and applicants for admission to the Medical Staff and Advanced Practice Professional Staff, (e) reporting variances to accepted standards of clinical performance to individual Practitioners and APPs and (f) for such additional purposes as may be set forth. Many activities of committees, subcommittees, Departments and individuals provided for in these Bylaws are carried out for purposes of evaluating and improving the quality and efficiency of services ordered or performed as well as reducing morbidity and mortality and operating in a manner to keep costs within reasonable bounds.

It is intended and understood that when so engaged each committee or subcommittee created or referred to in or authorized by these Bylaws or the Bylaws of the Hospital including but not limited to the Medical Staff Executive Committee; Medical Staff Council; Medical Ethics Committee; Clinical Oversight Committee; Committee on Physician Health, Credentials Committee; Critical Care Committee; Health Information Management Committee; Infection Committee; Continuing Medical Education Committee; Joint Conference Committee; Cancer Committee; Perinatal Morbidity and Mortality Committee; Pharmacy and Therapeutics Committee; Quality Improvement Patient Safety Committee; Surgical Services Committee; Tissue and Transfusion Committee; all committees, subcommittees and task forces created pursuant to these Bylaws; all Departments and Sections of the Medical Staff and their committees; any subcommittee or committee participating in a credentialing, recredentialing, investigative or disciplinary matter; any individual gathering information or providing services for or

acting on behalf of any such committee, subcommittee or entity; and the Board and its committees and subcommittees when acting on Medical Staff, quality review, or related matters, are serving as Medical Review Committees as defined in Section 19a-17b of the Connecticut General Statutes, as amended from time to time.

Any time that a committee is engaged in activities related to the evaluation and improvement of the quality and efficiency of services ordered or performed by a Physician, only Physician members of such committee shall participate in such activities and deliberate and vote on such matters, provided, however, that nothing contained herein shall prevent the attendance of witnesses or other individuals possessing information relevant to the matters being considered by the committee for purposes of providing such information, testimony or advice to such committee.

### 9.1.1 COMPOSITION OF AND APPOINTMENT TO COMMITTEES

All committees' members and chairs, other than those of the MSEC and MSC and as otherwise specifically provided in this Article, shall be appointed by the President of the Medical Staff and shall have at least three (3) Medical Staff members, representing a cross-section of the Medical Staff's Departments and Sections. If possible, and at the discretion of the President of the Medical Staff, Practitioners will be given the opportunity to serve on the committees of their choice. However, all Practitioners shall be required to participate in committee work and may be excused only due to extenuating circumstances with the approval of the President of the Medical Staff. Committee members and chairs shall serve at the pleasure of the President of the Medical Staff until a successor is appointed.

### 9.1.2 ACTION THROUGH SUBCOMMITTEES

Any standing committee may elect to perform any of its specifically designated functions by constituting any number of its members as a subcommittee for that purpose. Any such subcommittee may include individuals in addition to members of the standing committee. Such additional members shall be appointed by the committee chair after consultation with the President of the Medical Staff

### 9.1.3 SUBSTITUTION

At any time it deems it necessary and desirable for the proper discharge of the functions required of the Medical Staff by these Bylaws and the bylaws and policies of the Hospital, the MSEC may establish, eliminate or merge standing or special committees, change the functions of a committee, or assign the function to the Medical Staff as a whole.

### 9.1.4 VOTING

Notwithstanding anything to the contrary contained herein regarding the composition of committees, only Active Staff members shall be eligible to vote at any meeting of a committee or a subcommittee thereof, provided, however, that nothing contained herein shall prevent the attendance of witnesses or other

individuals possessing information relevant to the matters being considered by the committee for purposes of providing such information, testimony or advice to such committee.

## 9.2 MEDICAL STAFF COUNCIL (MSC)

### 9.2.1 PURPOSE AND DUTIES

The MSC shall be empowered to represent and act for the Medical Staff and to coordinate all activities and policies of the Medical Staff and its Departments, Sections and committees, subject to such limitations as may be imposed by the Medical Staff or these Bylaws. It shall meet at least eight (8) times per year, keep a permanent record of its proceedings, decisions and actions and communicate its decisions and actions that affect or define Medical Staff policies, rules or positions by periodic written summary reports. Such reports shall be available to all members of the Active Medical Staff. These reports shall include abstracts of Department, Section and committee reports submitted to the MSC, together with the actions taken by any of said groups and whether such actions were approved, modified or rejected by the MSC. Such summary reports also shall be provided to the Board and Hospital administration.

A report of each MSC meeting shall be distributed to all Department Chairs and presented at the next Department meeting.

Active Staff members representing ten percent (10%) of the voting membership of the Medical Staff may request, by a signed written petition, that an action taken by the MSC be considered by the Medical Staff for overturn. Such petition must be sent to the President of the Medical Staff within fourteen (14) days following the date of the MSC action. Such matter shall then be submitted for a vote at the next regular Medical Staff meeting or at a special meeting called for the purpose of considering the matter. The affirmative vote of two-thirds (2/3) of the Active Staff members eligible and qualified to vote shall be required to overturn an action of the MSC. Upon such affirmative vote, the action of the MSC shall be null and void as if it had not been taken. Nothing herein shall be construed as preventing the MSC from reconsidering the issues prompting the action and taking alternative action.

The MSC shall be responsible for:

(a) Making recommendations directly to the Board for its approval concerning: structure of the Medical Staff; mechanisms used to review credentials and delineate individual Clinical Privileges; individuals for Medical Staff and APP Staff membership; delineated Clinical Privileges; participation in quality improvement activities by the Medical Staff and mechanisms to conduct, evaluate, and revise such activities; the mechanisms by which interventions may be initiated and corrective actions may be taken in accordance with Article Ten; and the mechanisms for hearing and review of certain actions in accordance with Article Eleven.

(b) Receiving, coordinating and acting upon the reports and recommendations from Departments, Sections, committees, other assigned activity groups and offices concerning the functions assigned to them and the discharge of their delegated responsibilities.

(c) Assuming responsibility for the overall quality improvement patient safety program of the Medical Staff, receiving reports from the Quality Improvement Patient Safety committee(s) concerning these activities, and accounting to the Board and to the Medical Staff by written reports for the overall quality and efficiency of patient care rendered by Medical Staff members and APPs in the Hospital, as specified in the Hospital's and Medical Staff's quality improvement plan(s).

(d) Making recommendations on medico-administrative and Hospital's management matters.

(e) Informing the Medical Staff of the accreditation program and the accreditation status of the Hospital.

(f) Enforcing the Bylaws and the Rules and Regulations, including without limitation by initiating and overseeing investigations and the corrective action process in accordance with Article Ten.

9.2.2 COMPOSITION

The MSC shall consist of:

(a) The officers of the Medical Staff.

(b) Each Department Chair. In the event that the Department Chair is an officer of the Medical Staff, the Chair shall appoint a member from the Department to serve as the Department's representative on the MSC.

(c) The Section Chief for those Sections with greater than thirty (30) Active Medical Staff members at the time of the Annual Meeting.

(d) For those Departments with greater than thirty (30) Active Medical Staff members at the time of the Annual Meeting, one (1) extra member to be elected by the respective Department in even numbered years.

(e) Two (2) additional at-large members of the Medical Staff elected by plurality vote at the Annual Meeting in even numbered years.

9.2.3 VACANCY

In the event that a member of the MSC is unable to continue to serve during the course of a Medical Staff year for any reason, a new member shall be chosen in a manner similar to the manner in which the member being replaced was chosen,

following insofar as possible the provisions of these Bylaws setting forth the manner of selection.

#### 9.2.4 ATTENDANCE

Members of the MSC are required to attend a minimum of eighty percent (80%) of all regular MSC meetings in each calendar year. Failure to do so will be handled as follows: (1) if the delinquent member is a Department Chair, the President of the Medical Staff will notify the Department to elect a replacement representative for the remainder of the calendar year; (2) if the delinquent member is not a Department Chair, his replacement will be elected at the next regular Medical Staff meeting. At any regular or special meeting of the MSC, a quorum shall be fifty percent (50%) of the qualified members of the MSC.

Any delinquent removed member of the MSC is not eligible to be a representative on the MSC for at least one (1) calendar year following the election of his replacement.

All members of the Active/Senior Attending and Active/Senior Affiliate Attending Staff shall be eligible for membership on the MSC. The chair of the MSC shall be the President of the Medical Staff. The President of the Hospital, the chair of the Credentials Committee, the chair of the Quality Improvement Patient Safety Committee, the director of the Family Medicine Residency Program, the Chief Medical Information Officer, and the director of the Cancer Center shall be Ex Officio members without the right to vote. Representatives from Administration and the APP Staff may attend MSC meetings as invited guests at the discretion of the President of the Medical Staff.

#### 9.2.5 CONFLICTS OF INTEREST POLICY

Members of the MSC, as well as any Department Chairs and Section Chiefs not on the MSC, shall abide by the Conflicts of Interest policy adopted by the Hospital.

### 9.3 MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)

#### 9.3.1 PURPOSES AND DUTIES

The MSC shall have an Executive Committee that exercises the authority of the MSC in accordance with these Bylaws, and carries out such other duties as are set forth herein.

Specifically, the MSEC shall:

(a) Establish the agenda for meetings of the Medical Staff and the MSC.

(b) Draft appropriate policies to be presented to the Medical Staff and to the MSC.

(c) Review problems and issues facing the Medical Staff and recommend appropriate action.

(d) Interpret and implement MSC actions, interpret the Bylaws and the Rules and Regulations, and resolve any disputes concerning the interpretation of the Bylaws and the Rules and Regulations in consultation with the MSC.

(e) Review and recommend action with respect to quality of care issues presented to it by Departments, Sections, committees of the Medical Staff, and governmental or other outside agencies. Such activity shall be conducted and maintained on a confidential basis consistent with the requirements of these Bylaws and of applicable law.

(f) Strive to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff members and APPs, including initiating investigations and initiating and pursuing corrective action, when warranted.

(g) Act on behalf of the MSC between meetings of the MSC in regard to all matters requiring immediate action including, but not limited to, suspensions and investigations.

(h) Consult and advise the Hospital with respect to contracting in the following manner:

1. Whenever the Hospital intends to terminate any agreement with a physician or group of physicians for the providing of services to patients, the Hospital first shall provide reasonable advance notice to and consult fully with the MSEC.

2. In the event that the MSEC is of the view that a termination is not appropriate and so advises the Hospital, but the Hospital continues to intend to terminate the agreement, the MSEC may request that the JCC consider the matter and make a recommendation to the Board.

3. Requests to the JCC should be in writing and should set forth the views of the MSEC.

4. A copy of the JCC recommendation shall be provided to the Hospital.

(i) Serve as the nominating committee responsible for preparing and presenting a slate of candidates to the Medical Staff for election as Medical Staff officers and MSC representatives.

(j) Serve as the Medical Staff Multidisciplinary Peer Review Committee for oversight and direction of the Medical Staff quality improvement program and peer review processes.

### 9.3.2 COMPOSITION

The MSEC will consist of the officers of the Medical Staff and two (2) representatives elected from the MSC. These two (2) representatives will be elected in the first MSC meeting of each year by the members of the MSC from its membership. Each will serve a one-year term. The two (2) representatives should represent Departments other than those represented by the officers of the Medical Staff. These two representatives may not come from the same Department. Of the five (5) members of the MSC, there shall be representatives from the Departments of Family Medicine, Medicine, and Surgery. (If the officers of the Medical Staff are not representative of the three required Departments, an additional representative from the MSC will be elected to satisfy this requirement, increasing the MSEC membership to six (6) members.) Other persons deemed necessary for the proper function of the MSEC may be invited to attend meetings but shall not vote. At any regular or special meeting of the MSEC, a quorum shall be fifty percent (50%) of the qualified members of the MSEC. The President of the Hospital or their designee shall attend each meeting of the MSEC as an Ex Officio member without vote. Members are required to attend three-fourths (3/4) of all meetings. Failure to meet the attendance requirements will be addressed by the President of the Medical Staff. The MSEC shall meet regularly. The President of the Medical Staff may call emergency meetings of the MSEC.

