BYLAWS

And

RULES & REGULATIONS

of the

YALE NEW HAVEN HOSPITAL, INC.

for the

MEDICAL STAFF

JANUARY 27, 1982

(Revised to December 19, 2024)

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PREAMBLE

The Yale New Haven Hospital (hereinafter referred to as "the Hospital"), is a unique blend of a major community hospital serving as the primary teaching hospital of the Yale University School of Medicine. Since the basic objectives of the Medical Staff of this Hospital are to provide the best possible care for patients, to support the education of doctors, nurses, and paramedical personnel, to contribute to the development of medical knowledge, and thereby to enhance the provision of service to the community, the physicians, dentists, podiatrists and affiliated staff practicing in the Hospital are hereby organized as a single Medical Staff in conformity with the Bylaws hereinafter set forth.

In accordance with Hospital policy, all provisions of the Bylaws and of the accompanying Rules and Regulations shall be interpreted and applied so that no person, member of the Medical Staff, applicant for membership, patient or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activity of the Hospital. All patients are to be available for teaching undergraduate and graduate Medical School students at the discretion of the responsible physician and the patient.

For the purpose of these Bylaws:

"ASSOCIATE CHIEF" means an Associate Chief of Department selected in accordance with the provisions of ARTICLE XI of these Bylaws.

"ASSOCIATE SECTION CHIEF" means an Associate Chief of a Section appointed in accordance with the provisions of ARTICLE IX, SECTION B of these Bylaws.

"ATTENDING PRACTITIONER" means a physician, dentist or podiatrist member of the Medical Staff with appropriate privileges who serves as the individual who is immediately responsible for a patient. For purposes of these Bylaws and Rules & Regulations, licensed nurse midwives may serve as the "Attending Practitioner" for patients admitted for anticipated normal vaginal delivery.

"BOARD OF TRUSTEES" means the Board of Trustees of the Hospital. The Board of Trustees may take any action it deems appropriate with respect to the members or officers of the Medical Staff whenever, in its sole judgment, the good of the Hospital or the best interest of the patients therein may render such action desirable.

"CHIEF" means a Chief of Department selected in accordance with the provisions of ARTICLE X of these Bylaws.

"COMMUNITY PHYSICIAN" means a physician whose practice is based in the community and who is not a University Physician.

"DEAN" means the Dean of the Yale University School of Medicine.

"DENTIST" means any person who holds the degree of Doctor of Medical Dentistry or Doctor of Dental Surgery.

"DEPARTMENT" means one of the Departments of the Medical Staff of the Hospital.

"HEALTH SYSTEM" means Yale New Haven Health System

"HOSPITAL", whenever capitalized, means Yale New Haven Hospital and includes all of its locations and satellites.

"MEDICAL DIRECTORS" are members of the Active Medical Staff who are appointed by the Chief Medical Officer or Associate Chief Medical Officer in collaboration with Chiefs to oversee certain Hospital functions, clinical areas or specific units.

"MEDICAL REVIEW COMMITTEE" as defined in these Bylaws and in Chapter 368 of the Connecticut General Statutes (as amended from time to time), shall include but not be limited to, the following committees, whenever they are engaged in peer review as defined in Connecticut General Statute § 19a-17b (a)(2).:

- Professional Practice Evaluation Committee (PPEC) or Departmental / Section based quality assurance committees doing work on its behalf (known as "Agent" Committees as defined in the Medical Staff Policy regarding "Routine and Ongoing Professional Practice Evaluation" ("Peer Review");
- Medical Staff Professionalism Committee (MSPC)
- The Medical Executive Committee, its Credentials Committee, the Patient Safety & Clinical Quality Committee, the Human Investigation Committee, Department and Section committees, clinical practice councils, and their respective subcommittees or liaison committees;
- Peer review or Morbidity & Mortality Committee meetings of any Department or Section or any of their committees or subcommittees or liaison committees;
- Any other committee, subcommittee, liaison committee, or ad hoc committee referred to in or authorized by these Bylaws or those of the Hospital;
- The Board of Trustees and its committees, subcommittees and liaison committees; and
- Any individual gathering information or providing services for or acting on behalf of, and at the direction of, any such committee, including but not limited to the Chief Medical Officer and the Associate Chief Medical Officer, Department Chiefs, Section Chiefs and Associate Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, and experts or consultants retained to perform peer review functions.

Wherever practicable, peer review documents prepared for or by all such committees or their delegates, or studies of morbidity and mortality undertaken by such committees or their delegates, should be clearly identified as peer review documents, and their use should be restricted to peer review. Issues of significance identified in the course of peer review activities by any of the above committees shall be referred to the Professional Practice Evaluation Committee or Medical Staff Professionalism Committee as applicable.

All individuals, Committees and agents acting as a Medical Review Committee shall be bound to protect the confidentiality of information of the Committee engaged in peer review, pursuant to state law and a contract, if any between the Hospital and the agent. When participating in, or providing information to, a MEDICAL REVIEW COMMITTEE, in good faith and without malice, such individuals shall be indemnified from personal liability.

"MEDICAL SCHOOL" means the Yale University School of Medicine.

"MEDICAL STAFF" means all physicians, dentists and podiatrists who are appointed to one of the following Medical Staff categories: Active, Courtesy, Pediatric Network, Consulting, Telemedicine, Honorary, House Staff or Clinical Fellow.

"MEDICAL STAFF PRESIDENT, PRESIDENT-ELECT and PAST PRESIDENT" means the individuals elected in accordance with the provisions of ARTICLE VIII.

"NETWORK ASSOCIATE CHIEF" means a Network Associate Chief of a Department selected in accordance with the provisions of ARTICLE XI of these Bylaws.

"ORGANIZED MEDICAL STAFF" shall be defined as all of the physicians, dentists and podiatrists who are members of the "MEDICAL STAFF" as provided in these Bylaws.

Only members of the "ORGANIZED MEDICAL STAFF" in the Active category are eligible to vote on the adoption of or amendments to these Bylaws and the associated Rules & Regulations and any applicable medical staff policies.

"PATIENT SAFETY & CLINICAL QUALITY COMMITTEE" means the Patient Safety & Clinical Quality Committee of the Board of Trustees of the Hospital.

"PEER REVIEW" functions shall be peer review activities of the MEDICAL REVIEW COMMITTEES as defined in Connecticut General Statutes § 19a-17b(a)(2) and shall be kept in strict confidence.

"PHYSICIAN" means any person who holds the degree of Doctor of Medicine or its equivalent.

"PODIATRIST" means any person who holds the degree of Doctor of Podiatric Medicine and has graduated from an accredited College of Podiatric Medicine.

"PRESIDENT" means the President and Chief Executive Officer of the Hospital or, in the event such a position is designated by the Hospital Board of Trustees, the President and Chief Operating Officer of the Hospital.

"SECTION CHIEF" means a Section Chief appointed in accordance with the provisions of ARTICLE IX, SECTION B of these Bylaws.

"UNIVERSITY PHYSICIAN" means a physician who is a member of the full-time faculty of the Yale University School of Medicine.

"YALE" means Yale University.

CONFIDENTIALITY

All medical records and patient-specific information, records of peer review and other committee proceedings, quality assurance and risk management materials including incident reports, Medical Staff credentialing records and files, minutes of Medical Staff and Hospital meetings, business plans of the Hospital and Medical Staff, and other confidential Hospital and Medical Staff records, data, and information, may not be used for purposes other than patient care, peer review, risk management, and other proper Hospital and Medical Staff functions. Such confidential materials (whether maintained in hard copy, in computer memory or diskette, on microfilm or microfiche, or in any other format), may not be removed from the Hospital, duplicated, transmitted, or otherwise disclosed to parties outside of the Hospital without proper authorization in accordance with Hospital and Medical Staff policies and applicable laws. Compliance with this Confidentiality Policy shall constitute a condition of continuing Staff membership.

INTERPRETATION OF THE BYLAWS

In construing these Bylaws and Rules and Regulations, and the policies of Departments, Sections, and Committees, the Medical Staff may take into account its usual and customary policies and practices, whether written or unwritten, and may also bring to bear the expert knowledge of members of the Staff, provided that such policies, practices, and expert knowledge is applied in the manner fully consistent with the specific provisions of the Bylaws, Rules and Regulations, and policies.

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

It is intended that the reasonable construction of these Bylaws and Rules and Regulations and policies shall be recognized and deferred to by a court or administrative agency or accreditation body, and that the Bylaws and Rules and Regulations and policies shall be so interpreted with consideration given to the fact that the Medical Staff requires reasonable flexibility in interpretation and application.

ARTICLE I. NAME

The name of this organization shall be “Medical Staff” of the “Yale New Haven Hospital”.

ARTICLE II. PURPOSE

The purpose of the organization shall be:

1. To insure that all patients admitted to the Hospital, cared for in the emergency service, or treated in the ambulatory service and/or other Hospital locations receive appropriate care;

2. To insure that all members of the Medical and Affiliated Staffs have appropriate education, training and experience and are credentialed, and to insure that appropriate health care is provided only by credentialed staff.

3. To provide health care to patients referred by members of the Medical Staff for further diagnosis or treatment;

4. To provide exemplary education programs in which students and practitioners in the health professions may develop their understanding and skills;

5. To foster the development of facilities and programs for clinical research;

6. To provide mechanisms through which the Medical Staff, the Board of Trustees and the Administration of the Hospital may discuss matters of mutual concern.

ARTICLE III. PATIENT SAFETY & CLINICAL QUALITY COMMITTEE OF THE BOARD OF TRUSTEES

In addition to those matters outlined in these Bylaws which specifically require referral to the Patient Safety & Clinical Quality Committee of the Board of Trustees, the Committee, at the direction of the Board of Trustees, shall concern itself with all matters relating to the Medical Staff and the medical services provided by the Hospital.

The Patient Safety & Clinical Quality Committee of the Board of Trustees regularly reviews patient safety and clinical quality metrics and related reports to ensure the provision of the highest quality, most effective patient care.

Responsibilities:

- To ensure a high quality medical staff through oversight of the appointment and re-appointment of its members
- To monitor quality assurance and quality improvement activities as they relate to medical care via periodic review of the professional performance, judgment and technical skills of Medical Staff members and leaders, and Department of Public Health (DPH) reportable and other serious adverse clinical events
- To provide appellate review in matters pertaining to Medical Staff appointment, re-appointment, discipline and/or dismissal from the Medical Staff when there is an unfavorable recommendation rendered by the Hearing Committee or, as applicable, to serve as the Hearing Committee.
- To review, critique, and recommend the Hospital Clinical Performance Improvement Plan.

ARTICLE IV. THE MEDICAL STAFF

SECTION A. Staff Categories

1. The Medical Staff shall be divided into the following categories:
   a. The Active Staff (Active Attending, Active Referring)
   b. The Courtesy Staff
   c. The Pediatric Network (Attending, Referring) Staff
   d. The Consulting Staff
   e. The Telemedicine Staff
   f. The Honorary Staff
   g. The House and Clinical Fellows Staff

2. Members of each staff category shall limit the scope of their clinical activities to those specified in their delineated clinical privileges, a copy of which accompanies their official notices of appointment to the Medical Staff. The Active Referring and Pediatric Network Referring categories, by definition, are "membership only" categories and individuals appointed to this category do not have clinical privileges.

3. When access to operating rooms and beds become restricted because of patient demand, members of the Active Staff shall enjoy a higher priority of access for their elective admissions. If these resources become limited, the affected departments shall prepare a protocol that addresses such priority of access. Such protocol shall be reviewed by the Medical Executive Committee, which shall submit its recommendations to the Board of Trustees, through its Patient Safety & Clinical Quality Committee, for ultimate approval, rejection or amendment. Emergency admissions shall be accepted irrespective of Staff Category.

4. All Medical Staff members are required to comply with their obligations under the Emergency Medical Treatment and Labor Act and its corresponding regulations. The purpose of this requirement is to assure that all patients are screened and stabilized within the capability of the Hospital, as required by law. Except for those assigned to the Active Referring and Pediatric Network Referring categories, all physician members of the Medical Staff are authorized to conduct appropriate medical screening examinations. Other members of the Medical Staff and members of the Affiliated Health Care Professionals Staff are authorized to conduct medical screening examinations if appropriately privileged to do so.

SECTION B. The Active Staff (Active Attending, Active Referring)

The Active Attending and Active Referring categories shall comprise the Active Medical Staff and include Physicians, Dentists and Podiatrists.

1. **Active Attending Staff**
   The Active Attending Staff shall consist of selected physicians, dentists, and podiatrists who demonstrate substantial commitment to the welfare and programs of the Hospital as well as its purposes, objectives and mission.

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

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

   b. meet the requirements of Article VI, Section B relative to office location;

c. eligible for admitting, consulting and any other privileges for which they are qualified;

d. demonstrate a willingness to participate in teaching programs;

e. demonstrate a willingness to serve on committees, boards, or in administrative positions;

f. demonstrate a willingness to assume responsibility for emergency call and/or consultation and to provide other services as requested by the relevant Department or Section Chair/Chief consistent with applicable Medical Staff Policies and Rules & Regulations.

g. demonstrate a willingness to contribute to medical staff activities such as, but not limited to, quality review programs, teaching conferences, risk management and utilization management as requested by the relevant Department or Section Chair/Chief;

h. demonstrate a willingness to have patients participate as part of teaching;

i. demonstrate a willingness, with the concurrence of both the patient and the physician, to participate in research efforts:

j. participate in Departmental and Sectional meetings including quality review programs and teaching conferences; and

k. pay medical staff dues

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

a. may vote in Medical Staff elections, on adoption or amendment of the Bylaws and associated Rules & Regulations and on issues presented at any meetings of the Department, Section or Medical Staff Committees of which he or she is a member;

b. eligible for election to serve as a Medical Staff Officers consistent with the requirements of Article VIII;

c. eligible to serve in departmental and sectional leadership roles as further defined in Article IX, X and XI;

d. eligible to serve as Members of the Medical Executive Committee as applicable and further defined in Article XVI, Section B;

e. eligible to be a voting member or Chair of any medical staff committee; and

f. will be granted priority access to resources of the Hospital including, but not limited to, procedure rooms, operating rooms and beds when access becomes restricted due to high census or utilization

2. **Active Referring**

Active Referring is a membership-only, Active staff category that shall consist of selected Physicians, Dentists and Podiatrists who are not clinically active in the Hospital inpatient or outpatient setting and will not serve as the responsible Attending physician for hospitalized patients. Members of this category are expected to maintain a commitment to the clinical, educational and/or community service mission of the Hospital and typically include primary and ambulatory care practitioners and others who will access Hospital services and facilities for their patients by referral for admission and care.

Physicians, Dentists and Podiatrists qualify for Active Referring status by:

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

b. meet the requirements of Article VI, Section B relative to office location;

c. maintaining a strong relationship with the Hospital through participation in formal Hospital Committees or administrative functions that support patient care when asked to participate; and

d. demonstrating a willingness, as appropriate, based on practice capacity and payor participation, to accept the referral of patients who do not have a relationship with a primary care or other relevant outpatient provider for outpatient care upon their discharge from the hospital or emergency department

Members of this category must meet the basic qualifications outlined in these Bylaws with the exception of any requirements related to hospital patient care activity.

Members of the Active Referring category:

i. do not hold clinical privileges and may not provide any clinical care to patients in any hospital inpatient or outpatient setting but may, by ordering such studies in the Hospital's electronic medical record, refer patients to a Hospital facility for outpatient laboratory, radiologic or other outpatient studies or services as permitted by Hospital policy;

ii. may not write/enter orders or progress notes or give verbal or telephone orders to direct the care of hospitalized patients (except as noted in item "i" above);

iii. are encouraged to follow their patients when hospitalized under the care of another physician and to participate in that care by offering any pertinent information via the electronic medical record or personal communication with the responsible practitioner to support the care while the patient is hospitalized and/or post-discharge;

iv. may visit their hospitalized patients socially and view their medical records;

v. must have appropriate training on the electronic medical record in order to use it to communicate via "Staff Messaging" with the practitioners responsible for the patient while hospitalized;

vi. may attend and participate in Departmental and other Hospital meetings including educational meetings such as Grand Rounds and other CME activities;

vii. are eligible to vote in medical staff elections, on adoption or amendment of Medical Staff Bylaws, Rules and on issues presented at Departmental Committee meetings;

viii. are eligible for election to serve as a Medical Staff Officer;

ix. are eligible to serve on any Medical Staff Committee;

x. are required to pay Medical Staff dues; and

xi. are exempt from Ongoing Professional Practice (OPPE) and Focused Professional Practice Evaluation (FPPE)

Members of the Active Referring category who wish to resume or begin hospital-based practice or care for patients at any hospital inpatient or outpatient location are eligible to apply for clinical privileges. Consistent with applicable Medical Staff Rules, if approved for privileges, training on the Hospital's electronic medical record system appropriate to the area of practice must be completed before participating in patient care at any Hospital facility.

Requests for clinical privileges will be reviewed individually relative to evidence of current competence and consistent with the relevant sections of these Bylaws. Proctoring may be required.

SECTION C. The Courtesy Staff

The Courtesy Medical Staff shall consist of those Physicians, Dentists and Podiatrists eligible for Medical Staff membership whose hospital based practice is primarily at another Connecticut hospital.

Members of this category:

1. are eligible for admitting, consulting and any other privileges for which they are qualified;

2. meet the requirements of Article VI, Section B relative to office location;

3. may attend meetings of the Medical Staff and their Department or Section;

4. are not eligible to vote at any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;

5. cannot serve as Medical Staff officers or as members of the Medical Executive Committee, Credentials Committee or Bylaws Committee;

6. are required to have a minimum level of clinical activity at the Hospital as determined by the relevant Department Chair or Section Chief in order to remain in this category and allow assessment of performance;

7. in the event that activity at the Hospital reaches a level that is consistent with other practitioners in the same Department or Section who are members of the Active Attending staff, the member will be automatically reassigned to the Active Attending staff and expected to fulfill any and all requirements associated with that status;

8. when the resources of the Hospital including, but not limited to, procedure rooms, operating rooms and beds becomes restricted due to high census or utilization, members of this category shall have lower priority access to these areas; and

9. are required to pay medical staff dues

Requirements for and exceptions to specialty board certification and recertification shall apply to members of the Courtesy Staff appointed after July 1, 1991.

SECTION D. The Pediatric Network (Attending, Referring) Staff

1. Pediatric Network Attending and Referring staff shall consist of physicians, dentists and podiatrists who meet all of the basic qualifications for Medical Staff membership set forth in these Bylaws. The primary purpose of this category is to permit these members to provide care specifically to pediatric patients within the YNH Children's Hospital network.

2. Individuals who meet the requirements as specified in ARTICLE IV, SECTION B(1a) are eligible for appointment as a "Pediatric Network Attending"

3. Individuals who are not clinically active at an YNH Children's Hospital are eligible for appointment to the "Pediatric Network Referring category.

4. Members of the Pediatric Network Staff are:

    a. granted admitting and other privileges as appropriate based upon local physician coverage arrangements that assure patient safety and continuity of care;
    b. willing to participate in teaching programs and to have their patients participate as part of teaching efforts;
    c. willing to actively participate, when requested, in relevant committees;
    d. may vote in committees to which they are appointed but may not vote in general medical staff meetings or general meetings of the department to which they are assigned;
    e. not eligible to vote in Medical Staff elections;
    f. not eligible to vote on adoption or amendment of Medical Staff Bylaws and Rules & Regulations;
    g. not eligible to hold office

5. Requirements for, and exceptions to, specialty board certification and recertification as described in these Bylaws shall apply to members of this category.

6. Nothing contained in the description above shall prohibit a Pediatric Network Attending from consideration for Active Medical Staff membership if requirements for local patient coverage are fulfilled.

SECTION E. The Consulting Staff

The Consulting Staff shall consist of physicians, and dentists and podiatrists who:

1. have specialized clinical expertise that is deemed desirable for patient care and/or student and trainee education;

2. do not have an established practice within the Hospital community as defined in Article VI (5a);

3. do not meet the requirements for Active Attending staff appointment relative to utilizing the Hospital as the primary site of hospital based practice or any geographic office or other location requirements;

4. have an active staff appointment and privileges at another hospital or hospitals;

5. are granted clinical privileges but generally may not admit or serve as the responsible Attending;

6. may attend meetings of the Medical Staff and their Department or Section;

7. are not eligible to vote at any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;

8. cannot serve as Medical Staff officers; and

9. do not pay medical staff dues

In those instances where individual patients require the special and unique resources of the Hospital, members of the Consulting Staff may act as the responsible Attending only by the granting of such privileges upon recommendation of the Chief and the Chief Medical Officer.

Members of the Consulting Staff who wish to apply for appointment to the Active or Courtesy Staff shall do so in accordance with the provisions of ARTICLE VI, SECTION G.

SECTION F. The Telemedicine Staff

Physicians, dentists and podiatrists whose relationship with the Hospital is strictly limited to providing service via telemedicine and, therefore, never physically provide service to patients at any Hospital site will be appointed to the Telemedicine category.

Telemedicine is defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications for the purpose of providing patient care, treatment and services.

Teleradiology is a specific subset of telemedicine which refers to the practice of providing either official or preliminary readings of images solely through a telecommunications link.

In order to be eligible for appointment to the Telemedicine Staff category, a Member must meet all eligibility requirements as stated in these Bylaws with the exception of those related to office location identified in Article VI, 5(a).

Members of the Telemedicine staff:

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

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

3. may not serve as a Medical Staff officer, Department Chief, Associate Chief or Section Chief, or Chair or member of any committee; and may not vote in any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;

4. except as relevant to fulfill obligations in providing telemedicine services, are exempt from all responsibilities of emergency service care (call), consultation assignments, and other duties; and

5. are required to pay Medical Staff dues

SECTION G. The Honorary Staff

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

Members of the Honorary staff:

1. do not have clinical privileges;

2. are not required to undergo reappointment;

3. are not required to have malpractice insurance;

4. may not serve as a Medical Staff officers, Department Chief, Associate Chief or Section Chief, or Chair of any committee; and may not vote in any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;

5. cannot serve on committees except with permission of the Chief Medical Officer and under unique circumstances involving special expertise;

6. may attend Medical Staff and Departmental and Section meetings of an educational nature;

7. may participate in Medical Staff social events;

8. are appointed for life and may be removed only for cause by the Medical Executive Committee; and

9. do not pay medical staff dues

SECTION H. The House Staff and Clinical Fellows

1. The House Staff shall consist of residents appointed to Medical Staff membership in this category by the Patient Safety & Clinical Quality Committee of the Board of Trustees upon recommendation, in turn, by the Chiefs of Departments, following consultation with the Associate Chiefs and the Medical Executive Committee. Such appointments are subject to review by the Board of Trustees as circumstances may warrant.

2. Clinical Fellows are Postdoctoral Fellows or subspecialty residents who have been appointed by Departments, function as trainees, and are appointed to Medical Staff membership in the same manner as House Staff.

3. Clinical Fellows who intend to function as Attending physicians and who are qualified for Medical Staff membership must apply for and be granted Active Medical Staff membership and privileges before acting in an Attending capacity. In these cases, the delineation of clinical privileges will specify which Attending functions are authorized and which functions are considered “in training”.

4. House Staff and Clinical Fellow appointments to the Medical Staff are co-terminus with the training appointment. Physicians, dentist and podiatrists in these categories who wish to apply for membership to another category of the Medical Staff must do so pursuant to Article VI.

