

## **MEDICAL STAFF BYLAWS RULES & REGULATIONS**

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*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**TABLE OF CONTENTS**

	<b>PAGE</b>
<b>PREAMBLE</b>	<b>1</b>
<b>DEFINITIONS</b>	<b>1-2</b>
<b>INTERPRETATION</b>	<b>2-3</b>
<b>NON-DISCRIMINATION</b>	<b>3</b>
<b>NATIONAL PRACTITIONER DATA BANK AND CONNECTICUT DEPARTMENT OF PUBLIC HEALTH REPORTING REQUIREMENTS</b>	<b>3</b>
<b>NOTICE BY CERTIFIED MAIL, RETURN RECEIPT</b>	<b>4</b>
<b>ARTICLE I: NAME</b>	<b>4</b>
Section 1 AUTHORITY	4
<b>ARTICLE II: PURPOSES AND RESPONSIBILITIES</b>	<b>4</b>
Section 1 OVERVIEW AND PURPOSES	4-5
Section 2 RESPONSIBILITIES	5-6
<b>ARTICLE III: MEDICAL STAFF MEMBERSHIP</b>	<b>6</b>
Section 1 NATURE OF MEDICAL STAFF MEMBERSHIP	6
Section 2 BASIC QUALIFICATIONS FOR MEMBERSHIP	6-8
Section 3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP	8
Section 4 DUES OR ASSESSMENTS	8
Section 5 DURATION OF APPOINTMENT	8-9
Section 6 PROVISIONAL STATUS	9
Section 7 LEAVE OF ABSENCE	9-10
Section 8 CONFLICT OF INTEREST POLICY	10-11
<b>ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF</b>	<b>11</b>
Section 1 CATEGORIES	11
Section 2 ACTIVE STAFF	12
Section 3 ACTIVE AFFILIATE STAFF	12
Section 4 CONSULTING STAFF	12-13
Section 5 HONORARY STAFF	13
<b>ARTICLE V: HEALTH PROFESSIONAL AFFILIATES</b>	<b>13</b>
Section 1 QUALIFICATIONS	13
Section 2 PROCEDURES FOR APPOINTMENT, REAPPOINTMENT AND SPECIFICATION OF SERVICES	13-14
Section 3 RESPONSIBILITIES	14
Section 4 FAIR HEARING POLICY FOR HEALTH PROFESSIONAL AFFILIATE STAFF	14-15
<b>ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT</b>	<b>15</b>
Section 1 GENERAL PROCEDURE	15
Section 2 APPLICATION FOR INITIAL APPOINTMENT	16-17
Section 3 EFFECT OF APPLICATION	17-18

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**TABLE OF CONTENTS**

	<b>PAGE</b>	
Section 4	PROCESSING THE APPLICATION	18-19
Section 5	REAPPOINTMENT PROCESS	19-20
Section 6	REQUESTS FOR MODIFICATION OF APPOINTMENT	20-24
Section 7	NOTIFICATION REQUIREMENT	25-28
Section 8	REQUESTS FOR MODIFICATION OF STAFF CATEGORY OR CLINICAL PRIVILEGES	28
Section 9	NOTIFICATION REQUIREMENT	28-29
 <b>ARTICLE VII: DETERMINATION OF CLINICAL PRIVILEGES</b>		 <b>29</b>
 <b>POLICY IN REGARD TO ONGOING PROFESSIONAL PRACTICE EVALUATION (FPPE AND OPPE)</b>		 <b>29</b>
Section 1	EXERCISE OF PRIVILEGES	29
Section 2	DELINEATION OF PRIVILEGES IN GENERAL	29-30
Section 3	LIMITATIONS OF PROFESSIONAL PRIVILEGES	30
Section 4	SPECIAL CONDITIONS FOR DENTAL PRIVILEGES	30
Section 5	SPECIAL CONDITIONS FOR PODIATRY PRIVILEGES	30
Section 6	SPECIAL CONDITIONS FOR HEALTH PROFESSIONAL AFILIATE SERVICES	31
Section 7	TEMPORARY PRIVILEGES	31-32
Section 7	EMERGENCY PRIVILEGES	32-33
Section 8	DISASTER PRIVILEGES DURING ACTIVATION OF THE EMERGENCY PREPAREDNESS PLAN	33
 <b>ARTICLE VIII: COLLEGIAL INTERVENTION &amp; CORRECTIVE ACTION; AUTOMATIC AND SUMMARY SUSPENSION; PHYSICIAN'S HEALTH MATTERS; DISRUPTIVE BEHAVIOR</b>		 <b>33</b>
Section 1	COLLEGIAL INTERVENTION	33-34
Section 2	ROUTINE CORRECTIVE ACTION	34-36
Section 3	SUMMARY SUSPENSION	36
Section 4	AUTOMATIC SUSPENSION	37-38
Section 5	PHYSICIAN HEALTH	39-43
Section 6	DISRUPTIVE MEDICAL STAFF MEMBER	43-46
 <b>ARTICLE IX: STAFF DEPARTMENTS AND CLINICAL SERVICES</b>		 <b>46</b>
Section 1	ORGANIZATION OF STAFF DEPARTMENTS AND CLINICAL SERVICES	46
Section 2	DESIGNATION	46-47
Section 3	ASSIGNMENT TO DEPARTMENTS AND CLINICAL SERVICES	48
Section 4	RESPONSIBILITY, FUNCTIONS, AND ORGANIZATION OF DEPARTMENTS	48-49
Section 5	FUNCTIONS OF CLINICAL SERVICES	49
 <b>ARTICLE X: OFFICERS</b>		 <b>49</b>
Section 1	OFFICERS OF THE STAFF	49-51
Section 2	OTHER OFFICERS OF THE STAFF	51-53
Section 3	ADDITIONAL OFFICERS	53

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**TABLE OF CONTENTS**

	<b>PAGE</b>
<b>ARTICLE XI: COMMITTEES AND FUNCTIONS</b>	<b>53</b>
Section 1     MEDICAL REVIEW COMMITTEES; COMMITTEES CONDUCTING STUDIES OF MORBIDITY AND MORTALITY	53-54
Section 2     MEDICAL EXECUTIVE COMMITTEE	54-55
Section 3     CREDENTIALS COMMITTEE	55
Section 4     OBSTETRICS AND GYNECOLOGY	55-56
Section 5     BYLAWS COMMITTEE	56
Section 6     OTHER COMMITTEES	56
 <b>ARTICLE XII: MEDICAL STAFF MEETINGS</b>	 <b>57</b>
Section 1     REGULAR MEETINGS	57
Section 2     SPECIAL MEETINGS	57
Section 3     QUORUM	57
Section 4     REFERENDUM VOTE	57
Section 5     ATTENDANCE REQUIREMENTS	58
Section 6     AGENDA	58
 <b>ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS</b>	 <b>58</b>
Section 1     REGULAR MEETINGS	58
Section 2     SPECIAL MEETINGS	58
Section 3     NOTICE OF MEETINGS	58-59
Section 4     QUORUM	59
Section 5     MANNER OF ACTION	59
Section 6     RIGHTS OF EX-OFFICIO MEMBERS	59
Section 7     MINUTES	59
Section 8     ATTENDANCE REQUIREMENTS	59-60
 <b>ARTICLE XIV: RULES AND REGULATIONS</b>	 <b>60</b>
 <b>ARTICLE XV: ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES</b>	 <b>60</b>
 <b>ARTICLE XVI: INDEMNIFICATION</b>	 <b>61</b>
 <b>ARTICLE XVII: PHYSICIAN EMPLOYMENT &amp; EXCLUSIVE SERVICES AGREEMENTS</b>	 <b>61-62</b>
 <b>ARTICLE XVIII: FAIR HEARING PLAN</b>	 <b>62</b>
Section 1     PREAMBLE	62
Section 2     RECOMMENDATIONS OR ACTIONS	62-63
Section 3     WHEN DEEMED ADVERSE	63
Section 4     NOTICE TO PRACTITIONERS AND REQUESTS FROM PRACTITIONERS FOR HEARINGS/APPEALS	63
Section 5     APPOINTMENT OF HEARING COMMITTEE	63-64
Section 6     NOTICE OF HEARING AND STATEMENT OF REASONS	64
Section 7     WITNESS LIST	64
Section 8     RIGHT TO RELEVANT EVIDENCE	65
Section 9     PRE-HEARING CONFERENCE; SIDE BAR CONFERENCES	66
Section 10    RECORD OF HEARING	66
Section 11    HEARING PROCEDURE	66-67
Section 12    PERSONS TO BE PRESENT; NO "GUESTS"	67
Section 13    QUORUM AND VOTING	67

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**TABLE OF CONTENTS**

	<b>PAGE</b>
Section 14 HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS	67-68
Section 15 NOTICE OF THE REPORT OF THE HEARING COMMITTEE AND EFFECT OF RESULT	68
Section 16 ACTION ON THE REPORT OF THE HEARING COMMITTEE	68
Section 17 EFFECT OF ADVERSE RESULT	68
Section 18 APPEAL TO THE BOARD OF DIRECTORS	69
Section 19 WRITTEN NOTICE	69
Section 20 RIGHT TO ONE HEARING AND ONE APPEAL ONLY; NO FURTHER ACTION	69
 <b>ARTICLE XIX: AMENDMENTS</b>	 <b>70-71</b>
 <b>ARTICLE XX: CONFLICT RESOLUTION</b>	 <b>71-72</b>
 <b>ARTICLE XXI: SUCCESSOR IN INTEREST</b>	 <b>72</b>
 <b>ARTICLE XXII: BYLAWS ADOPTION</b>	 <b>72-73</b>

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### ***PREAMBLE***

WHEREAS, the Lawrence and Memorial Hospital is a non-profit community hospital organized under the laws of the State of Connecticut; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and that cooperative efforts of the Medical Staff, the President/CEO and the Board are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians, dentists, and podiatrists practicing in this hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

### ***DEFINITIONS***

1. **"Board"** means the Board of Directors of the Hospital, also referred to as "The Board," or, by The Joint Commission, as the "Governing Body."
2. **"Bylaws"** means these Bylaws of the Medical Staff and, when used as a generic description, also shall include the Rules and Regulations of the Medical Staff, and Medical Staff Policies.
3. **"Clinical Privileges"** or **"privileges"** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, or surgical services.
4. **"CMO"** means the Chief Medical Officer appointed by the Board to act on its behalf in Medical Staff affairs in cooperation with the President of the Medical Staff.
5. **"Ex-officio"** means service as a member of a body by virtue of an office or position and, unless otherwise expressly provided, means without voting rights.
6. **"Ongoing Professional Practice Evaluation" or "OPPE"** means the professional practice evaluation of applicants for membership and of Members of the Medical Staff, and may include chart review, monitoring clinical practice pattern, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of patients (e.g., consulting physicians, assistants at surgery, nursing or administration personnel).
7. **"Health Professional Affiliates"** means, and is limited to: Physician Assistants in Surgery, Physician Assistants in Ambulatory Care, Neonatology Physician Assistants, Nurse Anesthetists, Clinical Specialists Oncology, Oncology Nurses, Nurse Midwives, Personnel Health Nurse Practitioners, Neonatal Nurse Practitioners, Family Nurse Practitioners, Clinical Specialists-Psychiatry, Psychiatric Clinicians, Psychiatric Social Workers and Clinical Psychologists. These Health Professional Affiliates shall be individuals other than licensed physicians, dentists, and podiatrists whose patient care activities require that their

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

authority to perform specified patient care activities be under the direct supervision of a Physician or Chief of Service to which they are assigned. Specific privileges and obligations with regard to each category of Health Professional Affiliate shall be delineated by the Department to whom the Health Professional Affiliate is assigned.

8. **"Hospital-based physician"** means a Member of the Medical Staff who is in any one of the following categories: (1) the Member is considered by the Hospital to be a full-time employee of the Hospital in accordance with its usual and customary personnel policies; or (2) during any calendar year, the Member is regularly employed by the Hospital for 20 hours a week or more, or (3) the Member spends 50% or more of the Member's professional working time as a paid employee of the Hospital), or (4) the Member is employed by an entity which has an exclusive services agreement with the Hospital.
9. **"Medical Executive Committee" or "MEC"** means the Medical Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Board.
10. **"Medical Staff"** means the formal organization of all physicians, dentists, and podiatrists who are privileged to attend patients in the Hospital, duly licensed in the State of Connecticut for their appropriate practice.
11. **"Medical Staff Year"** means the period from October 1 through September 30.
12. **"Patient Contact"** means any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital.
13. **"Practitioner"** means an appropriately licensed medical physician, dentist, or podiatrist applying for or exercising clinical privileges in this Hospital.
14. **"President/CEO"** means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.
15. **"Professional Liability Insurance" or "Malpractice Insurance"** means a policy of insurance, issued by a carrier licensed or authorized to do business in Connecticut, which meets the coverage limits and other terms specified by the Board from time to time.
16. **"Special Notice"** means written notification sent by certified mail, return receipt requested.
17. **"Yale New Haven Health System Affiliated Hospital"** shall include Yale New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, Westerly Hospital and any other hospital that affiliates with Yale New Haven Health.

### **INTERPRETATION**

Whenever the Bylaws do not specifically address a topic or cover a matter, or there is a need for interpretation, the MEC may issue an interpretation. In arriving at an interpretation, the MEC may take into account the usual and customary policies and practices of the Medical Staff, whether

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

written or unwritten, and in its discretion may also bring to bear the expert medical knowledge of its members. MEC interpretations shall be maintained with the minutes of the MEC.