## 9.4 JOINT CONFERENCE COMMITTEE (JCC)

The Joint Conference Committee shall consist of five (5) members of the Board of Directors appointed or elected in accordance with the Bylaws of the Hospital, and all members of the MSEC. This committee shall serve as a liaison between the Medical Staff, the Board, and the President of the Hospital, and shall advise on problems of mutual interest. Its primary function shall be to provide a forum for conflict resolution and to promote better understanding and cooperation between the Board and the Medical Staff. This committee shall review and report upon any matter regarding Medical Staff membership or Clinical Privileges that is submitted to the committee for review in accordance with these Bylaws. Meetings shall be held on a regular basis. Special meetings may be called by the Chair of the Board, by the President of the Medical Staff, by the President of the Hospital, or upon request of any three (3) members of the JCC.

## 9.5 MEDICAL ETHICS COMMITTEE

### 9.5.1 PURPOSES AND DUTIES

The Medical Ethics Committee shall be actively involved in the education of the Medical Staff and nursing and ancillary Hospital staff in the field of medical ethics. Educational efforts shall also be extended to the community when appropriate. The committee shall assist in policy development and keep abreast of advances in health care law and medical ethics. It shall be available for consultation on individual cases as requested by the Medical Staff and nursing and hospital staff, as well as patients and their families. The committee shall assist in those cases to help identify and clarify bioethical issues. It shall meet as often as necessary, but at least quarterly.

### 9.5.2 COMPOSITION

The Medical Ethics Committee shall consist of no more than four (4) Physicians knowledgeable and interested in ethics whose knowledge would have clinical application and three (3) representatives from nursing services. In selecting these committee members, it is desirable to have persons from areas that generate higher numbers of ethical referrals, such as Critical Care, the Emergency Department, and the Hospital Medicine Section. In addition, there shall be up to four (4) representatives from Hospital staff including Social Work and Chaplaincy. There shall also be one (1) representative from Hospital administration and one (1) representative from the Board. There shall be up to four (4) representatives from the community at large, which may include such representatives as an attorney from the community, an educator with special expertise in ethics, and/or consumers who represent significant segments of the community. All are voting members. Others may be invited to serve as non-voting participants who bring special expertise or points of view that would enhance the work of the committee.

## 9.6 BYLAWS COMMITTEE

### 9.6.1 PURPOSES AND DUTIES

The Bylaws Committee shall fulfill Medical Staff responsibilities relating to revision of Medical Staff Bylaws and Rules and Regulations by conducting ongoing review of the Bylaws and Rules and Regulations, and submitting written recommendations to the MSC and to the Board for changes in these documents. It shall meet as often as necessary, and shall be responsible to the MSC.

### 9.6.2 COMPOSITION

The Bylaws Committee shall include the membership of the MSEC. The Secretary/Treasurer shall serve as chair.

## 9.7 CANCER COMMITTEE

### 9.7.1 PURPOSES AND DUTIES

The Cancer Committee shall oversee the functioning of the Cancer Center and its responsibilities including the following:

(a) Maintain a functioning tumor registry.

(b) Conduct multidisciplinary cancer conferences in which the diagnosis and treatment of cancer cases shall be reviewed and general recommendations will be developed. A written report will be forwarded to the physicians involved in that patient's care.

(c) Generate criteria concerning diagnosis, broad concepts of treatment, and standards for follow-up and rehabilitation of patients with neoplasms

according to tumor site in concordance with evidence based standards. The committee shall review the application of the above criteria and standards, which shall be revised as necessary or appropriate.

(d) Presentations shall be made to leadership as requested. Minutes of Cancer Committee meetings will be available.

### 9.7.2 COMPOSITION

The Cancer Committee shall include, but is not limited to, the Cancer Committee Chair and Cancer Liaison Physician, as well as physician representatives from Radiology, Pathology, Surgery, Medical Oncology, and Radiation Oncology. The committee shall also include, but is not limited to, non-physician members, including representatives from Cancer Program Administration, Oncology Nursing, Social Work, and a certified tumor registrar/oncology data specialist. Additionally, the Committee will include required coordinators in the areas of Cancer Conference, Quality Improvement, Cancer Registry, Clinical Research, Psychosocial Services and Survivorship. Representation is outlined by the American College of Surgeons Commission on Cancer. All are voting members. The committee shall meet regularly but at least quarterly.

## 9.7A BREAST PROGRAM LEADERSHIP COMMITTEE

### 9.7A.1 PURPOSES AND DUTIES

The Breast Program Leadership Committee shall oversee the functioning of the Middlesex Health Comprehensive Breast Program and its responsibilities including the following:

(a) Function according to the guidelines set forth by the National Accreditation Program for Breast Centers (NAPBC).

(b) Conduct multidisciplinary breast cancer conferences in which the diagnosis and treatment of breast cancer cases shall be reviewed and general recommendations will be developed. Case summaries will be available in the electronic health record.

(c) Generate criteria concerning diagnosis, broad concepts of treatment, and standards for follow-up and rehabilitation of patients with breast cancer in concordance with evidence based standards. The committee shall review the application of the above criteria and standards, which shall be revised as necessary or appropriate.

### 9.7A.2 COMPOSITION

The Breast Program Leadership Committee shall include at least three physician members representing three different medical disciplines, one of which must be the Breast Program Director. Examples of physician member disciplines include, but are not limited to, Radiology, Pathology, Surgery, Medical Oncology, and Radiation Oncology. The committee members may include, but are not limited to, representatives from Physical Medicine,

Genetic professionals, Certified Tumor Registrars/Oncology Data Specialists, Research, Nursing, Social Work, Hospital Administration. Representation is outlined by the National Accreditation Program for Breast Centers (NAPBC). All are voting members. The committee shall meet regularly but at least quarterly.

## 9.8 CLINICAL OVERSIGHT COMMITTEE

### 9.8.1 PURPOSES AND DUTIES

The Clinical Oversight Committee shall:

(a) Review existing clinical services by Department.

(b) Determine which services and procedures need to be added or expanded within Middlesex Health System.

(c) Adjudicate disputes between physicians or physician groups regarding the performance of procedures.

Specifically, the Clinical Oversight Committee shall review in detail services and procedures offered by the Departments to determine whether all services performed remain appropriate and relevant to the Hospital's mission. It may make recommendations, in the form of its annual report, to eliminate or modify existing services. It may also elect to suggest the implementation of new clinical procedures and services or strategies to improve the clinical excellence of the Hospital. When several suggestions are made, the committee shall rank such suggestions by priority.

The Clinical Oversight Committee shall review all new services or major modifications of existing services prior to their implementation. The committee shall give consideration to:

(a) The relevance or appropriateness of the procedure;

(b) Proven efficacy of the procedure, with reference to evidence-based literature;

(c) Safety and risks of the procedure;

(d) Probability of financial, material, or staffing problems; and

(e) The possibility that the new procedure may replace current procedures or affect other Medical Staff members.

The Clinical Oversight Committee shall be empowered to arbitrate and adjudicate disputes that arise between individual physicians, Sections or Departments around the performance of specific procedures, especially when a new procedure may affect the frequency with which an existing procedure is performed or where a new procedure performed by one physician group may replace a procedure performed by another physician group. The committee shall act upon receiving a formal petition for a

review from any physician or physician group.

First, every effort shall be made to negotiate a compromise acceptable to both parties. If negotiation is not successful, the committee may hold a formal hearing to determine which physician or physician group shall be given priority, or whether both parties may share the procedure. Careful, reasoned input shall be sought from both parties and other interested physician groups. The decision shall give careful consideration to several factors, including:

(a) The relevance or superiority of a new procedure which may be replacing an existing procedure.

(b) The training, competence and experience of the parties.

(c) The system wide implications of the decision.

Upon reviewing the evidence, the Committee shall make a formal recommendation to the MSC.

### 9.8.2 COMPOSITION

The Clinical Oversight Committee will consist of the Chairs of all the Medical Staff Departments or their designees and members of Hospital administration appointed by the President of the Hospital. A chairperson of the Clinical Oversight Committee shall be appointed by the President of the Medical Staff. Meetings will be called as required to perform the duties of the committee. The committee shall prepare periodic reports to the MSC.

## 9.9 COMMITTEE ON PROVIDER HEALTH

### 9.9.1 PURPOSES AND DUTIES

The Committee on Provider Health is a peer review committee designed to evaluate and advise, separate from actions taken for disciplinary purposes, on matters related to impairment, dysfunction and/or inability of a Practitioner or APP to practice medicine with reasonable skill and safety because of physical illness or mental illness or behavioral/disruptive issues, excessive use or abuse of drugs (including alcohol), or loss of motor skill through illness or the aging process. Meetings shall be called by the chair as needed. Emergency meetings may be called by the chair or any two (2) members of the committee.

Specifically the Committee on Provider Health shall:

(a) Conduct a review as promptly as possible.

(b) As appropriate, report applicable findings to the MSEC.

(c) Comply with and enforce the Medical Staff's Provider Health Policy.

(d) Educate the Medical Staff and other staff about illness and impairment recognition issues specific to Practitioners and APPs.

(e) Accept self-referrals by Practitioners and APPs and referrals to the committee by others.

(f) As appropriate, refer affected Practitioners and APPs to the appropriate internal or external professional resources for diagnosis and treatment of the condition or concern.

(g) Maintain the confidentiality of the Practitioner or APP seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the well-being or safety of a patient, staff member, or others may be threatened.

(h) Evaluate the credibility of any complaint, allegation or concern brought to the attention of the committee.

(i) Monitor or assist in the monitoring of the affected Practitioner or APP until the rehabilitation or any disciplinary process is complete.

In performing its duties, the committee shall have the authority by a vote of at least two-thirds (2/3) of its members to direct that a Practitioner or APP be examined by an independent Practitioner designated by the committee. The Hospital shall pay the cost of any such evaluation and the Practitioner or APP who is to be evaluated shall agree that the independent Practitioner's report shall be provided to the committee. Any Practitioner or APP who refuses to cooperate with the committee in this regard shall be referred to the MSEC for consideration of other action including action pursuant to Article Ten of the Bylaws.

### 9.9.2 COMPOSITION

The Committee on Provider Health shall include three (3) Medical Staff representatives appointed by the President of the Medical Staff from each of the Departments of Medicine, Surgery, and Psychiatry, and two (2) Medical Staff representatives from other Departments. The President of the Medical Staff shall appoint the chair.

## 9.10 CONTINUING MEDICAL EDUCATION COMMITTEE

### 9.10.1 PURPOSES AND DUTIES

The Continuing Medical Education Committee shall coordinate the various Medical Staff, Department and Section educational activities and recommend policies concerning postgraduate medical training, continuing Medical Staff education and the Hospital's medical library. The committee shall meet quarterly or more frequently as need requires and shall be responsible to the MSC.

Specifically, the Continuing Medical Education Committee shall:

(a) Develop, plan, implement and evaluate programs of, and requirements for, continuing education that are relevant to the type and scope of patient care services delivered in Hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to quality improvement findings.