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

SECTION I. Focused Professional Practice Evaluation

Consistent with the medical staff policy on Focused Professional Practice Evaluation (FPPE), a period of focused review is required for all new members of the medical staff who are granted clinical privileges and FPPE shall apply to all privileges. All individuals will be treated equally with respect to the length of FPPE unless there is justification to extend the period of FPPE as outlined in the FPPE Policy.

ARTICLE V. AFFILIATED HEALTH CARE PROFESSIONALS

Affiliated Health Care Professionals shall include the following:

Audiologists, nurse anesthetists, doctoral scientists, licensed nurse midwives, nurse practitioners, physician assistants, radiology assistants, physicists, psychologists and surgical assistants. Based upon the needs of the Hospital, other types of practitioners may be credentialed and privileged to this category upon recommendation of the Credentials Committee to the Medical Executive Committee and with approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.

Individuals appointed in this category are not considered Members of the Medical Staff and, as such, do not share in the rights of Medical Staff Members except as specifically outlined in these Bylaws. They are, however, subject to the same responsibilities and the same terms relative to provision of care and compliance with the Bylaws, Rules and Regulations and any applicable policies of the Medical Staff or Hospital.

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

Supervision

Nurse anesthetists, licensed nurse midwives, nurse practitioners and physician assistants shall practice under the supervision, control, responsibility and direction of a physician member of the Medical Staff and required to have a supervising (or collaborating) physician who is a member of the Medical Staff. The supervising or collaborating physician must have the training and experience relevant to the responsibilities of the Affiliated Health Care Professional.

Affiliated Staff in these professions may not exercise any clinical privileges without a supervising or collaborating physician and may only exercise privileges at the location(s) at which his/her supervising (or collaborating) physician is privileged to practice. In the event that a member of this staff who is required to have a supervising or collaborating physician is no longer sponsored by that physician, the member must immediately notify the Medical Staff Administration department, provide the name of the new supervising or collaborating physician or be deemed to have voluntarily resigned.

In the event that the supervising or collaborating physician becomes unexpectedly unavailable due to an emergency or another unforeseen circumstance for an extended period of time, one of or the alternative supervising or collaborating physician as identified in the written agreement shall assume responsibility until a permanent replacement can be confirmed.

A written supervising/collaboration agreement between a physician member of the Medical Staff and all nurse anesthetists, licensed nurse midwives, nurse practitioners and physician assistants is required. The agreements between a physician assistants and the supervising physician must be reviewed and renewed on an annual basis.

Supervision shall be defined as the oversight of, or the participation in, the work of the member of Affiliated Health Care Professional including availability of direct communication either in person or by telephone. The written supervising agreement shall define how alternate supervision by another appropriately privileged physician member of the Medical Staff shall be provided when the primary supervisor is unavailable.

Appointment and Privileging

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

Members in this category must have graduated from an accredited institution applicable to their profession and have and maintain certification and/or licensure by an appropriate body and, as applicable, in accordance with State of Connecticut statutes.

Affiliated Health Care Professionals shall be appointed in at least one of the Departments of the Medical Staff. Each Affiliated Health Care Professional shall be appointed in the same Department and, as applicable, Section as his or her supervising or collaborating physician.

Certain members of the Affiliated Health Care Professionals Staff are authorized to conduct medical screening examinations as defined under federal law. These include physician assistants and nurse practitioners and licensed nurse midwives, who are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms.

Affiliated Health Care Professionals:

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

2. may not vote in Medical Staff elections or on changes to the Medical Staff Bylaws, Rules or Regulations, medical staff policies or other Medical Staff matters;

3. are not required to pay medical staff dues

Referring Affiliated Health Care Professionals

Affiliated Health Care Professionals who practice in an outpatient setting only and wish to apply for membership only (no clinical privileges) as Affiliated Health Care Professionals must be under the supervision, as required, of a member of the Medical Staff. Individuals in this category typically seek this status for membership strictly for clinical support reasons (e.g. including, but not limited to, access to Hospital electronic medical records, conferences and meetings) and may be appointed to the Referring Affiliated Health Care Professionals category.

Members of this category, by definition do not hold clinical privileges, and shall be exempt from Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) requirements.

ARTICLE VI. STAFF MEMBERSHIP

SECTION A. Selection of Medical Staff

1. Yale New Haven Hospital, a major source of hospital service in the community, recognizes as its first and foremost obligation for the training of house staff, and, as the primary teaching hospital for the Medical School, to provide an optimal environment for the education of medical students, house staff and postdoctoral fellows, which environment and programs contribute significantly to the ability to deliver excellent patient care.

   Physicians, dentists, and podiatrists and Affiliated Health Care Practitioners who will be recommended for appointment will be those whose education, training, experience, professional competence and personal qualities enable them to provide excellent clinical care to their patients and qualify them to be directly involved in the formal teaching program. The standard of clinical care of each member of the staff must serve as an exemplary model for medical students and house officers. All applications for staff membership will be subjected to a critical review of clinical expertise.

2. The Board of Trustees, in order to fulfill its commitment to assure balanced use of Hospital resources, may impose restrictions upon or designate special circumstances for Staff selection. (ARTICLE VI, SECTION C.2)

SECTION B. Eligibility Requirements

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

1. **Bylaws, Rules, Regulations and Policies**
   Applicants and current Medical Staff must agree to abide by Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff Policies and Procedures

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

3. **Licensure**
   In order to be eligible for appointment, Medical Staff and Affiliated Medical Staff in all categories are required to have and maintain appropriate current licensure or a Medical School Permit (MSP) in the State of Connecticut in their profession as outlined herein.

   <u>Applicants for Initial Appointment</u>

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

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

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

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

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

Current Members

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

Section R. outlines the consequences of various licensure actions.

4. **Federal and State Drug Control Registration**

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

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

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

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

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

5. **Education**

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

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

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

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

CRNAs:
Certified Registered Nurse Anesthetists must be graduates of a state approved basic nursing education program and graduates of an education program accredited by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education Programs.

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

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

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

6. **Training**

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

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

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

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

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

7. **Competence**

Applicants for Initial Appointment

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

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

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

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

Current Members

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

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

b) Absent a sufficient volume of patient care activity at the Hospital, verification of competence and activity from another Hospital and/or from appropriate peers, acceptable to the Chief and Credentials Committee must be supplied in the form of references. References must be submitted consistent with the process and forms

required by Medical Staff Administration. This requirement is considered not applicable for individuals seeking appointment to the Active Referring or Referring Affiliated Health Care Professionals categories.

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

8. **Health Status**

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

New Applicants and current medical staff must disclose any limitations with their current physical or mental health that affects, or has the potential to affect, their ability to safely exercise the requested privileges and may be required to undergo specific testing.

Additionally, new applicants and current medical staff members must provide sufficient documentation to evidence fulfillment of requirements for mandatory vaccinations and any other standard health testing consistent with medical staff policies in order to be or remain eligible for membership and privileges.

Applicants and current members who fail to comply will be considered ineligible until all requirements are fulfilled.

Current members who do not comply will be automatically terminated.

Section R. outlines the consequences for failure to comply with health status requirements.

9. **Federal or State Health Care Programs**

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

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

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

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

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

10. **Insurance Coverage**

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

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

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

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

Section R. outlines the consequences of failure to maintain malpractice insurance coverage.

11. **Response Time**

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

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

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

12. **Continuing Education / Medical Staff Education**

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

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

Successful completion of any Medical Staff Education training required at the time of initial and reappointment must be done for an application for initial or reappointment to be deemed complete. The appointment and privileges of Medical Staff who fail to complete Medical Staff Education training before their current appointment lapses will be automatically terminated. Under these circumstances, the Medical Staff member will be eligible for reinstatement once there is evidence that training has been successfully completed.

Section R. outlines the consequences for failure to comply with the requirements related to continuing medical education or completion of medical staff education training.

13. **Medical Staff Dues**

The Medical Executive Committee shall establish the amount of medical staff dues to be collected and the categories of Medical Staff subject to payment of dues.

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

Dues are collected annually at the end of each calendar year. Payment is due the first Monday in January and invoices shall be sent a minimum of thirty (30) days before payment is due. Medical Staff who are required to pay dues are notified by Medical Staff Administration. Medical Staff dues are not prorated for any reason. A second notice is distributed to those who have not paid by the first Monday in January and the relevant Department Chief shall be informed of any members of their Department who are delinquent in making payment.

Medical Staff members subject to dues payment are appropriately informed of the required response time and consequences for failure to pay dues in a timely manner as outlined in Section R.

14. **Contracted and Exclusively Contracted Services**

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

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

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

Other Contractual Arrangements

Notwithstanding any other provision of the Bylaws, or of the Rules & Regulations, the Hospital may require that membership and clinical privileges be contingent upon, and expire simultaneously with, other agreements or understandings or contractual relationships that are not exclusive. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws, Rules & Regulations and policies of the Medical Staff with respect to a hearing shall not apply.

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

15. **Ethics and Professional Behavior**

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

Since the date of initial licensure to practice his/her profession, applicants and current members must have never been convicted of any felony or misdemeanor relevant to Medical Staff responsibilities.

16. **Board Certification**

Board Eligibility / Certification Requirements for Physicians, Dentists and Podiatrists

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

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

Members who are not certified at the time of appointment have five (5) years from the date of appointment to the Medical Staff by the Board of Trustees to achieve initial certification by the U.S. specialty certifying board applicable to his/her practice in order to remain eligible for membership and privileges.

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

This requirement shall not apply to physicians or dentists engaged in the general practice of Medicine or Dentistry who held an appointment prior to January 1, 1982, for members of the Courtesy Staff appointed prior to July 1, 1991, or for other Staff appointed prior to July 1, 1991, who, absent Specialty Board Certification, shall be re-assigned to the Courtesy Staff. This requirement shall also not apply to individuals appointed to as a result of the acquisition of the Hospital of Saint Raphael who were members of the Medical Staff of the Hospital of Saint Raphael prior to January 31, 1995.

Board Re-Certification Requirements for Physicians, Dentists and Podiatrists

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

Exceptions to Board Certification Requirements

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

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

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

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

Physicians

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

Dentists

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

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

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

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

SECTION C. Additional Requirements

1. **Practice History**
   At the time of application for appointment, each applicant shall answer the "Practice History Information" questions including whether or not the applicant has:

   (a) been convicted of or charged with or pled guilty to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent thereof;

   (b) been denied any license, certification, narcotics permit, hospital appointment or privilege;

   (c) had any license, certification, narcotics permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily;

   (d) been the subject of any disciplinary action including allegations related to any form of impairment, disruptive behavior or unprofessional conduct;

   (e) have any condition that would compromise his/her ability to practice with reasonable skill and safety; and

   (f) are currently engaged in illegal drug use or dependent upon any controlled substance or alcohol.

   Information provided by applicants in conformance with this requirement shall be treated as confidential.

2. **Moratoriums**
   In addition to the eligibility requirements set forth in Section B above membership in an Active Medical Staff category (Active Attending or Active Referring) is also is subject to limitation by appropriate action taken in accordance with the provisions of ARTICLE VI, SECTION H below. In addition, Medical Staff membership shall be granted and maintained based upon institutional needs to fulfill missions of service, education and research as determined by institutional and program planning processes.

3. **Establishment of Office Practice**
   In addition to those qualifications set forth in Section B., Active and Courtesy members of the Medical Staff shall:

a. occupy an office and be actively practicing in New Haven or a neighboring community[1]; or

b. at the time of application certify the intent, if appointed, to establish such practice within six months of the date of application.

Affiliated Health Care Practitioners shall occupy an office and be actively practicing and have a supervising (or collaborating) physician agreement with a member of the Active, Courtesy or Pediatric Network Medical Staff.

Physicians practicing remotely but providing care via telemedicine, teleradiology or in any other specialty to patients being cared for currently by or at the Hospital must be a member in good standing of the Medical Staff, meet eligibility and all relevant requirements contained in the these Bylaws and be appointed to the Telemedicine category.

Section D. Requirements for House Staff

An applicant for membership on the Medical Staff in the House Staff category shall:

a. be a graduate of a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), a dental school accredited by the Commission on Dental Accreditation (CODA), a podiatric school accredited by the Council on Podiatric Medical Education (CPME), or be a foreign medical or dental school graduate who is certified by the ECFMG;

b. be licensed without restriction to practice in the State of Connecticut or be permitted to practice without license by statute or regulation;

c. have valid malpractice insurance in the minimum amounts required by the Board of Trustees;

d. be recommended by the appropriate Chief of Department;

e. be required to respond to the "Practice History Information" required in ARTICLE VI, SECTION B, paragraph 3 above.

SECTION E. Responsibility of Applicants for Appointment / Re-Appointment

All applicants, members and affiliated members of the Medical Staff are responsible for providing information deemed adequate for an appropriate evaluation of education, training, experience, current competence, ethics, personal qualities and qualifications to serve as an exemplary model for medical students and house officers and for resolving any doubts that arise regarding their qualifications during the appointment or reappointment process.

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

[1] For purposes of ARTICLE IV "neighboring community" means one of the following towns: Ansonia, Beacon Falls, Bethany, Branford, Cheshire, Chester, Clinton, Deep River, Derby, Durham, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Madison, Meriden, Middlefield, Milford, Naugatuck, North Branford, North Haven, Old Saybrook, Orange, Oxford, Prospect, Seymour, Wallingford, Westbrook, West Haven, Woodbridge.

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

Any application for appointment or re-appointment that continues to be incomplete sixty (60) days after the applicant has been notified of additional information required will be deemed to have been withdrawn.
Applicants for appointment and re-appointment attest that all statements, answers and information contained in their application and supporting documents are true, correct and complete to the best of their knowledge. Any misstatement or omission from the application is grounds to cease processing the application. The applicant will be informed of the misstatement or omission and permitted to provide a written response. If, upon review, a misstatement or omission is determined to be immaterial and/or unintentional, processing will resume.

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

SECTION F. Time Limits

Action on completed applications for appointment and re-appointment and requests for clinical privileges as well as all other actions required under this ARTICLE VI for which no time limit is specified shall be taken within reasonable periods of time, which generally shall not exceed one month.

SECTION G. Code of Conduct

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

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

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

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

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

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

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

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

- derogatory comments or criticisms about the quality of care provided by the Hospital, another Medical Staff member, or any other individual made outside of an appropriate forum;
- impertinent or inappropriate comments (or illustrations) made in medical records or other official documents concerning the quality of care provided by the Hospital or another individual

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

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

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

Examples of serious violations of the Code of Conduct include, but are not limited to:

- deliberate destruction of any hospital property

- possession of any unauthorized firearm or weapon

- gross immoral, fraudulent or indecent conduct

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

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

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

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

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

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

Violations of the Code of Conduct shall be referred to and reviewed by the Medical Staff Professionalism Committee (MSPC) and referred to the Credentials Committee as deemed appropriate.

SECTION H. Procedure for Implementing Departmental Plans for Staff Selection and Establishing Temporary Moratoriums on New Staff Appointments

The designation by the Board of Trustees of limitations upon or moratoriums for either Staff appointment or for access to specific clinical privileges, as provided in ARTICLE VI, SECTION A, Paragraph 2 above, will be in accordance with the following procedures:

1. A Chief, after consultation with, and review by, the Associate Chief where applicable, the Departmental Committee, the President and the Chief Medical Officer, may recommend to the Medical Executive Committee the categories of specialties, the number of members of the Department and/or the number of applicants for access to a specified clinical privilege that appropriately can be supported by resources available within the Hospital. Where the clinical privileges in question are available to applicants in more than one Department, the Chiefs of the respective services shall submit a joint plan. If agreement cannot be reached, the opinions of all the affected Chiefs shall be submitted. Any recommendation of limitation shall include a written statement of justification. The recommendation(s) of the Chief(s) shall be subject to the review and approval of the Medical Executive Committee, the Patient Safety & Clinical Quality Committee, and the Board of Trustees.

2. Any limitation on Departmental or Section size, or limitations on the number of Medical Staff members possessing a specific clinical privilege will not affect existing staff or privileges. Such a limitation, however, will affect a current Medical Staff member who does not yet possess a requested clinical privilege that has been limited.

3. If one or more Chiefs or Associate Chiefs believe that an immediate need exists for consideration of a moratorium, either for new staff appointments or for specific clinical privileges, such Chiefs or Associate Chiefs may, after consultation with the appropriate Departmental committee, submit a written request for a moratorium to the Chief Medical Officer. A request for a moratorium may also be made by the Chief Medical Officer after consultation with the affected Chief(s). The written request for a moratorium shall delineate the type and extent of any limit requested, whether it be for new staff appointments or for access to a specified clinical privilege, the evidence justifying the moratorium request, the goal to be achieved by the moratorium, and such other pertinent documentation or information, including evidence of review by the Departmental or Sectional Committee, its recommendation, if any, and the views of other Chiefs whose Department will be affected if any.

4. The Chief Medical Officer shall, upon generation of or receipt of the request, immediately forward written notification of the request and its documentation to the President and to the Medical Executive Committee. The Chief Medical Officer shall also provide written notification to any applicant for appointment to the Medical Staff or any applicant for the specified additional clinical privilege whose application may be affected if the request for moratorium is approved.

5. The Medical Executive Committee shall review the request for the moratorium within thirty days and shall forward its recommendation to the Patient Safety & Clinical Quality Committee.

6. The Patient Safety & Clinical Quality Committee shall submit its recommendations to the Board of Trustees within sixty days of generation of or receipt of the recommendation by the Chief Medical Officer.

7. The Board of Trustees shall take final action within sixty days after receipt of the recommendation from the Patient Safety & Clinical Quality Committee.

8. If the Board of Trustees approves a moratorium as requested, unless otherwise specifically provided by the Board of Trustees, the moratorium shall apply to all new Medical Staff applications and/or all pending applications for the additional specified clinical privilege(s) that have not been forwarded by the Chief Medical Officer pursuant to Article VI, Section H, Paragraph 6.

9. The initial moratorium period will not exceed one year. To extend, modify or eliminate the moratorium, the Chief Medical Officer, or an affected Chief or Associate Chief may request an extension, modification or elimination that shall be processed in accordance with the provisions of this section.

10. The Patient Safety & Clinical Quality Committee, at its discretion, may declare a moratorium on processing applications either for Medical Staff appointments or applications for specified clinical privileges, as the case may be, upon the receipt of the written request by the Chief Medical Officer. Candidates for appointment or for the privilege in question whose applications are pending or are received during the period of the moratorium shall be so notified by the Chief Medical Officer immediately, and their applications shall be processed upon denial of the moratorium by the Board of Trustees, or upon termination or non-renewal of the moratorium, whichever comes first.

SECTION I. Application for Membership

1. Subject to any limitation or moratorium pursuant to ARTICLE VI, SECTION H, applications for membership on the Medical Staff shall be made available via the Hospital website.

2. Applicants must meet the eligibility requirements identified in Section B and C.

3. Applicants must apply for primary appointment in at least one of the Hospital Departments (See Article XI, Section (A)(1)) and must apply to a specific Section within that Department if the applicant requests approval to practice the clinical function delineated within that Section. The primary appointment shall be chosen based on the applicant's primary training and experience and intended area of clinical practice. In addition, an applicant may request a secondary appointment in another of the Hospital Departments and Sections if appropriate based on training and experience.

4. Applications for membership and clinical privileges shall be filed on the prescribed forms, which shall record the biographical data (including social security number) of, and list the references for, the applicant.

   Licensure, education and relevant training shall be verified for each applicant. Verification is obtained from the original source whenever possible and consistent with current accreditation and other relevant standards. Information may be sought from other sources as deemed appropriate during the credentialing process or validate or seek clarification regarding information contained in the application for appointment. Information will be obtained from the National Practitioner Databank as available and consistent with the requirements of the Health Care Quality Improvement Act of 1986.

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

6. The applicant shall be notified if any information obtained during the verification process renders him or her ineligible for membership consistent with the eligibility requirements as stated in Section B or C.

7. The application shall include a statement read and signed by the applicant in which the applicant agrees to abide by the Medical Staff Bylaws and the Rules and Regulations and policies of the Medical Staff, by Hospital policies applicable to the applicant's activities, and to practice within the scope of delineated clinical privileges. Moreover, the submission of an application shall also be deemed to automatically

constitute such an agreement. A copy of these Bylaws and Rules and Regulations are made available to each applicant on the Hospital website or through Medical Staff Administration.

SECTION J. Procedure for Appointment of New Members of the Medical Staff

1. Application for appointment to the Medical Staff shall be submitted to the Medical Staff Administration department and shall be accompanied by the required, non-refundable application fee. An application fee shall not be required of those applying to the House Staff or Clinical Fellow categories. Once deemed complete consistent with ARTICLE VI, SECTION C, the application shall be referred to the Chief of the appropriate Department and, where applicable, to the Associate Chief for consideration.

2. The Chief of Department and/or, where applicable, the Associate Chief, shall evaluate, or cause to be evaluated, the character, qualifications and standing of the applicant. This review may include a personal interview with the applicant and shall include review of a confidential record to comply with the requirements of ARTICLE VI, SECTION B, Paragraph 3.

3. Following such evaluation and consultation, the application, together with the recommendations of the Chief and Associate Chief, shall be submitted to the Chief Medical Officer. If the recommendation is for approval, a statement delineating clinical privileges signed by the applicant and the Chief and, where appropriate, by the Associate Chief shall accompany the application. Should a difference of opinion arise between the Chief and the Associate Chief, the application, together with the written recommendations of each, shall be submitted to the Chief Medical Officer.

4. The process described in paragraphs 2 and 3 above must be completed within a maximum of twenty (20) business days. If the application requires Sectional recommendation, the Section shall have a maximum of ten (10) business days to make a recommendation. With or without such recommendation, the application will then be forwarded to the Chief for recommendation by the Chief and Associate Chief, if applicable. The Office of the Chief shall have a maximum of ten (10) business days to make a recommendation. After twenty (20) business days, even if all the recommendations have not been recorded, the application will be forwarded to the Office of the Chief Medical Officer for review. All applications lacking one or more Departmental/sectional approvals will undergo mandatory Credentials Committee review. The Credentials Committee may choose to interview those whose recommendations were withheld.

5. The Chief Medical Officer or his designee(s) shall review the completed application and certify its compliance with ARTICLE VI, SECTION B, and with the procedures specified in ARTICLE VI, SECTION G, Paragraphs 1, 2, 3 above. A completed application may be held in abeyance in accordance with the provisions of ARTICLE VI, SECTION F.

6. The Chief Medical Officer or his designee(s) shall further review the completed application and shall either recommend approval or withhold approval. If approval is withheld by the Chief Medical Officer or his/her designee(s), the application will undergo mandatory Credentials Committee review. All applications recommended for approval shall be forwarded to the Medical Executive Committee or the Medical Executive Committee Administrative Committee pursuant to paragraph 7 below.

7. The Credentials Committee, established in accordance with provisions of ARTICLE XVI, SECTION F, Paragraph f of these Bylaws, shall review any application in which approvals have been withheld pursuant to paragraph 4 or 6 above, in which the applicant's qualifications or delineation of clinical privileges are contested in any other way, in which exceptions from routine eligibility requirements are sought, and any other application received by it. In each case the Credentials Committee shall make a determination if the application is eligible for expedited review. Initial applications for appointment shall be reviewed by the Credentials Committee Sub-Committee consistent with Medical Staff Policy.

The Credentials Committee shall then transmit its recommendation and the recommendations of its Sub-Committee, to the Medical Executive Committee or the Medical Executive Committee Administrative Committee if the application can be expedited, or to the Medical Executive Committee if not.