In the event that any law or regulation or mandatory Joint Commission or other applicable mandatory accreditation requirement clearly requires the Hospital or the Medical Staff to take particular action in connection with credentialing or any other matter covered by these Bylaws, such law, regulation, or accreditation requirement, unless specifically provided otherwise in the Bylaws, shall be complied with pending review by the Bylaws Committee, and to the extent possible, shall be construed as being consistent with the provisions of these Bylaws. Once the Medical Staff becomes aware of the law, regulation, or requirement, the Bylaws Committee shall meet as soon as practical to review the law, regulation, or requirement at issue, seek input from legal counsel or other appropriate individual as the Bylaws Committee see fit, and consider whether or not a revision to the Bylaws, based upon the law, regulation, or requirement is appropriate. If the Committee determines that an amendment to the Bylaws is appropriate, the Committee shall consider the appropriate amendment following the procedures set forth herein. In any case in which the Bylaws requires

These Bylaws are not intended to create rights in any third parties; there are no third-party beneficiaries to these Bylaws.

### **NON-DISCRIMINATION**

In accordance with Hospital and Medical Staff policy, all provisions of the Bylaws shall be interpreted and applied so that no person, Member, applicant for Membership, Hospital employee, patient, or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activity of the Hospital and its Medical Staff. Any reference to males or females, or use of the masculine or feminine gender shall be interpreted whenever possible as including both sexes.

### **NATIONAL PRACTITIONER DATA BANK AND CONNECTICUT DEPARTMENT OF PUBLIC HEALTH REPORTING REQUIREMENTS**

Except as otherwise required by law, the Hospital's authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as a final action by the Board and only using the description/information set forth in the final action as adopted by the Board following completion of the hearing process. Where no hearing was requested or granted, and the Member remains on the Medical Staff, the Member shall be granted the opportunity to meet with the President and the CMO to review and discuss the proposed Data Bank report before it is filed. The Hospital shall report all revisions of an adverse action as required by law.

The Hospital's authorized representative shall only report credentialing actions to the Connecticut Department of Public Health when reporting is required pursuant to the provisions of Chapter 370 of the Connecticut General Statutes as amended from time to time.

Nothing in this provision shall preclude the Hospital's authorized representative from properly and fully disclosing information about a Member to another Hospital or healthcare provider when authorized by the Practitioner.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**NOTICE BY CERTIFIED MAIL, RETURN RECEIPT**

In any case in which the Bylaws requires notice by Certified Mail, Return Receipt, it shall be acceptable to utilize other methods that can be tracked in order to document delivery and which require a signature upon delivery, such as Express Mail, FEDEX, and Messenger Hand Delivery.

***ARTICLE I: NAME***

The name of this organization shall be the "Medical Staff of the Lawrence and Memorial Hospital".

Section 1      **AUTHORITY**

These Bylaws, Rules and Regulations of the Medical Staff of the Lawrence and Memorial Hospital are created under the authority of the Hospital Bylaws, Article VII, which is made a part hereof by reference and appears in full as Appendix A herewith, said hospital Bylaws being those adopted by the Board of Trustees on December 12, 1953, and as amended thereafter.

***ARTICLE II: PURPOSES AND RESPONSIBILITIES***

Section 1      **OVERVIEW AND PURPOSES**

**OVERVIEW**

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

The purposes of the Medical Staff are:

- a. To promote the goal that all patients admitted to or treated in any of the facilities, Departments, or services of the Hospital shall receive high quality of care;
- b. To promote a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges that each practitioner may exercise in the hospital and through review and evaluation of each practitioner's performance in the hospital;
- c. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- d. To initiate and maintain, in cooperation with the Board, rules and regulations for self-government of the Medical Staff; and

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- e. To provide means, such as the Medical Executive Committee, and Representatives to the Board of Directors, whereby, the Medical Staff shall be consulted in the Hospital's policy making and planning process.

Section 2      RESPONSIBILITIES

The responsibilities of the Medical Staff in cooperation with the Board are:

- 2.1 To assume responsibility for the quality and appropriateness of patient care rendered by all practitioners authorized to practice in the Hospital through the following measures:
  - a. A credentials program, including mechanisms for appointment and reappointment and the granting of clinical privileges to be exercised. Reappointment process includes review of a practitioner's privileges and the practitioner's performance;
  - b. A continuing medical education program, fashioned at least in part on the needs demonstrated through patient care audit and other quality maintenance programs;
  - c. A concurrent utilization review program to allocate inpatient medical and health services based upon patient-specific determinations of individual medical needs;
  - d. A program of assessing and improving the quality of care throughout the organization.
  - e. A consistent process for the completion of Medical Records as outlined in the Rules and Regulations. Specifically, a medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours of admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition shall be completed. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission and prior to any surgical procedure or procedure requiring anesthesia services.
- 2.2 To recommend to the Board action with respect to:
  - a. Appointments, reappointments, staff category, Departmental assignments, and clinical privileges;
  - b. Specified services for health professional affiliates; and
  - c. Corrective action.

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

- 2.3 To communicate to the Board regarding the quality and efficiency of medical care rendered to patients in the hospital through regular reports and recommendations concerning the implementation, operation, and results of patient care audits and other quality maintenance activities.
- 2.4 To initiate and pursue corrective action with respect to practitioners, when warranted.
- 2.5 To develop, administer, and seek compliance with these Medical Bylaws.
- 2.6 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
- 2.7 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

### ***ARTICLE III: MEDICAL STAFF MEMBERSHIP***

#### **Section 1 NATURE OF MEDICAL STAFF MEMBERSHIP**

Membership on the Medical Staff of Lawrence and Memorial Hospital is a privilege that shall be extended only to professionally competent physicians, dentists, or podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the appointee or member only such clinical privileges as have been granted by the Board in accordance with these Bylaws. Gender, race, creed and national origin are not used in making decisions regarding Medical Staff membership and the granting or denying of clinical privileges.

#### **Section 2 BASIC QUALIFICATIONS FOR MEMBERSHIP**

##### **2.1 Basic Qualifications**

Only physicians, dentists, and podiatrists licensed to practice in the State of Connecticut, who:

- a. Document their background, experience, training, and demonstrate competency with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive high quality medical care; and
- b. Document their current physical and mental health status on request; and who
- c. Adhere to the ethics of their profession; and who
- d. Demonstrate their ability to work in a cooperative manner with others; and who
- e. Will faithfully participate in the discharge of Medical Staff responsibilities; shall be qualified for membership on the Medical Staff.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 2.2 Effect of Other Affiliation

No physician, dentist, or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that such individual is duly licensed to practice medicine or dentistry or podiatry in this or any other state, or that the individual is a member of any professional organization, or because such individual is certified by any clinical board, or that the individual had in the past, or presently has such privileges at another health care facility or in another practice setting.

### 2.3 Medico-Administrative Physicians

A medico-administrative physician employed by the hospital on a part-time or full time basis but whose duties include clinical responsibilities must be a member of the Medical Staff, achieving appointment by the customary procedures provided in Article VI. Such physician's clinical privileges must be delineated in accordance with Article VII. Such physician's Medical Staff membership and clinical privileges shall not be contingent on continued occupation of the medico-administrative position.

### 2.4 Basic Qualifications for Membership / Board Certification

Initial Board Certification and subsequent required Recertification by a Board approved by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Dental Association (ADA), or equivalent Podiatric organization (American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or the American Board of Podiatric Public Health) is required of all members of the Medical Staff.

Applicants for staff membership in any category must either be Board Certified or in the Board certification process (training completed with the intent to take the certification examination) as a basic requirement to make an application to the Medical Staff. At the sole discretion of the MEC, a foreign board certification may be accepted to fulfill this requirement on a case-by-case basis.

If any one of the following periods has elapsed and board certification or required recertification has not been achieved, the Member's membership to the Medical Staff may be withdrawn:

- a. Five years from the initial granting of Membership
- b. The certification process has ended and the Member is no longer eligible to sit for the board examination
- c. A candidate for Medical Staff reappointment fails to qualify for required recertification within five years of the required recertification date

A member or applicant who fails to meet the initial Board Certification or subsequent required recertification requirements as described in this section, shall be eligible for Medical Staff membership only if the Credentials Committee and the MEC recommend an exception. Such an exception may be recommended through the appointment or reappointment process only if the applicant can clearly demonstrate equivalent

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

qualification. The burden of such demonstration shall rest solely upon the applicant or member.

### 2.5 Requirements for Professional Liability Insurance

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

## Section 3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

- a. Provide patients with care of the generally professionally recognized level of quality and efficiency;
- b. Abide by the Medical Staff and Hospital Bylaws and by Rules and Regulations of the Medical Staff and Hospital;
- c. Discharge such staff, Department, service, committee and hospital functions for which the Member is responsible by appointment, election or otherwise;
- d. Prepare and complete in timely manner the medical and other required records for all patients under the Member's supervision; and
- e. Abide by the principles of Medical Ethics of the American Medical Association or by the Code of Ethics of the American Dental Association or the American Podiatric Medical Association, whichever is applicable.

## Section 4 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the Medical Staff by simple majority, and to determine the manner of expenditure of such funds.

## Section 5 DURATION OF APPOINTMENT

### 5.1 Duration and Renewal of Initial and Modified Appointments

All initial appointments, and modifications of appointments pursuant to Article VI, Section 6 and 7, shall be for a period of not more than two years. Renewal of provisional appointments (all initial appointments and those modifications of appointments that are made provisionally pursuant to Article III, Section 6 shall be for a period of not more than twenty-four months. Initial appointments for less than two years may be appealed by the physician through the Fair Hearing Plan.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 5.2 Appointments by the Board

Initial appointments and modifications of appointments shall be made by the Board which shall act only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws; provided that in the event of unwarranted delay by the Medical Executive Committee which delay is defined as a period of 100 days after receipt of the completed application, the Board may act without such recommendation provided that the Board bases its action on the same kind of information as is usually considered by the Medical Executive Committee.

### 5.3 Reappointments

Reappointments by the Governing Body to any category of the Medical Staff shall be for a period of not more than two years.

## Section 6 PROVISIONAL STATUS

### 6.1 Initial Appointments

All initial appointments to any category of the Staff shall be provisional for a period of twenty-four months. Each provisional appointee shall be assigned to a Department where the Member's performance shall be observed by the Chair of the Department or such Chair's designee to determine eligibility for regular Staff membership in the Staff category to which the Member was provisionally appointed and for exercising the clinical privileges provisionally granted. Provisional staff members will be eligible to vote but may not serve as an officer of the Medical Staff.

### 6.2 Modification in Staff Category and Clinical Privileges

The Medical Executive Committee may recommend to the Board that a change in Staff category of a current Staff member or the granting of additional privileges to a current Staff member pursuant to Article VI, Section 8, be made provisional in accordance with procedures similar to those outlined in Article III, Section 6 for initial appointments.

### 6.3 Renewals

Provisional status may not be renewed more than once. If the provisional appointee fails within that period to advance from provisional to regular Staff status, the Member's Staff appointment shall be deemed terminated. A provisional appointee whose membership is so terminated shall have the procedural rights accorded by these Bylaws to a Medical Staff member who has failed to be reappointed.

## Section 7 LEAVE OF ABSENCE

### 7.1 Leave Status

A Staff member may request a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee, Department Chair, and the President/CEO stating the exact period of time of the leave, which may not exceed one Medical Staff year. Any extension granted beyond this time can only be granted by the Medical Executive Committee with the approval of the Board. During the period of a leave, the Staff member's privileges and prerogatives shall be suspended. If the leave is to extend

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

beyond the Member's current appointment, the Member must apply for re-appointment or the Member's Medical Staff membership shall lapse, and the Member shall be so notified.

### 7.2 Termination of Leave

At least 45 days prior to the termination of the leave, or at any earlier time, the Staff member may request reinstatement of the Member's privileges and prerogative by submitting a written notice to that effect to the President/CEO for transmittal to the Medical Executive Committee. The Staff member shall submit a written summary of the Member's relevant activities during the entire period in which the Member did not admit patients to or practice in the hospital.

The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives. Failure, without good cause, to request reinstatement or to provide a requested summary of activities as above provided shall result in automatic termination of Staff membership. A request for Staff membership subsequently received from a Staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

## Section 8 CONFLICT OF INTEREST POLICY

This policy serves as a guideline for the disclosure of and resolution of potential conflicts of interest of any medical staff members serving on committees of the medical staff and hospital. Elected officers, Department Chairs, and any other medical staff members appointed or elected to committees have a fiduciary obligation to represent the highest interests of the medical staff in upholding the quality of care provided at Lawrence & Memorial Hospital. It is important for members of committees or medical staff meetings to be aware of potential conflicts of interest that may arise from a person's affiliations, activities, or compensation.