(b) Supervise the Hospital medical library services, including approval of printed and electronic information services.

(c) Work with the approved State Medical Society or ACCME and other professional organizations to ensure the members of the Medical Staff receive continuing education credit for attending the Hospital-sponsored activities.

(d) Maintain a written record of educational activities and Medical Staff and APP Staff member participation in them.

(e) Submit written minutes and/or reports, identifying items needing MSC action, at least quarterly to the MSC.

### 9.10.2 COMPOSITION

The Continuing Medical Education Committee shall include the Director of Medical Education; representatives from the Departments of Family Medicine, Obstetrics and Gynecology, Medicine, Pathology, Surgery; the Director of the Family Medicine Residency Program; at least two (2) other members of the Medical Staff; and one (1) representative from each of the Quality Improvement Patient Safety Committee and Hospital administration. All are voting members.

## 9.11 GRADUATE MEDICAL EDUCATION COMMITTEE

### 9.11.1 PURPOSES AND DUTIES

The Graduate Medical Education (GME) Committee shall oversee graduate medical education at the Hospital in compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements.

Specifically, the Graduate Medical Education Committee shall:

(a) Provide oversight of ACGME accreditation of both the Hospital and its residency and fellowship programs, the quality of the institutional learning and working environment, the quality of educational experiences, program evaluation and improvement processes, and all processes related to reduction or closure of individual programs, participating sites, and the sponsoring institution.

(b) Review and approve institutional GME policies and procedures, applications for accreditation of new programs, permanent changes in resident or fellow complement, major changes in structure or duration of education, appointment of new program directors, progress reports to the ACGME, and other requirements as outlined in the ACGME Institutional Requirements.

(c) Demonstrate effective oversight of ACGME institutional accreditation through performance of an Annual Institutional Review (AIR) in accordance with the ACGME Institutional Requirements, and submission of a written Executive Summary of the AIR annually to the MSC and Hospital Board of Directors.

(d) Demonstrate oversight of underperforming programs through a special review process in accordance with ACGME Institutional Requirements.

(e) Meeting at a minimum once every quarter. Each meeting must include attendance by at least one (1) resident or fellow.

(f) Submit written minutes at least quarterly to MSC.

#### 9.11.2 COMPOSITION

The Graduate Medical Education Committee shall include at a minimum the ACGME Designated Institutional Official, Director of all residency and fellowship programs; the Vice President for Safety and Quality; a minimum of two (2) peer-selected residents from each program; and one (1) or more physicians from Departments other than Family Medicine who are actively involved in graduate medical education.

### 9.12 CREDENTIALS COMMITTEE

#### 9.12.1 PURPOSES AND DUTIES

The Credentials Committee shall coordinate the Medical Staff credentials function and shall be responsible to the MSC.

Specifically, the Credentials Committee shall:

(a) Review, investigate and fully consider the credentials and qualifications of all applicants for all Medical Staff appointments and reappointments, make recommendations for Medical Staff membership, make assignments to clinical Departments, and delineate Clinical Privileges consistently in compliance with the provisions of these Bylaws.

(b) Issue a report to the MSC on each applicant for Medical Staff membership or reappointment or Clinical Privileges, including specific consideration of the recommendations from the Department or Departments in which the applicant requests privileges.

(c) Assure that a credentials file is maintained for each member of the Medical Staff and each APP, including records of participation in Medical Staff activities and results of quality improvement activities.

### 9.12.2 COMPOSITION

The Credentials Committee shall consist of the Secretary/Treasurer of the Medical Staff, one (1) Medical Staff representative from each Department appointed by the President of the Medical Staff, and a representative from Hospital administration. The representative from Hospital administration serving on this committee shall be a non-voting member of the committee. The Chief Nursing Officer and an APP representative appointed by the President of the Medical Staff may be invited as a non-voting member for those discussions related specifically to APP credentialing. The Credentials Committee shall meet regularly but at least quarterly.

## 9.13 CRITICAL CARE COMMITTEE

### 9.13.1 PURPOSES AND DUTIES

The Critical Care Committee shall oversee critical care services and the critical care unit at the Hospital. The committee shall meet at least quarterly, and shall be responsible to the MSC.

The Critical Care Committee responsibilities include the following:

(a) Strive to ensure that the quality, safety, and appropriateness of patient care services provided by the critical care unit is evaluated on a regular basis and that appropriate action is taken based on the findings of the review activities.

(b) Be responsible for assisting with triage and disposition of patients when patient load exceeds optimal operational capacity.

(c) Establish criteria for admission to and discharge from the critical care and intermediate care units.

(d) Make recommendations for acquisition of all equipment for the critical care units.

(e) Develop a program of education in the disciplines of critical care.

(f) Provide medical input and guidance to critical care nurses in the development of patient care policies and guidelines.

(g) Serve as a liaison between admitting Physicians and members of the critical care staff.

### 9.13.2 COMPOSITION

The Critical Care Committee shall include the Medical Director of the critical care unit, as well as one (1) additional representative from each of the following Departments: Anesthesiology, Medicine, Surgery, Family Medicine, and Emergency Medicine. All are voting members. Also, two (2) representatives from the Nursing Department, and one (1) representative from Hospital administration shall serve on the committee without a vote. The director(s) of nursing, supervisor(s) of the units, the nurse managers of the units and special care unit(s) staff nurse(s) may serve as Ex Officio members without a vote.

## 9.14 HEALTH INFORMATION MANAGEMENT COMMITTEE

### 9.14.1 PURPOSES AND DUTIES

The Health Information Management Committee shall develop and implement policies for the Hospital's health information services. This committee shall meet quarterly or more frequently as need requires and shall be responsible to the MSC.

Specifically, the Health Information Management Committee shall:

(a) Provide oversight of systems, policies and processes aimed at ensuring that all health information (electronic and paper-based medical records) is kept confidential as required by law and meets high standards for patient care, usefulness, and scientific value. The committee shall oversee systems, policies and processes which are designed to ensure that both electronic health information systems and paper-based medical records reflect accurate documentation of medical events, and that this documentation is timely, relevant, and complete.

(b) Oversee the Health Information Management Forms subcommittee and make recommendations concerning forms, format, and use of both electronic and paper-based medical record information.

(c) Review medical records and electronic health information to determine the overall quality of documentation, as measured by the promptness of completion, adequacy, and completeness.

(d) Advise and develop policies to guide the Director of Health Information Management.

### 9.14.2 COMPOSITION

The Health Information Management Committee shall include at least three (3) representatives from the Medical Staff, as well as representatives from Health Information Services, Information Technology Services, Nursing, Quality Improvement, Finance, and Hospital administration. All are voting members.

## 9.15 INFECTION COMMITTEE

### 9.15.1 PURPOSES AND DUTIES

The Infection Committee at the Hospital shall be responsible for oversight of infection potentials, review and analysis of actual infections and the development and implementation of a preventive and corrective program designed to minimize infection hazards. This committee shall meet at least monthly and shall report by the submission of written minutes to the MSC.

Specifically, the Infection Committee shall:

(a) Develop a system for reporting, identifying and analyzing the incidence and cause of all infections.

(b) Develop, evaluate and review preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities including: operating rooms, delivery rooms and special care units; central sterile services, housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested.

(c) Evaluate sterilization procedures.

(d) Evaluate isolation procedures.

(e) Recommend methods of prevention of cross-infection by anesthesia apparatus and respiratory therapy equipment.

(f) Investigate Hospital personnel for carrier status, as required.

(g) Make recommendations regarding the disposal of infectious material.

(h) Review and present findings and recommendations concerning the use of antibiotics and develop criteria for the prophylactic and therapeutic use of antibiotics.

(i) Monitor the sensitivity of all organisms and issue reports on a regular basis. The chair of the Infection Committee and the Hospital epidemiologist shall have the authority to institute or remove isolation measures, to order laboratory procedures for diagnosis of infectious disease, and to direct environmental sampling whenever indicated. These personnel have the authority to impose special medical isolation or quarantine when appropriate.

### 9.15.2 COMPOSITION

The Infection Control Committee shall include at least one (1) Physician representative from each of the Departments of Medicine, Surgery, Pathology, and Family Medicine, and representatives from the laboratory, Hospital administration, Nursing, Pharmacy, Infection Control, and the Hospital epidemiologist. All shall be voting members.

## 9.16 PERINATAL MORBIDITY AND MORTALITY COMMITTEE

### 9.16.1 PURPOSES AND DUTIES

The duties of the Perinatal Morbidity and Mortality Committee shall be to improve perinatal survival in this Hospital through documentation and analysis of all cases of perinatal morbidity and mortality. The committee shall meet at least quarterly and report periodically on its findings and recommendations to the MSC. Questions involving management of individual cases shall be referred to the Department in which the involved physician is a member for review through the Departmental quality improvement process.

### 9.16.2 COMPOSITION

The committee shall consist of at least one (1) Medical Staff member of each of the following Departments: Obstetrics, Pediatrics, and Family Medicine. In addition, representatives of the Obstetrical Nursing staff and Quality Improvement shall be included in the committee's membership. All of the previously mentioned members shall be voting members. On an ad hoc basis, Medical Staff members of the Department of Anesthesiology and Pathology will also be represented. The members shall be appointed by the President of the Medical Staff. The committee shall meet regularly but at least quarterly.

## 9.17 PHARMACY AND THERAPEUTICS COMMITTEE

### 9.17.1 PURPOSES AND DUTIES

The Pharmacy and Therapeutics Committee shall fulfill Medical Staff functions relating to pharmacy and therapeutics including receiving reports and following up on deficiencies identified. It shall meet quarterly or more frequently as need requires and shall be responsible to the MSC.

Specifically, the Pharmacy and Therapeutics Committee shall:

(a) Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital.

(b) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, and other matters relating to drugs in the Hospital.

(c) Serve as an advisory group to the Medical Staff and Pharmacy on matters pertaining to the choice of available drugs.

(d) Prevent unnecessary duplication in the procurement and inventory of drugs.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Oversee the Nutrition Support Subcommittee, established as a multidisciplinary subcommittee, to develop policies and procedures for enteral and parenteral nutrition. This subcommittee is responsible for establishing guidelines and monitoring compliance with enteral tube feedings, specialized oral feedings, and parenteral alimentation. The subcommittee will maintain and monitor the standards and utilization of nutrition as part of the methodology in the treatment of disease and make recommendations regarding monitoring of patients receiving nutritional support services.

(i) Oversee the Antimicrobial Stewardship Program (ASP), an interdisciplinary subcommittee, which develops policies and processes to ensure optimal antimicrobial use across the health system. This subcommittee is responsible for developing and maintaining approved protocols for treatment of infectious diseases, evaluating antimicrobial use in order to optimize therapy and reduce antimicrobial resistance (and other unintended consequences of antimicrobial use), and educating providers, nursing, and pharmacists on antimicrobial stewardship practices. The subcommittee will review new drugs for potential addition to the MH drug formulary and collaborate with Pharmacy and Infectious Disease on appropriate strategies for managing antimicrobial drug shortages. The ASP chair and pharmacist are responsible for reporting on antibiotic usage, rates of IV-to-PO conversions, days of therapy (DOT), and trends in multi-drug resistant organisms (MDROs) to the Antimicrobial Stewardship subcommittee, P&T Committee, and other committees as appropriate.

h) Review, coordinate and recommend changes to Hospital, Medical Staff, Department and Section rules, regulations, policies and procedures regarding the evaluation, appraisal, selection procurement, storage, distribution, use, safety procedures and all other matters relating to pharmaceuticals and isotopes in Hospital, at least once every three (3) years.