8. The Medical Executive Committee or the Medical Executive Committee Administrative Committee shall review the recommendation of the of the Chief Medical Officer (or his designee(s)), and the recommendation of the Credentials Committee and its Sub-Committee, if any, and, if it approves the application, shall make a formal recommendation to the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Patient Safety & Clinical Quality Committee thereupon shall consider the recommendation and, if it concurs, may grant final approval to the application.

   Since the approval of the Patient Safety & Clinical Quality Committee constitutes final action by the Board of Trustees, the Chief Medical Officer shall notify the applicant of the appointment including the approved privileges. If the applicant was ineligible for any initially requested privileges, he/she is notified of the reason (i.e. lack of eligibility or adequate experience).

   The Medical Executive Committee or Medical Executive Committee Administrative Committee may also determine that an application is incomplete and/or refer it back to the Credentials Committee or Department Chief or Associate Chief for further evaluation consistent with ARTICLE VI, Section C.

   In the event that the Medical Executive Committee does not recommend an applicant for initial appointment, the Fair Hearing Plan (ARTICLE VII) shall apply as appropriate.

11. In the event that the Medical Executive Committee or the Medical Executive Committee Administrative Committee recommends approval of an application and the Patient Safety & Clinical Quality Committee of the Board of Trustees does not accept such recommendation, the Patient Safety & Clinical Quality Committee of the Board of Trustees shall return the application to the Medical Executive Committee with a statement of its reasons for such action. As appropriate, the Medical Executive Committee thereupon shall reconsider the application or may, in turn, refer it back to the Credentials Committee or Department Chief or Associate Chief for further evaluation. If the application is deemed incomplete, consistent with ARTICLE VI, Section C, the Credentials Committee shall notify the applicant in writing of what is required in order for the application to be considered further.

12. In the event that the Medical Executive Committee, after reconsideration, does not change its recommendation, it shall return the application to the Patient Safety & Clinical Quality Committee of the Board of Trustees, stating its reasons for continuing to recommend approval. The Patient Safety & Clinical Quality Committee of the Board of Trustees thereupon shall reconsider the application. If, upon reconsideration, the Patient Safety & Clinical Quality Committee of the Board of Trustees concurs with the Medical Executive Committee, it shall transmit its favorable recommendation to the Board of Trustees.

    If, upon reconsideration, the Patient Safety & Clinical Quality Committee of the Board of Trustees continues to deem the application incomplete or the applicant ineligible, it shall transmit its recommendation, along with the recommendation of the Medical Executive Committee, to the Board of Trustees.

13. The Board of Trustees shall receive and take final action on all recommendations in which the Patient Safety & Clinical Quality Committee recommends unfavorable action or in which there has been appellate review.

14. Upon final action by the Board of Trustees, the Chief Medical Officer shall notify the applicant in writing of the decision as described in Paragraph #8. All appointments shall be effective from the date of final action by the Board of Trustees.

15. In the event that an application is denied in final action by the Board of Trustees, the Chief Medical Officer shall notify the applicant including the reason for the denial. Such applicants shall be given an opportunity for a hearing in accordance with the provisions of the Fair Hearing Plan, ARTICLE VII.

16. All hearings and appellate reviews shall be conducted in accordance with the provisions of the Fair Hearing Plan, ARTICLE VII. These Bylaws shall be construed so as to entitle an applicant with respect to Medical Staff membership or privileges to only one hearing and appellate review. The Departmental Appeal procedure set forth in ARTICLE XV is inapplicable, and all hearings and appeals under this Article shall be subject exclusively to the provisions of the Fair Hearing Plan, ARTICLE VII.

17. Upon approval by the Board of Trustees of an application for appointment contingent upon the establishment of an active practice as described in ARTICLE VI, SECTION B, Paragraph 5, the Chief Medical Officer shall:

    a. notify the applicant of that action;

    b. determine when the conditions of ARTICLE VI, SECTION B, Paragraph 5 have been fulfilled;

    c. determine that, during the interval since the original application, no change has occurred to alter the acceptability upon which earlier favorable action was taken;

18. Consistent with the Medical Staff Policy on Focused Professional Practice Evaluation (FPPE), all new clinical privileges for members and Affiliated Staff are subject to a period of focused review.

SECTION K. Procedure for Reappointment

1. Unless specifically provided otherwise by the Board of Trustees (See ARTICLE VI, Section J.), all Hospital Medical Staff reappointments shall be made by the Patient Safety & Clinical Quality Committee of the Board of Trustees on a rolling basis, but not less than biennially.

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

3. Applicants must meet the eligibility requirements identified in Section B and C.

4. A complete assessment process shall be conducted for each member of the Medical and Affiliated Staff who requests reappointment. Criteria to be included in the assessment process shall include:

    a. a satisfactory health status report submitted by the Medical Staff member including but not limited to supplying evidence of required health testing (such as PPD) and evidence of recommended or mandatory vaccination(s);

    b. verification of current medical licensure as required by ARTICLE VI (B)(1).

    c. a review of existing and any newly requested clinical privileges for which focused evaluation was required shall be conducted including an evaluation of current

performance competency based upon the ACGME six general competencies (Patient Care, Medical/Clinical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice);

d. review of Hospital activities and interactions;

e. review of participation in continuing medical education;

f. assessment of the appropriate use of hospital resources;

g. review of confidential information, including malpractice and claims losses

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

The Medical Staff Administration department shall be responsible for gathering data for reappointments.

5. Applicants for reappointment must meet the same standards as those required for initial appointment. Conformance with the qualifications needed for reappointment and information adequate to allow a delineation of clinical privileges must be documented by the applicant. (See ARTCLE VI. Section B.)

6. Medical and Affiliated Staff members shall maintain an activity level determined by the Department to be adequate to allow assessment of their performance and current competence.

7. Physicians, Dentists and Podiatrists members of the Active Staff shall be expected to attend a majority of Departmental patient review meetings as a criterion to be considered in the reappointment process. Where the primary and secondary appointments are in Sections of the same Department, with the approval of the Chief, the applicant may fulfill the conference/meeting requirements in either Section.

8. Compliance with (i) the provisions of these Bylaws and Rules and Regulations; (ii) policies of Departments and Sections that have been approved by Departmental or Sectional Committees that include equivalent University and Community representation in Departments or Sections with both University and Community members; and (iii) policies of Medical Staff and Medical Executive Committee Committees, also shall be used as a criterion for reappointment.

   Whenever failure to supply information required for reappointment or an incomplete application (See ARTICLE VI, Section C) results in the lapse of Medical Staff appointment, the member shall be required to reapply for Medical Staff membership and clinical privileges in the same manner as one applying for initial appointment.

9. The reappointment application and materials will be forwarded to the appropriate Department Chief(s) for consideration. In Departments that have Associate Chiefs, the Chief shall include the Associate Chief in the assessment process.

   In Departments with more than 100 members, the Chief may delegate the responsibility for evaluation of reappointment to Section Chiefs if the latter are deemed more familiar with applicant qualifications. The Department shall have a maximum of thirty (30) business days to make its reappointment recommendation. If the application requires Sectional recommendation, the Section shall have a maximum of fifteen (15) business days to make a recommendation.

   With or without recommendation from the Section, the application will then be forwarded to the Chief for recommendation by the Chief and Associate Chief, if applicable. The Office of the Chief shall have a maximum of fifteen (15) business days to make a recommendation. The recommendation shall include, as

applicable, the results of the FPPE conducted for privileges that were newly approved at the time of the last re-appointment.

In the event of a disagreement with respect to a recommendation for reappointment, the application shall be referred to the Medical Executive Committee via the Credentials Committee.

After thirty (30) business days, even if all the recommendations have not been recorded, the reappointment application will be forwarded to the Credentials Committee for consideration. All reappointment applications lacking one or more Departmental/Sectional approvals will undergo mandatory Credentials Committee review. The Credentials Committee may choose to interview those Chief, Section Chief and/or Associate Chiefs whose recommendations were withheld. The Credentials Committee shall function with respect to reappointment as required by ARTICLE VI, Section H.

10. The names of those members of the Medical and Affiliated Staffs nominated for reappointment shall be submitted by the Credentials Committee to the Medical Executive Committee or the Medical Executive Committee Administrative Committee.

11. The Medical Executive Committee or the Medical Executive Committee Administrative Committee shall consider such nominations and, if it recommends reappointment without change, transmit its recommendations to the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Patient Safety & Clinical Quality Committee of the Board of Trustees thereupon shall consider the recommendation and, if it concurs, may grant final approval to the application. Since approval by the Patient Safety & Clinical Quality Committee constitutes final action by the Board of Trustees, the Chief Medical Officer shall notify the applicant of the reappointment including the approved privileges. If any privileges requested for renewal or newly requested privileges are not recommended for approval, the applicant is notified of the reason (i.e. lack of eligibility or adequate experience.). Newly approved privileges are subject to Focused Professional Practice Evaluation consistent with medical staff policy. All reappointments shall be effective for no more than three years.

12. In any case in which a physician, dentist or podiatrist who is currently a member of the Medical Staff is not nominated for reappointment, or is nominated for appointment to a different staff category, or requested privileges are denied or reduced for reasons not related to administrative eligibility without the approval or agreement of the applicant, and the Medical Executive Committee or the Medical Executive Committee Administrative Committee contemplates recommending that such change in status be approved, or in the event that the Patient Safety & Clinical Quality Committee of the Board of Trustees disagrees with a recommendation of the Medical Executive Committee, the procedure set forth in ARTICLE VI, SECTION H, Number 10 - 15 and the Fair Hearing Plan (ARTICLE VII) shall apply as appropriate.

13. If a physician or dentist who was an Active Staff member on February 28, 1983 is not reappointed an Active Staff member solely because of a failure to meet the qualifications set forth in ARTICLE IV, SECTION B, Paragraph 1, such physician or dentist shall have the right to be appointed to the Courtesy Staff, but shall continue to have the same admitting privileges and access to Hospital resources as do members of the Active Staff, limited by the individual's delineation of clinical privileges.

14. The final action of the Patient Safety & Clinical Quality Committee of the Board of Trustees or the Board of Trustees (in contested cases) on reappointment shall be transmitted in writing by the Chief Medical Officer to each member of the Medical Staff consistent with Paragraph #3.

15. In the event that an application for re-appointment is denied in final action by the Board of Trustees, the Chief Medical Officer shall notify the applicant including the reason for the denial. Such applicants shall be given an opportunity for a hearing in accordance with the provisions of the Fair Hearing Plan (ARTICLE VII).

SECTION L. Conditional Re-Appointment

In the event that an investigation or hearing is pending and a member of the Medical Staff or Affiliated Staff is due for re-appointment, a short-term conditional re-appointment may be granted, pending the conclusion of the process. Conditional re-appointments are subject to the same requirements and are approved through the same process as all other re-appointments as outlined in Section I.

SECTION M. Requests for Additional Privileges

Medical and Affiliated Staff members may apply for additional privileges between re-appointment cycles.

Requests shall be made through submission of a new privilege delineation in the appropriate Department or Section based upon the applicant's training and experience. Evidence of current competence, including activity or other documentation necessary to meet credentialing criteria as specified on the privilege delineation, is required. Assessment of competence shall be evaluated through information provided by appropriate professional references.

Verification of appropriate current licensure and other applicable components of the assessment process as specified in ARTICLE VI, Section I, Number 2 shall be completed. Information will be obtained from the National Practitioner Databank as applicable

The approval process for privileges requested between re-appointment cycles shall be the same as outlined in ARTICLE VI, Number 8 – 13.

SECTION N. Temporary Privileges

1. Temporary privileges may be granted to a qualified candidate for Medical Staff membership by the Chief Executive Officer or his/her designee. A candidate shall not be considered qualified for temporary privileges until the application for privileges is complete consistent with ARTICLE VI, SECTION C. Temporary privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less.

    a. On the occurrence of any event of a professional or personal nature which casts doubt on the candidate's qualifications or ability to exercise the temporary privileges granted, the Chief Medical Officer, in consultation with the appropriate Chief and, where applicable, the Associate Chief, may suspend or terminate temporary privileges.

    b. A candidate shall have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges or termination of such privileges.

2. Guest Privileges for visiting Medical Staff. The Chief Medical Officer, on request of the department Chief, and either the Associate Chief or Chief of the applicable Section, may grant guest privileges. Guest privileges may be granted to officially recognize the professional credentials of a visiting physician, dentist or podiatrist who may be invited to participate in the delivery of patient care. They may also be granted in situations where the guest professional possesses skills that are required for patient care and cannot be supplied by currently privileged members of the Medical Staff. Guest privileges shall be for a period not to exceed 30 days.

3. Guest privileges may not be granted or renewed more than three times in a calendar year. With the approval of the Chief Medical Officer, exceptions may be made for continuity of care purposes.

4. Individuals seeking Guest privileges are required to submit an appropriate application and comply with the requirements set forth in the Medical Staff policy on Guest Privileges including satisfactory

documentation of immunization status and successful completion of the required Medical Staff Education program which includes, but is not limited to, training in infection control and prevention, standard precautions, blood and airborne pathogen precautions, use of patient restraints, pain management and other significant Hospital policies.

5. Guest privileges will be granted only after verification that the applicant's current competence, professional license and hospital privileges elsewhere are in good standing, and that malpractice insurance is in place and applicable at the Hospital. Other verifications may be required.

6. In the case of a Federal or State government or Hospital declared emergency and when resources of existing Hospital Medical Staff have been or are predicted to be exhausted, the Chief Medical Officer or his/her designee may grant Disaster Privileges to volunteer practitioners in accordance with Yale New Haven Health Medical Staff Policy and Procedure for Disaster Privileges. The Connecticut Statewide Emergency Credentialing Program may be used to assist in the identification and contact of potential volunteers. Disaster privileges will terminate immediately upon identification of any adverse information about the practitioner, and/or in accordance with the Disaster Privileging Policy and Procedure. In any case, privileges will be granted only for the duration of the emergency.

7. In each instance, those granted temporary/guest privileges of any kind shall be reported the next regular meeting of the Medical Executive Committee or the Medical Executive Committee Administrative Committee and then subsequently to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

SECTION O. Physician Health and Well-Being

1. A member of the Medical Staff or the Affiliated Staff who is or may be unable to practice with reasonable skill and safety, regardless of the reason, shall be evaluated in accordance with relevant Medical Staff Health policy. The primary purposes of this Medical Staff policy are the remediation and rehabilitation of the individual while at the same time emphasizing patient and staff safety.

2. The confidentiality of the individual involved shall be maintained to the extent possible and consistent with law, ethical obligations and patient safety.

3. If at any time during diagnosis, treatment or rehabilitation, it is determined that the individual is unable to safely perform the privileges granted, the matter will be forwarded to the Chief Medical Officer and Department Chief for appropriate corrective action.

SECTION P. Leaves of Absence

A leave of absence from the Medical Staff may be either: (1) requested by a Member or (2) activated by the Chief Medical Officer.

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

<u>Leaves of Absence Requested by Members</u>
Members typically request leaves of absence for, but not limited to, the following reasons: personal health or mental health concerns or health concerns of the medical staff member's family; maternity/paternity leave; practice relocation, or military duty.

University based Medical Staff members may request a leave of absence to coincide with an academic or research sabbatical.

In order to request a leave of absence, the Medical Staff member must personally submit a written or email notice to the Department Chief and Chief Medical Officer, copied to Medical Staff Administration. Medical Staff members are expected to request a leave any time they are away from Medical Staff or patient care responsibilities for longer than thirty [30] days due to circumstances which affect, or have the potential to affect, their ability to care for patients safely and competently.

The request for a leave must include the reason for the leave, the start date and anticipated return date. The period of time for a leave of absence may not initially exceed one year. A leave of absence may be renewable upon written request by the Medical Staff member, up to a maximum of two years.

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

Leave of Absence Activated by the Chief Medical Officer

At any point after becoming aware that a Member of the Medical Staff is away from patient care responsibilities or due to circumstances which affect, or have the potential to affect, the ability to care for patients safely and competently, the Chief Medical Officer may automatically place a member on leave of absence. The Chief Medical Officer may consult with the Department Chief and other medical staff leaders or the Medical Staff Health Committee as deemed necessary.

Approval of Leave of Absence

The Chief Medical Officer or his/her designee approves all leaves of absence and their duration. As a matter of routine, approved leaves of absence are reported along with other routine medical staff changes to the Credentials Committee, Medical Executive Committee and Patient Safety and Clinical Quality Committee of the Board of Trustees.

Notification

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

Return from a Leave of Absence

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

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

If the leave of absence was for personal physical (except for maternity leave) or mental health or other health conditions, the request for reinstatement must be accompanied by a report from the individual's physician or, as applicable, treatment facility or program, indicating that the individual is capable of resuming a hospital practice and there are no conditions which have or have the potential to affect the

member's ability to care for patients safely and competently. The member must execute any release(s) requested by the relevant medical staff leaders to facilitate communications with the individual's physician (or, if applicable, treatment facility or program) to adequately assess his or her ability to resume safe practice.

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

Applicable State licensure, DEA and state controlled substance registration and professional liability insurance coverage must be current and any reappointment application materials must be received in order for the Member to return from a leave.

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

Failure to Request Renewal of Leave or Reinstatement/Return from Leave of Absence

Failure to request renewal of a leave at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

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

Systemwide Notification

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

SECTION Q. Change of Practice

All Community and University-based members and Affiliated members of the Medical Staff, must notify the Medical Staff Administration department in writing of any change in practice location. The notification must include a statement about new coverage arrangements, proof of malpractice insurance that covers their practice at the Hospital and new request for privileges (as applicable). Information will be forwarded to the appropriate Chief/Associate Chief for a recommendation as applicable.

Changes in practice information must be submitted thirty (30) days prior to the anticipated practice change date. Membership and privileges of individuals who fail to notify the Medical Staff Administration department of their relocation within the required time frame will be considered automatically relinquished pending receipt of the required information and subsequent review and recommendation by the appropriate Chief/Associate Chief.

Additionally, all members and Affiliated members of the Medical Staff are obligated to inform the Medical Staff Administration department in a timely manner of any changes to any contact information regardless of whether it relates to a change in practice location.

SECTION R. Resignation from the Medical Staff

1. Any member of the Medical Staff may resign at any time. Resignation may be in writing or may be deemed to have occurred when the member no longer meets eligibility criteria, has not requested a Leave of Absence, fails to satisfy requirements to return from a leave of absence, or fails to request or complete his/her application for reappointment within required time frames and consistent with the requirements of ARTICLE VI, SECTION C.

2. A member of the Medical Staff is expected to have completed clinical and record-keeping responsibilities at the time of resignation. A physician, dentist or podiatrist or Affiliated Health Care Professional who resigns from the Medical Staff without having completed and signed medical records and fulfilled other clinical responsibilities will be deemed to have resigned but not in good standing.

   In accordance with Rule #19 of the Medical Staff Rules & Regulations, members of the Medical Staff who are subject to automatic termination of their membership and privileges due to failure to comply with requirements for delinquency of medical records and discharge summaries must fulfill medical record documentation requirements in order to be eligible for reinstatement to the Medical Staff.

SECTION S. Ethics and Ethical Relationships

Each member of the Medical Staff by acceptance of appointment to the Medical Staff pledges to:

(a) refrain from fee splitting or other inducements relating to patient referral;

(b) provide for continuous care of patients;

(c) refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a physician, dentist, or podiatrist or other individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(d) seek consultation whenever necessary;

(e) obtain proper informed consent as a prerequisite to any procedure requiring informed consent including the identity of the operating surgeon or the responsible physician; and

(f) comply with Medical Staff Rules & Regulations and Hospital and Health System Policies concerning confidentiality; and

(g) when providing professional services at 1450 Chapel Street, to abide by the Ethical and Religious Directives for Catholic Health Facilities as published by the United States Catholic Conference (the "Directives"). Application of the Directives shall be as set forth in policies of the Medical Staff, as such policies may be modified from time to time in consultation with the Hospital's Catholic Heritage Committee and approved by the Board of Trustees.

Failure to fulfill these and other obligations imposed by these Medical Staff Bylaws, Rules and Regulations shall result in appropriate formal disciplinary action.

SECTION T. Notification Requirements, Termination and Suspension from the Medical Staff

1 . **Medical Staff Members Obligation to Report**

All members of the Medical Staff shall immediately report the occurrence of any of the following to the Chief Medical Officer:

(a) loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation and/or fine) whether voluntary or involuntary that is taken regarding a professional license in Connecticut or any other state;

(b) loss (other than for routine non-renewal), suspension, consent order or any other action whether voluntary or involuntary that is taken with regard to state or federal authority to prescribe controlled substances;

(c) loss (other than routine non-renewal or resignation of unused clinical privileges), suspension, reduction, resignation, relinquishment, limitation (or any other action arising out of concerns related to competence or professional deportment of membership or clinical privileges at any other health care facility;

(d) initiation of formal investigation at any other health care facility;

(e) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and

(f) any arrest or the filing of any criminal charge by local, state or federal authorities .

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

2. **Adverse Professional Review Actions, Investigations or For Cause FPPE**

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

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

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

For actions taken by a hospital that is not affiliated with Yale New Haven Health, the matter shall be immediately brought to the attention of the Chief Medical Officer and relevant department Chief for

evaluation and determination as to the relevance to the practitioner's membership status and clinical privileges.

If currently privileged in the area of practice related to the action taken at the other hospital, related privileges shall be automatically relinquished pending review and recommendation by CC, MEC and approval by the PSCQ.

3. **Automatic relinquishment, termination or suspension**:

The following outlines situations under which Medical Staff membership and clinical privileges of a Medical Staff member may be subject to automatic relinquishment, termination or suspension and in which no hearing rights apply.

a. **Licensure:** The following licensure actions shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:

   i. Revocation, voluntary relinquishment or voluntary surrender or suspension of a license in any state;

   ii. Agreement with a governmental entity not to exercise a license to practice;

   iii. Permanent licensure restriction;

   iv. Lapse of a license to practice in Connecticut due to failure to renew

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

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

No hearing rights shall be afforded under circumstances leading to automatic relinquishment of membership and privileges related to licensure actions.

b**. Federal and State Drug Control Registration** The following shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:

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

No hearing rights shall apply under these circumstances.

Automatic relinquishment does not apply to the lapse or surrender of a Federal DEA or State of Connecticut Controlled Substance certificate under circumstances in which the member no longer

requires the certificate to exercise clinical privileges and the member had not entered into an agreement not to prescribe related to an investigation.

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

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

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

   Practitioners whose membership and privileges are automatically terminated related to debarment, exclusion or preclusion from federal health care program participation are not afforded hearing rights.

d. **Health Status** Failure to comply with any health status requirements as outlined in ARTICLE IV, Section B7 will result in automatic termination from the Medical Staff. Individuals who are automatically terminated for failure to comply with health status requirements are not afforded hearing rights.

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

   Hearing rights are not afforded under these circumstances.

f. **Medical Staff Dues** The membership and privileges of members who fail to pay Medical Staff dues within thirty (30) days of the second notice shall be considered automatically suspended. Membership may be immediately restored if payment is received within an additional thirty (30) days assuming that reappointment applications or any other required documentation has been submitted by the member. All others will be required to reapply in accordance with ARTICLE VI of these Bylaws.

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

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

   Members who have been approved for a Leave of Absence in accordance with Article VI of these Bylaws may pay medical staff dues upon receipt of notice or upon return from Leave of Absence.