- a. The Chairs of all committees, including ad hoc task forces, are encouraged to consider and discuss potential conflicts of interest. Standing committees shall use the guidelines of disclosure as follows:
- b. Committee members shall disclose the existence of:
  - 1) Ownership by a member or their immediate family of material financial interests in any company that furnishes goods or services to the hospital or is seeking to provide good or services to the hospital;
  - 2) Any honoraria, speaker's fees, research grants or funding, or consulting fees (for example, from a pharmaceutical company or a managed care organization);
  - 3) Personal compensation from the hospital especially if pertinent to discussion of certain programs or proposals;
  - 4) Participation on other organizations with potential conflicts of interest (e.g. other hospitals, HMO's, competing private healthcare businesses);

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- 5) Other personal relationships, activities, or interests which may inappropriately influence a member's decisions or actions; and/or
  - 6) Gifts, including goods and services or honoraria, from vendors who sell to the hospital. (Note: An "honorarium" or a payment for consulting services is a gift in whole or part unless it can be demonstrated that the recipient provided services of an equivalent value.)
- c. Members of the following standing committees shall make an annual disclosure by questionnaire to the chairs and will make disclosures as appropriate during meetings: Medical Executive Committee, Pharmacy and Therapeutics Committee, Operating Room Committee, and Credentials Committee. Ad hoc committees and other standing committees shall decide at the first meeting and annually thereafter if an annual disclosure by questionnaire will be required.
  - d. A general requirement that committee members with any potential conflicts of interest be excused from discussion of an issue may diminish the ability of the committee to have full, informed debate. If a member's ability to render a fair and independent decision is jeopardized by the conflict of interest, the member should ask to be excused from discussion and/or vote. If a member does make such a request, and the majority of the other committee members believe that the Member should be excused from discussion or vote, the chair shall require the member to do so.
  - e. If a member discloses a potential conflict of interest and seeks a deliberation as to whether abstention from participation in discussion or vote is warranted, he/she should leave the room while the remaining members determine whether a conflict of interest exists.
  - f. If a committee member has reasonable cause to believe that another member has failed to disclose a potential conflict of interest, such member shall inform the chair who shall provide an opportunity for the member in question to address the committee about the expressed concerns. The committee shall then deliberate as above. Any member who is required to request to be excused from participation in deliberations will be given an opportunity to appeal to the committee in person.
  - g. The minutes of the meeting shall include the names of persons excused for conflicts of interest and whether any discussion of potential conflicts of interest occurred. The nature of the conflict shall also be identified in the minutes.

**ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF**

Section 1 CATEGORIES

The Medical Staff shall be divided into Active, Active Affiliate, Consulting and Honorary categories.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 2 THE ACTIVE MEDICAL STAFF

The Active Medical Staff shall consist of physicians, dentists, and podiatrists who regularly render services to patients within the hospital, or who have admission privileges and have adequate patient contacts as determined by Medical Staff credentialing policy, and who are located closely enough to the hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care and consultation assignments and service assignments. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, to hold office and to serve on Medical Staff committees, shall be encouraged to attend Departmental and Medical Staff meetings, shall be required to actively participate in patient care audits, and are subject to the 50 hours biennial education requirement and Medical Staff dues.

Members in good standing of the Active Staff who have served on the Active Staff for a period of time designated by each Department may apply to the Chair of their respective Department, for a change of Staff category to Senior Active Staff. The Departmental Chair will act on the request and forward the Chair's recommendation to the Medical Executive Committee at their next regularly scheduled meeting. Members of the Senior Active Staff retain all the rights, privileges and responsibilities of the Active Staff except they are no longer required to provide Departmental emergency service call.

### Section 3 ACTIVE AFFILIATE STAFF

The Active Affiliate Staff shall consist of physicians, dentists and podiatrists who have no admitting privileges but may refer patients for admission to the Hospitalists or other medical or surgical subspecialties. They are encouraged to follow their patients' course of treatment and to maintain adequate communication with the practitioners responsible for inpatient care. Members of the Active Affiliate Staff may write progress notes but not orders. They must be willing to provide follow-up care when their patients are discharged, are required to participate in pertinent Departmental call for unassigned patients, whether discharged from the Hospitalist Service or directly from the Emergency Department. Members of the Active Affiliate Staff are encouraged to attend Departmental and General Medical Staff meetings, shall be eligible to vote, to serve on Medical Staff committees, and to hold office. They are required to pay dues and are subject to the education requirements.

### Section 4 CONSULTING STAFF

The Consulting Staff shall consist of physicians, dentists, and podiatrists who wish to provide subspecialty services to hospitalized patients. Members may consult on request of the attending physician and may treat patients in the hospital; they may not admit patients as attending physicians. Members of the Consulting Staff are eligible to vote, are subject to the education requirement; and may hold office. Duties include consultation on request, payment of dues and committee assignments. Members are required to participate in emergency service call for their specialty section. They are encouraged to attend Departmental and Medical Staff meetings. Consulting Staff members who are not practicing in the community served by the hospital shall be

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

exempt from dues and from the requirement to serve on emergency call. They shall not, however, be eligible to vote or hold office.

### **Section 5 HONORARY STAFF**

The Honorary Medical Staff shall consist of physicians, dentists, and podiatrists who are not active in the hospital. These may be physicians, dentists, and podiatrists who have retired from long-standing active hospital practice or who are of outstanding reputation, not necessarily residing in the community. These may also be physicians, dentists, and podiatrists recognized for their noteworthy contributions to the medical sciences. Honorary Staff members shall not be eligible to vote, hold office, serve on standing Medical Staff committees, or care for patients. They are exempt from dues, from on-call requirements, and from the education requirements; they may attend Departmental and Medical Staff meetings. Honorary Staff members will be queried by the Medical Staff Office every five years to determine whether they wish to continue their honorary membership. If there is no response, they will be dropped from membership.

## ***ARTICLE V: HEALTH PROFESSIONAL AFFILIATES***

Health Professional Affiliates are not Members of the Medical Staff. The provisions of these Bylaws shall apply to Health Professional Affiliates only where specifically provided or where the context makes it clear that they apply to all individuals holding delineated clinical privileges. They do not in any manner apply to Hospital employment decisions.

### **Section 1 QUALIFICATIONS**

Physician Assistants, Nurse Anesthetists, Nurse Midwives, and other Advanced Practiced Registered Nurses (Nurse Practitioners/APRNs) and Clinical Psychologists who are licensed to practice in the State of Connecticut, and who have not been excluded from Medicare, Medicaid, or any federal health care program, shall be eligible to be Health Professional Affiliates at this hospital. Applications for this position shall (a) document their background, experience, training, and demonstrate competency with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient services rendered by them will be of the highest quality; (b) document their current physical and mental status; and (c) document their adherence to the ethics of their profession and the American Medical Association Code of Ethics. Health Professional Affiliates will be assigned to various Departments and their responsibilities and obligations will be determined by the Chair of that Department. Health Professional Affiliates are not members of the Medical Staff.

### **Section 2 PROCEDURES FOR APPOINTMENT, REAPPOINTMENT AND SPECIFICATION OF SERVICES**

Physician Assistants, Nurse Anesthetists, Nurse Midwives and other Advanced Practiced Registered Nurses (Nurse Practitioners/APRNs) and Clinical Psychologists shall apply for Health Professional Affiliate status through the Chair of their Department. Applications shall be made to the various Departments and to the hospital for those affiliates who are hospital employees. All

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Health Professional Affiliate privileges and appointments shall be provisional for a period of twenty-four months. All Health Professional Affiliates would undergo reappointment in the same procedure as other staff members. The Chair of the Department shall specify the duties of the Health Professional Affiliate within the Department. Corrective action with regard to Health Professional Affiliates, including termination or suspension of authorized services, shall be implemented on written recommendation of the Chair of their Departments.

### Section 3      RESPONSIBILITIES

The responsibilities of a Health Professional Affiliate shall be to:

- a.      Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the limitations stated in Article VII, Section 5.
- b.      Write orders to the extent established in the rules of the Staff and of the Department to which the individual is assigned, but not beyond the scope of the individual's license, certificate or other legal credentials.
- c.      Serve on Department and hospital committees if requested.
- d.      Attend meetings of the appropriate section or service if requested.
- e.      The duties and responsibilities of each H.P.A. will be kept on file in the appropriate Department Chair's Office.

### Section 4      FAIR HEARING POLICY FOR HEALTH PROFESSIONAL AFFILIATE STAFF

The Fair Hearing and Appellate Review Mechanism for Health Professional Affiliates shall be as follows:

- a.      Adverse decisions with respect to the denial of appointment or reappointment, the denial or removal of clinical privileges, or corrective action may be appealed by the practitioner to the Medical Executive Committee (MEC).
- b.      If a decision is appealed, the Department Chair, or the Chair of the committee making the adverse decision, and the practitioner shall file written statements with the Medical Executive Committee.
- c.      The Medical Executive Committee (or an ad hoc subcommittee of the Medical Executive Committee authorized by the Medical Executive Committee or its Chair to hear and decide the matter) may request to meet with the Chair and the practitioner. In the absence of such a request by the Medical Executive Committee or its authorized subcommittee, the practitioner shall have the right to such a meeting at the practitioner's request.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- d. The decision of the Medical Executive Committee or its subcommittee shall be in writing and shall set forth the reasons for the decision. In the case of a subcommittee of the MEC, the report shall be presented to MEC for approval, modification, or rejection.
- e. The Chair or the practitioner may appeal the decision of the Medical Executive Committee to an ad hoc committee of the Board of Directors appointed by the Chair of the Board.
- f. In its sole discretion, the ad hoc committee of the Board of Directors shall establish a procedure to review the decision of the Medical Executive Committee, but at a minimum shall permit the Chair of the MEC and the practitioner to file written statements. The decision of the ad hoc committee of the Board of Directors shall be in writing and shall be final.
- g. The Medical Executive Committee and the ad hoc committee of the Board of Directors may establish reasonable time limits to implement the provisions of this section.
- h. No person with a conflict of interest shall serve as a member of a reviewing body under this sub-section.

***ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT***

Section 1      GENERAL PROCEDURE

The Medical Staff through its designated Departments, committees, and officers shall evaluate and consider each application for appointment or reappointment of physicians, dentists, and podiatrists to the Staff and each request for modification of Staff membership status and shall transmit recommendations thereon to the Board. The Medical Staff shall also perform these same evaluation and recommendation functions in connection with physicians employed by the hospital, those in administrative positions, and any health professional affiliates who are required to be Members of the Medical or Health Professional Affiliate Staff with delineated clinical privileges approved by the Board.

Each recommendation concerning the reappointment of a member of the Medical or Health Professional Affiliate Staff and the clinical privileges to be granted upon reappointment shall be based upon such individual's professional ability and clinical competence to perform the privileges requested, peer recommendation, clinical judgment in the treatment of patients, professional ethics, cooperation with other practitioners, hospital staff, and with patients, and other matters bearing on the individual's ability and willingness to contribute to good patient care practices in the hospital.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Section 2      REQUIREMENTS FOR APPLICANTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

- a. Individuals seeking initial appointment or reappointment to the Hospital Medical Staff shall complete and submit an application and provide any relevant supporting documentation as requested.
- b. Acknowledgment and Agreement: Applicants acknowledge receipt of and that they have read the Bylaws, Rules and Regulations of the Medical Staff and agree to be bound by the terms thereof for purposes of processing the application. Additionally, if the applicant is granted membership and/or clinical privileges, he/she agrees to provide for continuous care for his/her patients. The acknowledgement shall indicate that the applicant agrees to be bound by the provisions of the Bylaws and Rules and Regulations in all matters relating to consideration of the application regardless of whether appointment is ultimately granted.
- c. Qualifications: Detailed information is required concerning the applicant's qualifications, including information demonstrating satisfaction of the basic qualifications specified in Article III, Section 2.1 and of any additional qualifications specified in these Bylaws or in Medical Staff Policies for the particular Staff category to which the applicant requests appointment, including evidence of education, training, and current clinical competence to perform the clinical privileges requested. Qualifications must continue to be met in order for members of the Medical or Health Professional Affiliate Staff to remain eligible for continued appointment.
- d. Each applicant shall answer “Practice History Information” questions contained in the application, which include whether or not the applicant:

  - 1. has been convicted of or charged with or pled guilty or nolo contendere to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent thereof;
  - 2. has been denied any license, certification, narcotics permit, hospital appointment or privilege;
  - 3. has had any license, certification, narcotics permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily;
  - 4. has been the subject of disciplinary action for any reason including disruptive behavior or unprofessional conduct;
  - 5. has any condition that would compromise his/her ability to practice with reasonable skill and safety; and
  - 6. is currently dependent upon any controlled substance or alcohol or presently using illegal controlled substances (any for which the applicant does not have a prescription or using contrary to the prescribed dosage).

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Information provided by applicants in conformance with this requirement shall be treated as confidential and shall be used only for purposes of appointment and reappointment in accordance with the provisions of these Bylaws.

If any such actions were ever taken with respect to (1) through (6) above, details will be required as part of the initial appointment or reappointment process. Applicants must also provide information regarding any pending challenges, complaints, investigations, or other proceedings that might lead to any of the actions cited in this section. This information will be shared with the relevant Department Chair and the Credentials Committee.

- a. The relevant Department Chair, Credentials Committee, Medical Executive Committee, Board, or any individual designated on behalf of these persons or committees may also require additional information to appropriately assess the education, training and clinical competence for privileges requested, and/or qualifications for initial or continued membership. When such information can only be obtained from organizations or individuals that are not part of the Hospital, it shall be the responsibility of the applicant to provide or make available such information consistent with Section 4. Failure on the part of the applicant to provide, or cause to be provided, such information shall constitute a failure to complete an application for initial appointment or reappointment.
- b. **Authorization to Obtain Information; Immunity.** Applicants acknowledge and agree that the Hospital and Medical Staff may seek, obtain, and use all information that it deems necessary to carry out their obligations under these Bylaws and Rules and Regulations and, with respect to employed Medical or Health Professional Affiliate Staff, for purposes of employment. Applicants who are employed by the Hospital or by a Hospital affiliate within the Yale New Haven Health System authorize all such information to be shared with the Hospital Administration or Human Resources to the extent relevant for purposes of employment. Applicants authorize all third parties to release such information to the Hospital and further authorize all third parties and the Hospital to release such information to the Hospital's affiliates within the Yale New Haven Health System.