(i) Develop and review periodically a formulary for use in Hospital, prescribe the necessary operating rules and regulations for its use, and assure that said rules and regulations are available to and observed by all Medical Staff members.

(j) Review all unexpected drug reactions and review significant medication errors.

(k) Submit written minutes and/or reports, identifying those items needing MSC action at least quarterly to the MSC and the Quality Improvement Patient Safety Committee of the Medical Staff concerning drug utilization policies and practices in the Hospital.

9.17.2 COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least three (3) representatives of the Medical Staff and one (1) representative each from Pharmacy Services, the Nursing Department, and Hospital administration. In addition, the Director of Pharmacy Services shall be a member of and act as secretary for the Committee. All are voting members.

## 9.18 QUALITY IMPROVEMENT PATIENT SAFETY COMMITTEE

### 9.18.1 PURPOSES AND DUTIES

The Quality Improvement Patient Safety Committee shall be responsible for monitoring the performance improvement activities of the Medical Staff Departments, Sections, clinical support services, and committees having Hospital-wide quality improvement and patient safety functions. Monitoring activities shall be conducted in accordance with the Hospital Quality Improvement Patient Safety Plan.

The committee shall develop a written Hospital Quality Improvement Patient Safety Plan (the "Plan"). The Plan shall set forth its objectives and scope, and the mechanisms to be used to monitor effective implementation. The Plan shall be reviewed at least annually by the Board of Directors and revised whenever necessary. Copies of the Plan shall be distributed to all Departments.

The Quality Improvement Patient Safety Committee shall coordinate and monitor the Medical Staff data-gathering and analysis components of the Hospital's quality improvement patient safety program(s) and develop the Medical Staff Quality Improvement Patient Safety Plan. The committee shall review the Medical Staff's quality improvement and patient safety activities annually for effectiveness, comprehensiveness, integration, and cost efficiency. The committee shall meet at least quarterly and shall send reports and minutes to the Board of Directors and to the MSEC and MSC.

Specifically, the Quality Improvement Patient Safety Committee shall:

(a) Review and oversee the quality improvement and patient safety activities of all Departments, Sections and committees through reports and assessment procedures. The committee's report or minutes shall reflect its findings on the quality and safety of care provided by Departments and Sections.

(b) Identify problems and make recommendations for follow-up to the Departments and Sections of the Medical Staff and, through its chair, communicate to the Departments and Sections any concerns relating to quality and appropriateness of assessments.

(c) Respond to issues identified by Hospital administration which are medical in nature or have potentially significant impact upon medical care.

9.18.2 COMPOSITION

The composition of the committee shall be set forth in the Hospital Quality Improvement Patient Safety Plan. The President of the Medical Staff shall designate a member of the Active Medical Staff as chair.

9.19 SURGICAL SERVICES COMMITTEE

9.19.1 PURPOSES AND DUTIES

The Surgical Services Committee will serve as a forum for discussion of issues relevant to surgical services, including the Operating Room, Outpatient Surgery Department**,** the Outpatient Surgery Center, and all post anesthesia care units. The committee shall meet quarterly or more frequently as need requires and shall be responsible to the MSC.

Specifically, the Surgical Services Committee shall:

(a) Develop policies and rules and regulations relating to the management and function of surgical services.

(b) Monitor quality improvement activities and risk management activities related to surgical services.

(c) Initiate and refine long range planning for surgical services.

(d) Participate in and contribute to the Hospital's budget process.

(e) Communicate and collaborate with nursing staff in decisions and policies concerning staffing and performance.

(f) Establish and maintain a current roster of surgical Clinical Privileges granted to each member of the Medical Staff.

9.19.2 COMPOSITION

The Surgical Services Committee shall consist of the Chairs of the Departments of Surgery and Anesthesiology, the Section Chiefs of all Sections of the Department of Surgery (including General Surgery, Neurosurgery, Ophthalmology, Oral Maxillofacial Surgery/Dental Medicine, Orthopedics, Otolaryngology, Plastic Surgery, Podiatry**,** Urology, Vascular Surgery), the Section Chief of Gastroenterology, a Medical Staff representative of the Department of Obstetrics/Gynecology, as well as the Director of Outpatient Surgery, the Director of the Surgical Services, the Clinical Coordinator of the Operating Room, the Clinical

Coordinator of the Surgery Center, and the Vice President of Nursing. A Medical Staff representative from the Department of Radiology is encouraged to attend. The Chair of the Department of Surgery or, if the Chair of the Department of Surgery is unable to serve, the Chair of the Department of Anesthesiology will be the chair of the Surgical Services Committee. All shall be voting members.

## 9.20 TISSUE AND TRANSFUSION COMMITTEE

### 9.20.1 PURPOSES AND DUTIES

The Tissue and Transfusion Committee shall:

(a) Determine the correlation between preoperative and postoperative pathology diagnoses. This review shall also render an opinion on whether surgical care management was within acceptable limits of proper surgical and medical practice.

(b) Review all procedures involving tissue removal, and determine whether there were approved indications for the procedures.

(c) Monitor the blood bank. The review shall include inventory control, evaluation of blood wastage, evaluation of blood transfusions based on established indicators, and evaluation of transfusion reactions.

(d) Act as an advisory committee to the laboratory in the development and review of blood bank policies and procedures.

(e) Meetings shall be held at least quarterly and written minutes and/or reports, identifying those items needing MSC action, shall be submitted to the MSC.

Opinions with respect to discrepancies uncovered by the committee shall be brought to the attention of the Physician responsible for the case. Physicians involved shall provide adequate explanation to the Tissue and Transfusion Committee before its next regular meeting. Cases with serious discrepancies or inadequate explanation shall be referred to the monthly meeting of the appropriate Department for discussion.

### 9.20.2 COMPOSITION

The Tissue and Transfusion Committee shall consist of a pathologist who shall be the chair of the committee, at least three (3) members of the Department of Surgery, one (1) member of the Department of Obstetrics and Gynecology, one (1) member of the Department of Medicine, and one (1) member of the Department of Family Medicine. All are voting members.

# ARTICLE 10. MEDICAL STAFF INTERVENTIONS AND ACTIONS

## 10.1 MEDICAL STAFF INTERVENTIONS

There are three (3) types of intervention (collegial intervention, discretionary intervention, and corrective action) which may be undertaken to address attitude, behavior and/or performance out of compliance with these Bylaws, the Rules and Regulations, applicable policies and standards of care, and applicable laws and regulations. The Medical Staff leadership will select the most appropriate intervention(s) depending upon the facts and circumstances. The interventions are independent and need not be progressive.

### 10.1.1 COLLEGIAL INTERVENTION

Collegial intervention is an informal communication between a Practitioner and a colleague under the direction of the Medical Staff leadership. Medical Staff leaders and Hospital administration should use collegial and educational efforts to address questions relating to an individual's clinical practice and professional conduct. The goal of collegial intervention is to arrive at voluntary, responsive actions. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders. The President of the Medical Staff in conjunction with the MSEC shall determine whether to direct a matter to be handled in accordance with another Section of the Bylaws, such as the corrective action process, or the Policy on Provider Health. The collegial intervention provided in this Section 10.1.1 is not a procedural right of the Practitioner and shall not be conducted according to the procedural rules provided in Article Eleven of these Bylaws. The Practitioner shall not be permitted to bring an attorney or other representative to interviews. All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional peer review activities.

### 10.1.2 DISCRETIONARY INTERVIEW PRIOR TO CORRECTIVE ACTION

Prior to initiating corrective action against a member of the Medical Staff, the initiating party may, but is not obligated to, afford the Practitioner a formal interview at which the circumstances prompting the corrective action shall be discussed and the Practitioner shall be permitted to present relevant information in the Practitioner's own behalf. A formal interview shall be initiated by Special Notice to the Practitioner from the Chair of the appropriate Department or President of the Medical Staff, with copies transmitted to the President of the Medical Staff and the members of the MSEC (if initiated by a Department Chair). The President of the Medical Staff may be present as an observer at a formal interview. If the Practitioner fails to respond to the Special Notice or declines to participate in the interview, corrective action shall immediately proceed in accordance with these Bylaws. The formal interview provided in this Section 10.1.2 is not a procedural right of the Practitioner and shall not be conducted according to the procedural rules provided in Article

Eleven of these Bylaws. The Practitioner shall not be permitted to bring an attorney or other representative to formal interviews.

10.1.3 CORRECTIVE ACTION

Whenever a member of the Medical Staff with Clinical Privileges engages in, makes or exhibits acts, statements, demeanor or professional conduct, either within or outside of the Hospital, and the same is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, disruptive to Hospital or Hospital operations or an impairment to the community's confidence in the Hospital, an evaluation of the possible need for corrective action or proceeding with corrective action against the Practitioner may be requested by an officer of the Medical Staff, by the Chair of any Department or Chief of any Section in which the Practitioner holds membership or exercises Clinical Privileges, by the President of the Hospital, or by the Board.

(a) REQUESTS AND NOTICES

All requests for corrective action shall be in writing, submitted to the MSEC, and supported by reference to the specific activities or conduct constituting the grounds for the request.

(b) INVESTIGATION

After deliberation, the MSEC shall either act on the request or direct that an investigation concerning the grounds for the corrective action request be undertaken. The MSEC shall conduct such investigation itself or assign this task to a Medical Staff officer, Department or Section, standing or ad hoc committee, or other organizational component of the Medical Staff. Expert assistance may be obtained to assist in an investigation. This investigative process is not a "hearing" as that term is used in these Bylaws for purposes of hearing and appellate review. It may include a consultation with the Practitioner involved and with the individuals who may have knowledge of the events involved. If the investigation is conducted by a group or individual other than the MSEC, that group or individual shall forward a written report of the investigation to the MSEC as soon as is practicable. Failure to submit information requested by the MSEC (or a Medical Staff officer, Department or Section, standing or ad hoc committee, or other organizational component of the Medical Staff) as part of an investigation within the time specified in the request shall result in voluntary relinquishment of Privileges and Medical Staff membership. The MSEC may at any time within its discretion, terminate the investigative process and proceed with action as provided below. If an investigation is conducted by the MSEC pursuant to a request or inquiry by the Board, the results of such investigation and recommendation shall be forwarded to the Board.

(c) MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within thirty (30) days after receipt of the request for corrective action,

unless deferred pursuant to Section 10.1.3(d) below, the MSEC shall act upon such request. Its action may, without limitation, recommend:

(1) Rejection of the request for corrective action.

(2) A warning or formal letter of reprimand.

(3) A probationary period with monitoring of cases but without special requirements of prior or concurrent consultation or direct supervision, including without limitation mandatory ongoing professional practice evaluation (OPPE) or focused professional practice evaluation (FPPE).

(4) Suspension of Membership Prerogatives that do not affect Clinical Privileges.

(5) Individual requirements of consultation or supervision.

(6) Reduction, suspension, or revocation of Clinical Privileges.

(7) Reduction of Medical Staff category or suspension or limitation of any Membership Prerogatives affecting Clinical Privileges.

(8) Suspension or revocation of Medical Staff membership.

(9) Further inquiry or other appropriate action.

A copy of any and all documentation related to the decision of the MSEC shall be retained in the Practitioner's permanent file and may be utilized in the reappointment process for such Practitioner.

(d) DEFERRAL

If additional time is needed to complete the investigative process, the MSEC may defer action on the request for good cause. A subsequent recommendation for any one (1) or more of the actions provided in Section 10.1.3(c) shall be made as promptly as possible.