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

g. **Leave of Absence**. Failure to request renewal of a leave of absence at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments. Hearing rights are not afforded under these circumstances.

h. **Insurance Coverage**. Failure of a Medical Staff member to maintain professional liability insurance to the extent required by the Board of Trustees shall result in automatic suspension of the member's clinical privileges. If the Medical Staff member does not provide evidence of required professional liability insurance within thirty (30) calendar days after written warning of the delinquency from Medical Staff Administration, his Medical Staff membership shall be automatically terminated. Hearing rights are not afforded under these circumstances.

i. **Board Certification**. Failure of a Medical Staff member to obtain or maintain board certification consistent with the requirements, as applicable, as outlined in Section B.15 shall result in automatic termination. Hearing rights are not afforded under these circumstances.

j. **Cooperation with Peer Review Activities**. As a matter of routine proceedings, the Professional Practice Evaluation Committee (PPEC), the Medical Staff Professionalism Committee (MSPC) or the Credentials Committee may request that a member of the Medical Staff participate in a review of his/her own Hospital cases, aspects of Hospital based practice or matters involving professional behavior. Clinical privileges and Medical Staff membership may be considered automatically relinquished for refusal to cooperate with such reviews when requested until the necessary input has been provided.

Under these circumstances, provisions relating to hearings, appeals, and appellate reviews shall not apply.

4. **<u>Other Actions</u>**

Staff appointments may be revoked, suspended, or limited for due cause for other reasons not otherwise identified in this Section related to failure to provide appropriate patient care, exceeding the scope of clinical privileges or otherwise failing to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff or Hospital, including the Code of Conduct and approved policies of Departments, Sections, and Committees.

Proposals to revoke or limit the appointment of a member of the Medical Staff for due cause shall be submitted to the Medical Executive Committee. The matter shall be considered by the Medical Executive Committee and shall thereafter follow as closely as possible the procedures set forth in ARTICLE VI, SECTION R and, if applicable, the Fair Hearing Plan provisions of ARTICLE VII.

5. **Summary Suspensions**

Any one of the following: the President, the Chief Medical Officer, a Chief, the Medical Executive Committee, the Executive Committee of the Board of Trustees, or the Board of Trustees shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff, and such suspension shall become effective immediately upon imposition.

Consistent with ARTICLE VII, in the event that all or a portion of the clinical privileges of a member of the Medical Staff have been summarily suspended, the member shall be notified both verbally and in writing and informed of hearing rights. Consistent with the terms of ARTICLE VII, after hearing the matter, the Hearing Committee may modify or terminate the summary suspension, or recommend that it continue.

Following a Hearing, the Medical Staff member who is the subject of summary suspension shall be entitled to appellate review of the Medical Executive Committee's decision in accordance with the provisions of the Fair Hearing Plan, ARTICLE VII. In the event that a summary suspension is upheld after completion or waiver of appellate review, unless provided otherwise in the final decision, the Medical Staff membership of the individual shall simultaneously terminate and there shall be no further right to a hearing or appellate review under these Bylaws.

6. **Notification to Medical Staff Members**

In the event that the privileges of a member of the Medical Staff are automatically relinquished or summarily suspended, the member shall be notified in writing and alternate medical coverage shall be provided for the staff member's patients who remain in the Hospital. The desires of the patient should be considered. The Chief or Associate Chief shall be responsible for ensuring that such coverage is provided.

7. **Completion of Medical Records**

Provisions of these Bylaws relating to appeals, hearings, and appellate review shall not apply to automatic relinquishment of Medical Staff appointment and/or clinical privileges that result from failure to comply with requirements as stated in Rule No. 19, "Medical Records – Completion".

8. **National Practitioner Databank Reports**

The Chief Medical Officer shall comply with the requirements of the Health Care Quality Improvement Act of 1986 and the Regulations of the Department of Health and Human Services implementing the Act. In order to fulfill these requirements, the Chief Medical Officer will report, or cause to be reported, adverse actions when required and will obtain necessary information from the National Practitioner Data Bank in accordance with the law. The provisions of the Act and the Regulations, as they may be amended from time to time, hereby are incorporated into the Bylaws by this reference and to the extent possible shall be construed as being consistent with the provisions of these Bylaws and the Rules and Regulations.

SECTION U. Investigations

When concerns are raised regarding the clinical practice of a Medical or Affiliated Health Care Professional, if he/she demonstrates behavior that is inconsistent with the Medical Staff Code of Conduct (ARTICLE VI, Section E) or if he/she violates acceptable ethical standards or Medical Staff or Hospital Bylaws, policies or Rules & Regulations, a review of the matter and circumstances may be indicated. These issues are generally evaluated by the Chief Medical Officer, Department Chief, Associate Chief, Section Chief or others as delegated by the Professional Practice Evaluation Committee (PPEC) or the Medical Staff Professionalism Committee (MSPC) and

addressed with the individual. All efforts are made to address and resolve these issues at one of these levels through collegial intervention.

In some instances, following inquiry into the matter, referral is made to the PPEC or MSPC for review. A Focused Professional Practice Evaluation (FPPE) may also be undertaken and coordinated with the appropriate Chief consistent with the Medical Staff FPPE Policy.

Following unsuccessful documented attempts at collegial intervention at this level or in the event that there are concerns about a practitioner are of a very serious nature, further inquiry may be initiated. After sufficient inquiry and validation that the issues identified are credible, the Chief Medical Officer, the PPEC, MSPC, the Medical Executive Committee or the Patient Safety & Clinical Quality Committee of the Board of Trustees may recommend a formal investigation to the Credentials Committee, Medical Executive Committee or Patient Safety & Clinical Quality Committee of the Board of Trustees.

In addition, a Department Chief or Associate Chief may also request that the Chief Medical Officer, PPEC, MSPC, Medical Executive Committee or the Patient Safety & Clinical Quality Committee of the Board of Trustees review a matter regarding a member of his/her Department for consideration of an investigation.

The Credentials Committee, Patient Safety & Clinical Quality Committee of the Board of Trustees or Medical Executive Committee considers the recommendation and, if they agree, formally commences an investigation by making a resolution to do so. Resolutions must be approved by a majority of those present and voting.

The body identified to conduct the investigation shall be deemed to be the Investigation Committee.

The Committee that resolved to initiate the investigation may choose to serve as the Investigation Committee, may request that another Committee serve as the Investigation Committee or may appoint or request another Committee to appoint an Investigation Committee. The Investigation Committee may establish a sub-committee for the purpose of "fact-finding" in the investigation. The sub-committee reports its findings to the Investigation Committee.

None of the above shall be construed to limit the ability of the individuals authorized in Section Q, Number 5 of ARTICLE VI to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff whenever such action must be taken immediately in the best interest of patient care. In such instances, the process identified in ARTICLE VI, Section Q, Number 6 shall follow.

The practitioner in question is notified in writing of the investigation, the steps that will be taken during the investigation, his/her responsibilities, rights and options and that he/she will have an opportunity to participate in the process before any final determinations are made.

The Investigation Committee shall not include partners, associates or relatives of the individual being investigated and shall have the authority to review relevant documents and interview individuals with information pertinent to the matter at hand as well as the authority to use outside consultants, if needed. It may also require physical and mental examinations/evaluations of the individual under investigation.

The individual under investigation shall have the right to meet with the Investigation Committee, be informed of the allegations against him/her that form the basis of the investigation and discuss, explain or refute the evidence presented.

The investigative process of this committee is not considered a hearing and, as such, the individual under investigation shall not have the right to be represented by legal counsel during the proceedings.

At the conclusion of this process, the Investigation Committee shall submit its recommendation(s) to the Medical Executive Committee or Credentials Committee if the Investigation Committee is not the Credentials Committee. The individual under investigation is informed of the recommendation of the Medical Executive Committee.

If the recommendation is adverse and the Medical Executive Committee concurs in whole, in part or modifies a recommendation that remains ultimately adverse, the individual under investigation shall be entitled to a Fair Hearing as described in Article VII.

SECTION V. Care of Patients

The care of the patient is the responsibility of the physician, dentist or podiatrist in whose name the patient has been admitted or to whom the patient has been transferred. Members of the Medical Staff are responsible for providing for continuous care for their patients; this responsibility may be carried out by ensuring that appropriately credentialed and privileged members of the Medical Staff provide coverage when the responsible Member of the Medical Staff is unavailable to his/her patients. It shall be the obligation of the House Staff, when assigned, to assist and be accountable to the responsible practitioner in caring for the patient.

ARTICLE VII. FAIR HEARING PLAN

SECTION A. Right to Hearing and Appellate Review

The right to a hearing before the Medical Executive Committee or the Patient Safety & Clinical Quality Committee of the Board of Trustees and to appellate review by the Patient Safety & Clinical Quality Committee or by the Board of Trustees arises under ARTICLE VI, SECTIONS H, I, Q and R of the Bylaws. ARTICLE VII, which sets forth the standards for such hearing and review, except for time limits, is procedural only and shall not be deemed to create any substantive rights or in any way modify substantive rights arising under the Bylaws.

It is only during the Fair Hearing process as described in this ARTICLE VII that a member of the Medical Staff is entitled to be accompanied by and advised by an attorney during proceedings.

SECTION B. Notices to and Requests from Appellants

1. An appellant, who is entitled to a hearing or to appellate review, shall promptly be advised of such right by certified mail, return receipt requested or documented hand delivery. Where relevant, the appellant should be advised of Medical Staff status pending further action, or be provided with the basis for the adverse decision in order to prepare for a hearing or appeal. Hearings or oral argument should be scheduled as soon as possible after the receipt of a request by the appellant. However, the appellant should be given an adequate period of time within which to prepare. Therefore, the appellant should be consulted in regard to all scheduling matters.

2. Any appellant who has received notice of the right to a hearing or to appellate review of a decision shall request such hearing or appellate review in writing, by registered or certified mail, return receipt requested or documented hand delivery, addressed to the Chief Medical Officer, or shall be deemed to have waived the right to such hearing or appellate review. Such request shall be made within fifteen (15) calendar days of the date the notice was mailed.

3. If the hearing has been requested on a timely basis, the appellant will be provided with a notice by certified or registered mail, return receipt requested or documented hand delivery, setting forth the place, time and date of the hearing, which date shall not be less than thirty days after the date of the initial notice of the right to a hearing unless an earlier date is requested by the appellant and agreed to by the Hearing Committee. In addition, the appellant shall be provided with a list of the witnesses, if any, expected to testify at the hearing on behalf of the body or individual making the adverse recommendation. The appellant shall be instructed to provide the Chief Medical Officer by certified or registered mail, return receipt requested or documented hand delivery, with a list of the witnesses, if any, expected to testify at the hearing on behalf of the appellant. Additional witnesses may be permitted to testify at the hearing at the discretion of the Hearing Committee.

SECTION C. The Hearing Committee

The Hearing Committee shall be either the Medical Executive Committee or the Patient Safety & Clinical Quality Committee, as appropriate. Any member of a Hearing Committee who is presenting an adverse recommendation to the Hearing Committee shall abstain from voting as a member of the Hearing Committee or participating in its deliberations, and accordingly shall be deemed not to be a member of the Hearing Committee. In addition, any member of the Hearing Committee who is in direct economic competition with the appellant or is an associate, partner or relative, shall abstain from voting as a member of the Hearing Committee or participating in its deliberations, and accordingly shall be deemed not to be a member of the Hearing Committee.

SECTION D. Conduct of Hearing

1. The hearing shall be conducted fairly, but is to be informal and not according to the rules of evidence. All reasonably relevant information should be heard or accepted in evidence as exhibits. The Chair shall preside over the hearing and rule upon matters of procedure, assure that all participants have a reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of exhibits.

2. An accurate record shall be made, which, at the discretion of the Hearing Committee, may be by means of a stenographic transcript, or a recording device. If the appellant requests that the hearing be recorded by means of a stenographic transcript, the costs of the public stenographer shall be born equally by the appellant and the Hospital. Copies of the stenographic transcript may be obtained by the appellant upon payment of any reasonable charges.

3. The body which made the adverse recommendation shall designate a representative to present information in support of its decision. Such representative shall have the right to present witnesses, examine other participants in the hearing, and, at the discretion of the representative, make opening and closing statements. During the hearing and appellate review process, the representative shall be entitled to be represented by an attorney who shall represent the interests of the Medical Staff and the Board of Trustees.

4. 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.

5. Both sides are required to prepare their cases so that a hearing shall be concluded after a maximum of twelve hours of hearing, or three hearing sessions. Under extraordinary circumstances, the Hearing Committee in its sole discretion may depart from this requirement; however, a hearing shall not be extended due to delay, repetition, or lack of appropriate deportment in the course of the presentation of a case.

SECTION E. Rights of the Appellant

1. The appellant shall have the following rights:

    a. to present all reasonably relevant information;

    b. to call witnesses and examine witnesses produced by the representative of the adverse decision maker;

    c. to be accompanied and advised by a member of the Medical Staff in good standing, or by a member of a professional society, or by an attorney; provided, however, that, if the appellant is to be accompanied by any of these individuals that the Chair of the Hearing Committee is notified in advance;

    d. to make, at the appellant's discretion, opening and closing statements, and to submit a written statement at the close of the hearing.

2. If the appellant fails to appear at the hearing, the right to the hearing and to any subsequent appellate review shall be deemed to have been waived; provided, however, that the Hearing Committee, for good cause shown, may, in its sole discretion, continue the hearing. Good cause shall not include any circumstances reasonably avoidable.

3. After completion of the hearing, the Hearing Committee, as promptly as possible, shall prepare a written opinion setting forth its recommendations, including a statement of the basis for the recommendations. The written opinion shall be forwarded, together with all exhibits and, if available in whole or in part, the hearing record (including a copy of the stenographic or recorded record of the hearing), to the Patient Safety & Clinical Quality Committee of the Board of Trustees or to the Board of Trustees, as appropriate. A copy of the written opinion also shall be provided to the appellant.

4. The foregoing procedures for a hearing are intended as guidelines for insuring the appellant a fair hearing and are not to be construed as establishing any rigid format for the hearing or action by the Hearing Committee.

SECTION F. Appellate Review

1. Subsequent to an unfavorable recommendation by the Hearing Committee, the appellant is entitled to appellate review by the Patient Safety & Clinical Quality Committee of the Board of Trustees or by the Board of Trustees, as determined by the Board of Trustees. Such action shall be taken on the basis of the available record, provided, however, that the appellant or the appellant's attorney upon timely notice shall have the right to present a written statement and appear before the reviewing body for the purpose of oral argument. Statements and argument shall be confined to the record. The reviewing body may set reasonable time requirements on arguments and appellate review.

2. Upon request for appellate review, the appellant shall be entitled upon request, to copies of any documents in the record of the Hearing Committee, and, if available in whole or in part, a copy of the stenographic or recorded record of the hearing.

3. If appellate review has been before the Patient Safety & Clinical Quality Committee of the Board of Trustees, it shall forward its recommendations to the Board of Trustees.

4. Subsequent to appellate review, the Board of Trustees shall take final action. The decision of the Board shall be reduced to writing and shall include a statement of the basis for the decision. The appellant shall be notified by the Chief Medical Officer of the Trustee's action, and shall be provided with a copy of the Trustees' decision.

ARTICLE VIII. MEDICAL STAFF OFFICERS

SECTION A. Composition

1. The Medical Staff officers shall consist of a Medical Staff President, a Medical Staff Past President (who shall also act as Treasurer), a Medical Staff President-elect and a Medical Staff Secretary.

2. At all times:

    a. two of the four officers shall be Community Physicians and two of the four officers shall be University Physicians and;

    b. the officers of Medical Staff President-elect and Medical Staff Secretary shall be rotated biennially between Community and University physicians.

SECTION B. Nominations

1. Nominations shall be made by a Nominating Committee consisting of the Medical Staff Past President, who shall serve as chair, two former Medical Staff Presidents who no longer are serving as officers, and the Chief Medical Officer who shall serve ex officio without vote. In the event that the Medical Staff Past President and all former Medical Staff Presidents eligible to serve as members of the Nominating Committee are all Community Physicians or all University Physicians, the Chief Medical Officer shall appoint one of the three members of the Nominating Committee from among the members of the Active Staff, so that there always shall be representatives of both Community and University Physicians on the Nominating Committee.

2. The Nominating Committee biennially shall select two candidates for Medical Staff President-elect and two candidates for Medical Staff Secretary, such candidates to be selected so as to comply with the requirements of SECTION A, Paragraph 2 above.

3. The Medical Executive Committee may establish a mechanism for selecting additional candidates which shall be consistent with the provisions of SECTION A, Paragraph 2 above requiring equal Community and University participation.

4. Members of the Medical Staff eligible for nomination will be those who can be expected to remain members of the Active Staff throughout their terms of office and who have demonstrated a primary commitment to, and involvement in, the affairs of the Hospital.

SECTION C. Election

1. The Active Staff shall elect the officers by a plurality of mail ballots or an appropriate electronic means.

SECTION D. Terms of Office

1. The officers shall take office on the first day of September.

2. The Medical Staff Secretary shall serve for two years.

3. The Medical Staff Presidential officers shall serve for six years as follows:

    a. the first two years as Medical Staff President-elect

    b. the third and fourth years as Medical Staff President; and

c. the fifth and sixth years as Medical Staff Past President and Treasurer.

SECTION E. Vacancies

1. Should an office of the Medical Staff become vacant for any reason, the Medical Staff shall elect a replacement who shall come from the same group (Community or University) as the original officer.

2. The replacement officer shall serve out the term of the original officer.

SECTION F. Removal of a Medical Staff Officer

An officer of the Medical Staff may be removed from office by majority vote of the Medical Executive Committee.

SECTION G. Duties

1. Officers shall serve as members of the Medical Executive Committee and members of the Medical Staff Committees as appropriate.

2. The Medical Staff President and Medical Staff President Elect shall serve as members of the Professional Practice Evaluation Committee (PPEC) and Patient Safety & Clinical Quality Committee of the Board of Trustees.

3. The Medical Staff Past President, Medical Staff President and Medical Staff President Elect shall serve as members of the Medical Staff Professionalism Committee (MSPC).

4. Officers may convene periodic meetings of the Active Medical Staff for the purposes of education, information and discussion of matters of common interest.

5. Without regard to whether they are Community or University Physicians, officers shall represent and exercise all of their duties to the Medical Executive Committee and to the administration of the Hospital as representatives of all members of the Medical Staff.

6. The Medical Staff Secretary shall be responsible for recording transactions of Medical Staff Meetings and shall serve as Chair of the Credentials Committee and a member of the Bylaws Committee. The Medical Staff Past Secretary shall also serve as a member of the Bylaws Committee

7. The Medical Staff Past President shall also act as the Medical Staff Treasurer and serve as Chair of the Medical Executive Committee Finance Committee. The Treasurer shall be responsible for collection of the annual Medical Staff dues, and for making recommendations to the Chief Medical Officer and the Medical Executive Committee for the use of these funds via the Medical Executive Committee Finance Committee.

8. The Medical Staff President will work in a collaborative manner with the Chief Medical Officer and will review the agendas for Medical Staff leadership meetings, such as the Medical Executive Committee, Medical Executive Committee Administrative Committee, PPEC, and Medical Staff meetings as applicable.

9. With the recognition that physicians actively engaged in patient care will give dimension to discussions about the Hospital's programs and planning, the Medical Staff President and Medical Staff President-elect of the Medical Staff will be invited to attend meetings of the Board of Trustees. In addition, the Medical Staff President and Medical Staff President Elect are invited to attend meetings of the Clinical Chiefs and Associate Chiefs and may be requested to assist in such Hospital activities as fund raising.

ARTICLE IX. HOSPITAL DEPARTMENTS

SECTION A. Departments

1. The Medical Staff shall be organized in the following clinical hospital departments:

    a. Anesthesiology
    b. Child Psychiatry
    c. Dentistry
    d. Dermatology
    e. Emergency Medicine
    f. Internal Medicine, including general medicine and medical specialties
    g. Laboratory Medicine
    h. Neurology
    i. Neurosurgery
    j. Obstetrics and Gynecology
    k. Ophthalmology
    l. Orthopedics and Rehabilitation
    m. Pathology
    n. Pediatrics
    o. Podiatric Medicine & Surgery
    p. Psychiatry
    q. Radiology & Biomedical Imaging
    r. Surgery, including general surgery and surgical specialties
    s. Therapeutic Radiology
    t. Urology

2. Departmental status shall be designated upon recommendation of the Medical Executive Committee to the Patient Safety & Clinical Quality Committee of the Board of Trustees, and approval of the Board of Trustees. Designation of a new Hospital Department shall ordinarily follow such approval by the University and the Hospital President.

SECTION B. Sections

1. If, in the interest of Departmental organization, it is desirable to subdivide the clinical activities of a Department into formally constituted Sections, the Chief, and the Associate Chief, in the case of Departments with such position, may so recommend to the President with identification of the clinical scope of the proposed Sections. The President's recommendation will be forwarded to the Patient Safety & Clinical Quality Committee.

2. Section Chiefs and Associate Section Chiefs shall be members of the Active Staff as Attending Physicians and appointed by the Board of Trustees upon nomination to the Patient Safety & Clinical Quality Committee of the Board of Trustees. Section Chiefs usually will be University Physicians, and Associate Section Chiefs will be Community Physicians.

3. Nomination shall be by a Committee composed of (a) the Chief of the Department involved, (b) the Associate Chief, where applicable, and (c) the Chief Medical Officer Additional members of the Active Staff may be identified to participate as indicated at the discretion of the individuals listed in a-c above.

4. The Committee shall review the qualifications and interview, as applicable, candidates it identifies for the position of Section Chief or Associate Section Chief. Candidates must be members in good standing of the Active Medical Staff.

5. The recommendation of the Committee shall be transmitted in writing to the Patient Safety and Clinical Quality Committee of the Board of Trustees which shall, in turn, submit is recommendation to the Board of Trustees.

   The Board of Trustees shall reserve the right to reject a nomination of a Section Chief or Associate Section Chief which the Board of Trustees has reason to consider inappropriate. In the event of such rejection, the Committee shall continue to nominate until an appointment has been made.

6. Section Chiefs and Associate Section Chiefs shall be appointed annually by the Board of Trustees in the manner hereinbefore prescribed and shall be eligible for reappointment.

7. Any Section may, by vote of the majority of its Active members voting thereon, decide to establish or eliminate the position of Associate Section Chief, provided a majority of the Active community members of such Section vote in the affirmative.

SECTION C. Departmental and Sectional Meetings

Each Department or Section shall meet periodically as a committee of the whole to review the care and treatment of patients served by the Hospital. This review shall include consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnosis or treatment and relevant reports originating from ongoing medical care audits. Members are expected to attend such meetings. Minutes or records shall adequately reflect the conclusions and recommendations of such meetings, and actions taken by such committees.

ARTICLE X. CHIEFS OF DEPARTMENT

SECTION A. Selection

1. There shall be a Chief of each Department.

2. Chiefs usually will be individuals selected to be Chair of their respective Department in the Medical School. Criteria for selection will include a candidate's interest and expertise in clinical affairs, as well as an ability to manage the dual interests of Community and University physicians. Chiefs must be members of the Active Staff and certified as diplomats of their specialty board or be equivalently qualified.

3. Search committees for the selection of Chiefs shall be appointed by the University and shall have representation of the President and of the Medical Staff, including Community Physicians. The Dean will recommend the candidate for Chief to the President, who will submit the nomination, by way of the Patient Safety & Clinical Quality Committee, to the Board of Trustees for approval.

4. The Board of Trustees shall have the right to reject a nomination of a Chief that the Board of Trustees has reason to consider inappropriate. In case of such rejection, the University shall make a further nomination in the manner set forth above in SECTION A, Paragraphs 2 and 3 and continue to do so until an appointment has been made.