### Section 3 EFFECT OF APPLICATION FOR INITIAL APPOINTMENT OR REAPPOINTMENT

By applying for initial appointment or reappointment to the Medical Staff, the applicant:

- a. Signifies the applicant's willingness to appear for interviews in regard to the application and to furnish such additional information as may be requested.
- b. Authorizes hospital representatives to consult with others who have been associated with the applicant or who may have information bearing on the applicant's competence and qualifications.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- c. Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of the applicant's professional qualifications and ability to carry out the clinical privileges the applicant requests as well as of the applicant's professional ethical qualifications for membership.
- d. Releases from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and the applicant's credentials.
- e. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for appointment and clinical privileges.
- f. For purposes of this Section the term "hospital representative" includes the Board, its directors and committees; the President/CEO; Chief Medical Officer, all Medical and Health Professional Affiliate Staff members, Departments and committees, and employees and agents, which have responsibility for collection or evaluating the applicant's credentials or acting upon the applicant's application; and any authorized representative of any of the foregoing.
- g. Agrees to execute additional authorizations/releases required to implement the provisions of this section.

### Section 4 COMPLETION OF THE APPLICATION / RESPONSIBILITY OF APPLICANTS

All applicants, members and health professional affiliate 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 trainees and for resolving any doubts that arise regarding their qualifications during the initial appointment or reappointment process.

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

If an applicant for initial 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 or health Professional Affiliated Staff as applicable until/unless required documentation can be provided and the application approved in accordance with ARTICLE VI, Section 5.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

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

Applicants for initial 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 initial 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 5 APPLICATION PROCESS FOR INITIAL APPOINTMENT

#### 5.1 Additional information required for initial appointment:

The following shall be required for initial appointment in addition to the material outlined in Sections 2 and 3 above:

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

Specific guidelines as to requirements for references depending upon education and training as well as length of time in practice are incorporated into the application for initial appointment.

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

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

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- b. Professional Liability Insurance and Experience: Based on the information provided or obtained during the credentialing process, additional information pertaining to professional liability insurance and experience may be requested and shall be required for the application to be deemed complete .

Section 6. PROCESSING THE INITIAL APPOINTMENT APPLICATION

6.1 Verification of Information

Applications for initial appointment shall be submitted to Medical Staff Administration, which shall, in timely fashion, solicit appropriate references and perform primary source and other verification of licensure and other qualifications as required by The Joint Commission. All verifications shall be through a primary source whenever possible or through a source approved by The Joint Commission as satisfying the requirement for primary source verification. Medical Staff Administration shall promptly notify the applicant about any difficulty in collecting and/or verifying required information.

6.2 Transmission of Information

Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chair for review.

6.3 Department Action

Upon receipt, the Chair of each Department in which the applicant seeks privileges shall review the application and supporting documentation, whenever possible, conduct a personal interview with the applicant, and then transmit his or her recommendation regarding appointment, staff category, Department and section assignment and clinical privileges to the Credentials Committee. Any special conditions, as applicable, will also be communicated. Generally speaking, special conditions shall be incorporated into the Focused Professional Practice Evaluation (FPPE).

The Departmental action shall include, when appropriate, a review and recommendation regarding appointment and clinical privileges requested by the appropriate Section Chief(s) prior to the Chair's final recommendation.

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

The recommendation of the Department Chair shall be forwarded to the Credentials Committee.

6.4 Credentials Committee Action

The Credentials Committee shall review the application, the supporting documentation, review the Department Chair's recommendation, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

and clinical privileges requested. In addition, the Credentials Committee may determine that more information is needed in order to make its recommendation. In this case, an application becomes incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this Article. Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendations as to appointment, staff category, Department and Section, clinical privileges to be granted and any special conditions associated with the appointment to the Medical Executive Committee.

The Credentials Committee may recommend an appointment of less than two (2) years to the Medical Executive Committee. Typically, this will occur if information obtained in the credentialing process suggests that there may be concerns about the practitioner's performance or qualifications that are not of significant magnitude to deem the applicant ineligible for appointment and privileges but warrant a period of initial monitoring. In such cases, the requirements and expectations shall be articulated as part of routine FPPE and the applicant notified accordingly of such expectations and consequences of not fulfilling them in the manner or timeframe outlined.

### 6.5 Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendations, the Medical Executive Committee shall consider the recommendations of the Credentials Committee. In addition, the Medical Executive Committee may request additional information from the applicant that the Committee deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this Article. The Medical Executive Committee shall then forward its recommendations to the Board including staff category, Department and Section, clinical privileges recommended to be granted and any special conditions to be attached to the appointment.

- a. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the Committee shall promptly forward it to the Board.
- b. Unfavorable Recommendation: When the recommendation of the Medical Executive Committee is unfavorable in whole or in part, the unfavorable recommendation will be considered an adverse action. In such cases, the applicant shall be entitled to the Fair Hearing Process as set forth in Article XVIII.

### 6.6 Appointments of Less than Two Years:

The Medical Executive Committee may recommend an appointment of less than two (2) years to the Board under the circumstances described in Section 6.4 above.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

The recommendation for an appointment of less than two (2) years is not considered adverse.

### 6.7 Board Action

- a. On Favorable Medical Executive Committee Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. The applicant shall be promptly informed of the Board's action by a mechanism that will allow for confirmation of receipt to be secured. If the Board rejects a favorable recommendation of the Medical Executive Committee, this shall be deemed an adverse action and entitle the applicant to a Fair Hearing pursuant to Article XVIII of these Bylaws.
- b. In addition, the Board may request additional information from the applicant that the Board deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this Article.
- c. EXPEDITED APPROVAL  
In the sole discretion of the Medical Staff, expedited board approval may be requested for the following medical staff actions:
  - Initial appointment to the Medical or Health Professional Affiliate Staff
  - Reappointment to the Medical or Health Professional Affiliate Staff
  - Granting of additional privileges to Medical or Health Professional Affiliate Staff

The authority to render this expedited decision may be delegated by the Board to a committee of at least two voting members of the Board when the following criteria are met:

- The application for initial appointment, reappointment or granting of additional privileges has been deemed complete in accordance with Section 4;
- The Credentials Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges; and
- The Medical Executive Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

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

- The application is incomplete; or
- The Medical Executive Committee makes a final recommendation that is adverse or has limitations.

Other situations in which expedited approval shall be evaluated on a case-by-case basis include, but are not limited to the following:

- There is a current challenge or a previously successful challenge to licensure or registration in any state; or
- The applicant's membership at another hospital or health care facility has been subject to involuntary termination; or
- The applicant's clinical privileges have been subject to involuntary limitation, reduction, denial or loss at another hospital or health care facility; or
- The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant; or
- The Hospital Department Chair makes a recommendation not to approve or refuses to make a recommendation; or
- The applicant has prior arrests or convictions

### 6.8 The Hospital's Inability to Accommodate Applicant

The Medical Executive Committee or the Board may determine that the application and credentialing process cannot be completed, in whole or in part, based upon limitations in terms of the availability of Hospital resources or facility to accommodate the applicant's practice. This determination may be based upon either:

- a. The Hospital's present inability as supported by documented evidence satisfactory to the Board or to the Medical Executive Committee to provide adequate facilities or support services for the applicant and the applicant's patients, or
- b. The Hospital's written plan of development or plan of patient care, including the types of patient care services to be provided or currently implemented.

Any such decision that an application cannot be completed, in whole or in part, based upon the hospital's inability to accommodate the applicant shall not be deemed adverse, shall not be considered a denial of privileges or membership, and shall not entitle the applicant to the rights and provisions of the Fair Hearing Plan (Article XVIII).

### 6.9 Notice of Final Decision

The applicant shall be notified of the Board's decision by way of a letter copied to the relevant Department Chair which includes the following: (1) the staff category to which the applicant is appointed; (2) the Department and, when appropriate, the clinical section to

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

which the applicant is assigned; (3) the clinical privileges the applicant may exercise; (4) obligations and expectations concerning the Focused Professional Practice Evaluation (FPPE) process for new privileges and (5) any special conditions associated with the appointment.

### 6.10 Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical or Health Professional Affiliate Staff until he/she is able to provide sufficient documentation evidencing that the concerns which led to the initial adverse decision have been addressed. A new application will be required and it shall be processed as an initial application.

### 6.11 Time Periods for Processing

Applications for appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause or as otherwise provided for in these Bylaws, shall be processed within the time periods specified in this Section. Medical Staff Administration shall initiate the recommendation and approval process of applications by transmitting the application to the Department Chair upon confirming that the applicant has submitted all required information allowing the application to be deemed complete consistent with Section 4.

The relevant Department Chair shall act on completed applications within twenty (20) business days of receiving it from Medical Staff Administration. Unless approved for Temporary Privileges consistent with Section 7, the application shall be reviewed at the next regularly scheduled Credentials Committee meeting.

The Medical Executive Committee shall review the application and make its recommendation to the Board at the committee's next regularly scheduled meeting following the Credentials Committee.

The Board or, under circumstances involving Expedited Approval as outlined in Section 6.7.c the appropriate committee thereof, shall then take final action on the application at its next regular meeting.

This time frame may be delayed if any of the committees or individuals responsible for reviewing an application pursuant to these Bylaws, and acting in good faith, deem that additional information is required to complete the application as provided for in this Article, or if circumstances beyond their reasonable control cause a delay.

### 6.12 Staff Applicant Interviews

Applicants for initial appointment shall be interviewed by the Chair of the Department(s) in which appointment is sought whenever possible, and at the sole discretion of the Credentials Committee, may be interviewed by the Credentials Committee, and by any other persons recommended by the Credentials Committee. At the sole discretion of the Committee or individual responsible to conduct an interview, such interviews may be performed by phone to accommodate special needs of the individual conducting the interview, the Committee or the applicant.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 7 REAPPOINTMENT APPLICATION PROCESS

The following shall be required for re-appointment in addition to the material outlined in Sections 2 and 3 above:

#### 7.1 Reappointment Application

At least one hundred and twenty (120) days prior to the expiration date of the present appointment of each Medical and Health Professional Affiliate Staff member, each member shall be provided with an application for reappointment.

Except for good cause, the application shall be completed and submitted to Medical Staff Administration at least ninety (90) days prior to the expiration date of the current appointment along with the items as outlined in Sections 2 and 3 above.

Failure to return the application, with all required information provided in sufficient time to allow processing and approval, shall be considered a voluntary resignation from the Medical or Health Professional Affiliate Staff at the expiration of the individual's current appointment.

In the event of a voluntary resignation due to failure to submit a complete application for re-appointment, as long as the reappointment application is returned with updated information within one (1) year of the resignation date, it will be accepted and processed. The applicant will be required to document activities that occurred during the period of the lapse in membership and privileges. Such documentation of activities may require verification and, depending upon the reason for the delinquency of the return, additional information may be required including, but not limited to references.

Members who fail to return a reappointment application within one (1) year of voluntary resignation will be required to complete an application for initial appointment.

#### 7.2 Content of Reappointment Application

The reappointment application shall contain information necessary to maintain as current for the Medical or Health Professional Affiliate Staff member including, but not limited to, the following:

- a. Any additional training, education and experience that qualify the applicant for the privileges requested;
- b. Information about other hospital, health care organization or practice setting where the applicant provided clinical services during the preceding two (2) years;
- c. An update regarding professional liability experience, including proof of appropriate insurance coverage and limits of liability;

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 7.3 Transmission of Information

Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chair for review.

### 7.4 Department Action

The Department Chair shall review, among other things, the reappointment application as well as information about the applicant's activity at the Hospital including any available information from routine Ongoing or Focused Professional Practice Evaluation, Focused Professional Practice Evaluation conducted for cause and the applicant's peer review file as relevant. Information and references from external organizations as applicable shall also be considered.

All information pertinent to the physician's clinical competence to perform the privileges requested shall be considered in the recommendation of the Chair as well as the applicant's attendance and participation at relevant Departmental and Staff meetings; assigned committee meetings and continuing education meetings.

The Department Chair may also request additional information as deemed necessary to appropriately assess qualifications for appointment and privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing consistent with Section 4. The Chair shall transmit his/her recommendation to the Credentials Committee as to whether the appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

### 7.5 Credentials Committee Action

The Credentials Committee shall review the application for reappointment, the supporting documentation, the Department Chair's recommendations, and such other information available to it that may be relevant to consideration of the reappointment of the applicant with the privileges that have been requested. The Committee may also request additional information as it deems necessary to appropriately assess qualifications for appointment and requested privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this Article.

Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendation as to reappointment, and if reappointment is recommended, category, Department and Section, clinical privileges to be granted and any special conditions associated with the reappointment to the Medical Executive Committee.