## 10.2 SUMMARY SUSPENSION

### 10.2.1 SUMMARY SUSPENSION

The President of the Hospital, the chair of the Board, and the President of the Medical Staff, or their respective delegates, shall each have the authority to summarily suspend all or a portion of the Clinical Privileges or the Medical Staff membership of a Practitioner where the failure to take such an action could result in an imminent danger to the health of any individual. Such suspension shall become effective immediately upon imposition.

10.2.2 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as possible, but in any event within five (5) business days after a summary suspension is imposed, the MSEC shall convene to review and consider the action taken. The MSEC may recommend modification, continuation, or termination of the suspension.

10.2.3 PROCEDURAL RIGHTS

If the MSEC recommends immediate termination or modification of the suspension to one of the sanctions provided for in Section 10.1.3(c) (3) through (8), the Practitioner shall be entitled to the procedural rights contained in Article Eleven. If such procedural rights are exercised, the hearing and appellate review process concerning the summary suspension may be combined with the hearing and appellate review process for other related adverse actions.

10.2.4 OTHER ACTION

An MSEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights shall be transmitted immediately, together with all supporting documentation, to the chair of the Board and the President of the Hospital. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board, as applicable.

10.3 AUTOMATIC REVOCATION, RESTRICTION, SUSPENSION OR PROBATION

10.3.1 LICENSE

(a) Revocation: Whenever a Practitioner's license to practice in Connecticut is revoked or voluntarily relinquished, the Practitioner's Medical Staff membership and Clinical Privileges shall be immediately and automatically revoked without resort to the provisions of Article Eleven. If the license subsequently is restored or a new license is issued, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.

(b) Restriction: Whenever a Practitioner's license is partially limited or restricted in any way, those Clinical Privileges which had been granted that are within the scope of the limitation or restriction shall be similarly limited or restricted automatically. Further action on the matter shall proceed under Section 10.3.4.

(c) Suspension: Whenever a Practitioner's license is suspended, Medical Staff membership and Clinical Privileges shall be automatically suspended effective upon and for at least the term of the suspension. Further action on the matter shall proceed under Section 10.3.4.

(d) Probation: Whenever a Practitioner is placed on probation by a licensing authority, the Practitioner's voting and office-holding Membership

Prerogatives shall be automatically suspended effective upon and for at least the term of the probation. Further action on the matter shall proceed under Section 10.3.4.

(e) Non-Renewal: Whenever a Practitioner's license lapses because of non-renewal, as determined by the State of Connecticut, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended. Presentation of a valid license within ninety (90) days shall allow reinstitution of Medical Staff membership and Clinical Privileges if reinstatement is requested by the Practitioner in writing and granted pursuant to Section 10.3.4. After ninety (90) days, the Practitioner's Medical Staff membership and Clinical Privileges shall automatically terminate and upon reinstatement of the Practitioner's license, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.

(f) In the event of a revocation or suspension of Medical Staff membership or Clinical Privileges pursuant to this Section 10.3.1, the provisions of Article Eleven of these Bylaws shall not apply.

10.3.2. DEPARTMENT OF CONSUMER PROTECTION (DCP) AND DRUG ENFORCEMENT ADMINISTRATION (DEA)

(a) Revocation: Whenever a Practitioner's controlled substance registration with either the DEA or DCP is revoked or voluntarily relinquished, the Practitioner shall be immediately and automatically divested of the right to prescribe medications covered by the registration. Further action on the matter shall proceed under Section 10.3.4.

(b) Restriction: Whenever a Practitioner's controlled substance registration with either the DEA or DCP is partially restricted or limited in any way, the Practitioner's right to prescribe medications covered by the registration shall be similarly restricted or limited effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation. Further action on the matter shall proceed under Section 10.3.4.

(c) Suspension: Whenever a Practitioner's controlled substance registration with either the DEA or DCP is suspended, the Practitioner shall be divested of the right to prescribe medications covered by the registration effective upon and for at least the time of the suspension. Further action on the matter shall proceed under Section 10.3.4, below.

(d) Probation: Whenever Practitioner is placed on probation, insofar as the use of the controlled substance registration is concerned, action on the matter shall proceed under Section 10.3.4 below.

(e) Non-Renewal: Whenever a Practitioner's controlled substance registration with either the DEA or DCP lapses due to non-renewal the Practitioner shall be divested of the right to prescribe medications covered by the controlled

substance registration effective upon the date of expiration and for the duration of time until a valid controlled substance registration is reinstated.

(f) In the event of revocation, restriction, suspension or probation of a Practitioner's right to prescribe medications pursuant to this Section 10.3.2, the provisions of Article Eleven of these Bylaws shall not apply.

10.3.3 EXCLUSION OR SUSPENSION FROM PARTICIPATION IN FEDERALLY FUNDED HEALTH CARE PROGRAMS

(a) Exclusion, Revocation or other Termination: Whenever a Practitioner is listed as being barred from participation in Medicare, Medicaid or such other federally or state funded health care programs, the Practitioner's Medical Staff Membership and Clinical Privileges shall automatically be revoked.

(b) Suspension: Whenever a Practitioner's participation in Medicare, Medicaid or such other federally or state funded health care programs is suspended or otherwise restricted, the Practitioner shall be automatically suspended effective upon and for at least the time of the suspension of the Practitioner's participation in such program(s). Further action on the matter shall proceed under Section 10.3.4, below.

(b) In the event of a revocation or suspension of a Practitioner's Medical Staff Membership or Clinical Privileges pursuant to this Section 10.3.3, the provisions of Article Eleven of these Bylaws shall not apply.

10.3.4 MEDICAL STAFF EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable (a) after Practitioner's license is revoked, restricted, suspended, or placed on probation, (b) after a Practitioner's controlled substance registration is revoked, restricted, suspended or placed on probation or (c) after a Practitioner's participation in Medicare, Medicaid or such other federally or state funded health care programs is suspended or otherwise restricted, the MSEC shall convene to review and consider the facts upon which such action was taken. The MSEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of Membership Prerogatives. Such further action may be subject to Article Eleven of these Bylaws.

10.3.5 MEDICAL RECORDS

After a written warning for failure to complete medical records in a timely fashion, if the Practitioner or APP has not completed such medical records within the timeframe set forth in the written warning (a) a Practitioner's or APP's Clinical Privileges (except with respect to patients already in Hospital), and a Practitioner's or APP's (to the extent applicable) right to admit patients, to schedule procedures, and to consult with respect to patients, and (b) voting and office-holding Membership Prerogatives, may be suspended by the MSEC effective on the date specified in the written warning and continuing until the delinquent medical records are completed. The Practitioner or

APP shall be notified of the suspension by the President of the Medical Staff. The provisions of Article Eleven shall not apply. The MSEC may recommend further corrective action in the event that the Practitioner or APP is suspended more than once in any six (6) month period or otherwise demonstrates a pattern of failing to complete medical records in a timely manner. In such event, such further action may be subject to Article Eleven of these Bylaws.

10.3.6 PROFESSIONAL LIABILITY INSURANCE

For failure to maintain the minimum amount of professional liability insurance, if any, required in accordance with these Bylaws, a Practitioner's Medical Staff membership and Clinical Privileges shall be immediately suspended. In the event of such suspension, the provisions of Article Eleven of these Bylaws shall not apply, and the Practitioner's Medical Staff membership and Clinical Privileges shall remain suspended until such time as the Practitioner obtains the specified minimum amount of professional liability insurance and provides proof thereof to the President of the Medical Staff. If a suspension under this Section is in effect at the time of reappointment, the member's Medical Staff appointment shall terminate and the provisions of Article Eleven shall not apply.

10.3.7 FAILURE TO MAINTAIN THE CONFIDENTIALITY OF HEALTH INFORMATION

(a) In the event that a Practitioner fails to comply with the confidentiality of health information requirements set forth in Sections 3.6.8 and 3.6.9 of these Bylaws, the President of the Medical Staff, Department Chair, or Section Chief shall issue a written warning to the Practitioner. If after receipt of a written warning, the Practitioner fails to comply with the confidentiality of health information requirements, the Practitioner's (a) Clinical Privileges, (b) right to admit patients and to consult with respect to patients, and (c) voting and office-holding Membership Prerogatives shall be suspended by the President of the Medical Staff, Department Chair, or Section Chief effective immediately and continuing until the earlier of thirty (30) days from the effective date of the suspension or such date on which the Practitioner agrees in writing to comply with the confidentiality of health information requirements. Except as provided in Section 10.3.7(b) the provisions of Article Eleven shall not apply.

(b) In the event that a Practitioner fails to agree in writing to comply with the confidentiality of health information requirements of Sections 3.6.8 and 3.6.9 within ten (10) days from the effective date of a suspension permitted by Section 10.3.7(a) or concurrent with the second suspension of a Practitioner pursuant to Section 10.3.7(a) for failure to comply with the confidentiality of health information requirements of Sections 3.6.8 and 3.6.9, the President of the Medical Staff, Department Chair, or Section Chief shall request an investigation by the MSEC pursuant to Section 10.1.3(b). Thereafter, the procedures for corrective action set forth in Article Eleven shall apply.

#### 10.3.8 OMISSION OR MISREPRESENTATION

In the event that an applicant for appointment or reappointment to the Medical Staff and/or for Clinical Privileges omits or misrepresents information in support of such application determined by the Credentials Committee to be material to its decision on the application, the applicant's application shall be withdrawn, or if such omission or misrepresentation is found following appointment or reappointment to the Medical Staff, such Medical Staff member's membership or Clinical Privileges shall immediately terminate, and in either case the applicant shall not be entitled to any due process or other rights, including, without limitation, the right to a hearing or appellate review pursuant to Article Eleven of these Medical Staff Bylaws.

#### 10.3.9 CONVICTION OF A FELONY

If any member of the Medical Staff is convicted of a felony, their Medical Staff membership and Clinical Privileges shall be immediately and automatically terminated.

### 10.4 NATIONAL PRACTITIONER DATA BANK

The Hospital and the Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 and the regulations of the U.S. Department of Health and Human Services implementing the HCQIA. In order to fulfill these requirements, the Medical Staff will report adverse actions and will obtain necessary information from the NPDB as required by law and/or accrediting agency requirements (at the time of request for appointment, reappointment or additional Clinical Privileges). The provisions of the HCQIA and its implementing regulations, as may be amended from time to time, hereby are incorporated into the Bylaws by this reference and these Bylaws, to the extent possible, shall be construed as being consistent with the HCQIA and its implementing regulations.

## ARTICLE 11. PROCEDURAL RIGHTS

In the event that any other provision of these Bylaws provides that Article Eleven does not apply to a particular action or decision, then the provisions of this Article shall not apply regardless of whether the action or decision otherwise would appear to be subject to this Article.

### 11.1 STANDARDS FOR PROFESSIONAL REVIEW ACTIONS

#### 11.1.1 IN GENERAL

All professional review actions shall be taken:

(a) In the reasonable belief that the action is in furtherance of quality health care.

(b) After a reasonable effort to obtain the facts of the matter.

(c) In the case of adverse professional review actions, after adequate notice and hearing procedures are afforded to the Practitioner, as set forth in these

Bylaws, or after such other procedures as are fair to the Practitioner under the circumstances.

(d) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of subparagraph (c), above.

11.1.2 DEFINITION OF PROFESSIONAL REVIEW ACTION

For purposes of Section 11.1.1, the term "professional review action" shall mean an action or recommendation of the Medical Staff Executive Committee, Board, or other Hospital professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of a Practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the Practitioner's Medical Staff membership or Clinical Privileges. Such term includes a formal decision not to take such an action or make such a recommendation and also includes professional review activities relating to a professional review action.