5. The Chiefs of the Departments of Dentistry and Podiatric Medicine & Surgery shall be selected in the following manner. The President shall consult with the Chief Medical Officer and the Chief and Associate Chief of Surgery to nominate a candidate for Chief of Dentistry and shall consult with the Chief Medical Officer and Chief of Orthopedics & Rehabilitation to nominate a candidate for Chief of Podiatric Medicine & Surgery. Nominations for the Chief of Dentistry or Chief of Podiatric Medicine & Surgery shall then be forwarded to the Patient Safety & Clinical Quality Committee. Upon approval by the Patient Safety & Clinical Quality Committee, the nomination shall be presented to the Board of Trustees, which shall either appoint the Chief or reject the nomination. In the case of rejection by the Board of Trustees, the President shall select a new nominee in the manner set forth herein.

SECTION B. Duties

1. Acting within the policy expressed in these Medical Staff Bylaws and in accordance with the Rules and Regulations approved by the Board of Trustees, the Chiefs are responsible for aspects of the credentialing and recredentialing functions detailed elsewhere in these Medical Staff Bylaws including the Ongoing and Focused Professional Practice Evaluation Processes. These responsibilities include recommending criteria for relevant clinical privileges, and evaluating initial and reappointment applications within their respective services. The Chiefs shall have the authority within their respective areas to enforce the rules and regulations governing the professional care of patients. The Chiefs will participate actively in the academic programs of the Medical School, will be responsible for supervision of the professional services rendered in and the House Staff assigned to the patient care areas under their respective jurisdictions, and will direct the development and implementation of departmental performance improvement, patient safety and quality control professional policies and programs.

2. The Chief is responsible for Departmental management. These responsibilities include activities designed to promote integration of the Department within the Hospital mission, coordination of interdepartmental and intradepartmental services, and making recommendations that support the provision of patient care, including Hospital-based training programs within the context of Hospital policies, objectives and available resources. The Chief or Associate Chief shall also be responsible for orientation of new Members of the Medical Staff to Medical Staff requirements.

3. When the Chief is unavailable, he/she shall direct that one of the following perform his/her duties: the Associate Chief or Vice Chair/Chief, the Assistant Chief, or a designated member of the Active Staff approved by the Chief Medical Officer. In the event that the Chief is unavailable for a considerable length of time or is unable to make such designation, an Interim Chief shall be proposed by the President for approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees and Board of Trustees.

4. The Chief of the Department of Surgery shall be responsible for enforcing professional policies and procedures in the Operating and Cystoscopic Rooms, in consultation with the Associate Chief of Surgery and the Chiefs of Anesthesiology, Neurosurgery, Ophthalmology, Obstetrics and Gynecology, Podiatric Medicine & Surgery, and Orthopedics and Rehabilitation and Urology. The development and modification of professional policies and procedures shall be the responsibility of the Perioperative Executive Leadership Group, as defined in ARTICLE XVI, SECTION F, Paragraph (m).

5. The Chief of the Department of Obstetrics and Gynecology, in consultation with the Associate Chief, shall be responsible for enforcing professional policies and procedures in the Labor and Delivery Rooms. The development and modification of such policies and procedures shall be reviewed with the Departmental Committee and Chief Medical Officer prior to implementation.

6. Chiefs will be appointed annually following the performance assessment described in ARTICLE X, SECTION C.

7. Except as noted in ARTICLE VI, SECTION I, Number 8 relative to Departments with greater than 100 Medical Staff members, the Chief and, where applicable, the Associate Chief shall be responsible for reappointment of each member of the Medical Staff in the Department, including consideration of current competence and physical and mental capabilities consistent with the process described in ARTICLE VI. Section I.

8. After consultation with the Associate Chief, where applicable, and in conjunction with the Departmental Committee, the Chief will periodically assess Departmental programs, policies and needs; will initiate and develop Departmental plans, and will report as needed to the Medical Executive Committee, the Chief Medical Officer and the President on these matters. This will include proposals on the appropriate mix and size of the Department (of both Community and University components), criteria for Medical Staff privileges in the Department, reviews of the quality of care, including assessments of individual performance; proposals for new programs; assessment of resource availability and utilization, and the need for additional resources, both financial and physical; and assessment of the relative importance of both current and new programs to the overall Hospital mission. The frequency of these reports will be determined by the Medical Executive Committee.

9. Except with respect to the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery, where the position of Associate Chief is mandated, the Chief will review with the Departmental Committee the need for, and the role of, an Associate Chief for the Department and recommend such to the President and Board of Trustees by way of the Patient Safety & Clinical Quality Committee, if found desirable. The Chief may also recommend the appointment of a Network Associate Chief specifically to provide information to support the appointment and re-appointment of members of the Department consistent with ARTICLE XI, Section D.

10. Following consultation with the Associate Chief and Network Associate Chief (if applicable), in the case of Community-based applicants, the Chief will approve all applicants for Medical Staff membership in the Department, considering both the standards of excellence, the needs of the Department and the ability of the institution adequately to support the applicant. Following action by the Chief, applications will be reviewed by the Credentials Committee in accordance with ARTICLE VI.

11. Chiefs will be members of the Medical Executive Committee.

SECTION C. Performance

1. The performance of Chiefs will be reviewed annually by the President and reported to the Patient Safety & Clinical Quality Committee of the Board of Trustees. This evaluation will be coordinated with periodic external assessments jointly made with the Medical School. Such annual assessments will include recommendations to the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding reappointment, as well as collaboration with the Dean regarding appropriate compensation arrangements. Assessments will include input from the Departmental Committee, other Chiefs, the Associate Chief, where applicable, the Chief Medical Officer, the President, and others deemed appropriate to such reviews.

2. Chiefs shall be accountable to the President:

    a. Through the Chief Medical Officer, for the performance of their professional responsibilities including performance improvement

    b. Through a Vice President, working with assigned Administrative Clinical Coordinators, for their management responsibilities.

SECTION D. Assistant Chiefs

The Chief may recommend to the President a member of the Active Staff for appointment as Assistant or Vice Chief of Department. The President's recommendation shall be forwarded to the Patient Safety & Clinical Quality Committee of the Board of Trustees which, in turn, shall make its recommendation to the Board of Trustees, which shall take appropriate action.

ARTICLE XI. ASSOCIATE CHIEFS OF DEPARTMENT

SECTION A. Selection

1. There shall be an Associate Chief of each of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery. Any such Department may, however, by a vote of the majority of its Active Members voting thereon, decide to eliminate the position of Associate Chief, provided a majority of the Active Community Members of such Department vote in the affirmative and provided such action is approved by a vote of two-thirds of the Medical Executive Committee. Associate Chiefs and Associate Section Chiefs shall be members of the Active Staff as Attending Physicians, and will be Community Physicians.

2. Each Associate Chief must be qualified by training, professional experience and demonstrated ability.

3. Any other Department or any Section of any Department may, by the affirmative vote of the respective Departmental or Sectional Committee, create the position of Associate Chief of Department or Section.

4. The Associate Chief of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery shall be nominated by the Chief to the President and Board of Trustees upon receipt of the recommendations of a search committee. There shall be a Search Committee for each such Department, appointed by the Chief after consultation with the Departmental Committee, whose membership shall be composed of Community Physicians and University Physicians in such proportion as the respective Departmental Committees of such Departments shall prescribe; provided, however, that the membership of Community Physicians on each such Search Committee shall be not less than one-third of the membership thereof. The Community members of each such Search Committee shall be chosen from a slate endorsed by the Community Active Staff. The Board of Trustees shall have the right to reject the nomination of an Associate Chief, which the Board of Trustees has reason to consider inappropriate. In case of such rejection, a further nomination or nominations shall be submitted until an appointment has been made.

5. Nominees for Associate Chief of any other Department or of any Section shall be selected in a manner agreed upon by the Chief and the Departmental or Sectional Committee and shall be recommended in the same manner to the President and the Board of Trustees by way of the Patient Safety & Clinical Quality Committee.

SECTION B. Duties

1. Each Chief, subsequent to consultation with the Associate Chief and receipt of the recommendations of the Departmental Committee, shall prescribe the role and powers of the Associate Chief. The role and powers, thus defined, shall be submitted to the Medical Executive Committee for approval. In general, the Associate Chief will participate actively in the academic programs of the Department, and will be responsible to the Chief for:

    a. supervision of professional services rendered by Community Physicians, including practice in the operating rooms, cystoscopy suite and the labor and delivery suite as appropriate;

    b. participation in performance improvement initiatives;

    c. execution of administrative responsibilities relating to the care of patients by Community Physicians; and

    d. supervision of House Staff involved in caring for patients of Community Physicians.

2. Associate Chiefs of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery will be members of the Medical Executive Committee.

SECTION C. Performance

1. The performance of an Associate Chief will be reviewed annually by the President and reported to the Patient Safety & Clinical Quality Committee. Such annual assessments will include recommendations to the Patient Safety & Clinical Quality Committee regarding reappointment. Assessments will include input from the appropriate Chief, the appropriate Departmental Committee, the Chief Medical Officer, the President, and others deemed appropriate to such reviews, including Community members of the Department whose Associate Chief is being reviewed.

2. Not less often than every five years, a Review Committee shall be appointed for each of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery, and such other Departments which have an Associate Chief, whose duties shall be to make recommendations to the President and Board of Trustees regarding the performance of the Associate Chief for such Departments, respectively. The membership of each such Review Committee shall be the same as that provided for the Search Committee with respect to the initial appointment of each Associate Chief. Consideration will be given to the inclusion of an outside consultant(s) to the review process. To the extent practicable, such review will be done in conjunction with periodic departmental reviews.

SECTION D. Network Associate Chief

In order to provide care at any facility considered as part of the Hospital's vertical network, individuals must be appointed to an appropriate Medical Staff category or to the Affiliated Medical Staff. In some cases, the practice, qualifications and competency of these individuals are better known to a medical staff leader at another Health System organization.

Under these circumstances, the Department Chief, after consultation with the Associate Chief and Section Chief (as applicable) and the Chief Medical Officer, may recommend the creation of a Network Associate Chief position for the Department. The recommendation for the position, as well as the candidate for appointment, is submitted to the President and the Board of Trustees by way of the Patient Safety & Clinical Quality Committee.

Candidates for Network Associate Chief must be current members of the Medical Staff qualified by training, professional experience and demonstrated ability. Network Associate Chiefs will generally be current chairs, chiefs, section chiefs, medical directors, executive directors, or other leaders the equivalent thereof, at a Health System organization.

The appointment as Network Associate Chief shall be co-terminous with the individual's appointment as a medical staff leader as described above at the relevant Health System organization.

The duties of the Network Associate Chief shall be limited to validating the qualification of candidates for initial and re-appointment to the Medical Staff and providing input for the Ongoing and Focused Professional Practice Evaluation processes.

ARTICLE XII. DEPARTMENTAL AND SECTIONAL COMMITTEES

SECTION A. Role

1. Departmental or Sectional Committees shall serve as an advisor to the respective Chiefs. Through regular meetings, their role is to review, initiate review and comment on the following:

    a. Quality of care provided;

    b. Need for and/or role of an Associate Chief;

    c. Departmental policies; existing or proposed;

    d. Departmental programs: strengths, weaknesses, omissions, duplications;

    e. Departmental resources: facilities and manpower;

    f. Concerns of members of the Department;

    g. Specific Departmental criteria for evaluating fulfillment of commitment obligations set forth in ARTICLE IV, SECTION B, Paragraph 1, which criteria shall be submitted to the Medical Executive Committee for approval.

2. The Committee will hear and decide appeals properly brought before it.

SECTION B. Membership

1. Departmental Committees in the Departments of Medicine and Surgery shall initially be equally representative of the Community and University components, unless an alternative arrangement is approved by a majority of both Community and University Active Staff members present at a meeting of the Department called to act upon such an alternative plan. Since the Department of Medicine has developed a plan approved by both Community and University members, that plan shall be followed unless modified hereafter.

2. With respect to Sectional Committees and to Departmental Committees, other than for the Departments of Medicine and Surgery, the Chief shall propose, to a duly called meeting of all Active Staff Members of such Department or Section, a membership pattern and method of selection. When an arrangement has been approved by a majority of those Active Staff members present and voting, such plan shall be presented to the Medical Executive Committee for its consideration. If the Medical Executive Committee rejects the plan, the Department or Section shall prepare and submit an alternative plan.

    Fair representation, taking into account facility usage patterns and the composition of the Department or Section, shall be the essential criterion to be applied by the Medical Executive Committee in judging the appropriateness of committee make-up.

SECTION C. Sectional Committees

In Departments in which there are formally constituted Sections, it is appropriate for sections to have Sectional Committees to function in the same manner, vis-à-vis the Section Chief, as Departmental Committees do with the Chief.

SECTION D. Meetings

Meetings of Departmental and Sectional Committees shall be held regularly and shall be chaired by the Chief, except when it considers an appeal from a decision of the Chief. When deliberating an appeal from a decision of the Chief, the Chief will not be a Committee member, and the Committee will appoint a chair pro tem. The chair pro tem should be from the staff component (Community or University) of which the appellant is a member. The Chief and the appellant will meet with the Committee to review the appealed decision.

ARTICLE XIII. CHIEF MEDICAL OFFICER

SECTION A. Selection

The Chief Medical Officer may be selected from among the Community or University based Medical Staff or from outside the Medical Staff. The Chief Medical Officer shall be appointed by the President who shall notify the Board of Trustees of such appointment. Prior to appointing the Chief Medical Officer, the President shall consult the Medical Staff Officers and the past Medical Staff Secretary regarding the appointment. The President of the Medical Staff will be regularly updated concerning the search and progress for the identification of a new Chief Medical Officer.

SECTION B. Duties

1. The Chief Medical Officer functions as the senior administrative officer of the Medical Staff. Successful performance of this key position will help ensure effective Medical Staff functioning. This result will be accomplished by maintaining broad participation in Medical Staff affairs by Community and University Physicians, by frequent interaction with all elements of the Staff, especially those in leadership positions, i.e., Chiefs, Associate Chiefs and elected representatives, and by closely monitoring areas of special sensitivity, e.g., operating rooms and emergency service. Specific responsibilities include:

    a. Management of Medical Staff affairs: appointment and reappointment processes, committee performance, compliance with Joint Commission and State of Connecticut Department of Public Health licensure requirements as they pertain to medical practice and patient concerns regarding medical services.

    b. Acts as an agent of the Professional Practice Evaluation Committee (PPEC) and Medical Staff Professionalism Committee (MSPC) between meetings to address issues of immediate concern having to do with Medical and Affiliated Medical Staff including, but not limited to, patient/family complaints, general competence, health/fitness to work, and compliance with the Medical Staff Code of Conduct. Reports actions taken, as appropriate, to the PPEC and/or MSPC.

    c. Representation of the Medical Staff: to the Board of Trustees, as a member of Hospital Management, in councils of Yale New Haven Medical Center, Inc., and to various organizations, locally and statewide.

    d. Administrative supervision of functioning of medical services through the Chiefs.

    e. Assistance to elected Medical Staff officers in the discharge of their duties.

    f. Coordination of house staff affairs on matters outside of departmental purview.

    g. Overall medical responsibility for all medical services in the Hospital.

    h. Communication with the Dean on matters of mutual interest.

SECTION C. Reporting

1. The Chief Medical Officer reports jointly to the President and to the Chief Clinical Officer of the Health System. He or she is also accountable to the Board of Trustees relative to medical practice, through the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Chief Medical Officer's

performance will be reviewed annually by the President, the Health System Chief Clinical Officer and the Board of Trustees following consultation with the current Medical Staff President.

2. The Chief Medical Officer will be a member of the Medical Executive Committee and may be an ex officio member of the Patient Safety & Clinical Quality Committee of the Board of Trustees and the Board of Trustees.

ARTICLE XIV. ASSOCIATE CHIEF MEDICAL OFFICER

SECTION A. SELECTION

The Chief Medical Officer may recommend one or more members of the Active Medical Staff for appointment as Associate Chief Medical Officer. The recommendation requires the concurrence of the President.

SECTION B. DUTIES

The Associate Chief Medical Officer shall perform such administrative and Medical Staff functions as are delegated by the Chief Medical Officer. In the absence of the Chief Medical Officer, the Associate Chief Medical Officer shall assume the authority and responsibilities of the Chief Medical Officer.

SECTION C. REPORTING

The Associate Chief Medical Officer reports to the Chief Medical Officer. Performance of the Associate Chief Medical Officer will be evaluated annually by the Chief Medical Officer, who shall consult with the President and other appropriate Hospital executive and clinical leaders.

ARTICLE XV. DEPARTMENTAL APPEALS

SECTION A. Access to Appeals

In order to assure equity, all members of the Medical Staff shall have access to a mechanism through which decisions may be challenged which are perceived to be inappropriate or unfair. Except as otherwise provided in ARTICLE VI, decisions of individuals or groups which deal with Medical Staff privileges, access to Hospital resources or departmental or Hospital policies may be appealed only after efforts to resolve disputes at lower levels have been exhausted. Provision shall be made to stay the implementation of a decision pending the final determination of an appeal with respect thereto, except under emergency circumstances involving an immediate threat to the welfare or safety of patients or staff.

SECTION B. Procedure on Appeal

1. The following steps will provide the framework for a timely and effective means of responding to grievances:

    a. Concerning a decision of a Chief or any other departmental source, an appellant may appeal to either the Departmental Committee or to the Chief Medical Officer. After this step is exhausted, and if satisfaction is not found by the appellant or the Chief, the appeal is to the Medical Executive Committee.

    In Departments with formal Sections, the appeal of a Section Chief's decision is either to the Sectional Committee or the Chief. If satisfaction is not found, the appeal is to the Chief Medical Officer or the Departmental Committee as delineated above.

    b. From the decision of the Chief Medical Officer, an appellant may appeal to the Medical Executive Committee.

    c. The Medical Executive Committee decision on an appeal will normally be the final step, if such decision is made with support of two-thirds or more of votes cast, unless the Patient Safety & Clinical Quality Committee of the Board of Trustees chooses to review the decision. Decisions with less support than two-thirds will be automatically forwarded to and reviewed by the Patient Safety & Clinical Quality Committee of the Board of Trustees.

    d. The Patient Safety & Clinical Quality Committee of the Board of Trustees will serve as the Trustee (and final) step in the Appeal Process, with its decision subject to Board of Trustees approval. Upon request of any physician adversely affected by the decision being reviewed, the Patient Safety & Clinical Quality Committee of the Board of Trustees shall obtain an independent written opinion from a qualified, disinterested physician of its choice as to the reasonableness of the decision being reviewed in order to assist the Committee in its review of the decision.

2. In summary, an appellant will begin the grievance process at the appropriate level only after exhausting efforts to resolve the dispute with involved parties.

Level	From the Decision of:	May Appeal to Either (only one):
1.	Section Chief	Sectional Committee or Chief
2.	Sectional Committee or Chief	Departmental Committee or Chief Medical Officer
3.	Departmental Committee or Chief Medical Officer	Medical Executive Committee
4.	Medical Executive Committee	Patient Safety & Clinical Quality Committee

ARTICLE XVI. MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee (MEC) has the authority to carry out medical staff responsibilities acting on behalf of the Organized Medical Staff in matters as outlined in these Bylaws. The scope and authority of the MEC may be altered via amendment of these Bylaws as outlined in Article XVII.

SECTION A. Duties

1. Subject to review and approval by the Organized Medical Staff and the Board of Trustees, the duties of the Medical Executive Committee shall be:

    a. To monitor the quality of care delivered within the Hospital by its members;

    b. To evaluate and recommend Medical Staff membership and clinical privileges and, as applicable, termination of Medical Staff membership and clinical privileges for each physician, dentist, podiatrist and Affiliated Health Care Practitioner to the Patient Safety and Clinical Quality Committee of the Board of Trustees;

    c. To make recommendations to the Patient Safety and Clinical Quality Committee of the Board of Trustees regarding review of and any actions taken on reports of its Committees, Hospital departments and any other assigned activity groups;

    d. To formulate and recommend medical policy;

    e. To propose and recommend approval of Medical Staff Bylaws, Rules and Regulations and Medical Staff policies;

    f. To discharge responsibilities essential to maintaining accreditation and licensure, including the appointment of and monitoring of Medical Staff committees; and

    g. To advise Hospital management regarding assignment of beds, operating rooms and other clinical resources.

    h. To approve any new or changes to exclusively contracted services.

SECTION B. Membership

1. The MEC includes physicians and may include dentists and podiatrists. The majority of MEC members with vote shall be physicians who are actively practicing in the Hospital. A broad institutional perspective is required of all MEC members to ensure responsible deliberation and decision making.

2. The total membership of the MEC shall be twenty five (25) and shall be representative of the Organized Medical Staff.

3. The membership of the Medical Executive Committee shall consist of:

    a. The President, Chief Medical Officer and Chief Nursing Officer of the Hospital all of whom shall serve ex officio; with vote;
    b. The elected officers of the Medical Staff, namely, the President, Past President (Treasurer), President Elect and Secretary;

c. The Chief of each of the Departments of Medicine, Surgery, Pediatrics and Obstetrics and Gynecology;
d. The Associate Chief of each of the Departments of Medicine, Surgery, Pediatrics and Obstetrics and Gynecology;
e. From among the remaining sixteen (16) Hospital Departments identified in Article IX, an additional four (4) Department Chiefs will be selected by the Yale Medicine Nominating and Governance Committee;
f. Six (6) members at large to be elected by the Active Staff and nominated in accordance with the procedure identified in Section C below. A minimum of two (2) members at large must be from among community based or North East Medical Group employed physicians.

SECTION C. Nominating Committee

1. Six (6) members at large shall be elected as follows:

   a. The four (4) Medical Staff Officers shall constitute a Nominating Committee.
   b. In selecting candidates, consideration shall be given by the Nominating Committee to the desirability of achieving appropriate representation on the MEC of the various physicians and specialties who practice in the Hospital as well as the Organized Medical Staff in general.
   c. Consistent with 2f. above, the Nominating Committee shall select six (6) members at large. The Nominating Committee shall identify and nominate as many individuals to fill vacancies as it deems appropriate. The MEC itself may provide its recommendations/nominations to the Nominating Committee for consideration.
   d. Election of members at large shall be by electronic ballot of members of the Active Staff.

SECTION D. Term Limits

MEC terms for Chiefs selected by the Yale Medicine Nominating and Governance Committee and members at large elected by the Active Medical Staff shall be three (3) years, with a maximum of two (2) consecutive terms. These MEC members may be nominated and elected again following a break of a minimum of three (3) years.

SECTION E. Removal of a Medical Executive Committee Member

A member of the MEC will be removed as described below:

1. President, Chief Medical Officer and Chief Nursing Officer: As of the effective date upon which the individual is no longer serving in the respective role;
2. Medical Staff Officers: Upon completion of the respective term or such time at which the individual is no longer a member of the Active Medical Staff;
3. Chief and Associate Chiefs: As of the effective date upon which the individual no longer serves as Chief/Associate Chief;
4. Members at Large: At the end of having served a maximum of two terms, at the end of the first term if not re-elected to serve a second term or at such time at which the individual is no longer a member of the Active Medical Staff;
5. In the event that the appointment and/or privileges of a member of the Medical Staff who is serving on the MEC is/are automatically relinquished, summarily or otherwise suspended or revoked.

SECTION F. Organization and Voting

1. The Medical Staff President shall serve as Chair of the MEC, and the Medical Staff President-Elect of the Medical Staff shall serve as Vice Chair.