The Credentials Committee may recommend a reappointment of less than two (2) years to the Medical Executive Committee. Typically this will occur if information obtained in the reappointment process identifies concerns not previously identified through Ongoing or Focused Professional Practice Evaluation or if re-appointment is concurrent with a for cause

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Focused Professional Practice Evaluation. In such cases the practitioner will be notified and given an opportunity to meet with the Credentials Committee before its recommendation is forwarded to the Medical Executive Committee.

### 7.6 Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendation, the Medical Executive Committee shall consider the recommendations of the Credentials Committee. In addition, the Medical Executive committee may request information from the applicant that it deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the responsibility of the applicant to provide, or cause to be provided, any information necessary for completion consistent with Section 4.0.

The Medical Executive Committee shall forward its recommendation to the Board as to whether appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

In the event that the recommendation of the Medical Executive Committee is adverse, in whole or in part, the final adverse recommendation shall not be made or forwarded to the Board for action until the applicant has been informed and offered the opportunity to request a Fair Hearing pursuant to Article XVIII of these Bylaws. The Board shall be apprised of these actions.

The Medical Executive Committee may also defer action for further discussion or consideration. The Committee may also request additional information as noted above in order to fully assess the applicant's qualifications.

### 7.7 Conditional Re-Appointment

In the event that the Credentials Committee or Medical Executive Committee requires additional time to consider an application for reappointment or an investigation or hearing is pending, a short-term conditional re-appointment may be recommended, 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 herein.

In such cases, the applicant will be notified and given an opportunity to meet with the relevant Committee. Any plan for monitoring or other criteria for regaining a two (2) year appointment will be discussed with the practitioner. This action is not considered adverse.

### 7.8 Board Action

Thereafter, the procedure provided in Sections 6.7 through 6.12 shall be followed as closely as possible.

### 7.9 Time Periods for Processing

Transmittal of the reappointment application and its return shall be carried out in accordance with Section 7.1 of this Article. Thereafter, and except for good cause, each

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

person, Department, and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all recommendations concerning the reappointment shall have been transmitted to the Credentials Committee for its consideration and action pursuant to Article VI, Section 7.5, to the Medical Executive Committee for its consideration and action pursuant to Article VI, Section 7.6 and to the Board for its action pursuant to Article VI, Section 7.7, all prior to the expiration date of the membership of the individual being considered for reappointment.

### Section 8      REQUESTS FOR MODIFICATION OF STAFF CATEGORY OR CLINICAL PRIVILEGES

A Member of the Medical or Health Professional Affiliate Staff, as applicable, may, either in connection with reappointment or at any other time, request modification of his/her staff category, Departmental assignment or clinical privileges by submitting the request in writing or via email to Medical Staff Administration. Requests shall be processed in substantially the same manner as provided in Article VI, Section 7 for reappointment.

### Section 9      NOTIFICATION REQUIREMENT

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

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

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

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

The circumstances surrounding any of the above occurrences, or failure to comply with the requirement to report them, will be evaluated individually in terms of pursuing disciplinary or other action. Fair hearing or appellate review rights are not applicable under circumstances in which practitioners fail to meet eligibility requirements.

### ***Article VII: DETERMINATION OF CLINICAL PRIVILEGES***

#### **POLICY IN REGARD TO FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION (FPPE AND OPPE)**

It is the Policy of the Hospital to establish and provide a systematic, consistent process to assure that there is sufficient information available to confirm the current competency of Medical and Health Professional Affiliate Staff in the granting of new privileges at the time of initial appointment, reappointment or between reappointment cycles and to address issues concerning the ability of these individuals to provide safe care. FPPE and OPPE provide the basis for obtaining Hospital-specific information of the current competency of all individuals holding delineated clinical privileges. Proctoring requirements are to be adhered to appropriately and uniformly applied to all members of the Medical and Health Professional Affiliated Staff.

#### **Section 1 EXERCISE OF PRIVILEGES**

Every physician, dentist, podiatrist or other health affiliate professional who provides direct clinical services at this hospital by virtue of Medical or Health Professional Affiliate membership shall, in connection with such practice and except as provided in Sections 5 and 6 of this Article, be entitled to exercise only those clinical privileges or specified services specifically granted by the Board. No individual shall be required to perform an act which is in violation of his/her ethical, moral, or professional principles, standards, or good medical judgment.

#### **Section 2 DELINEATION OF PRIVILEGES IN GENERAL**

##### **2.1 Requests**

Each application for appointment and reappointment to the Medical or Health Professional Affiliate Staff must contain a request for the specific clinical privileges desired by the applicant. A request for modification of privileges pursuant to Article VI, Section 8 must be supported by documentation of training and/or demonstrated clinical competence.

##### **2.2 Basis for Determination of Clinical Privileges**

Requests for clinical privileges shall be evaluated on the basis of the applicant's documented education, training, demonstrated clinical competence, and demonstrated ability and judgment. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, patient contacts, and the documented results of the patient care audit and other quality maintenance activities required by these and the hospital corporate Bylaws to be conducted at the hospital. Clinical privileges granted or modified on initial appointment, reappointment, or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

practitioner exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for Medical and Health Professional Affiliate Staff. It shall be the applicant's responsibility to make such information available pursuant to Article VI, Sections 4.

### 2.3 Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI.

## Section 3      LIMITATIONS OF PROFESSIONAL PRIVILEGES

All Members and Health Professional Affiliate 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 Medical Staff or Health Professional Affiliate member of the Medical Staff may perform any medical or surgical procedure permitted by his or her respective training and experience and Connecticut license.

## Section 4      SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges for dentists shall be processed, evaluated, and granted in the manner specified in Section 2.5 of this Article. Surgical procedures performed by dentists shall be provided in accordance with the relevant provisions of the Rules and Regulations of the Department of Surgery. Members of the dental section may admit patients directly. Such patients must have an admission history and physical examination. This examination on patients with no medical or other surgical problems may be performed by oral surgeons provided such a privilege has been previously approved by the Credentials Committee; otherwise, an admission history and physical examination must be rendered by a consultant physician with the dentist being responsible for the portion of the H&P relating to dentistry. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical sections.

## Section 5      SPECIAL CONDITIONS FOR PODIATRY PRIVILEGES

Requests for clinical privileges for podiatrists shall be processed, evaluated, and granted in the manner specified in Section 2.5 of this Article. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. Members of the podiatry section may admit patients directly. Procedures on patients with an ASA Classification of III or higher require that the history and physical examination be performed by a consulting physician, with the podiatrist responsible for the portion related to podiatry. All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 6 SPECIAL CONDITIONS FOR HEALTH PROFESSIONAL AFFILIATE SERVICES

Requests to perform specified patient care services from Health Professional Affiliates, including the performance of History & Physical Examinations, shall be processed, evaluated, granted, or denied, in the manner specified in Article VII, Section 2. A Health Professional Affiliate may, subject to any licensure requirements or other legal limitations, participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

### Section 7 TEMPORARY PRIVILEGES

Temporary privileges may be granted to a qualified candidate for Medical or Health Professional Affiliate Staff membership by the Chief Medical Officer or his designee under two circumstances as described below:

- (1) Complete, clean application pending approval; or
  - (2) Urgent patient care need
- 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 Department Chair 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.
  - c. In the event of any such termination, the individual's patients then in the hospital shall be assigned to another practitioner by the Department Chair responsible for supervision. When feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

In exercising temporary privileges, the applicant shall act under the supervision of the Chair of the Department to which the applicant is assigned. Temporary privileges shall not exceed 120 days and shall normally not extend past the date of the earliest Board meeting at which the applicant's request for privileges can be acted upon.

#### Complete, clean application pending approval:

A candidate shall not be considered qualified for temporary privileges until the application for privileges is complete consistent with ARTICLE VI, Section 4 and a recommendation of the Department Chair has been received. Temporary privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less. The Credentials Committee will be informed of all temporary privileges granted at its next regularly scheduled meeting.

#### Urgent Patient Care Need

This is defined as circumstances in which the condition of a Hospital patient requires urgent or emergent care from a physician with special clinical expertise or training. Temporary privileges for urgent patient care need may not be invoked to accommodate scheduling conflicts or issues.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

In cases of bona fide urgent patient care need, the Chief Medical Officer on the recommendation of the Department Chair and Credentials Chair, or their respective designees, may grant temporary privileges for a specified period of time. Such temporary privileges will be time limited specifically to the dates of the specific services the physician is asked to provide and, as applicable, the specific patient/s.

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

1. Evidence demonstrating that the applicant meets basic requirements as outlined in ARTICLE III
2. Verification of current, unencumbered license
3. Verification of malpractice insurance to cover services provided at the Hospital;
4. Complete application to the Medical Staff specifying the privileges requested, dates and, as applicable, specific patients;
5. Verification of appointment and relevant clinical privileges at a Joint Commission (or equivalent) accredited hospital ;
6. Verification of completion of education and appropriate training;
7. Evidence of current competence and ability to perform the requested privileges with reasonable skill and safety as confirmed via the usual reference request form, written statement or a documented phone call from, at minimum, the Department Chair or section chief or individual in a position with direct knowledge of the applicant's performance at the applicant's primary hospital;
8. Confirmation that there are no pending actions or investigations at any current or prior organization at which the applicant holds or held an appointment and/or clinical privileges.

Generally speaking, applicants with any of the following shall not be considered "clean" applicants and, therefore, ineligible for temporary privileges:

- Current or previously successful challenges to licensure or registration in any state;
- Involuntary termination of medical staff membership at another organization;
- Involuntary limitation, reduction, denial or loss of clinical privileges;
- Hospital Department Chair recommendation is not to approve or refuses to make a recommendation; or
- Pending or prior arrests or convictions for any reason

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 8 DISASTER PRIVILEGES DURING ACTIVATION OF THE EMERGENCY PREPAREDNESS PLAN

Disaster privileges may be granted when the Emergency Preparedness Plan has been activated and the organization is unable to handle the immediate patient needs. The granting of such privileges shall be consistent with Joint Commission standards and pursuant to the Medical Staff policy for “Disaster Privileges During Activation of the Emergency Preparedness Plan”. This policy shall, in addition to being kept in the Medical Staff Policy Manual, shall also be kept in the Hospital Emergency Preparedness Manual.

Individuals granted emergency privileges under this provision are not considered to be Members of the Medical staff or applicants for membership.

### ***ARTICLE VIII: COLLEGIAL INTERVENTION, CORRECTIVE ACTION; AUTOMATIC AND SUMMARY SUSPENSION; PHYSICIAN’S HEALTH MATTERS; DISRUPTIVE BEHAVIOR***

The purpose of this Article is to provide appropriate, effective, and flexible ways for Medical Staff to address issues relating to an individual practitioner’s clinical practice, behavior that is disruptive to the Medical Staff or Hospital operations, or any other conduct by a Member of the Medical Staff that requires action to comply with the provisions of these Bylaws (or with federal or state law). Regular peer review or quality committee/risk management activities, evaluations performed by Department Chairs or the Credentials Committee at the time of re-appointment, and matters brought to the attention of the Medical Executive Committee, may lead to collegial interventions or corrective actions. Whenever possible, collegial intervention should be considered prior to resorting to other provisions of this Article.

#### Section 1. COLLEGIAL INTERVENTION

##### 1.1 The Goal of Collegial Intervention

Collegial Intervention is intended to encourage collegial and educational efforts by Medical Staff leaders to address questions relating to a practitioner’s clinical practice and professional conduct. The goal of these efforts is to attempt to arrive at voluntary, responsive actions by the practitioner to resolve questions that have been raised.

Disruptive behavior, as defined in Section 5 below, is intended to be handled in accordance with the provisions of Section 5. However, if the behavior was minor and deemed not likely to reoccur, the decision may be made to refer the matter for Collegial Intervention pursuant to the provisions of this Section.

##### 1.2 Definition of Collegial Efforts

Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. The Chair of a Department, the MEC, the CEO, the Credentials Committee, or the Chief Medical Officer (“CMO”) may

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

refer a Medical Staff member for Collegial Intervention, which can be provided by the Chair, the CMO, or by a designated Member (or Members) of the Medical Staff appointed by the MEC or by the Chair of the MEC to serve as a special committee.

### 1.3 Collegial Action is discretionary

Collegial Intervention efforts are encouraged but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

### 1.4 Informal Counseling or Assistance

Nothing in this Section is intended to preclude informal efforts by any Member of the Medical Staff to counsel or assist another Member, provided that such efforts are not in violation of the provisions of these Bylaws.

### 1.5 Documentation

Documentation of collegial action should be maintained in the practitioner's peer review file.

### 1.6 Relationship to Corrective Action, Summary Suspension, etc.

If the situation warrants, matters referred to Collegial Intervention may lead to a request for Corrective Action (investigation), or for other action as provided by these Bylaws.

## Section 2 ROUTINE CORRECTIVE ACTION

### 2.1 Criteria for Initiation

Whenever the activities or professional conduct of any practitioner with clinical privileges are, or are reasonably probable of being, detrimental to patient safety or to the delivery of quality patient care, or are reasonably probable of being disruptive to Hospital operations, corrective action, in the view of one of the individual or committees identified in this section, corrective action against such practitioner may be initiated by the President of the Medical Staff, by the Medical Executive Committee, by the Chair of any Department, by the CEO, by the CMO, or by the Board. Information about such conduct may come from peer review activities, in particular practitioner-specific, focused reviews (as described in the Peer Review Policy of the Medical Staff), and from Quality/Risk management activities, as well as from documented complaints about a practitioner. Matters that appear to be minor, or that seem appropriate for Collegial Intervention, may alternatively be referred for Collegial Intervention.