11.2 ADVERSE ACTIONS

11.2.1 ADVERSE RECOMMENDATIONS AND DECISIONS DEFINED

The following recommendations or decisions are adverse when made under circumstances described in Section 11.2.2.

(a) Denial of initial Medical Staff appointment.

(b) Denial of reappointment.

(c) Suspension of Medical Staff membership.

(d) Revocation of Medical Staff membership.

(e) Denial of requested appointment to or advancement in Medical Staff category.

(f) Reduction in Medical Staff category, other than a reassignment from the Active Staff to Courtesy Staff for failure to meet the requirements of Active Staff pursuant to Section 4.2.5.

(g) Suspension or limitation of the right to admit patients or of any other Membership Prerogative directly related to the Practitioner's provision of patient care.

(h) Denial of requested Department or Section affiliation.

(i) Denial or restriction of requested Clinical Privileges.

(j) Reduction in Clinical Privileges.

(k) Suspension of Clinical Privileges.

(l) Revocation of Clinical Privileges.

(m) Individual application of or individual changes in mandatory prior or concurrent consultation or direct supervision.

(n) Any other such recommendation or decision reducing, restricting, suspending, revoking, denying, or failing to renew Clinical Privileges.

(o) Reappointment for a period of less than six (6) months.

11.2.2 WHEN DEEMED ADVERSE

A recommendation or decision described in Section 11.2.1 shall be deemed adverse only when it has been:

(a) Recommended by the MSEC, or

(b) Adopted by the Board under circumstances where no prior right to request a hearing existed.

11.2.3 ACTIONS NOT DEEMED ADVERSE

Only actions specified in Section 11.2.1 shall entitle the Practitioner to any hearing or appellate review rights. Actions in regard to members of the Advanced Practice Professional Staff are not subject to the provisions of this Article Eleven and are provided for in Section 4.11.3(d). Furthermore, the following actions or circumstances shall not entitle the Practitioner to any hearing or appellate review rights:

(a) The issuance of a warning.

(b) The issuance of a formal letter of reprimand.

(c) The imposition of a probationary period with monitoring of practices but without special requirements of prior or concurrent consultation or direct supervision.

(d) The Practitioner's failure to maintain professional liability insurance as required by Section 3.2.5.

(e) The Practitioner's failure to maintain a currently valid Connecticut license to practice medicine, osteopathy, dentistry, or podiatry as required by Section 3.2.1 or a currently valid registration to prescribe controlled substances if required by Section 3.2.1.

(f) The Practitioner's failure to achieve board certification.

(g) Any actions taken with regard to a Practitioner's Clinical Privileges as a result of the revocation, restriction, suspension, probation or non-renewal of the Practitioner's license to practice, in accordance with Section 10.3.1.

(h) Any actions taken with regard to a Practitioner's right to prescribe medications as a result of the revocation, restriction, suspension, probation or non-renewal of the practitioner's controlled substances registration, in accordance with Section 10.3.2.

(i) The suspension or restriction of Clinical Privileges, for a period of not longer than fourteen (14) days, during which time an investigation is being conducted to determine the need for corrective action.

(j) Any other actions not specifically subject to hearing and appellate review under this Article Eleven.

(k) Exclusion, debarment or suspension from participation in federally or state funded health care programs, in accordance with Section 10.3.3.

(l) The suspension of Clinical Privileges for a period not to exceed thirty (30) days for failure to comply with the confidentiality of health information requirements of Sections 3.6.8 and 3.6.9 in accordance with Section 10.3.7(a).

(m) The termination of Medical Staff membership and Clinical Privileges due to an omission or misrepresentation pursuant to Section 10.3.8 hereof.

(n) Any action described in Section 11.2.1 which is based solely on the Practitioner's failure to meet the minimum qualifications for a Medical Staff category, as described in Article Four hereof.

## 11.3 PROCEDURES FOR HEARINGS AND APPELLATE REVIEWS

All hearings and appellate reviews shall be conducted in accordance with the procedures and safeguards set forth in this Article to assure that the affected Practitioner is accorded all rights to which the Practitioner is entitled.

### 11.3.1 RIGHT TO HEARING AND TO APPELLATE REVIEW

(a) When any Practitioner receives Special Notice of a recommendation by the MSEC that, if ratified by decision of the Board, will adversely affect the Practitioner's appointment to or status as a member of the Medical Staff or the Practitioner's exercise of Clinical Privileges, the Practitioner shall, upon proper and timely request, be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the MSEC following such hearing is still adverse, the Practitioner shall, upon proper and timely request, then be entitled to an appellate review by the Board before the Board makes a

final decision on the matter.

(b) When any Practitioner receives Special Notice of a decision by the Board that will adversely affect the Practitioner's appointment or status as a member of the Medical Staff or the Practitioner's exercise of Clinical Privileges, and such decision is not based on a prior adverse, recommendation by the MSEC with respect to which the Practitioner was entitled to a hearing and appellate review, the Practitioner shall, upon proper and timely request, be entitled to an appellate review by the Board, before the Board makes a final decision on the matter. Such appellate review shall be conducted by Board members who did not participate in the hearing or on the hearing committee.

11.3.2 REQUEST FOR HEARING

(a) The President of the Medical Staff shall be responsible for giving prompt Special Notice of an adverse recommendation or decision to the affected Practitioner who shall be entitled to a hearing or to an appellate review. Such Special Notice shall state (1) that a professional review action has been proposed to be taken against the Practitioner and the reasons for the proposed action; (2) that the Practitioner has a right to request a hearing on the proposed action and that a request for a hearing must be made in writing within thirty-five (35) days; and (3) a summary of the Practitioner's rights in the hearing. A copy of these Bylaws with regard to hearing and appellate review shall accompany this Notice.

(b) The failure of a Practitioner to request a hearing to which the Practitioner is entitled by these Bylaws within thirty-five (35) days and in the manner herein provided shall be deemed a waiver of the Practitioner's right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled on the matter.

(c) When the waived hearing or appellate review relates to an adverse recommendation of the MSEC or of a hearing committee appointed by the Board, the same shall become and remain effective against the Practitioner pending the Board's final decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall become and remain effective against the Practitioner in the same manner as a final decision of the Board provided for in Section 11.3.7 of this Article. In either of such events, the President of the Medical Staff shall promptly notify the affected Practitioner of the Practitioner's status by Special Notice.

11.3.3 NOTICE OF HEARING

(a) Within thirty (30) days after receipt of a request for a hearing from a Practitioner entitled to the same, the MSEC or the Board, as the case may be, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the Practitioner of the time, place, and date of the hearing, by Special Notice. The hearing date shall be not less than thirty-five

(35) days or more than ninety (90) days from the date of the Special Notice to the Practitioner. Granting of an earlier hearing or a postponement shall be made in the sole discretion of the hearing committee.

(b) The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned or the other reasons or subject matter that was considered in making the adverse recommendation or decision. Such notice shall contain a list of the witnesses (if any) expected to testify at the hearing on behalf of the MSEC or the Board. Additional witnesses may be called as necessary and notice that they will be called shall be provided whenever possible.

11.3.4 COMPOSITION OF HEARING COMMITTEE

(a) When a hearing relates to an adverse recommendation of the MSEC, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Medical Staff appointed by the President of the Medical Staff in consultation with the MSEC and one (1) of the members so appointed shall be designated as chair. No Medical Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff. No individual who is in direct economic competition with the Practitioner involved shall be appointed a member of this hearing committee.

(b) When a hearing relates to an adverse decision of the Board that is not based on a prior adverse recommendation of the MSEC, the Board shall appoint a hearing committee of not less than three (3) members to conduct such hearing and shall designate one (1) of the members of this committee as chair. At least one (1) representative from the Medical Staff shall be included on this committee. No individual who is in direct economic competition with the Practitioner involved shall be included on this committee.

11.3.5 CONDUCT OF HEARING

(a) There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

(b) An accurate record of the hearing shall be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. The Practitioner for whom the hearing is held has the right to obtain copies of the records upon payment of any reasonable charges.

(c) The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the rights herein provided in the same manner as provided in Sections 11.3.2 (b) and (c)

of this Article and to have accepted the adverse recommendation or decision involved and the same thereupon shall become and remain in effect as provided in said Sections.

(d) The affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by an attorney or other person of the Practitioner's choice. The presenter of the adverse recommendation or decision as well as the hearing committee also may be represented by counsel.

(e) Either a hearing officer, if one is appointed, or the chair of the hearing committee or the hearing officer's or chair's designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The hearing officer or the chair of the hearing committee shall be a Physician. Any person who does not comply with the orders or ruling of the chair or hearing officer, or who ignores such orders or rulings and, for example, continues to make repetitive objections or submit repetitive testimony, may be required by the hearing committee to leave the hearing.

(f) Formal rules of evidence and procedure shall not apply to the hearing. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make the evidence inadmissible over objection in a civil or criminal action. The Practitioner for whom the hearing is being held shall, prior to, during, or at the close of the hearing but not subsequent thereto, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

(g) The MSEC, when its action has prompted the hearing, shall appoint one (1) of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendations and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision.

(h) The affected Practitioner shall have the following rights: to call and examine witnesses; to introduce any evidence determined to be relevant by the hearing officer or the chair of the hearing committee, as applicable, regardless of its admissibility in a court of law; to cross-examine any witness on any matter relevant to the issue of the hearing; to challenge any witness, to rebut any evidence and to submit a written statement at the close of the hearing. If the Practitioner does not testify in the Practitioner's own behalf, the Practitioner may be called and examined as if under cross-examination. The affected Practitioner shall provide the hearing committee and the presenter of the

adverse recommendation with a list of witnesses expected to testify at least five (5) business days in advance of the hearing. Additional witnesses may be called as necessary and notice that they will be called shall be provided whenever possible.

(i) At its discretion, the hearing committee may call its own witnesses or obtain expert assistance in connection with any matter pending before it. Any written reports by such experts shall be provided to all parties to the hearing. The hearing committee may, without Special Notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.

(j) After final adjournment of the hearing, the hearing committee shall promptly prepare a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the MSEC or to the Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MSEC or decision of the Board, and shall include a statement of the basis for the recommendation. The Practitioner shall be given a copy of the report and shall be advised of the Practitioner's right to request an appellate review in accordance with these Bylaws.

(k) The MSEC, when its action has prompted the hearing, shall consider the recommendations of the hearing committee and may accept, modify, or reject such recommendations. The MSEC shall then make written recommendations to the Board which shall include a statement of the basis for its recommendations. The Practitioner shall be given by Special Notice a copy of the written recommendation of the MSEC and written notices of the Practitioner's right under these Bylaws to request, within thirty (30) days of the date of said Notice, an appellate review by the Board.

(l) The Board, when its action has prompted the hearing, shall receive the recommendations of the hearing committee and shall notify the Practitioner by Special Notice of the Practitioner's right under these Bylaws to request within thirty (30) days an appellate review by the Board.

11.3.6 APPEAL TO THE BOARD

(a) Within thirty (30) days after receipt of a Special Notice by an affected Practitioner of an adverse recommendation made after a hearing as above provided, the Practitioner may, by Special Notice to the Board delivered to the President of the Hospital, request an appellate review by the Board. The Practitioner may file a written statement and/or request that oral argument be permitted.

(b) If such appellate review is not requested within thirty (30) days, the affected Practitioner shall be deemed to have waived the Practitioner's right to the same and to have such adverse recommendation or decision and the same shall become effective immediately as provided in Section 11.3.7 of this Article.