2. Except for the Credentials Committee, Professional Practice Evaluation Committee (PPEC), Medical Staff Professionalism Committee (MSPC), Finance Committee, and others where specific members are identified in Section F., members of the MEC standing committees shall be appointed by the MEC on nomination from the relevant Committee Chair.

3. Decisions on any issue concerning Medical Staff policy, Bylaws, Rules and Regulations (See ARTICLE XVII for full detail), Departmental Criteria for evaluating fulfillment of commitment obligations, and matters involving contested Medical Staff privileges must be approved by two-thirds of those present and voting at any meeting.

4. Decisions on all appeals under ARTICLE XV require a two-thirds vote of those present and voting in order to uphold the original decision of two-thirds of the entire membership of the MEC. Recommendations for approval of uncontested Medical Staff appointments and privileges and other uncontested matters may be approved by a simple majority by those present and voting.

5. Any appeal decision which has not been approved by two-thirds or more of those present and voting will be automatically referred to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

6. There may be occasion whereby the MEC is asked to vote on matters that arise between meetings and/or require immediate action. The Medical Staff President shall be consulted as to the appropriate mechanism through which this should be accomplished. Options include, but are not limited to, calling a special in-person meeting or conference call meeting of the Medical Executive Committee to allow for a timely decision on urgent matters while ensuring adequate discussion and interchange of ideas on the matter.

SECTION G. Meetings and Attendance

1. The Medical Executive Committee will meet monthly unless called more frequently by the Chair, Chief Medical Officer or by petition of twenty-five per cent or more of the Medical Executive Committee membership.

2. Two-thirds of the membership of the Medical Executive Committee shall constitute a quorum for action on items as identified in Section F above.

3. Attendance at Medical Executive Committee meetings is not assignable for voting purposes. A substitute may attend a meeting but may not vote and will not count in the quorum.

SECTION H. Committees

Appointment of and charge to ad hoc and standing committees shall be made by the Medical Executive Committee. These Committees may include finance, nominating and other committees established to manage the internal administrative business of the Medical Executive Committee, as well as those listed below. All committees should be appropriately representative of the Medical Staff. The membership of each committee, together with its charge, shall be incorporated in the permanent records of the Medical Executive Committee, and a copy shall be distributed to the members of the Committee.

The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or 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 or activities of the Medical Staff and Affiliated Health Care Professionals or applicants for admission hereto, (e) reporting variances to accepted standards of clinical performance by, and in some cases to, individual practitioners and (f) for such additional purposes as may be set forth in the charges to each

committee. The Medical Executive Committee may also create subcommittees which report to the Standing Committees.

a. **Bioethics Committee:**
Charge: Separate Adult and Pediatric Bioethics Committees shall review and propose policies and guidelines that address ethical aspects of Hospital practices; to provide consultation on individual adult and pediatric cases where ethical issues have been raised; to design and make available to the Hospital staff educational and other resources regarding medical ethical issues. Provides an annual written report to the Medical Executive Administrative Committee.

Composition: Chairs of each Committee shall be appointed by the Medical Executive Committee; membership shall include representatives from the Attending and House Staffs, nursing, Religious Ministries; Legal & Risk Services; and other members deemed appropriate.

Meetings: Monthly; consultations as required

b. **Bylaws Review Committee**
Charge: review the Medical Staff Bylaws and Rules and Regulations with consideration to compliance with the recommendations of accrediting and regulatory agencies; evaluate potential changes for proposed amendments from the voting members of the organized medical staff; recommend to the Medical Executive Committee such revisions as are considered practical and necessary to appropriately update the Medical Staff Bylaws and Rules and Regulations as needed. Changes recommended by the Bylaws Review Committee shall be reviewed by the representative from Legal & Risk Services who serves on the Committee prior to presentation to the Medical Executive Committee.

Changes recommended by the Bylaws Review Committee will be provided in writing to members of the Medical Executive Committee at least one week in advance of the regularly scheduled meeting at which they will be presented. Depending upon the nature and extent of the changes, voting on proposed changes may take place at the same meeting at which the changes are presented or be deferred until the next meeting. Approval shall be consistent with ARTICLE XVII "AMENDMENTS."

Composition: the Past President of the Medical Staff shall serve as Chair, Medical Staff President, Chief Medical Officer or his/her designee, Medical Staff Secretary and past Medical Staff Secretary; representative from Legal & Risk Services, other participants may include additional members of the Medical Staff and Hospital Administration. Only members of the Medical Staff are considered "voting" members of the Bylaws Review Committee.

The composition of the Bylaws Review Committee shall be made available to the Medical Staff through the Medical Staff Administration department. Interested members of the voting Medical Staff may request membership on the Committee by contacting the Medical Staff President. The Medical Staff President and Past Medical Staff President may select up to an additional two (2) representatives from the community and university based Medical Staff to serve on the Committee.

Meetings: will be held as necessary; the Medical Executive Committee members will be notified as to when the Bylaws Review Committee will meet providing opportunity for Medical Executive Committee members to give input in advance of the scheduled meeting.

c. **Cancer Committee***:*
Charge: coordinate clinical cancer activities to a degree consistent with the American College of Surgeon's standards for approval; oversee the Tumor Registry; report at least annually to the Medical Staff concerning the activities of the Registry, including analysis of data on survival and end results for various types of cancer; provides an annual written report to the Medical Executive Administrative Committee.

Composition: Chair shall be the Physician Chief of the Smilow Cancer Hospital; Representatives include a broad array of community and university physicians from the following departments: adult and pediatric medical oncology, neuro-oncology, gynecologic oncology, surgical oncology, neurosurgery, thoracic surgery, orthopedics, diagnostic and therapeutic radiology, pathology, laboratory medicine and psychiatry; the Cancer Liaison Physician to the ACOS, the Hospital Director of Quality Improvement and representatives from Hospital administration, nursing, social work, tumor registry, religious ministries, clinical nutrition, pharmacy and rehabilitation services.

d. **Credentials Committee**.

Charge: review applications for appointment to the Medical Staff and Affiliated Medical Staff referred to it by the Credentials Committee Sub-Committee and the Chief Medical Officer or his designee(s); review concerns of the Chiefs and Associate Chiefs, as applicable; review matters such as, but not limited to, competence/performance, results of ongoing professional practice review and violations of the Code of Conduct referred by the Professional Practice Evaluation Committee (PPEC) or the Medical Staff Professionalism Committee (MSPC); conduct personal interviews of candidates for appointment or reappointment at its discretion; conduct a personal interview with the Chief and Associate Chief in instances of disapproval of an application by the Chief or Associate Chief or both at its discretion. In the event of the intent of the Committee to recommend disapproval of an application, personal interviews shall be held with the Chief or designee and Associate Chief, and with the candidate as deemed appropriate. Between reappointment cycles, review the status and appropriateness of clinical privileges when referred by the PPEC, the Department Chief, Associate Chief or Chief Medical Officer. Receive reports as to the results of focused professional evaluations conducted on Medical Staff members. At the request of the PPEC, MSPC or Chief Medical Officer, review selected reappointment applications or other identified concerns relative to members of the Medical or Affiliated Medical Staff brought to their attention; review new/proposed changes to delineation of clinical privileges form(s); recommend appropriate action to the Medical Executive Committee or the Medical Executive Committee Administrative Committee relative to all activities on a monthly basis. Upon delegation from an authorized entity as described in Article VI, Section Q, the Credentials Committee may also serve as the Investigation Committee in formal Medical Staff investigations.

With approval from the Medical Executive Committee, some or all of the responsibilities of the Credentials Committee may be assumed by a Centralized Credentials Committee that includes representation from each of the participating YNHHS Affiliated Hospital Medical Staffs. Representatives from the Yale New Haven Hospital Medical Staff shall include individuals selected by the President of the Medical Staff in consultation with the Chief Medical Officer.

Any recommendations made by the Centralized Credentials Committee shall be forwarded directly to the Medical Executive Committee for action.

Composition: shall include, but not be limited to, one member from each of the Departments of Medicine, Diagnostic Radiology, Obstetrics and Gynecology, Pediatrics, Psychiatry, Surgery, and Nursing Administration. Except for Nursing and Radiology & Biomedical Imaging, these representatives shall alternate between University and Community groups. The Medical Staff Secretary shall serve as Chair. Except for the Medical Staff Secretary, Nursing Administration and Radiology & Biomedical Imaging members, members shall be nominated by the appropriate Chief and Associate Chief. The Nursing Administration member shall be nominated by the Senior Vice President for Patient Services. The Radiology & Biomedical Imaging member shall be nominated by the Chief of Radiology & Biomedical Imaging. The term of appointment of each member shall be two years. The Chief Medical Officer or his designee shall participate ex officio with vote.

Meetings: monthly

e. **Emergency Service Committee**:
Charge: determines the scope of emergency services provided and develops, evaluates and updates associated policies and procedures for emergency care; recommends qualifications required for emergency services staff; plans, coordinates and evaluates delivery of patient care in the Emergency Service; plans, develops and implements patient care programs for improved quality of care in conjunction with community needs, resources and affiliated facilities; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chief of Emergency Medicine shall serve as Chair; membership includes community and university based representatives of the Medical Staff, Nursing and the Hospital clinical service coordinator for emergency services.

Meetings: Quarterly

f. **Equipment and Products Standards Committee**:
Charge: advise administration and Director of Purchasing on matters relating to purchase of medical and surgical equipment and supplies; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes members of the Medical Staff and representatives from the departments of nursing, purchasing, engineering and Hospital administration.

Meetings: monthly

g. **Finance Committee**
Charge: advises the Medical Executive Committee as to the management of funds collected through the medical staff dues including the following: recommends and revises guidelines for use of the funds; reviews requests for funding from the Medical Staff dues account and makes recommendations to the Medical Executive Committee. Provides a written annual and intermittent (as necessary) reports to the Medical Executive Committee identifying which programs/projects meet requirements for funding.

Composition: immediate past five Medical Staff Presidents; the Immediate Medical Staff Past President shall serve as Finance Committee Chair; in the event that one of the members is not able to complete his/her responsibilities or unable to serve as a member, the Medical Staff President shall recommend a replacement to the Medical Executive Committee.

Meetings: annually or more frequently, as needed

h. **Graduate Medical Education Committee**
Charge: Monitor and advise on all aspects of resident education, as required by the ACGME. Responsibilities include, but are not limited to, oversight of program job descriptions, progressive responsibilities during training, and monitoring quality and safety of patient care, treatment and services provided by participants in the GME programs.

Composition: the Designated Institutional Officer and Director, Graduate Medical Education shall serve as Chair; membership includes the Chief Medical Officer or his/her designee, Graduate Medical Education specialty and subspecialty program training directors, House Staff and Clinical Fellow representatives, representatives from Hospital Human Resources, Legal & Risk Services and other

selected departments. Provides an annual written report to the Medical Executive Administrative Committee.

Meetings: At least six times a year with additional meetings as required

i. **Infection Control Committee**:
Charge: define, survey, correlate, review, evaluate, revise and institute whatever recommendations and policies are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chief of Hospital Epidemiology and Infection Control shall serve as Chair; membership shall include representatives of the Medical and Hospital Staff including the director of occupational health a nurse epidemiologist and members of the Nursing, Environmental Services, Food and Nutrition, Pharmacy and Ambulatory Services Departments and Hospital Administration.

Meetings: monthly

j. **Professional Practice Evaluation Committee (PPEC)**
Charge: (a) oversee the gathering and analysis of data and information among clinical departments of Hospital and the committees of the Medical Staff for purposes of: evaluating and improving the quality of health care services ordered or delivered by health care professionals; studying and reducing morbidity and mortality; conducting medical audits; considering the appropriate utilization of institutional resources; and analyzing clinical practices. In some circumstances, malpractice claims review may also be conducted. (b) receive reports from Medical Staff committees and sub-committees and Hospital departments, services, and sections conducting peer review; (c) designates and appoints members or other Hospital personnel to evaluate and conduct root cause analyses as the Committee specifically authorizes or directs, including , but not limited to serious safety events and other significant unanticipated outcomes at the Hospital, reports the results of these activities to the Committee; (d) designates the Chief Medical Officer to act between meetings to address issues of immediate concern having to do with Medical and Affiliated Medical Staff including, but not limited to, general competence, (e) facilitate mechanisms for correction of problems identified; (f) assist the Hospital in maintaining compliance with the requirement of The Joint Commission; (g) report to the Medical Executive Committee and the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding institutional concerns related to patient safety and practitioner performance; (h) refer issues, as applicable, having to do with qualifications for credentialing and privileging to the Credentials Committee for deliberation; and (i) communicates accordingly with, and involves individuals whose practice, or aspects of practice, are under review as well as with the applicable Chief, Associate Chief or Section Chief. Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence. The Committee shall carry out such additional quality improvement activities as it deems appropriate. Reports directly or via the Credentials Committee as needed to the Medical Executive Administrative Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

Composition: Medical Staff President who shall serve as Chair, Medical Staff President Elect, Chief Medical Officer or representative of Chief Medical Officer's Office, two community based members of the Medical Executive Committee, two Department Chiefs and supported by a Legal & Risk Services representative. Additional members may be added at the discretion of the Chief Medical Officer or the Medical Staff President.

Meetings: Monthly

k. **Medical Record and Clinical Information Committee**

Charge: advise the Medical Executive Committee and, where appropriate, administration and medical personnel in matters pertaining to medical records and clinical information; establish criteria and approve new systems and changes to existing computerized and non-computerized systems used for the collection, storage, retrieval, and release of patient specific medical information on all patients of the Hospital to ensure patient confidentiality and appropriate access; approve changes in format and usage of the medical records; implement the provisions of the Rules and Regulations that pertain to the charge of the Committee; develop guidelines for safeguards to be incorporated into systems to prevent breach of confidentiality; develop a program for continuing review of medical records as to adequacy and quality of content; provide a written report monthly to the Medical Executive Committee on matters related to delinquent medical records and, when appropriate, report problems in compliance with guidelines approved by the Medical Executive Committee. Provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership shall include representatives from the Medical Staff, Clinical Information Services, Ambulatory Services, Nursing and Administration and the Director of Clinical Information Service.

Meetings: monthly

l. **Medical Staff Health Committee.**

Charge: To establish and maintain a mechanism for educating Medical Staff and trainees to recognize the signs and symptoms of potential or actual health impairment among colleagues; to assist in identifying such potential or actual health impairment; to implement Medical Staff policy when incidents of actual or potential health impairment require evaluation; make recommendations to the Medical Executive Committee regarding Medical Staff Health policy changes and report as needed.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes representatives from the Medical and Affiliated Medical Staffs, Chief Medical Officer or his/her designee; Senior Vice President for Patient Services or his/her designee. Other Hospital staff may participate ex officio as appropriate.

Meetings: Meets as needed

m. **Medical Staff Professionalism Committee (MSPC)**

Charge: (a) review alleged violations of the Medical Staff Code of Conduct referred by the Chief Medical Officer or Department Chiefs; (b) designate the Chief Medical Officer to act between meetings to address issues of immediate concern having to do with compliance with the Medical Staff Code of Conduct; (c) facilitate mechanisms for correction of problems identified including, but not limited to, referral of practitioners to external programs or counseling as appropriate; (f) assist the Hospital in maintaining compliance with the requirements of The Joint Commission; (g) report to the Medical Executive Committee and the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding institutional concerns related to practitioner behavior; (h) refer issues, as applicable, having to do with alleged violations of the Code of Conduct or health/fitness to work to the Credentials Committee or, as appropriate, Medical Staff Health Committee, for deliberation; (i) communicates accordingly with and involves individuals whose practice or aspects of practice are under review as well as the applicable Chief, Associate Chief or Section Chief. Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17b (a)(2) and shall be kept in strict confidence. Reports directly or via the Credentials Committee as needed to the Medical Executive Administrative Committee and to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

Composition: Medical Staff Past President who shall serve as Chair, Medical Staff President, Medical Staff President Elect, Chief Medical Officer or representative of the Chief Medical Officer's office, two community based members of the Medical Executive Committee, Chair of Credentials Committee, Senior Vice President of Human Resources or designee; supported by a Legal & Risk Services representative. Additional members may be added at the discretion of the Chief Medical Officer or Medical Staff Past President.

Meetings: at least annually

n. **Nutrition Committee:**
Charge: reviews, and/or makes recommendations on nutrition standards of practice, policies and procedures, and monitors the quality of patient care related to medical nutritional therapies (diet/nutritional support), nutrition education and patient satisfaction with meals; selects and approves all enteral products and tube feeding systems; approves enteral and parenteral nutrition formularies; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes members of the Medical Staff, the Nutrition Support Team, Hospital administration, nursing, pharmacy, and unit service management.

Meetings: monthly

o. **Organ & Tissue Donation Committee:**
Charge: Oversees activity related to all organ and tissue procurement activities and the relationship of the Hospital with the New England Organ Bank (NEOB). Responsible for the development and implementation of all related policies and procedures including, but not limited to, staff training and education and patient confidentiality and keeping all organ procurement policies and procedures current with applicable standards. Oversees performance improvement and quality assurance initiatives related to organ procurement. Oversees and manages the activities of representatives of the NEOB and transplant teams from other institutions when present at the Hospital.

Provides an annual written reports to the Medical Executive Administrative Committee or more frequently as necessary relative to significant changes in policy and/or requirements.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership shall include Medical Directors of the Pediatric, Neuro, Medical and Surgical Intensive Care Units; Medical Staff representatives from transplant surgery, neurology, internal medicine, emergency medicine and other specialties as applicable; representatives from nursing, social work, and religious ministries who are involved in the care of potential donors.

Meetings: monthly

p. **Pathology & Tissue Committee:**
Charge: review indications for surgery in all cases in which there is an apparent major discrepancy between the preoperative and pathologic diagnoses; establish a screening mechanism, based on predetermined criteria, to review cases in which the physicians involved (surgeon, referring doctor or pathologist) have concerns that cannot be resolved by mutual discussion. Refer cases, based on Committee investigation, to the appropriate Department Chief for action. The Committee will review all cases of interpretive errors causing frozen section/permanent section discordance; major discrepancies between cytology and tissue sections; and summary quarterly reports on frozen section / permanent section discrepancies submitted by the Director of Surgical Pathology; and on cytology/surgical

pathology discrepancies submitted by the Director of Cytology; provides an annual report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes Medical Staff representatives, including the Hospital Director of Quality Improvement and a representative from the Ambulatory Services Tissue Committee, as applicable.

Meetings: monthly

q. **Surgical Services Governance Committee:**
Charge: plan, coordinate and evaluate delivery of surgical and anesthesia care and services in all Operating Rooms consistent with Hospital goals; ; develop, review and modify all relevant policies and procedures; monitor key performance efficiency indicators and recommend and implement changes; facilitate implementation of performance improvement initiatives; oversee and direct safety, quality, patient and surgeon satisfaction efforts; in conducting all activities involve Chiefs and other leaders of affected Departments such as, but not limited to Anesthesiology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Surgery. Provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chief of Surgery and Senior Vice President responsible for Surgical Services shall be members and serve as Co-Chairs; other members shall include; the Chief Operating Officer, Chief Medical Officer, Chief of Anesthesiology, Associate Chief of Surgery, Vice President of Surgical Services, Medical and Nursing Directors of Perioperative Services, a representative from Performance Improvement, a representative from the Ambulatory Services off campus operative site(s); Chiefs of all areas that utilize the Operating Rooms and members of Medical, Nursing and Administrative Staffs as needed. Community and University surgeons will be represented.

Meetings: monthly

r. **Pharmacy and Therapeutics Committee:**
Charge: recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to drugs; recommend programs designed to meet the needs of the professional staff of the Hospital for complete current information on matters related to drugs and drug practices; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership shall include representatives from the Medical Staff and Hospital Departments of nursing, pharmacy, and Hospital administration.

Meetings: monthly

s. **Radiation Safety Committee:**
Charge: assure compliance with the regulations of the Nuclear Regulatory Commission, the Department of Environmental Protection, the Department of Transportation, and other City, State, or Federal agencies regarding the use, transportation, and disposal of all sources on ionizing radiation; assure that all Hospital staff who are occupationally exposed to ionizing radiation are properly trained and monitored; recommend procedures that will reduce the radiation exposure of Hospital staff and patients to as low as reasonably achievable; establish procedures and methods for the safe storage and disposal of radioactive wastes; recommend disciplinary action for Hospital Staff who disregard rules for the safe use of ionizing radiation; review amendments to the Hospital's Broad Human Use By-Product Materials License (NRC); review applications and issue in-house authorizations for the conduct of clinical research protocols which use radioactive materials or other sources of ionizing radiation and which have

prior approval of the Human Investigation Committee; review the credentials of and issue letters of authorization to attending physicians whose clinical practice entails the prescription and application of radioactive materials to Hospital patients; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes members of the Medical Staff who utilize radioactive materials and radiology equipment including the Gamma Knife; representatives from nursing, Hospital administration, radiation safety, and other members as required to be in accordance with NRC rules and regulations, Subpart B, 10 Code of Federal Regulations, Section 35.34(f).

Meetings: quarterly

t. **Rehabilitation Committee:**
Charge: responsible for the scope of rehabilitation services offered, associated operation of the Department including all operational issues as well as appropriate number and qualifications of staff and quality assurance and performance improvement. Reviews (a) policies and procedures of the Department of Rehabilitation Services and Hearing, Speech, and Language; (b) services offered, (c) future plans and past performance, (d) capital budget needs ; (e) Quality Assessment/Quality Improvement reports; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be the Medical Director of Rehabilitation Services, membership shall include representatives from the Medical and Nursing Staff; Hospital administration and the Director of Rehabilitation Services.

Meetings: Three times yearly

u. **Respiratory Services Committee:**
Charge: responsible for the scope of respiratory care services offered, associated operation of the Department including all operational issues as well as appropriate number and qualifications of staff; Departmental quality assurance and performance improvement initiatives. Reviews (a) and, as appropriate, modifies policies and procedures (b) services offered, (c) future plans and past performance, (d) annual capital budget needs; (e) Quality Assessment/Quality Improvement reports; provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be the Medical Director of Respiratory Services, membership shall include representatives from the Medical and Nursing Staff; Hospital administration and the Director of Respiratory Services.

Meetings: Three times yearly

v. **Resuscitation/Rapid Response Review Committee:**
Charge: To review all Code 5 and Code 7 events to assure appropriate pre-emergency use of rapid response teams and adherence to ACLS/PALS resuscitation guidelines. Analyze and report outcomes of resuscitation and rapid response calls. Create and implement policies that optimize resuscitation training and patient outcomes. To evaluate the areas to which Code response is provided and requests for extension of the Code response to non-served areas. To provide quality assurance and peer review to aspects of the Code and rapid response function. Provides an annual written report to the Medical Executive Administrative Committee.
Composition: The Chair shall be a member of the Active Medical Staff and appointed by the Medical Executive Committee. The Committee membership shall include, but not be limited to, representatives from the Departments of Anesthesiology, Surgery, Internal Medicine (including

Hospitalist Team), Nursing, Chief residents in Medicine and Pediatrics Pharmacy, Protective Services, Respiratory Therapy, and Performance Management.