### 2.2 Requests and Notices

All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct that constitute the grounds for the request, such as data arising from a focused peer review. The Medical Executive Committee shall make a preliminary inquiry, which may be delegated by the

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

MEC to a Member or a sub-committee of the MEC, to a special committee of Medical Staff Members, or, where deemed appropriate, to an outside consultant. The person or entity making the preliminary inquiry shall provide the Member of the Medical Staff with an opportunity for a meeting to discuss the request. Such meeting shall be informal and is not a hearing.

The body or individual conducting the preliminary inquiry shall report back to the MEC in writing.

Based on the preliminary inquiry, the MEC shall decide how the matter is to proceed. It may be referred for Collegial Intervention, for an investigation, or for other action as provided by these Bylaws.

### 2.3 Investigation

If after the preliminary inquiry, it is decided by the MEC that the matter should be investigated, the MEC shall deem that a formal investigation is to be conducted, and will forward the request for corrective action to an investigating committee established by the MEC, which may be a sub-committee of the MEC or a special committee composed of members of the Medical Staff. If deemed necessary, the matter may be referred for investigation to an outside consultant.<sup>1</sup> The MEC shall notify the involved Member of its action, and the investigation shall be deemed to have commenced on the date of such notification. The investigating body shall provide the involved Member with an opportunity to meet with the committee or with one or more of its members; however, such a meeting is informal and the practitioner may not be accompanied by legal counsel. In its discretion, the investigating committee shall have access to all peer review minutes, Department Chair and Credentialing files, and medical records, and may conduct such interviews of Medical and other Staff Members and patients as it deems appropriate. As promptly as possible, but no later than 60 days after the commencement of the investigation, the investigating committee shall forward a written report of the results of the investigation to the Medical Executive Committee; a copy of this report shall be provided to the practitioner in question. Reports shall include findings of fact and recommendations, where appropriate. In the event that the investigating committee cannot complete its investigation in 60 days, it may request an extension of time from the MEC, which may be granted for good cause as determined by the MEC.

### 2.4 Medical Executive Committee Action

After receipt of the report of the investigating committee, the Medical Executive Committee shall review the report, and permit the practitioner to appear before the MEC and provide his or her views on the report. The practitioner is not entitled to be accompanied by an attorney at this meeting. After considering the report, and the views of the practitioner if presented, the MEC may take action, which may include, without limitation:

- a. Rejecting the request for Correction Action.

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<sup>1</sup> If referred to a consultant, references to the investigating committee shall be deemed to include references to the consultant.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- b. Directing that the matter be handled under the Collegial Intervention provisions of these Bylaws.
- c. Issuing a warning, a letter of admonition, or a letter of reprimand.
- d. Recommending terms of probation or requirements of consultation.
- e. Recommending reduction, suspension, or revocation of clinical privileges.
- f. Recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care.
- g. Recommending suspension or revocation of Staff membership.

### 2.5 Procedural Rights

Actions taken in accordance with the provisions of this Article shall entitle a practitioner to access to the Fair Hearing and appeal process only as specifically provided in Article XVIII of these Bylaws.

## Section 3 SUMMARY SUSPENSION

### 3.1 Criteria and Initiation

Summary suspension only may be imposed under extraordinary circumstances. Whenever it appears highly likely that a practitioner's conduct or situation requires that immediate action be taken to prevent imminent danger to the health or safety of any patient, Staff member, or other person in the Hospital, the chair of the clinical Department, or the President of the Medical Staff, or in their absence the Chief Executive Officer of the Hospital shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Such summary shall become effective immediately upon imposition, and subsequently the President/CEO shall, on behalf of the imposer of such suspension, promptly give notice of the suspension to the practitioner.

### 3.2 Medical Executive Committee Action

Within seven business days after such summary suspension, a special meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation, or termination of the terms of the summary suspension.

### 3.3 Duration of the Summary Suspension

The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall, if so determined by the MEC, remain in effect pending final resolution.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 4      AUTOMATIC SUSPENSION

An automatic suspension shall not entitle the practitioner to a fair hearing.

#### 4.1      License

A Staff member, or health professional affiliate, whose license, certificate or other legal credential authorizing him to practice in this State is revoked, suspended, or has lapsed shall immediately and automatically be suspended from practicing in the Hospital.

#### 4.2      Drug Enforcement Administration (DEA) and Connecticut DCP Number

A practitioner whose DEA or Connecticut DCP (Narcotics Registration) number is revoked, suspended, or has lapsed shall immediately and automatically be divested of the privilege to prescribe medications covered by such number. In the case of a revocation or suspension of a registration, and as soon as possible after such automatic suspension of privileges, the Medical Executive Committee, or a sub-committee of the MEC appointed by the President of the Medical Staff, shall convene to review and consider the facts under which the DEA or Connecticut DCP (Narcotics Registration) number was revoked or suspended. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its review.

#### 4.3      Failure to Satisfy Special Appearance Requirement

A practitioner who fails to satisfy the requirements of Article XIV, Section 8(c) shall immediately and automatically be suspended from exercising all or such portion of his clinical privileges in accordance with the provisions of said Article XIV, Section 8(c).

#### 4.4      Malpractice Insurance

Failure to maintain malpractice insurance shall result in automatic suspension of all clinical privileges.

#### 4.5      Suspension for a Federal Health Care Program

- a.      If a practitioner is debarred or suspended (“excluded”) from the Medicare or Medicaid program, or any federal health care program, the practitioner immediately shall notify the President of the Medical Staff. In addition, the practitioner shall notify the President of the Medical Staff and the President-CEO of the Hospital of exclusions from managed care and insurance plans that result directly or indirectly from the federal exclusion.
- b.      An excluded practitioner shall provide a detailed written statement to the President of the Medical Staff explaining why the practitioner was excluded, and shall answer any questions that are asked of the practitioner by any officer of the Medical Staff or by the Medical Executive Committee.
- c.      Upon learning of an exclusion from the practitioner or otherwise, the practitioner’s clinical privileges shall be automatically suspended for the period of such exclusion.
- d.      The clinical privileges of a suspended practitioner who remains a member of the Medical Staff automatically shall be reinstated upon dissolution of the exclusion.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- e. If a practitioner remains excluded at the time of reappointment, the practitioner nevertheless may apply for reappointment. If re-appointed, the practitioner shall remain suspended until such time as the dissolution of the exclusion.
  - f. If an excluded practitioner resigns from the Medical Staff, or the practitioner's appointment lapses, or the practitioner is not reappointed, the practitioner nevertheless is eligible to reapply for appointment at the time the exclusion is dissolved, provided that such application shall be viewed and processed as an initial application for appointment and not an application for reappointment.
  - g. Excluded providers will not be eligible for initial application to the Medical Staff during the period of the exclusion.
- 4.6 Requirements for Reappointment: Failure to document requirements for reappointment or provisional reappointment pursuant to Bylaws, Rules and Regulations, and/or Medical Staff Policy shall be cause for automatic suspension of clinical privileges.
- 4.7 Dues: Failure, without good cause as determined by the MEC, to pay medical staff dues set by the Medical Executive Committee and approved by the Medical Staff shall be cause for automatic suspension of clinical privileges.
- 4.8 Notice: Once it has been determined that a condition or circumstance exists warranting automatic suspension pursuant to this section, the practitioner shall be notified of the automatic suspension. Such notification shall include the reason for the automatic suspension, the effective date of the automatic suspension, and the conditions under which such suspension shall be lifted. Except for administrative suspension for failure to complete medical records, such notification shall be signed by the President or Vice President of the Medical Staff. If the President or Vice President of the Medical Staff is unavailable, the CEO or the CMO may issue the notification. Except for the case of automatic suspension for Medical Records, the MEC shall be apprised of the automatic suspension at its next regularly-scheduled meeting. In the case of suspension for medical records, the Health Information Management Department may develop a process for the notification of practitioners, which process shall be approved by the MEC.
- 4.9 Termination of Automatic Suspension: Unless otherwise provided for in this article and in the absence of any corrective action taken in association with an automatic suspension, the automatic suspension shall be terminated at such time as it is confirmed by the President of the Medical Staff, Vice President of the Medical Staff, the CEO, or the CMO that the circumstances causing the suspension no longer exist. In the case of automatic suspension for Medical Records, this determination may be made by the Department of Health Information Management.
- 4.10 Continuous suspension of a medical staff member for three (3) months pursuant to this section, shall be considered a voluntary resignation from the Medical Staff and the member's Medical Staff membership shall be terminated upon the approval of the MEC.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Section 5      PHYSICIAN HEALTH

5.1      Reporting Suspected Impairment

- a.      An impaired physician or practitioner is defined by the AMA as “one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.” Suspicious behavior would include any instance in which a physician, Health Professional Affiliate (HPA), hospital employee, a patient or a patient’s family, or another person, witnesses inappropriate behavior of a physician during the exercise of his/her professional duties. These incidents may include, but are not restricted to, perceived problems with judgment, behavior, speech, alcohol odor, physical illness or loss of motor skill, depression, illness, or substance abuse.
  
- b.      If a practitioner or a member of Hospital Management witnesses suspicious behavior, or otherwise has reason to suspect a practitioner is impaired, it must be reported immediately to the President of the Medical Staff, the Department Chair, or the CMO. These three physicians will be referred to as the “designated” physicians and shall constitute the “Committee on Physician Health”, a medical review committee as provided for by Article XII, Section 1 of these Bylaws. A quorum for action shall be three of the three members; however, individual members may meet individually with the practitioner and/or gather information for the Committee. Another officer of the Medical Staff or a Department Chair may substitute as a designated physician if any of these physicians are unavailable; such designated physician shall be designated by the President of the Medical Staff, if readily available; if not readily available, such designated Member shall be designated by the CMO, or in the absence of the CMO, by the President-CEO of the Hospital. It is of extreme importance that one of the designated physicians be contacted as soon as possible. A nurse or other Hospital employee witnessing similar behavior may also report this to the President of the Medical Staff, Department Chair, or CMO. Alternatively, the employee may make the report to her/his supervisor who will then report the problem to one of the designated individuals.

The individual who suspects the physician of being impaired must provide a confidential report to the Committee on Physician Health. The report shall be factual and shall include a description of the incident(s) that led to the belief that the physician might be impaired. If the report is not in writing, the member/members of the Committee who receive the report shall reduce it to writing. The individual making the report does not need to have proof of the impairment, but must state the facts or circumstances that led to the suspicions. If reports are not in writing and signed, they will not be admissible in later proceedings. Any facts or evidence independently obtained in the course of the investigation may be admissible.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 5.2 Initial Review

- a. Upon receiving notice as described above (immediate or delayed), the Committee on Physician Health, or one or more of its Members, should as promptly as possible conduct an interview with the physician in question. A Committee member should also attempt to speak, in confidence, to the individual submitting the report. The practitioner is not entitled to be represented by an attorney at any interview or meeting.
- b. If the Committee on Physician Health agrees that the report is completely without foundation, then no further action would be taken. The purpose of this step is to screen out frivolous complaints or problems not related to impairment (i.e. bedside manner, financial issues, or quality complaints), which, at the discretion of the Committee, may be referred for Collegial Intervention.

### 5.3 Referral to a Professional Assistance Program established pursuant to the provisions of Public Act 07-103 (the Haven Program) or another program selected by the Committee (“the Program”)

In the event that the Committee on Physician Health has reasonable suspicion that the allegations have merit, they shall review all applicable material with the physician and may recommend to the physician referral to Connecticut State Medical Society (CSMS) Professional Assistance Program established pursuant to the provisions of Public Act 07-103 (the Haven Program), or another program selected by the Committee (“the Program”). If the Program accepts the referral, the Program shall then assume responsibility for follow-up, evaluation, and treatment in accordance with its established policies and protocols. If the physician declines to accept this referral, the Committee on Physician Health will notify him/her that they will present the case to the MEC for consideration of Corrective Action in accordance with these Bylaws. If the MEC then proposes Corrective Action, the physician will again be presented with the choice of referral to a Program or of accepting the Corrective Action and accessing the Fair Hearing Process to the extent it may be available under these Bylaws. The physician will be notified that the MEC will comply with any governmental requirements for reporting the corrective action, especially as they pertain to possible impairment.

- a. Conditions of Referral – Referral to a Program shall be in lieu of any Corrective Action provided that the Physician/Practitioner agrees in writing to the following conditions:
  1. to fully cooperate with the Program and any treatment program recommended by the Program, including the release of information to either the President of the Medical Staff, the Department Chair, or the CMO (one of “the designated physicians”) as required by the MEC or the Committee on Physician Health;
  2. to comply with whatever is required in order to successfully complete the treatment program or follow through with any recommendations the Program may make;

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

3. to waive any rights to a hearing or appellate review under these Bylaws that may exist with respect to the circumstances that resulted in the referral. It is acknowledged that should the corrective action process be instated or reinstated for failure of the physician to accept the referral, refusal of the Program to accept the case, or failure of physician to follow through with the Program's recommendations and the physician's additional obligations required by this policy, then the practitioner would have such rights of fair hearing and appeal as are provided by these Bylaws;
4. to authorize the Hospital and Members of its Staffs to provide whatever information may be requested by the Program or the treatment program, and to make whatever periodic or interim reports may be required by the Program or by the treatment program;
5. to comply with terms and conditions established by the MEC or the Committee on Physician Health, including the requirement to sign forms authorizing the release by the Program and the treatment program of all progress reports to the MEC, the Committee on Physician Health, and to the Hospital, and including terms and conditions of any medical leave of absence.