(c) Promptly after receipt of such request for appellate review, the Board shall schedule a date for such a review, including a time and place for oral argument if such has been requested, and shall, through the President of the Hospital by Special Notice, notify the affected Practitioner of the same. The date of the appellate review ordinarily shall be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for appellate review, except that when the Practitioner requesting the review is under a suspension which is then in effect, upon the request of the Practitioner, such review shall be scheduled as soon as arrangements for it may reasonably be made. For good cause shown, the Board or a duly appointed appellate review committee may, in its sole discretion, extend the time period for appellate review.

(d) The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than seven (7) members. If the adverse recommendation being reviewed was made by a hearing committee appointed by the Board, appellate review shall be by a committee of the Board made up of members who did not participate in the hearing or on the hearing committee.

(e) The affected Practitioner shall have access to the report and any available transcription of the hearing and all other written material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against the Practitioner. The Practitioner shall have the opportunity to submit a written statement in the Practitioner's behalf, in which those factual and procedural matters with which the Practitioner disagrees, and the Practitioner's reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted by the Practitioner via Special Notice to the Board through the President of the Hospital at least fifteen (15) days prior to the scheduled date for the appellate review; a copy also shall be simultaneously provided to the MSEC, to the hearing committee, and to the representative presenting the adverse decision or recommendation. A similar statement may be submitted by the MSEC or by the hearing committee appointed by the Board and, if submitted, the President of the Hospital shall provide by Special Notice a copy thereof to the Practitioner at least fifteen (15) days prior to the date of such appellate review.

(f) The Board or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subparagraph (e) of this Section for the purpose of determining whether the adverse recommendation or decision

against the affected Practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Practitioner shall be present at such oral argument, shall be permitted to speak against the adverse recommendation or decision and shall answer questions raised by any member of the appellate review body. The MSEC, the Board or the hearing committee, as the case may be, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions raised by any member of the appellate review body.

(g) New or additional matters not raised during the original hearing or in the hearing committee report, or otherwise reflected in the record, shall only be introduced at the appellate review under extraordinary circumstances as determined in the sole discretion of the Board or committee thereof appointed to conduct the appellate review.

(h) If the appellate review is conducted by the Board, it may affirm, modify, or reverse the decision or recommendation under review or, in its discretion, it may refer the matter back to the MSEC for further review and recommendation within a period of time to be specified by the Board. Such referral may include a request of the MSEC for further hearing to resolve specified disputed issues.

(i) If the appellate review is conducted by a committee of the Board, such committee shall, after the scheduled or adjourned date of the appellate review, make on a timely basis a written report recommending that the Board affirm, modify or reverse the decision or recommendation under review, or it may refer the matter back to the hearing committee or MSEC whichever entity made the decision or recommendation under review, for further review and recommendation within a period of time to be specified by the appellate review committee. Such referral may include a request that the hearing committee or MSEC, as the case may be, arrange for a further hearing to resolve disputed issues. After receipt of such recommendation after referral, the committee shall convene and promptly make its recommendations to the Board as above provided.

(j) The appellate review shall not be deemed to be concluded until all the procedural steps provided in this Section have been completed or waived. Where permitted by the Hospital's Bylaws, all action required of the Board may be taken by a committee of the Board.

11.3.7 FINAL DECISION BY THE BOARD

(a) After conclusion of the appellate review, the Board shall promptly make its final decision in the matter and shall send notice thereof to the MSEC and, through the President of the Hospital, to the affected Practitioner by Special Notice. Such Notice shall include a statement of the basis for the decision. If this decision is in accordance with the MSEC's last recommendation in the

matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the MSEC's last such recommendation, the Board shall refer the matter to the Joint Conference Committee for further review and recommendation within a period of time to be specified by the Board and shall include in such notice of its decision the statement that a final decision will not be made until the Joint Conference Committee's recommendation has been received. At its next meeting after receipt of the Joint Conference Committee's recommendations, the Board shall make its final decision with like effect and notice as first provided in this Section.

(b) Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one (1) hearing and one (1) appellate review on any matter or group of related matters that was the subject of action by the MSEC, or by the Board, or by a duly authorized committee of the Board, or by both.

11.3.8 TIME LIMITS

All actions required under this Article for which no time limit is specified shall be taken within a reasonable period of time, which shall, when practical, not exceed one (1) month.

11.3.9 PROCEDURE

The foregoing procedures for hearing and appellate review are intended as guidelines for assuring the Practitioner a fair hearing and review and shall not be construed as establishing any rigid format for the hearing committee, the Board, or other committees involved in the hearing and review process.

## ARTICLE 12. MEETINGS

### 12.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the Medical Staff Year shall commence on January 1, and expire on December 31.

### 12.2 MEDICAL STAFF MEETINGS

12.2.1 REGULAR MEETINGS

An Annual Meeting shall be held in January of each year. The MSEC may authorize the holding of additional Medical Staff meetings by resolution. The resolution authorizing any such additional meeting(s) shall require notice specifying the place, date and time for the meeting, and that the meeting can transact any business as may come before it.

### 12.2.2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the President of the Medical Staff and shall be called by the President of the Medical Staff at the written request of the Board, the MSEC or 10% of the members of the Active Staff. The President of the Medical Staff shall call this special meeting within fifteen (15) days of such request.

## 12.3 DEPARTMENT, SECTION AND COMMITTEE MEETINGS

### 12.3.1 REGULAR MEETINGS

Departments, Sections, and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is then required. Departments and Sections shall meet at least quarterly but frequently enough to consider both patient care outcomes and business issues.

### 12.3.2 SPECIAL MEETINGS

A special meeting of any Department, Section, or committee may be called by the Chair, Chief or chair thereof and shall be called by the Chair, Chief or chair at the written request of the Board, the MSEC, the President of the Medical Staff, or five (5) of the group's current members.

## 12.4 ATTENDANCE REQUIREMENT

### 12.4.1 GENERALLY

At the time of reappointment, each member of the Active Medical Staff must complete an attestation confirming ongoing participation in Continuing Medical Involvement (CMI) activities within Middlesex Health System. The reappointment attestation will be reviewed by the respective Department Chair and considered with their recommendation for member's reappointment.

### 12.4.2 SPECIAL APPEARANCES OR CONFERENCES

(a) A Practitioner whose patient's clinical course of treatment is scheduled for discussion at a Medical Staff Department, Section, or committee meeting shall be notified and invited to present the case.

(b) Whenever a Medical Staff, Department, Section, or educational program is prompted by findings of quality improvement program activities, the Practitioner whose performance prompted the program shall be notified of the time, date, and place of the program, of the subject matter to be covered, and of its special applicability to the Practitioner's practice. Except in unusual circumstances the Practitioner shall be required to be present.

(c) Whenever a pattern of apparent or suspected deviation from standard clinical practice is identified within a Practitioner's practice, the President of the

Medical Staff, or the applicable Department Chair or Section Chief may require the Practitioner at the earliest mutually acceptable time to confer with such officer, Chair and/or Chief or with a standing or ad hoc committee that is considering the matter. The Practitioner shall be given documented notice of the conference at least five (5) days prior to it, including the date, time and place, a statement of the issue(s) involved, and a reminder that the Practitioner's appearance shall be mandatory.

(i) Failure of a Practitioner to appear at any such conference, unless excused by the individual calling the conference, shall result in automatic referral to the MSEC for appropriate corrective action.

(ii) Notification of the results of this conference shall be shared with the MSEC and the Quality Improvement Patient Safety Committee

## 12.5 MEETING PROCEDURES

### 12.5.1 NOTICE OF MEETINGS

Written notice of any regular Medical Staff meeting, or of any regular committee, Department or Section meeting not held pursuant to resolution, shall be delivered personally or by mail or through accepted electronic means to each person entitled to be present not less than five (5) days nor more than fifteen (15) days before the date of such meeting. Notice of any special meeting of the Staff, a Department, Section, or committee shall be given orally or in writing at least seventy-two (72) hours prior to the meeting and shall be posted. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened. No business shall be transacted at any special meeting except that stated in the meeting notice.

### 12.5.2 QUORUM AND ACTION

#### (a) MEDICAL STAFF MEETINGS

At any regular or special meeting of the Medical Staff, a quorum shall be ten percent (10%) of the qualified members of the Active Medical Staff. Vote shall be decided by simple majority of those present at the time of the vote and may be conducted by an electronic ballot.

#### (b) DEPARTMENTS, SERVICES AND COMMITTEE MEETINGS

At any Department, Section, or committee meeting, except the MSEC and MSC, the quorum shall be defined as those members present, but not less than two (2) members. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee, Department, or Section. Action may be taken without a meeting by unanimous consent in writing, setting forth the action so taken signed by each member entitled to vote.

12.5.3 RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise specifically provided in these Bylaws, persons serving under these Bylaws as Ex Officio members of a committee shall have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum and shall not be allowed to vote.

12.5.4 MINUTES

Minutes of each regular and special meeting of a committee, Department or Section shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval and, after such approval by a majority of the attendees is obtained, forwarded to the MSC. Each committee, Department, and Section shall maintain a permanent file of the minutes of each of its meetings.

12.5.5 PROCEDURAL RULES

Meetings of the Medical Staff, Departments, Sections, and committees shall be conducted according to the then current edition of Sturgis' Rules of Order. In the event of conflict between said Rules of Order and any provision of these Bylaws, these Bylaws shall control.

## ARTICLE 13. CONFIDENTIALITY, IMMUNITY, AND RELEASES

### 13.1 SPECIAL DEFINITIONS

For purposes of this Article, the following definitions shall apply:

(a) INFORMATION shall mean records or proceedings, minutes, interviews, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in Section 13.5.

(b) MALICE shall mean the dissemination of a known falsehood or of information with a reckless disregard for the truth.

(c) PRACTITIONER/APP shall mean, for purposes of this Article Thirteen, a Medical Staff or Advanced Practice Professional Staff member or applicant.

(d) REPRESENTATIVE shall mean the Board of the Hospital or any of its subsidiaries and any director, trustee, or committee of the Hospital or any of its subsidiaries; the President of the Hospital or any designee; registered nurses and other employees of the Hospital or Hospital subsidiaries; the Medical Staff organization and any member, officer, Department, Section, or committee thereof, including without limitation the

MSC or MSEC; and any individual authorized by any of the foregoing to perform specific Information gathering, analysis, use, or disseminating functions.

(e) THIRD PARTIES shall mean both individuals and organizations providing Information to any Representative.

## 13.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Medical Staff or Advanced Practice Provider Staff membership or by applying for or exercising Clinical Privileges or providing specific patient care services in the Hospital, a Practitioner/APP shall be deemed to:

(a) Authorize Representatives of the Hospital and its subsidiaries and the Medical Staff to solicit, provide, and act upon Information bearing on the Practitioner/APP's professional ability and qualifications, and to agree to cooperate with reasonable requests for Information by Representatives.

(b) Agree to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.

(c) Acknowledge that the provisions of this Article are express conditions to the Practitioner/APP's application for, or acceptance of, Medical Staff or APP Staff membership and to the exercise of Clinical Privileges or provision of specified patient services at any Hospital.

## 13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner/APP submitted, collected, or prepared by any Representative of the Hospital or its subsidiaries or the Medical Staff or representative of any other health care system, facility, organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than an appropriate Representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record.

## 13.4 IMMUNITY FROM LIABILITY

### 13.4.1 FOR ACTION TAKEN

No Representative shall be liable to a Practitioner/APP for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of such Representative's duties, if the Representative acts in good faith and without Malice after reasonable effort under the circumstances to ascertain the truthfulness of

the facts and in the reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts.