Meetings: At least quarterly

w. **Transfusion & Tissue Banking Committee:**
Charge: To periodically establish and review criteria for the transfusion of blood and blood components and to conduct transfusion audits; to work to ensure the continual availability of a safe and adequate blood supply for the care of Hospital patients; to make transfusion medicine study findings known to the clinical services; and to review the results of transfusion error and accident monitoring and make recommendations for corrective action. Develops procedures to acquire, retrieve and store tissue products; monitor use and proper storage and maintenance of tissues used in operating rooms; establish and maintain an appropriate electronic recordkeeping system for accountability and traceability of tissues used. Provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be appointed by the Medical Executive Committee; membership includes representatives from the Medical Staff, Laboratory Medicine, Perioperative Services, Hospital Administration.

Meetings: three times yearly

x. **Utilization Review & Discharge Planning Committee:**
Charge: Develops, implements and evaluates relevant policies and programs for utilization management and discharge planning; activities include, but are not limited to, appropriate reviews to expedite quality patient care and effective, efficient usage and delivery of resources, facilities and service; oversight of discharge planning activities to identify patients with continuing care needs and ensure proper coordination of services following discharge; development and implementation of screening procedures for early identification of patients at high risk for discharge planning; maintenance of current resource information about available post-discharge health and social facilities and services. Provides an annual written report to the Medical Executive Administrative Committee.

Composition: the Chair shall be the Medical Director of Utilization Review & Discharge Planning; other members include the Medical Director of Emergency Services, Associate Director, Clinical Effectiveness, manager of utilization review and discharge planning; representatives from Hospital departments of Patient Financial and Admitting Services and other members of the Medical and Hospital administrative Staff as needed based upon patient needs.

Meetings: monthly

In addition to the foregoing committees, the following Hospital departments listed below shall provide an annual report to the Medical Executive Committee which shall, at a minimum include the following: (a) updates concerning operational, policy, procedure and scope of service issues, (b) regulatory changes and (c) departmental performance improvement/quality assurance initiatives and results.

Radiology & Biomedical Imaging
Laboratory Medicine

Other departmental and multidisciplinary peer review, morbidity and mortality review, and quality assurance committees also shall be established as appropriate for the purposes set forth above and for such other purposes as are deemed necessary.

SECTION I. Committee Policies

Policies developed by committees shall be consistent with the provisions of the Bylaws and Rules and Regulations. Upon approval by the Medical Executive Committee, Committee Policies shall be effective and binding on all members of the Staff.

SECTION J. Additional Authority of Committees

Committees shall exercise such additional authority as may be specifically provided by other provisions of these Bylaws, Rules and Regulations, or as may be authorized by the Medical Executive Committee.

ARTICLE XVII. AMENDMENTS

SECTION A. Proposing Amendments
Proposed amendments to the Medical Staff Bylaws, Rules & Regulations or medical staff policies are referred to the Medical Executive Committee, Medical Executive Committee Administrative Committee or Bylaws Committee of the Medical Executive Committee.

If 25% of the voting members of the Organized Medical Staff sign a petition to do so, they may propose amendments to the Bylaws, Rules & Regulations or medical staff policies by submitting their proposals in writing to the Bylaws Committee of the Medical Executive Committee. A representative(s) from the petitioning group will be invited to participate in the Bylaws Committee.

SECTION B. Medical Executive Committee Action
All proposed amendments, regardless of source, shall ultimately be presented to the Medical Executive Committee. Proposals for Bylaws and Rules and Regulations changes or amendments shall be distributed to members of the Medical Executive Committee at least 7 days in advance of the meeting at which they will be considered.

Two thirds of those present and voting at the Medical Executive Committee may recommend approval, disapproval, approve recommendations with modifications or refer proposed amendments in whole or in part to the Bylaws Committee for initial review or re-evaluation.

SECTION C. Voting by the Medical Staff
All amendments approved by the Medical Executive Committee shall be submitted to the voting members of the Organized Medical Staff. Voting members shall be allowed a minimum of thirty (30) calendar days to respond to notification. Notifications shall be sent electronically. Failure to respond by thirty (30) calendar days after notification will be considered a vote for approval.

In the event that 25% or more of voting members signify disagreement with any of the proposed amendments, their concerns will be transmitted to the Bylaws Committee of the Medical Executive Committee for review. One or more representative from the dissenting group will be invited to participate in the Bylaws Committee.

If fewer than 25% of voting members voice objection, the amendments shall be forwarded for action to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

SECTION D. Patient Safety & Clinical Quality Committee of the Board of Trustees
Amendments approved by the Medical Executive Committee and the voting members of the Organized Medical Staff shall be forwarded to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

If the Patient Safety & Clinical Quality Committee of the Board of Trustees approves the amendments, they shall be forwarded to the Board of Trustees for ratification.

In the event that the Patient Safety & Clinical Quality Committee of the Board of Trustees or the Board of Trustees modifies or disapproves any amendments proposed by the Medical Executive Committee and the voting members of the Organized Medical Staff, such modifications shall be returned to the Medical Executive Committee which may accept or reject the modifications.

If the Medical Executive Committee accepts the modifications, they shall be submitted once again to the voting members of the Organized Medical Staff as outlined in Section C. above.

If the Medical Executive Committee rejects the modifications, the amendment and arguments against the modifications shall be resubmitted to the Patient Safety & Clinical Quality Committee of the Board of Trustees or Board of Trustees.

If that group approves the amendment, the approval process will proceed.

If the group is the Patient Safety & Clinical Quality Committee of the Board of Trustees, the disagreement between it and the Medical Executive Committee shall be referred to the Board of Trustees. The matter will be referred to the Patient Safety & Clinical Quality Committee of the Board of Trustees if the Board of Trustees was the body that recommended the modifications that were not approved by the Medical Executive Committee.

SECTION E: Approval Requirements
The Bylaws which include the accompanying Rules and Regulations and medical staff policies may be changed or amended as described in Sections A through D above.

In addition, the Patient Safety and Clinical Quality Committee of the Board of Trustees or the Board of Trustees itself may initiate such changes.

SECTION F. Affiliation Agreement with Yale University
No change in or amendment to these Bylaws and the accompanying Rules and Regulations shall be inconsistent with the Affiliation Agreement between Yale and the Hospital dated March 22, 1965 as amended from time to time.

SECTION G: Effective Date
Amendments shall be considered effective the date of the approval by the Patient Safety & Clinical Quality Committee of the Board of Trustee

SECTION H: Non Substantive Edits
Notwithstanding any of the above, the Medical Executive Committee is authorized to make non-substantive changes to the Bylaws, Rules & Regulations and medical staff policies relating to the organization of these documents including renumbering, grammar, spelling, typographical errors and similar technical revisions without approval of the voting members of the Organized Medical Staff.

RULES AND REGULATIONS

of the

YALE-NEW HAVEN HOSPITAL, INC.

for the

MEDICAL STAFF

JANUARY 27, 1982

(Revised to October 1, 2019)

<u>NOTE</u>: Please refer to page 5 of the BYLAWS for a definition of the term "ATTENDING PRACTITIONER" used throughout these Rules & Regulations

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RULES & REGULATIONS

YALE-NEW HAVEN HOSPITAL

Rules and Regulations
for the
Medical Staff[2]

ACCEPTANCE OF PATIENTS

Rule No. 1 Acceptance of Patients and Function of Special Services

a. Acceptance of Patients

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

b. Special Services

The Hospital recognizes its commitment to special services such as organ transplantation and the trauma service; such special services shall function in accordance with requirements of relevant accrediting agencies.

STAFF PRIVILEGES

Rule No. 2 Patient Care Privileges

Only physicians, dentists, podiatrists and licensed nurse midwives who have been granted appropriate clinical privileges by the Board of Trustees or temporary privileges in accordance with these Bylaws are considered in good standing, are eligible to serve as an Attending Practitioner or otherwise provide care to patients within Hospital facilities.

Rule No. 3 Care of Family Members

Members of the Medical Staff may not serve as the Attending Practitioner for any member of their own family. Similarly, Medical Staff and Affiliated Medical Staff members may not schedule or perform operations or procedures on members of their own families in the operating rooms, procedure rooms or laboratories except in extreme emergencies when no other qualified member of the Medical Staff is available or with explicit approval by the Department Chief or Chief Medical Officer.

Rule No. 4 Limitations of Professional Privileges

<u>General</u>

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

[2] The terms “doctor” and “practitioner” are used synonymously to refer to physicians, podiatrists and dentists as applicable

Members and Affiliated Members of the Medical Staff with clinical privileges may conduct fecal occult blood testing, dip stick urinalysis and finger stick blood glucose testing using Hospital approved testing equipment and supplies in all Hospital sites and locations.

The clinical practice at 1450 Chapel Street shall be consistent with the Ethical and Religious Directives for Catholic Health Facilities as published by the United States Catholic Conference (the "Directives"). Application of the Directives shall be as set forth in policies of the Medical Staff as such policies may be modified from time to time in consultation with the Hospital's Catholic Heritage Committee and approved by the Board of Trustees.

As described in the Disaster Privileges Policy and Procedure, in the event of a formally declared Hospital emergency ("Plan D"), Members and Affiliated members of the Medical Staff may be asked by the Chief Medical Officer or his/her designee to assist at the Hospital in a role atypical for his/her usual practice. In such cases and for the duration of the assignment, Members and Affiliated members of the Medical Staff shall be accountable directly to the Chief Medical Officer or his/her designee.

Requests for changes or additions to the current privilege delineation form(s) shall be made by or delivered to the Medical Staff Administration Department. Modification of a delineation form must be reviewed and recommended by the relevant Chief, Section and Associate Chief if applicable, and the Chief Medical Officer. Requests to add a privilege or procedure that will be available in more than one specialty will be reviewed and recommended by all of the affected Chiefs. Modifications will be approved by the Credentials Committee, Medical Board and Patient Safety and Clinical Quality Committee of the Board of Trustees. A member of the Medical Staff requesting an additional privilege must apply for that privilege and must be credentialed through the routine credentialing process.

Members of the Medical Staff appointed in the Department of Surgery may not practice elective gynecological surgery and members of the Medical Staff appointed in the Department of Obstetrics and Gynecology may not practice primary elective general surgery without the specific approval of the Medical Board.

The history and physical examination may be performed and documented accordingly by any member of the Medical Staff from the following categories: Active Attending, Courtesy, Pediatric Network, and Consulting in order to satisfy history and physical examination requirements except as noted below. Physician Assistants and Advanced Practice Registered Nurses are also authorized to perform a history and physical with attestation[1] by the Attending Practitioner. Certified Nurse Midwives may perform history and physical examinations related specifically to patients admitted to the hospital for anticipated normal vaginal delivery.

<u>Dentists/Oral Surgeons</u>

All patients admitted for dental services shall be assigned to the Oral Surgery Section of the Department of Surgery. A history and physical examination pertinent to the admission must be performed and recorded by a physician or oral surgeon who is a member of the Medical Staff in addition to the dental history and examination recorded by the dentist.

Admission history and physical examinations documented by a member of the House Staff (excluding dental but including oral and maxillofacial surgery House Staff), an advanced practice registered nurse or a physician assistant with attestation[1] by the Attending Practitioner also satisfies this requirement.

Dentists specifically privileged in dental anesthesiology are authorized to perform pre-operative history and physical examinations for dental procedures and to authenticate such exams performed by a member of the House Staff (excluding dental but including oral and maxillofacial House Staff), an advanced practice registered nurse or a physician assistant. Continuing medical supervision of the patient shall remain the responsibility of an appropriately privileged physician.

[1]Attestation: Defined as verification that the Attending Practitioner personally evaluated a patient. This is evidenced in the electronic medical record by either a documented addendum or an independently completed report authenticated by the Attending Practitioner.

Podiatrists

Podiatrists who are currently board qualified or certified by the American Board of Foot and Ankle Surgery (ABFAS), (formerly known as the American Board of Podiatric Surgery (ABPS)), and appropriately privileged to admit and/or provide operative care may perform the admission and/or pre-operative history and physical examination for their patients.

Patients admitted by podiatrists who are not currently board qualified or certified by the ABFAS must have a consulting physician or another appropriately privileged podiatrist who is a member of the Medical Staff perform the admission history and physical and the preoperative history and physical as applicable.

Admission history and physical examinations documented by a member of the House Staff, an advanced practice registered nurse or a physician assistant with attestation[1] by the responsible Attending Practitioner or appropriately privileged podiatrist also satisfy the admission history and physical requirement.

Patients with active medical conditions admitted by any podiatrist, regardless of ABFAS status, must have a consulting physician who will follow the patient through the hospital admission and be responsible for the treatment of such conditions during hospitalization. Appropriate consultation from a physician must be sought for the diagnosis and treatment of any medical conditions that arise during hospitalization.

Rule No. 5 Privileges of Affiliated Health Care Professionals

Individuals appointed to the Affiliated Staff shall participate in the management of patients under the supervision of a member of the Medical Staff. Specific privileges of Affiliated Staff shall be delineated by the Department Chief and reflected in the appropriate delineation of privileges.

Rule No. 6 Reporting Requirements

All members of the Medical Staff shall immediately report the occurrence of any of the following to the Chief Medical Officer:

(a) loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation and/or fine) taken regarding a professional license in Connecticut or any other state;

(b) loss (other than for routine non-renewal), suspension, consent order or any other action taken with regard to state or federal authority to prescribe controlled substances;

(c) loss (other than routine non-renewal or resignation of unused clinical privileges), suspension, reduction, resignation, relinquishment, limitation (or any other action arising out of concerns related to competence or professional deportment of membership or clinical privileges at any other health care facility;

(d) initiation of formal investigation at any other health care facility;

(e) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and

(f) any arrest or the filing of any criminal charge by local, state or federal authorities .

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

[1]Attestation: Defined as verification that the Attending Practitioner personally evaluated a patient. This is evidenced in the electronic medical record by either a documented addendum or an independently completed report authenticated by the Attending Practitioner.

ADMISSION AND DISCHARGE OF PATIENTS

Rule No. 7 Admitting Principles

No patient shall be admitted to the Hospital unless a provisional diagnosis has been stated and the admitting office has cleared the patient. There must be an order for hospital admission for all inpatients. The order must be completed by an Attending Practitioner. If the Attending Practitioner delegates this responsibility to a member of the House Staff, an advanced practice registered nurse, or physician assistant, the Attending Practitioner must authenticate the order. Admissions shall be assigned to patient divisions in accordance with Hospital policies.

Rule No. 8 Protection / Continuous Coverage of Patients

Admitting Medical Staff shall provide appropriate Hospital personnel with information concerning their patients as may be required to enable the Hospital to protect the patient and other patients, staff and visitors from possible sources of danger. Medical Staff members with privileges to admit must have a coverage arrangement that assures continuity of care for their patients. This should be affected by means of an agreement with another appropriately credentialed and privileged member of the Medical Staff. Other coverage arrangements will require Departmental approval.

Rule No. 9 Patient-Doctor Assignment

In the event that a patient does not request a specific physician or if the patient's personal physician or consultant cannot be identified, cannot be contacted or chooses not to provide inpatient care, the patient shall be assigned to a member of the Active Attending Staff with appropriate clinical privileges. Assignment of the patient by the Emergency Department shall be based on the relevant on-call schedule as applicable. If the assigned Attending Practitioner chooses not to accept responsibility for a patient's inpatient care, it will be incumbent upon him/her to arrange for transfer of the responsibility to another Attending Practitioner with appropriate clinical privileges who agrees to provide inpatient care.

Rule No. 10 Discharges

Patients shall be discharged either on the order of an Attending Practitioner or a member of the House Staff, nurse practitioner or physician assistant may complete the discharge order with approval from the Attending Practitioner.

The Attending Practitioner is obligated to ensure that communication occurs with the patient's outpatient or referring doctor regarding all appropriate medical information and shall provide the same information to any institution or agency to which a patient is referred following discharge from the Hospital. In those instances in which a patient is to be transferred directly from the Hospital to another institution, the patient will not be permitted to leave the Hospital until the transfer information, including an appropriate Discharge Summary, has been completed.

Whenever possible and appropriate, a responsible practitioner should be identified who will provide follow-up care for each patient discharged from the Hospital. If that practitioner was not a member of the House Staff or an Attending Practitioner caring for the patient during the Hospital stay, the Attending Practitioner must ensure that an appropriate follow-up practitioner is contacted. The follow-up practitioner must be informed of the course of the patient's hospitalization, the patient's discharge date, medications, and needs for continuing care.

It is the responsibility of the Attending Practitioner to plan discharge in a timely fashion. The discharge date must be coordinated with the House Staff, nursing staff, social worker and discharge planning staff. Nursing and discharge planning staff as well as the patient and the patient's family, must be informed of the anticipated discharge date as early as possible. Patients and their families should be notified on the day prior to discharge of the scheduled discharge time so that transportation and support services can be arranged.

INPATIENT CARE

Rule No. 11 Patient-Doctor Relationship

Within 24 hours of a patient's admission or transfer to the inpatient service, the Attending Practitioner shall personally examine the patient, establish a personal and identifiable relationship with the patient if such was not established prior to the admission or transfer, and record, or cause to be recorded, an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment in the electronic medical record (EMR) (See Rule #18). In the event that the EMR is not functioning, documentation must be made on paper.

Admission history and physical examinations may be performed by a member of the House Staff or others in accordance with Rule #4.

The Attending Practitioner is responsible for continuing evaluation of the care of the patient and plans for treatment, for ensuring communication to the patient of the treatment plan and realistic goals of care, and for subsequent communication about significant variances from expected outcomes that occur during medical treatment or surgery.

Rule No. 12 Medical Students

Appropriately prepared medical students are permitted to function within the Hospital for educational purposes only and are not to be used for clinical service needs. Medical students always function under supervision, but the supervision does not necessarily need to be in-person. The type and intensity of supervision required is determined by the Attending Practitioner responsible for each individual patient.

Medical students may participate with the patient care team and, for educational purposes, may perform a history and physical examination and record progress notes in the electronic medical record. History and physical examinations and progress notes entered by medical students shall not be considered valid until or unless they are authenticated by a member of the Medical Staff or House Staff.

Patient care orders may be entered by medical students but will remain in suspension until electronically signed by a member of the Medical Staff or House Staff.

Medical students may not obtain informed consent for procedures or surgery or disclose adverse events or unanticipated outcomes to patients or their family members. Furthermore, medical students may not complete operative reports or discharge summaries and are not authorized to write orders for limitation of treatment or restraints.

Rule No. 13 House Staff

The Attending Practitioner is responsible for supervising the performance of, and the care rendered by, members of the House Staff in accordance with Medical Staff and departmental policies. Types of supervision can include, but are not limited to, in person, electronic or telephonic, review of documentation, and submission and review of performance evaluations. In general, the Attending Practitioner will determine the nature of the required supervision, based on the complexity of the patient care situation, the level of training and experience possessed by the House Staff member, and departmental guidelines concerning graded House Staff responsibility and supervision.

Consistent with other Medical Staff Rules, House Staff may enter all types of diagnostic and treatment orders for patients, including but not limited to, orders for restraints. However, orders to limit life-sustaining treatment may only be entered by House Staff with the approval and subsequent authentication by the Attending Practitioner. House staff members may enter orders for oncology chemotherapy but they must be authenticated by an Attending Practitioner who has current privileges to prescribe chemotherapy.

Rule No. 14 Consultations

It is the responsibility of individual Medical Staff members to call for consultations when provision of care is outside the scope of their privileges or expertise. Attending Practitioners who participate in on-call schedules must be willing to provide inpatient and Emergency Department consultation at all Hospital sites/locations as applicable based upon Department/Section determined schedules.

Medical Staff members who provide consultation must be qualified and appropriately privileged to give an opinion in their respective specialties. Judgment as to the seriousness of the illness and the validity of diagnosis and treatment rests with the Attending Practitioner responsible for the overall care of the patient.

Regardless of the location or nature of the consultation, it is expected that the consulting Attending Practitioner will personally examine the patient within twenty four (24) hours. Under certain circumstances the consulting Attending Practitioner may direct appropriately qualified House Staff, Clinical Fellow, advanced practice registered nurse or physician assistant to provide the consultation to inpatient or Emergency Department patients.

In the event that the consulting Attending Practitioner requests that one of these practitioners sees a patient in his/her stead, the consultation is still the consulting Attending Practitioner's ultimate responsibility as is the responsibility to follow up accordingly to ensure that appropriate documentation is made in the patient's record within twenty four (24) hours as described below. Documentation must indicate the specific level of involvement of the consulting Attending Practitioner and, if the consulting Attending did not personally see the patient, the reason why this did not occur.

<u>Emergency Department and Inpatient Consultations</u>

For inpatients and patients who are ultimately discharged from the Emergency Department, the consulting Attending Practitioner must document one of the following within twenty four (24) hours of the request for the consultation or discharge (in the case of patients discharged from the Emergency Department). The documentation must evidence the consulting Attending's involvement in the consultation.

1. Patient was personally seen and examined with findings and recommendations outlined by the consulting Attending Practitioner;

2. Patient was personally seen and examined, chart reviewed and case was discussed with the House Staff member, Clinical Fellow, advanced practice registered nurse or physician assistant who also saw and

examined the patient. Findings and recommendations are outlined by the consulting Attending Practitioner;

3. Patient was not personally examined, patient chart was reviewed and case was discussed with the House Staff member, Clinical Fellow, advanced practice registered nurse or physician assistant who actually saw the patient. Findings and recommendations are outlined by the individual who saw the patient and documentation by the consulting Attending Practitioner must include the reason why he/she did not personally see the patient as well as a notation as to whether there is agreement with the findings and recommendations entered or modifications to same.

4. Patient chart was directly reviewed but the patient was not personally examined and the case was not discussed with the House Staff member, Clinical Fellow, advanced practice registered nurse or physician assistant who actually saw the patient. Findings and recommendations are outlined by the individual who saw the patient and documentation by the consulting Attending Practitioner must include the reason why he/she did not personally see the patient or speak with the individual who did see the patient as well as a notation as to whether there is agreement with the findings and recommendations entered or modifications to same.

For inpatients, documentation must also include frequency of follow-up until final sign off of the case.

Notwithstanding the above, the individual who requests the consultation may require that the consultation be provided by the Attending Practitioner and not be delegated. In this case, it is expected that the consulting Attending Practitioner will appropriately document that the patient has personally been seen and examined and appropriate findings and recommendations outlined.

The consulting Attending Practitioner's electronic signature alone does not satisfy the documentation requirements as stated above.

It is the consulting Attending Practitioner responsibility, regardless of whether or not he/she personally saw and examined the patient, to ensure that appropriate documentation is completed as noted above within twenty four (24) hours of the patient's discharge (ED patients) or request of the consultation (inpatients).

Consultations Resulting in Procedures

In the event that a consultation results in the immediate performance of a procedure or intervention by the consulting Attending Practitioner, the consultation and operative/procedural reports may be combined and must be dictated immediately following the procedure. (See Rule#18)

Consultation Orders in Suspension

Except in the case of an emergency, in the event that a consulting Attending Practitioner or his/her designee enters orders the orders must be entered in suspension for activation by the patient's requesting Attending Practitioner or his/her designee. This does not apply to the following: (1) peri-procedural/intervention orders and (2) recommendations made by appropriately credentialed mental health professionals for the initiation or discontinuation of sitters for patients identified at risk for suicide or the application or removal of restraints.

Outpatient/Ambulatory Consultations

All ambulatory consultations are the responsibility of an Attending Practitioner. The consulting Attending Practitioner must personally provide the services if so requested by another Attending Practitioner. Departments/Sections may define specific types of consultations, which may be completed by members of the House Staff, Clinical Fellows, physician assistants or advanced practice registered nurses having specified and documented appropriate training, experience, and PGY level (as applicable)--- without direct involvement of the consulting Attending Practitioner. However, the consulting Attending Practitioner must review any case within twenty four (24) hours in which he/she does not personally provide the consultation.