The terms and conditions set forth in this Section shall apply to and be deemed to have been agreed to by any physician who has agreed to be referred to the Program whether or not such terms and conditions have been reduced to written form.

b. Refusal to Accept a Referral to a Program

In the event a physician declines to cooperate with the initial review, or declines to accept a referral to, or cooperate with a Program or the Committee on Physician Health, or if the recommended treatment program reports that the physician is not cooperating with the recommended treatment program, the physician shall no longer be entitled to the benefit of the provisions of this Section and shall be fully subject to any other applicable provision of these Bylaws.

5.4 In the Course of Reviewing a Collegial Action or a Corrective Action

In the course of a Collegial Intervention, or a Corrective Action as provided in these Bylaws, the MEC or the Department Chair, or the Committee on Physician Health may recommend that a physician who appears to be impaired as a result of emotional disorder, mental illness, or abuse or excessive use of drugs, including alcohol, narcotics, or chemicals, may, be referred to a Program provided that the Program is willing and able to assume jurisdiction and the physician agrees to accept the referral. This referral will be subject to all of the conditions set forth in this Section. At the discretion of the referring Medical Staff officer or committee, the Collegial Intervention or Corrective Action either shall continue simultaneously, or be temporarily delayed.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 5.5 Medical Leave of Absence

This section applies to medical leave of absence in the context of an impaired practitioner and referral to the Physician Health Program. The conditions of this section do not apply to Leave of Absence as described in Article III, Section 6 of these Bylaws.

A physician who has agreed to enter into a referral to a Program and/or a recommended treatment program may be placed on a medical leave of absence when requested by the physician or recommended by the Program or program or by the Committee on Physician Health. The terms and conditions of such medical leave of absence shall be agreed upon by the physician and the Committee on Physician Health and approved by the MEC, and deemed to be part of the agreement referred to in this Section. The purpose of such leave shall be to permit the physician to successfully complete the prescribed course of treatment and to protect patients. If, at any time, the Program has determined that the physician cannot practice with reasonable skill and safety, Medical Leave of Absence shall be mandatory as the only alternative to Summary Suspension. (Medical leave of absence will, of course, not be mandatory if the Program has determined that the physician can continue to practice with skill and safety). No medical leave of absence shall terminate unless the physician has successfully completed the course of treatment and/or the Program and the Committee on Physician Health has determined that the physician can practice with skill and safety. Notification to that effect must be received from the Program, and the MEC or the Committee on Physician Health may then determine that the leave may terminate. Refusal of a physician to accept the terms of a medical leave of absence proposed by the MEC shall constitute a refusal to comply with the referral to the Program for purposes of this Section and may result in corrective action or summary suspension.

A Medical Leave of Absence may not continue beyond the term of the practitioner's then current Medical Staff appointment.

### 5.6 Compliance with Provisions of Law

It is the intention of the Medical Staff and the Hospital to permit a physician to enter into a treatment program in order, whenever practicable, to assist that physician to recover from an impairment and continue to practice medicine. However, permitting a physician to enter into a treatment program shall not be deemed to relieve the Medical Staff or the Hospital of its continuing obligation to protect patients and provide that all Members of the Medical Staff are able to practice with reasonable skill and safety and continuously meet the requirements of these Bylaws for Membership on the Medical Staff and the enjoyment of clinical privileges. In addition, the Hospital and Medical Staff shall comply with any applicable provisions of law such as mandatory reporting requirements.

### 5.7 Consent Agreements and other Governmental Arrangements

Any physician who enters into a Consent Agreement or Consent Order with a governmental agency or authority shall, whether or not such physician has signed a written document, be considered fully subject to all of the terms and conditions of this Section including but not limited to the requirement to authorize the release of information including progress reports to the Committee on Physician Health. It is the obligation of each Member to inform the Committee on Physician Health whenever such

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Member has signed a Consent Agreement or similar document, or whenever the Member has entered into a treatment program as a condition of such an agreement.

### 5.8 Duty to Provide Information

Any Member receiving information in his/her official Medical Staff capacity shall keep the MEC informed concerning physicians who have been referred to the Physician Health Program, who is a party to a Consent Agreement or similar arrangement, or who is under investigation by the Department of Public Health, the DEA, the DCP, the OIG, CMS, or another governmental agency. Members shall promptly report all Consent Agreements (or similar arrangements), and investigations to the MEC.

### 5.9 Records and Documentation

All reports, documents, and records of meetings and communication related to actions taken in accordance with this Section shall be maintained in a secure and confidential manner by the Medical Staff Office under the supervision of the CMO.

### 5.10 Employed Physicians

Except as otherwise provided in their agreements with the Hospital, physicians who are employees of the Hospital shall have the same rights, privileges, and responsibilities of other Members of the Medical Staff. Nothing in these Bylaws, Rules and Regulations, and Policies, however, is intended to supersede any provision of such agreements or the Human Resources policies and procedures of the Hospital.

## Section 6      DISRUPTIVE MEDICAL STAFF MEMBER

### 6.1 Policy

It is the policy of this Hospital that all persons within its facilities be treated with courtesy, respect, and dignity. To that end, the Medical Staff requires that all members of the Medical Staff conduct themselves in a professional and cooperative manner in the Hospital.

If a member fails to conduct himself or herself appropriately, as outlined in this Section or in the Code of Conduct (which, as amended from time to time, is incorporated into the Bylaws by this reference), the matter shall be addressed as follows. It is the intention of this Medical Staff and this Hospital that this Section be enforced in a firm, fair, and equitable manner.

Disruptive behavior by members will be addressed by the Department Chair, President of the Medical Staff, and/or the CMO as described below.

If at any step under this Section it is decided that the behavior at issue was minor and is unlikely to reoccur, the matter may be referred to be handled under the Collegial Intervention provisions of Section 1 of this Article.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### 6.2 Objective

The objective of this policy is to promote a safe, cooperative, and professional health care environment, and to prevent or eliminate, to the extent possible, conduct that

- affects the ability of others to do their jobs;
- creates a “hostile work environment” for Hospital employees or members of the Medical and other staffs;
- interferes with an practitioner’s ability to practice competently;
- has or could have a negative effect on patient care or safety; or
- constitutes harassment or abusive personal behavior; or
- constitutes conduct that appears to be contrary to the standards of conduct set forth in the Code of Conduct.

This policy is intended to apply to conduct, and is not intended to interfere with a physician’s freedom of speech or to a physician’s ability to engage in any form of legitimate business or professional activity.

### 6.3 Guidelines

Unacceptable disruptive conduct means any conduct (behaviors and attributed) referred in §6.2 above or in the Code of Conduct adopted from time to time by the MEC, which by this reference is incorporated into these Bylaws.

Documentation of disruptive conduct is critical because it is ordinarily not one minor incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. Such documentation shall include:

- the date and time of the questionable behavior;
- a statement of whether the behavior affected or involved patient care in any way, and, if so, the name (or Medical Record Number) of the patient;
- the circumstances that precipitated the situation;
- a description of the questionable behavior that is limited to factual, objective language;
- the consequences, if any, of the disruptive behavior as it relates to patient care or Hospital operations; and
- a record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening.

All complaints and documentation should be in writing and signed by the complainant and/or observer. If reports are not in writing and signed, they will not be admissible in a later proceeding. Any facts or evidence independently obtained in the course of the investigation may be admissible.

### 6.4 Procedure

Any practitioner, employee, patient, or visitor may report disruptive or potentially disruptive conduct. The report will normally be submitted to the Department Chair. The report may also be forwarded to the President of the Medical Staff and/or the CMO. In

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

the case of an employee wishing to make a report, the employee may make the report to the appropriate supervisor who will forward the complaint to either the Department Chair, the President of the Medical Staff, or the CMO.

Once received, a report will be reviewed by either the Department Chair, President of the Medical Staff, and/or the CMO. Normally, the Department Chair will have this responsibility. If conflicts exist or it is otherwise appropriate, however, one of the other physicians noted may be delegated the authority to act. Unfounded reports shall be dismissed, and the individual initiating such report shall be notified. Those reports considered to have a reasonable basis in fact will be addressed as follows:

1. A single confirmed incident warrants a discussion with the practitioner; the Department Chair or designee shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The initial approach should be collegial and helpful to the practitioner. This discussion will be documented and a follow-up letter sent to the practitioner. The individual making the complaint shall be notified that the problem is being addressed.
2. If it appears that a pattern of disruptive behavior is developing, the Department Chair or designee shall discuss the matter with the practitioner as outlined below:
  - Emphasize that if such repeated behavior continues, more formal action will be taken to stop it. The MEC will be notified.
  - All meetings shall be documented.
  - A follow-up letter to the practitioner shall state the nature of the problem and inform the practitioner that he or she is required to behave professionally and cooperatively within the Hospital.
  - The involved practitioner may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.
3. If such behavior continues, the Department Chair or designee shall meet with and advise the practitioner that such conduct is intolerable and must cease. A letter of reprimand will be sent to the offending practitioner. This letter shall constitute the practitioner's final warning. The MEC shall also be notified. The letter shall also inform the practitioner that any further incidents shall be cause to institute the formal Corrective Action process, referral to the a Program as provided above, or for other action under these Bylaws. The next confirmed incident shall be referred to the MEC or other appropriate body for action.
4. A single egregious incident such as physical or sexual harassment, assault, a felony conviction or conviction for a crime involving health care, a fraudulent act, stealing, damaging Hospital property, inappropriate physical behavior, or personal or professional confrontation that is intimidating or could reasonably be construed

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

as retaliation for lodging a complaint shall initiate immediate action in accordance with the appropriate provision(s) of these Medical Staff Bylaws.

### **6.5 Records, Documentation, Notice, Outside Consultants, and Confidentiality**

1. The President of the Medical Staff, the Department Chair, the CEO and the CMO are deemed to be acting in their roles as members of the Medical Executive Committee, the Committee on Physician Health, and other Medical Review Committees of the Medical Staff.
2. All reports, documents, and records of meetings and communication related to actions taken in accordance with this policy shall be maintained in a secure and confidential fashion by the Medical Staff Office under the supervision of the CMO.
3. “Notice” as required by this Article or by any other Article of the Bylaws may be given by one or more of the following methods: by FEDEX or other Courier Service; by hand delivery; by certified mail return receipt requested; by facsimile; by E-mail. Proof that the notice was sent and/or received shall be retained.
4. Whenever an outside consultant is engaged pursuant to the provisions of this Article, the consultant shall be deemed to be acting as a consultant to the MEC.
5. All proceedings conducted pursuant to this Article are intended to be confidential and, where appropriate, to constitute peer review or studies of morbidity and mortality, and therefore to be considered protected pursuant to the relevant provisions of law.

## ***ARTICLE IX: STAFF DEPARTMENTS AND CLINICAL SERVICES***

### **Section 1 ORGANIZATION OF STAFF DEPARTMENTS AND CLINICAL SERVICES**

Each Department shall be organized as a separate part of the Medical Staff and shall have a Chair who is selected and has the authority, duties, and responsibilities as specified in Article XI. Each clinical service shall be organized as a specialty service within a Department, shall be directly responsible to the Department within which it functions and shall have a chief of service who is selected and has the authority, duties, and responsibilities as specified in Article X Section 5.

### **Section 2 DESIGNATION**

#### **2.1 Current Departments and Services or Sections**

- a. The current Departments are: Ambulatory Care, Anesthesia, Medicine, Obstetrics/Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, Rehabilitation Medicine and Surgery.
- b. The current services or sections are:

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

	<u>Responsible Department</u>
Allergy & Immunology	Medicine
Cardiology Cath Lab Service	Medicine
Cardiology Service	Medicine
Electrocardiography Service	Medicine
Dermatology Service	Medicine
Endocrinology Service	Medicine
Family Medicine Service	Medicine
Gastroenterology Service	Medicine
GI Endoscopy Service	Medicine
Infectious Disease Service	Medicine
Internal Medicine Service	Medicine
Medical Oncology/Hematology Service	Medicine
Nephrology Service	Medicine
Neurology Service	Medicine
Neurodiagnostic Service	Medicine
Pulmonary Service	Medicine
Respiratory Service	Medicine
Radiation Oncology Service	Medicine
Rheumatology Service	Medicine
Obstetrics Section	OB/GYN
Gynecology Section	OB/GYN
Neonatology Service	Pediatrics
Nuclear Medicine Section	Radiology
Diagnostic Ultrasound	Radiology
CT Service	Radiology
General Surgery Section	Surgery
Neurosurgery Section	Surgery
Ophthalmology Section	Surgery
Orthopedics Section	Surgery
Otolaryngology Section	Surgery
Plastic/Hand Section	Surgery
Podiatry Section	Surgery
Thoracic Surgery Section	Surgery
Trauma Section	Surgery
Urology Section	Surgery
Vascular Surgery Section	Surgery
Dental Section	Surgery

2.2 Future Departments and Services

When deemed appropriate, the Medical Executive Committee and the Board, by their joint action, may create a new, eliminate, subdivide, further subdivide or combine Departments or services.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 3 ASSIGNMENT TO DEPARTMENTS AND CLINICAL SERVICES

Each member of the Staff shall be assigned membership in at least one Department, but may be granted membership and/or clinical privileges in one or more of the other Departments and services. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of that Department and the authority of the Department Chair.