13.4.2 FOR PROVIDING INFORMATION

No Representative and no Third Party shall be liable to a Practitioner/APP for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative or to any health care system, facility or organization of health professionals concerning a Practitioner/APP who is or has been an applicant to or member of the Medical Staff or Advanced Practice Provider Staff or who did or does exercise Clinical Privileges or provide specified services at Hospital, provided that such Representative or Third Party acts in good faith and without Malice and provided further that such Information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

13.5 ACTIVITIES AND INFORMATION COVERED

13.5.1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, proceedings, interviews, reports, records, minutes, forms memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, or disclosures performed or made in connection with the activities of the Hospital, the Medical Staff, or any other health care system, facility or organization concerning, but not limited to:

(a) Applications for Medical Staff or Advanced Practice Provider Staff appointment, Clinical Privileges or specified services.

(b) Periodic reappraisals for reappointment, Clinical Privileges or specified services.

(c) Corrective or disciplinary action or other interventions.

(d) Hearings and appellate reviews

(e) Quality improvement program activities.

(f) Utilization reviews.

(g) Claims reviews.

(h) Profiles and profile analyses.

(i) Risk Management.

(j) Other Hospital and Medical Staff activities related to monitoring and maintaining

quality and efficient patient care and appropriate professional conduct.

13.5.2 INFORMATION

The Information referred to in this Article may relate to a Practitioner/APP's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

13.6 RELEASES

Each Practitioner/APP shall, upon request, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of Malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be consistent with applicable law. Execution of such releases is not a prerequisite to the effectiveness of this Article which shall be binding on all Practitioners/ APPs including all members of the Medical Staff and Advanced Practice Provider Staff as well as applicants for membership and all persons who apply for or exercise Clinical Privileges or apply to provide specific patient care services.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

## ARTICLE 14. GENERAL PROVISIONS

14.1 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such rules and regulations and policies as may be necessary to implement more specifically the general principles found in these Bylaws. Such Rules and Regulations shall be a part of these Bylaws. The procedures outlined in Article Fifteen of these Bylaws shall be followed in the adoption and amendment of the rules and regulations and policies, except that Medical Staff action concerning Rules and Regulations may occur at any regular meeting at which a quorum is present and without previous notice, or, upon notice, at any special meeting at which a quorum is present by majority vote of those present who are eligible and qualified to vote. In the event of a conflict between such rules and regulations and these Bylaws, these Bylaws shall control.

## 14.2 DEPARTMENT AND SECTION POLICIES

Subject to the approval of the MSC, each Department and Section may formulate its own written bylaws and policies for the conduct of its affairs and the discharge of its responsibilities. Such written bylaws and policies shall be consistent with these Bylaws and the Rules and Regulations of the Medical Staff. In the event of a conflict between such Department and Section bylaws and policies and these Bylaws, these Bylaws shall control.

## 14.3 RELATIONSHIP OF MEDICAL STAFF WITH THE BOARD OF DIRECTORS

It is the Medical Staff's understanding that the Board shall be responsible for the following functions:

### 14.3.1 CREDENTIALS OVERSIGHT

To receive from the Medical Staff and to act upon written recommendations and completed applications for Staff assignment, clinical unit affiliations, Membership Prerogatives, Clinical Privileges, and corrective action.

### 14.3.2 EVALUATION AND MONITORING OVERSIGHT

To cooperate with and assist the Medical Staff and other health care professionals providing patient care services in implementing a quality improvement program to review, evaluate, monitor and improve the quality and efficiency of care delivered within Hospital and receive written reports on the findings of, and specific recommendations resulting from, the quality improvement program.

### 14.3.3 ADMINISTRATIVE OVERSIGHT

To continuously assess the effectiveness and results of the Medical Staff's review, evaluation and monitoring activities, evaluate the changes that have been or should be made to improve the quality and efficiency of patient care within Hospital, and take action as warranted by its findings.

### 14.3.4 ORGANIZATIONAL OVERSIGHT

To receive Medical Staff recommendations on the adoption, amendment or repeal of Medical Staff Bylaws and Rules and Regulations, and to act upon them in accordance with the provisions of the Hospital's corporate bylaws governing adoption and amendment of the Medical Staff Bylaws.

### 14.3.5 OTHER

To perform such other duties concerning professional staff matters as may be appropriate.

## 14.4 INDEMNIFICATION

To the extent permitted by law, the Hospital shall indemnify and provide a defense to any member of the Medical Staff who is named a defendant or respondent in any claim, suit, or proceeding that arises out of the member's good faith performance of any Hospital or Medical Staff function authorized by these Bylaws or Rules and Regulations, including, but not limited to, services as a member of a committee conducting peer review or a fair hearing, or service as a Department Chair or Section Chief.

## 14.5 CONSTRUCTION OF MEDICAL STAFF AND HOSPITAL BYLAWS

When construing these Bylaws, the following principles shall apply.

### 14.5.1 WAIVER

Failure of the Medical Staff and/or the Board to follow or enforce any provision of these Bylaws shall not constitute abrogation of the right to follow or enforce the same or any other provision at any future date.

### 14.5.2 SEVERABILITY

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

### 14.5.3 COMPLIANCE WITH LAWS, ETC.

In the event that any law or regulation or mandatory Joint Commission provision requires the Board or the Medical Staff to take specific action in connection with credentialing or any other matter covered by these Bylaws, such law, regulations, or accreditation requirement shall be deemed to be a part of these Bylaws and to the extent possible shall be construed as being consistent with the provisions of these Bylaws.

### 14.5.4 CONSTRUCTION

To the extent possible, these Bylaws, the Medical Staff Rules and Regulations, bylaws and policies of Departments and Sections, and agreements between the Hospital and members of the Medical Staff shall be construed as being consistent with each other. If consistent construction is not possible, then provisions which specifically provide that the Medical Staff Bylaws supersede inconsistent provisions shall be given effect. This Section 14.5.4 is not intended to alter or supersede other provisions of these Bylaws which specify how such provisions are to be interpreted, construed, or applied.

#### 14.5.5 HOSPITAL BYLAWS

Nothing contained in these Bylaws shall be deemed to supersede, waive or otherwise affect the bylaws and/or rules and regulations of the Hospital and if there be any conflict between these Bylaws and the bylaws and/or rules and regulations of the Hospital, the said bylaws and/or rules and regulations of the Hospital shall govern.

#### 14.5.6 HEADINGS

All captions and titles used in these Bylaws are for convenience only and shall not limit or otherwise affect in any way the scope or interpretation of any provisions of these Bylaws.

#### 14.5.7 REVIEW

The Medical Staff Bylaws and Rules and Regulations shall be reviewed periodically by the Bylaws Committee. The report of its review shall be forwarded to the MSC with appropriate recommendations.

### 14.6 CORPORATE COMPLIANCE

Medical Staff members share in the Hospital's commitment to strong ethical standards and compliance with all federal and state laws. Medical Staff members are subject to all compliance policies and procedures of the Hospital to the extent applicable. In addition, Medical Staff members must maintain the confidentiality of patient protected health information in accordance with these Bylaws, as well as the Hospital's policies related to patient confidentiality generally and the Health Insurance Portability and Accountability Act of 1996 (including its implementing regulations).

## ARTICLE 15. ADOPTION AND AMENDMENT

### 15.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board has delegated to the Medical Staff the authority and responsibility to initiate and recommend to the Board the Medical Staff Bylaws and Rules and Regulations and policies. The adoption and amendment of these Bylaws shall require the actions specified in the applicable provisions of this Article. Copies of revisions to any portion of the Medical Staff Bylaws and Rules and Regulations and policies shall be made available to all members of the Medical Staff.

### 15.2 ADOPTION

These Bylaws, together with the appended Rules and Regulations and policies, shall be adopted by the Medical Staff to serve as the Bylaws for the Medical Staff and shall replace the current Medical Staff Bylaws and Rules and Regulations and policies at the Hospital.

## 15.3 AMENDMENT

A proposed amendment shall be submitted either to the Bylaws Committee directly, the MSEC directly, the Board directly, or to any regular or special meeting of the Medical Staff. Any proposed amendment to the Bylaws shall be referred to the Bylaws Committee, which shall make its recommendation to the MSEC. The MSEC shall provide a report of its recommendations to the Medical Staff as an electronic notice, with the notice of a regular meeting, or a special meeting called for such purpose. The notice of any meeting at which an amendment will be considered by the Board will be provided at least fifteen (15) days before such meeting. A copy of proposed documents or amendments, with the recommendations of the MSEC, shall be delivered personally or by mail or through accepted electronic means to, and posted for, Medical Staff members entitled to vote thereon with the notice of the meeting. Adoption or amendment of these Bylaws or Rules and Regulations shall require the affirmative vote of a majority of the Medical Staff members present, eligible and qualified to vote on Bylaws, at a regular or special Medical Staff meeting at which a quorum is present. In the event approval of amendments need to be accomplished in the period of time between regularly scheduled annual meetings and a special meeting is not planned, an electronic ballot may be used. Each use of an electronic ballot must be specifically approved by a majority of the membership of the Medical Staff present and voting. The ballot, the proposed amendment(s) and a summary of the issues will be hand delivered, sent by regular mail or through accepted electronic means to those Medical Staff members eligible and qualified to vote. The ballot must be returned to the Medical Staff Services office by the date specified in the ballot, which shall not be less than fifteen (15) days from the date the ballot was mailed. Approval by mail ballot requires the majority of those responding. The Medical Staff's action to adopt or amend shall be forwarded to the Board for its action.

In cases of a documented need for an urgent amendment to Bylaws, Rules and Regulations, necessary to comply with law or regulation, the MSC may provisionally adopt, and submit to the Board for provisional approval, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MSC. The Medical Staff shall perform a retrospective review of and comment on the provisional amendment at their next schedule meeting. If there is no conflict between the Medical Staff and the MSC, the provisional amendment stands. If there is a conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the MSC in section 9.2.1 shall be implemented. If necessary, a revised amendment is then submitted to the Board for action.

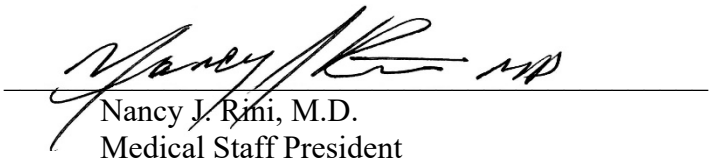
## 15.4 BOARD ACTION

In accordance with the corporate bylaws of the Hospital, Medical Staff recommendations concerning adoption or amendment of these Bylaws and Rules and Regulations are effective only upon the affirmative vote of the Board.

## 15.5 RELATED PROTOCOLS

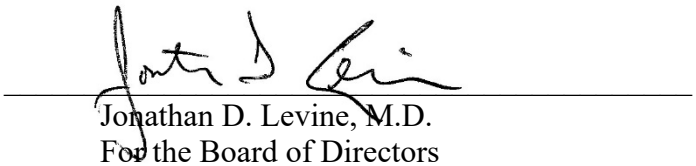
Department and Section policies and other Medical Staff policies and protocols that are not part of the Medical Staff Bylaws or Rules and Regulations must be consistent with such Bylaws and Rules and Regulations and shall be effective upon adoption by the MSC and approval by the Board.

Approved by the Medical Staff on September 12, 2025



Nancy J. Rimi, M.D.
Medical Staff President

Approved by the Board of Directors on September 19, 2025



Jonathan D. Levine, M.D.
For the Board of Directors