Except in an emergency, consultations with one or more qualified Attending Practitioners are required in:

(1) all cases of induced abortion involving minors where the consent of the parent has not been obtained, and all cases involving the cognitively impaired or incapable;

(2) elective sterilization procedures on all cases involving mentally retarded or incapable persons;

(3) cases on all services in which, according to the judgment of the physicians,
(a) the diagnosis is obscure, or
(b) there is doubt as to the best therapeutic measures to be utilized; and

(4) when diagnostic or therapeutic interventions are beyond the privileges of the responsible Attending Practitioner.

Rule No. 15 Informed Consent
(*See also: Clinical Administrative Policy C-10: "Consent for Procedures and Treatment"*)

Except in emergency situations, the Attending Practitioner or his/her appropriately qualified designee shall obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate (see Medical Staff Policy "Surgery and Other Procedures / Treatment Requiring Informed Consent), including transfusion and the use of blood products. Evidence of this consent shall be provided by completion of the "Consent for Operation or Special Procedure (Form #1696) or other hospital approved specialized consent form. This form, signed by the patient and the Attending Practitioner or his/her appropriately qualified designee shall be placed in the patient's hospital record. The extent of information to be supplied by the Attending Practitioner to the patient shall include the following:

(1) the name of the specific procedure or treatment;
(2) the purpose and benefits of the procedure or treatment;
(3) reasonably foreseeable risks; and
(4) reasonable alternatives for care or treatment

Consent must be obtained within ninety (90) days prior to the procedure.

It is the responsibility of the Attending Practitioner (identified as the "responsible practitioner" in Policy C-10) to evaluate, examine and counsel patients and/or their legal guardians or representatives prior to elective surgical procedures. Documentation of these interactions in the form of the Attending Practitioner's preoperative evaluation note is required in advance of the day of elective surgery (see Rule #18). This responsibility may not be delegated. Screening endoscopic procedures are excluded from this requirement. However, examination of the patient by the gastroenterologist who will perform the procedure prior to its performance is required.

In all procedures carried out in procedural areas the Attending Practitioner in whose name the permission for operation is obtained shall participate in person as a member of the operating team and shall be present during the critical portion(s) of the procedure. Such participation shall not be delegated without the informed consent of the patient or the patient's authorized representative.

Rule No. 16 Tissue Removed at Operation

Except as exempted by Pathology department policy, all tissue and foreign bodies, including implants, removed at the time of surgery must be sent to the Hospital Pathology department. Any tissue identified for

research, teaching or other non-diagnostic purposes must be obtained under the supervision, and with the agreement of, the Department of Pathology.

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

Rule No. 17 Treatment and Patient Care Orders

Before participating in patient care at any Hospital facility, all members of the Active Attending, , Pediatric Network, Courtesy, Consulting , Telemedicine and Affiliated Health Care Professional staff as well as all House Staff and clinical fellows must complete training in the use of the Hospital's electronic medical record. Members of the Active Referring Medical Staff category and Referring Affiliated Health Care Professionals who do not have clinical privileges are encouraged, but not required, to complete this training.

All orders for inpatient care and treatment shall be entered in the electronic medical record unless such system is inoperative. Initial admission diagnostic and treatment orders may be entered by the Attending Practitioner or may be entered by a member of the House Staff, a physician assistant, or a nurse practitioner as appropriate. Orders shall be entered only with the approval, or under the supervision of, the Attending Practitioner responsible for the patient.

Once services are requested of a Hospital-contracted Department as defined in Article VI, Section A(3), providers in that Department may enter orders relevant to the services requested or may revise previously entered orders in order to assure as much as possible that the providers requesting the services are provided with the diagnostic information or therapeutic outcome sought.

Orders not personally entered by the Attending Practitioner shall be regularly reviewed by the Attending Practitioner.

In an emergency, an order may be dictated by an Attending Practitioner to a registered nurse, dietitian, pharmacist, or respiratory therapist. Verbal orders for the initial application of restraints for medical recovery, medications, and nutrition must be electronically signed within 24 hours by the prescriber or another Attending Practitioner directly responsible for the patient's care. Verbal orders for extending restraints for medical recovery beyond the initial 24-hour period must be electronically signed by the next calendar day. Any verbal order for restraints for violent or destructive behavior should be authenticated in the electronic medical record at the time of face-to-face evaluation of the patient, but must be authenticated no later than the age-determined expiration time for that order. Any orders to limit life- sustaining treatment must be in writing and/or entered into the electronic medical record and must be signed electronically by the Attending Practitioner after the order is printed from the electronic medical record. Any verbal orders exempt from mandatory authentication within 24 hours shall be electronically signed at or prior to the discharge of the patient.

The Pharmacy Department is authorized to dispense generic equivalents of brand name drugs. If an Attending Practitioner prefers to order a brand name drug, he/she must request this through the non-formulary process.

At the time a patient is admitted to or discharged from a recovery room or critical care area, or transferred from one service to another, the patient's Attending Practitioner or designee shall review all of the patient's current orders. The reviewer must determine which orders to maintain and must enter any new orders that are indicated at that time. It is the responsibility of the Attending Practitioner to review all orders with the same frequency with which progress or consultation notes are documented. All controlled drugs shall be renewed or discontinued after 7 days. All other medication orders must be renewed every 30 days.

Only a single individual diagnostic test may be ordered more than 24 hours in advance. Repetitive or standing orders for individual tests are not permitted. Only patients on approved Human Investigation Committee protocols are exempt from this policy.

MEDICAL RECORDS

Rule No. 18 Medical Records — Preparation

With rare exceptions and time limitations, granted by the Chief Medical Officer all medical record documentation must be entered in the electronic medical record. The text and signature(s) contained in any handwritten Hospital records shall be legible, dated and timed.

Medical History & Physical Examination Requirements

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

(1) all inpatient admissions;

(2)outpatients receiving ongoing primary care; and

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

The specific types of H&Ps and requirements are specified in (a) and (b) below. Patients whose visit is limited to the administration of medication or modification of medicines prescribed are not required to have a H&P but other documentation is required as noted in (c) below.

All H&Ps performed by a member of the House Staff, an advanced practice registered nurse or a physician assistant must be accompanied by an attestation[1] as defined in Rule #4 to satisfy H&P requirements.

Dentists, and podiatrists who admit patients and are not privileged to perform a H&P must have a consulting physician who is a member of the Active Medical Staff. The consulting physician shall have responsibility for the admission history and physical and, as applicable, the preoperative history and physical. (See Rule #4)

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

History shall include the following:

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

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

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

- extremities (including vessels);

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

b. "Surgical / Invasive Procedure H&P": patients undergoing a surgical or invasive procedure involving sedation or anesthesia

History shall include the following:

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

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

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

The Attending Practitioner who will be performing the surgery/invasive procedure may choose one of the following three options to satisfy H&P requirements:

(1) assume responsibility for personally performing the "Surgical / Invasive Procedure " H&P as described in "b", or;
(2) delegate responsibility for completion of the "Surgical / Invasive Procedure" H&P as described in "b" to an appropriately qualified House Staff member, clinical fellow, physician assistant or advanced practice registered nurse and subsequently attest[1] to it, or;
(3) use a H&P performed by another member of the Medical Staff privileged to conduct H&P consistent with Rule #4

Unless option #1 above is chosen, the Attending Practitioner who will be performing the surgery / invasive procedure must personally complete and document a pre-operative evaluation note consisting of the following:

- indications for and descriptions of the surgery / invasive procedure to be performed including verification that it is the same surgery / invasive procedure for which informed consent has been obtained consistent with Rule #15)
- review and consideration of relevant results of diagnostic tests including appropriate laboratory data and diagnostic imaging and a diagnostic assessment and plan for care
- specialty relevant physical examination
- fulfill the requirements of informed consent as described in Rule #15

The pre-operative evaluation note must be performed by the Attending Practitioner who will be performing the surgery / invasive procedures and responsibility for this may not be delegated.

The surgical / invasive procedure H&P must be completed within thirty (30) days of the procedure. If the H&P was not completed within thirty (30) days of the procedure, the H&P must be re-done via one of the options (#1 - #3) described above.

Surgical / Invasive Procedure "Update"

In addition to the Surgical / Invasive Procedure H&P that must be completed within 30 days of the procedure, an "update" must be performed after admission and always prior to the procedure. The only exception to the

requirement for the "update" is if a Surgical / Invasive Procedure H&P was performed within the 24 hours prior to the procedure.

The "update" may be performed by the Attending Practitioner or his/her appropriately qualified designee which may be another Attending Practitioner, a member of the House Staff, a physician assistant or an advance practice nurse practitioner. The update must include any significant clinical changes that have occurred since the original H&P was performed in addition to a cardiopulmonary exam. If no significant clinical changes are identified then a statement indicating that the H&P was reviewed, the patient was examined and no change has occurred must be indicated. Regardless of whether or not significant clinical changes have been identified, if the planned procedure is still appropriate then this must also be documented.

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

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

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

A medication and allergy list must be documented but neither a "Complete" nor a "Surgical / Invasive Procedure" H&P is required.

Pre-Anesthesia Evaluation

For each patient who receives anesthesia, including general, regional, moderate or monitored, a pre-operative anesthesia evaluation must be completed by an Attending Practitioner who is an anesthesiologist.

The evaluation must include, at minimum, the following:

- a review of the patient's medical history, anesthesia history and drug and allergy history;
- interview and examination of the patient including identification of his/her American Society of Anesthesiology (ASA) risk class;
- documentation of the risk class in the electronic medical record;
- identification and documentation of potential anesthesia issues;
- identification and securing of any additional pre-anesthesia evaluations/consultations as appropriate from other specialties;
- development of the plan for the patient's anesthesia care including type of medications for induction, maintenance and post operative care and discussion of risks and benefits of the delivery of anesthesia;
- identification of any additional testing as indicated from the anesthesia exam or other evaluations/consultations as appropriate to determine the patient's anesthesia associated risks and appropriate care

Requirements for Completion of the Medical Record

The final obligation for completion of the electronic medical record rests with the Attending Practitioner. For all inpatients, notwithstanding the requirements set forth in Rule #4, the Attending Practitioner is obligated at a minimum:

a. To enter a note within 24 hours of admission or transfer containing a problem specific history and physical examination, working diagnostic impression(s) and plan for treatment (See Rule #11). For emergency admissions, such entry shall justify the designation of emergency status.

b. In the event that a patient is transferred to the care of another service, the identity of the new service must be indicated in the electronic medical record entry. Additionally, the Attending

Practitioner responsible for accepting the transfer of a patient must change the attending of record designation in the electronic medical record.

c. A brief operative note must be entered electronically into the medical record immediately following surgery. The brief note must include the following elements:

- procedure performed;
- post-operative diagnosis;
- findings;
- estimated blood loss;
- any specimens removed

In addition, a full operative report shall be documented within one (1) day of surgery and include the same elements with a detailed account of the findings at surgery as well as the details of the surgical technique employed during the procedure.

In the event that the full operative report is documented immediately following surgery and prior to the patient's transition to the next level of care (without a transcription delay), a brief operative note is not required.

The Attending Practitioner who performed the surgical procedure may delegate completion of the brief note and/or full operative report to a member of the House Staff, physician assistant, or an advanced practice registered nurse who was present for the entire procedure. The full operative report must be authenticated by the Attending Practitioner.

d. Ensure that a daily progress note has been entered by a member of the Medical Staff, House Staff, physician assistant or advanced practice registered nurse. The Attending Practitioner must enter progress notes with a frequency that reflects appropriate involvement but at least every other day except in exceptional circumstances as approved by the Chief Medical Officer. When the patient is stable and disposition/placement is the only active issue, the Attending Practitioner must enter a progress note at least once a week.

e. Within twenty-four (24) business hours after discharge, create or cause to be created and then authenticate in the electronic medical record, a Discharge Summary for each patient discharged from the Hospital except in instances of:

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

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

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

Members of the House Staff and Affiliated Staff are directly supervised by the Attending Practitioner and may obtain a clinical history, perform a physical examination, and enter these and appropriate progress notes in the electronic medical record. (See Rule #13) Individuals recording information in any handwritten portion of the permanent medical record shall identify themselves legibly by name and position.

For all inpatients and ambulatory surgery patients with a principal discharge diagnosis of a neoplastic disease, the Attending Practitioner must document, or cause to be documented, the clinical or pathological (if available) TNM staging (or equivalent) in the electronic medical record in the designated American Joint committee on Cancer (AJCC) staging format.

The Medical Record and Clinical Information Committee will monitor compliance with requirements related to Medical Record documentation and completion as described in Rules #18 and 19. Where an audit of records determines that documentation requirements are not being met, the Committee will notify the

responsible Attending Practitioner of the deficiencies. If, after two such notifications, an audit within the same calendar year reveals continuing non-compliance, the Attending Practitioner will be notified that his or her Medical Staff privileges have been summarily suspended pursuant to Article VI, Section P of the Bylaws. Restoration of clinical privileges may occur upon the presentation by the physician to the Chief Medical Officer or the Medical Board, as the case may be, of a satisfactory plan for appropriate and timely fulfillment of documentation responsibilities.

Rule No. 19 Medical Records – Completion

Medical records must be completed and authenticated within 21 days. In addition to overall medical record timeliness, discharge summaries must be documented and authenticated within one calendar day of discharge to ensure patient safety during transition of care. Failure to complete overall medical records or discharge summaries within established timelines will result in the actions described below.

All documentation deficiencies will be assigned to the Attending Practitioner and will appear in his or her electronic medical record "inbasket". It is the responsibility of the Attending Practitioner to monitor electronic medical record "inbasket" notifications and ensure all deficiencies are completed in a timely manner to avoid the actions described below. In the event of extenuating circumstances (defined as illness and other unanticipated occurrences) the Attending Practitioner or his/her office must notify the Health Information Management (Medical Records) department. Planned absences such as vacations or attendance at conferences will not be considered extenuating circumstances.

Health Information Management will notify Medical Staff Administration of any actions taken consistent with this Rule which will be recorded in the permanent medical staff file.

A. <u>Delinquent Medical Records</u>

Weekly notifications will be sent to the Attending Practitioner at seven (7) day intervals. The Chief will be notified about any member of their Department for whom action is pending fourteen days (14) or greater post discharge or service date. Attending Practitioners who continue to have medical records outstanding at twenty-one (21) days post discharge or service date, will be subject to automatic relinquishment of their privilege to admit new patients. Both verbal and written notification will be given to the practitioner.

Attending Practitioners with delinquent medical records that remain after twenty-eight (28) days of discharge or service date will not be able to serve as the Attending Practitioner for any new patients.

If any of the records remain delinquent at thirty-five (35) days, the individual's Medical Staff appointment, in addition to all of his/her clinical privileges will be considered automatically relinquished. Assignment of an alternate Attending Practitioner will be required in accordance with the provisions of ARTICLE VI, SECTION P, of the Bylaws.

Provisions for automatic relinquishment of both Medical Staff appointment and all clinical privileges shall also apply to practitioners whose privileges to admit have been subject to automatic relinquishment three (3) times in a year defined as the period from July 1st to June 30th.

In the event that membership and all clinical privileges are subject to automatic relinquishment as described above, restoration of membership and privileges will require completion of delinquent records and reapplication in accordance with the provisions of ARTICLE VI of the Bylaws.

See Table A.

B. <u>Delinquent Discharge Summaries</u>

Daily alert letters for discharge summaries that have been outstanding for greater than one (1) day post-discharge will be sent to the Attending Practitioner with notification of pending automatic relinquishment of privileges to admit. The Attending Practitioner will also be sent a certified letter with concurrent notification to the relevant Chief.

Attending Practitioners who continue to have discharge summaries that are outstanding at seven (7) days post discharge/service date, will be subject to automatic relinquishment of their privilege to admit new patients. Both verbal and written notice will be given to the practitioner.

Attending Practitioners with outstanding discharge summaries that remain after fourteen (14) will not be able to serve as the Attending Practitioner for any new patients.

If outstanding discharge summaries remain after twenty-one (21) days of discharge, the individual's Medical Staff appointment, in addition to all of his/her clinical privileges will be considered automatically relinquished. Assignment of an alternate Attending Practitioner will be required in accordance with the provisions of ARTICLE VI, SECTION P, of the Bylaws.

Provisions for automatic relinquishment of both Medical Staff appointment and all clinical privileges shall also apply to practitioners whose privileges to admit have been subject to automatic relinquishment three (3) times in a year defined as the period from July 1st to June 30th. Restoration of membership and privileges will require completion of delinquent records and reapplication in accordance with the provisions of ARTICLE VI of the Bylaws.

See Table B.

Table A: Medical Record Notifications and Timeline :

Timeframe	Action	Impact on Attending Practitioner
7 days	Reminder Letter	None
14 days	Alert Letter	Applicable Chief notified
21 days	Automatic relinquishment of privilege to admit <u>new</u> patients	No impact on prescheduled cases / admissions; Unable to schedule <u>new</u> cases /admissions Ability to document not impacted
28 days	Automatic relinquishment of privileges to serve as the Attending Practitioner	No impact on current patients; Unable to serve as the Attending Practitioner on new cases Ability to document not impacted
35 days (or three suspensions 7/1 -6/30)	Automatic relinquishment of Medical Staff Appointment, in addition to all clinical privileges	Ability to complete delinquent medical records not impacted No longer a member of the Medical Staff; must complete delinquent records and reapply as if a new applicant*
**All medical record deficiencies included in notice must be completed to reinstate privileges*		

Table B: Discharge Summary Notification and Timeline:

Timeframe	Action	Impact on Attending Practitioner
2 days	Alert Letter	Applicable Chief/Section Chief notified
7 days	Automatic relinquishment of privilege to admit new patients	No impact on prescheduled cases / admissions; Unable to schedule new cases / admissions Ability to document not impacted
14 days	Automatic relinquishment of privileges to serve as the Attending Practitioner	No impact on current patients; Unable to serve as the Attending Practitioner on new cases Ability to document not impacted
21 days (or three suspensions 7/1 -6/30)	Automatic relinquishment of Medical Staff Appointment, in addition to, all clinical privileges	Ability to complete delinquent medical records not impacted No longer a member of the Medical Staff; must complete delinquent records and reapply as if a new applicant*
**All medical record deficiencies included in notice must be completed to reinstate privileges*		

Administrative Closure

In the event a medical staff member is unable to complete medical records prior to resignation or termination from the medical staff for any reason, deficiencies will be referred to the relevant Chief to assign to the care of patients to another Attending Practitioner as applicable. In the event there is not another Attending Practitioner who is able to complete the documentation (e.g. operative report); the medical record will be submitted to the Medical Record and Clinical Information Committee for approval of administrative closure. Medical records which are administratively closed will be noted as such in the electronic medical record.

Rule No. 20 Medical Records – Removal

All Medical records are the property of the Hospital and, except for those inactive records, which may be removed for off-site storage, shall be taken or electronically transmitted from the Hospital only pursuant to proper court order or subpoena. In the event that a patient is readmitted, all existing previous records shall be made available for the use of the responsible Attending Practitioner. However, appropriate confidentiality requirements shall be observed.

GENERAL RULES AND REGULATIONS

Rule No. 21 Confidentiality

Pursuant to state and federal law, including HIPAA, and Hospital policy, all medical records and patient-specific information, records of peer review and morbidity and mortality review proceedings, risk management material including incident reports, medical staff credentialing records and files, minutes of Medical Staff and Hospital meetings, and other confidential Hospital and Medical Staff records, data, and information, are the property of the Hospital and may not be used for purposes other than patient care, peer review, risk management, approved research, education, and other proper Hospital and Medical Staff functions. Such records, materials, files, minutes, and other confidential information (referred to below collectively as "confidential materials") may not be removed from the Hospital, duplicated, transmitted, or otherwise disclosed

to parties outside of the Hospital without proper authorization in accordance with Hospital and Medical Staff policies or specific requirements of law.

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

Sharing of and/or misuse of passwords or access to electronic medical records or other electronic systems that contain patient and/or other confidential material is prohibited. If the Hospital becomes aware that an access code and/or password has been shared with another person , the authorized user will be required to immediately change passwords and will be given an oral and written warning. A second incident within a five year period shall result in an immediate suspension of all Medical Staff privileges for a period of twenty-five (25) days. A third incident within a ten year period of the date of the first warning shall result in termination from the Medical Staff. Medical staff privilege suspensions will be reported as required to the Connecticut licensing board(s) and/or the National Practitioner Data Bank. The same penalties and disciplinary action as described above for sharing of access codes/passwords applies to members of the Medical or House Staff who are found to have inappropriately accessed an electronic medical record.

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

Rule No. 22 Peer Review Materials; Studies of Morbidity and Mortality; the Protection of Documents

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

Rule No. 23 Protective Clothing – Operation Areas

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

Individuals who work in the semi-restricted or restricted areas described above may not wear the same scrub-wear worn outside of Hospital facilities in the semi-restricted or restricted areas. Scrub wear worn in semi-restricted or restricted areas may be worn within Hospital facilities but must be covered by a lab coat or other appropriate attire. Such lab coat or other attire used to cover scrub-wear must be removed and left in the respective locker room or other appropriate pre-operative area before returning to a semi-restricted or restricted area.

Rule No. 24 Autopsies (*See also: Clinical Administrative Policy C:P-3: "Permission for Post-Mortem Examination*)

Every member of the Medical and House Staff is expected to request permission for autopsy unless the patient or family has previously declined permission.

Rule No. 25 Departmental Rules

Medical Staff members should refer to departmental rules and regulations for specific items pertaining to their respective departments. Where departmental and Medical Staff Rules & Regulations appear inconsistent, Medical Staff Rules & Regulations will supersede departmental rules.

Rule No. 26 Human Investigation

Research involving human subjects shall be so conducted as to assure that the welfare, health and safety of the subjects are paramount. Prior approval must be obtained from the Human Investigation Committee and patient's Attending Practitioner. The Medical Staff member identified as the Principle Investigator must notify the Credentials Committee of any new procedures, or investigational approaches to standard procedures, so the Committee can determine if further evaluation or additional privileges is necessary. Rights, including the right of privacy, shall be preserved, and an informed consent shall be obtained from the patient or the patient's authorized representative.

Rule No. 27 Responsibilities for Infection Prevention/Standard Precautions and Transmission Based Precautions

Members of the Medical and Affiliated Health Care Professional staff must comply with infection prevention policies, including but not limited to the Medical Staff policy regarding hand hygiene and contact precautions, the Hospital policy regarding natural and artificial fingernails and any sanctions that apply to any such policy. Routine hand hygiene is to be performed before and after any patient contact. Standard precautions must be used in the care of all patients that will or may include contact with blood or body fluids. The responsible Attending Practitioner, nurse and/or hospital epidemiologist or a designee determines the need for additional transmission based precautions. Orders for such precautions are to be entered into the applicable electronic medical record and a note entered in the patient's chart delineating the reasons for initiating precautions. The hospital epidemiologist has final authority in determining the initiation and/or discontinuation of transmission based precautions.

In addition to the above, the Infection Control Committee through its Chair or physician members, is authorized to institute any appropriate control measures or studies when there is a reasonable possibility of danger to one or more patients or personnel.

Rule No. 28 Revision Procedure

These Rules and Regulations are considered a component of the Medical Staff Bylaws and, therefore, are revised in the same manner as outlined in Article XVII. Revisions recommended by the Medical Executive Committee and voting members of the Organized Medical Staff and reviewed by the Patient Safety & Clinical Quality Committee of the Board of Trustees and shall be effective upon approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.