### Section 4 RESPONSIBILITY, FUNCTIONS, AND ORGANIZATION OF DEPARTMENTS

The primary responsibility delegated to each Department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Department shall:

- a. In collaboration with the Quality Assurance and Utilization Review Committees, conduct retrospective patient care audits for the purpose of analyzing, reviewing, and evaluating the quality of care within the Department. The number of such audits to be conducted during the year shall be as determined by the Medical Executive Committee, but shall not be less than the number required by the Joint Commission on Accreditation of Hospitals, or if higher, the number required by law. Each Department shall review all clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that Department. Family practitioners shall be subject to review by each Department in which they exercise clinical privileges and shall be subject to such review as the services of family practice may conduct.
- b. Establish guidelines for the granting of clinical privileges within the Department and submit the recommendations required under Articles VI and VII regarding the specific privileges each Staff member or applicant may exercise and the specified services that each health professional affiliate may provide.
- c. Conduct or participate in, and make recommendations regarding the need for, continuing medical education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.
- d. Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; (4) fire and other regulations designed to promote patient safety.
- e. Coordinate the patient care provided by Department's members with nursing and other non-physician patient care services and with administrative support services.
- f. Foster an atmosphere of professional decorum within the Department appropriate to the healing arts.
- g. Meet at least nine times a year for the purpose of receiving, reviewing, and considering patient care audit findings and the results of the Department's other review, evaluation and

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

education activities and of performing or receiving reports on other Department and staff functions.

- h. Establish such committees, services, or special care units, or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

### Section 5      FUNCTIONS OF CLINICAL SERVICES

Each service shall, upon the approval of the Medical Executive Committee and the Board, perform the functions assigned to it by the Departmental Chair to which it is assigned. Such functions may include, without limitation, the continuous monitoring of patient care practices, retrospective patient care audit, continuing education programs and credentials review and privileges delineation. The service shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

## **ARTICLE X: OFFICERS**

### Section 1      OFFICERS OF THE STAFF

#### 1.1      Identification

The elected officers of the Staff shall be:

- a. President
- b. Vice-President
- c. Immediate Past President
- d. Secretary-Treasurer

#### 1.2      Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term in office. Failure to maintain such status shall immediately create a vacancy in the office involved.

#### 1.3      Nominations

- a. By Nominating Committee: The Nominating Committee shall be appointed by the President of the Medical Staff from members of the Active Staff. The Nominating Committee shall convene and shall submit to the Secretary of the Staff one or more qualified nominees for each office. The names of such nominees shall be prominently posted on the Medical Staff Bulletin Board at least two weeks prior to the annual meeting.
- b. By petition: Nominations may also be made from the floor at the time of the annual meeting.

#### 1.4      Election

Officers shall be elected at the annual meeting of the Staff. Only Staff members accorded the prerogative to vote for general Staff officers under Article IV shall be eligible to vote.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Voting shall be by written ballot on the day of the annual meeting and during the subsequent three business days, and voting by proxy shall NOT be permitted. A signed ballot sent directly to the Medical Staff Office via email or fax and verified, shall be considered acceptable. Secret balloting is available only at the annual meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

### 1.5 Term of Elected Office

Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following the officer's election. Each officer shall serve until the end of the officer's term and until a successor is elected. Re-election for two consecutive terms is not permissible. Future re-election is permissible.

### 1.6 Vacancies in Elected Office

Vacancies in offices, other than that of President, shall be filled by the Medical Staff by a special election. If there is a vacancy in the office of President, the Vice-President shall serve out the remaining term.

### 1.7 Duties of Officers

a. President: The President shall serve as the chief administrative officer of the Medical Staff to:

1. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
2. Serve as Chair of the Medical Executive Committee.
3. Be an ex-officio member, with vote, of all committees except the nominating committee.
4. Serve as a member of the Hospital's Board of Directors with full vote. Represent the views, policies, needs and grievances of the Medical Staff to the Medical Executive Committee, to the Board, and to the President/CEO.
5. Be a spokesman for the Medical Staff in its external professional and public relations, and participate in public relation activities of the Hospital.
6. Appoint special ad hoc committees.

b. Vice President: In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall be a member of the Medical Executive Committee and serve as a member of the Hospital's Board of Directors with full vote. The Vice President shall automatically succeed the President when the latter fails to serve for any reasons.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- c. Immediate Past President: The Immediate Past President will be a member of the Medical Executive Committee and a member of the Hospital's Board of Directors with full vote.
- d. Secretary-Treasurer: The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to this office. The Secretary shall also be a member of the Medical Executive Committee.

### 1.8 Removal of Officers

The Executive Committee, by a two-thirds vote, may recommend the removal of any Medical Staff Officer for conduct detrimental to the interests of the Medical Staff or if the Officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office; provided that notice of the meeting at which such action shall be taken is given in writing to such Officer at least ten (10) days prior to the date of the meeting. The Officer shall be afforded the opportunity to speak at the meeting at which the decision is to be taken and prior to the taking of any vote on such removal. The removal shall be effective when approved by the majority of the Medical Staff and Board.

## Section 2 OTHER OFFICERS OF THE STAFF

### 2.1 Departmental Chair

- a. Qualifications: Each Chair shall be a member of the Active Staff. Additionally, each Chair shall be certified by an appropriate specialty board, or have affirmatively established comparable competence through the credentialing process, and shall be willing and able to faithfully discharge the functions of the office.
- b. Selection: The selection of the Department Chair shall be made by a simple majority of the members of the respective Department and a simple majority of the Medical Executive Committee. The proposed Chair shall be approved by the Board on the basis of training, experience and administrative ability.
- c. Term of Office:  
Where feasible, Department Chair should enjoy continuity of tenure so long as they are carrying out the duties and responsibilities provided for them in these Bylaws to the satisfaction of the members of their Department, of the Medical Executive Committee, and of the Board. A mandatory vote of the respective Departmental Chair shall be undertaken every three years during the month prior to the Annual Meeting. Only Staff members accorded the prerogative to vote under Article IV shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Removal of a Department Chair from office may be initiated by the Board acting upon its own recommendation, or upon the recommendation of the Medical Executive Committee or a two-thirds majority vote of the Department members eligible to vote. Removal from office shall be accomplished pursuant to Article X, Section 1.8 of these Bylaws.

- d. Duties: Each Chair shall:
1. Account to the Medical Executive Committee for all professional and administrative activities within the Chair's Department, and particularly for the quality of patient care rendered by members of the Chair's Department and for the effective conduct of the patient care audit and other quality maintenance functions delegated to the Chair's Department. Render regular reports on each member at least at the time of reappointment.
  2. Develop and implement Departmental programs in cooperation with the President of the Medical Staff and with input from the CMO, and consistent with the provision of Article X and Article XII, for credentials review and privileges delineation, continuing medical education, utilization review, concurrent monitoring of practice and retrospective patient care audit.
  3. Be a member of the Medical Executive Committee, give guidance on the overall medical policies of the hospital and make specific recommendations and suggestions regarding the Chair's own Department.
  4. Maintain continuing review of the professional performance of all practitioners within clinical privileges and all affiliates with specified services in the Chair's Department and report regularly thereon to the Medical Executive Committee.
  5. Transmit to the appropriate authorities, as required by Articles VI through VIII, recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners in the Chair's Department.
  6. Appoint such committees as are necessary to conduct the functions of the Department specified in Article X and designate a Chair and secretary for each.
  7. Enforce the Hospital and Medical Staff Bylaws, rules, policies and regulations within the Chair's Department including initiating corrective action and investigation of clinical performance and ordering required consultations, when necessary.
  8. Implement within the Chair's Department action taken by the Medical Executive Committee.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

9. Participate in every phase of administration of the Chair's Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.
10. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Chair's Department as may be required by the Medical Executive Committee, the President/CEO, or the Board.
11. Perform such other duties commensurate with the office of Chair as may from time to time be reasonably requested of the Chair by the President of the Medical Staff, the Medical Executive Committee, or the Board.
12. Appoint Chief of Services assigned to the Department with the concurrence of the Medical Executive Committee and the Board.
13. Make service roster assignments for the Department.
14. Prepare a description of the qualifications of the respective Chiefs of Service, and their duties as Chiefs of Service.

Section 3      **ADDITIONAL OFFICERS**

The Board may, after considering the advice and recommendations of the Medical Staff, appoint additional practitioners to medico-administrative positions within the Hospital to perform such duties as prescribed by the Medical Executive Committee and the Board, or as defined by amendment to these Bylaws. Such a practitioner must become and remain a member of the Staff. In all events, such practitioner is subject to these Bylaws and to the other policies of the Hospital.

**ARTICLE XI: COMMITTEES AND FUNCTIONS**

Section 1      **MEDICAL REVIEW COMMITTEES; COMMITTEES CONDUCTING STUDIES OF MORBIDITY AND MORTALITY**

It is intended and understood that, when engaged in any peer review activity, each committee or subcommittee created or referred to in or authorized by these Bylaws or the Bylaws of the Hospital, is a "Medical Review Committee" as such term is defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time. Such medical review committees, all of which have been deemed to be established by the Bylaws, include but are not limited to:

- all committees and subcommittees identified in or created pursuant to or under authority of these Bylaws, including all those committees created or approved by the Medical Executive Committee pursuant to Article XII, Section 7 of these Bylaws,
- all Departments and Services and Sections of the Medical Staff and their committees and subcommittees,

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- meetings of the Medical Staff at which peer review actions are taken,
- the Board of Directors and its committees and subcommittees, and
- any individual gathering information or providing services for or acting on behalf of any such entity, including but not limited to Department Chairs, Service or Section Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, the CMO, and experts or consultants retained to perform peer review.

The Joint Commission, while performing accreditation services for the Hospital, shall be acting as part of a medical review committee engaged in peer review, as an agent of the hospital and the committee. In its capacity as agent, the Joint Commission shall be bound to protect the confidentiality of information of the medical review committee engaged in peer review, pursuant to state law and the contract between the Joint Commission and the Hospital.

It is further intended that all persons and entities referred to in this provision, when conducting studies of morbidity and mortality, are intended to function in accordance with and be subject to the protections are set forth in the Connecticut General Statutes.

### Section 2      MEDICAL EXECUTIVE COMMITTEE

The MEC is accountable to the Medical Staff for its performance of all of these duties.

- a. Composition: All members of this committee shall be voting members of the Medical Staff. The President/CEO, or designated representative, shall be required to attend meetings and to provide a recording secretary. The President/CEO shall attend ex-officio without vote. The Chief Medical Officer and the Vice President for Patient Care Services will attend ex-officio without vote. Full voting members shall consist of the President of the Medical Staff as Chair, the Vice-President, Secretary-Treasurer, and immediate Past President of the Medical Staff, the Chairs of all Departments, the Chief of the Family Practice Service, the Medical Director of the Hospitalist Service, and three at-large members elected from and by the Medical Staff. The elected members shall be elected at the annual meeting, may serve for two consecutive 2-year terms, may be re-elected for another cycle after a two-year hiatus.
- b. Duties: Receiving and acting upon the reports and recommendations from medical staff committees, Departments, services and assigned activity groups; implementing the approved policies of the medical staff; recommending to the Board all matters relating to appointments, reappointments, staff categorization, Department/ service assignments, clinical privileges, and corrective action; acting as an oversight committee to each Departments' actions taken to improve quality/performance and effectiveness fulfilling the medical staff's accountability to the Board for the quality of overall medical care rendered to patients in the hospital; initiating and pursuing corrective action when warranted, in accordance with these bylaws; and informing the medical staff of Joint Commission accreditation programs and the accreditation status of the hospital. In addition, the Medical Executive Committee may act on

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

behalf of the organized medical staff between Medical Staff meetings subject to such limitations as may be imposed by these bylaws.

- c. Meetings: The Medical Executive Committee shall meet at least ten times a year and maintain a permanent record of its proceedings and actions. A report of the proceedings and actions of the Medical Executive Committee shall be made by the senior elected Medical Staff representative serving on the Medical Executive Committee at the regularly scheduled Medical Staff meeting. A copy of the minutes of committee meetings shall be kept in the office of the President/CEO and shall be available for inspection by any member of the Active Medical Staff. In the event of special meetings, Members may participate by telephone or by other remote means of accessing the meeting; this shall be noted in the minutes.
- d. Removal of Medical Executive Committee members: Medical Executive Committee members may be removed for the same reasons and in the same manner as the removal of Officers (Article XI, Section 1.8).

### Section 3 CREDENTIALS COMMITTEE

- a. Composition: The Credentials Committee shall consist of practitioners who are members of the Active, Active Affiliate or Consulting Staff selected by the Medical Executive Committee on an annual basis that will insure representation of the major clinical specialties, the hospital-based specialties, and the Medical Staff at-large. This committee shall have the right and authority to enlist ad hoc participation of any member of the Medical Staff for the purpose of interviewing a new Staff applicant, or reviewing the application of a prospective Staff member, or interviewing and/or reviewing a change in Staff status or clinical privileges of a current Staff member.
- b. Duties: The duties of the Credentials Committee shall be:
  - 1. To review the credentials of all applicants and to make recommendation for membership and delineation of clinical privileges in compliance with Articles IV, V, VI, and VII of these Bylaws.
  - 2. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendation from the Departments in which such applicant requests privileges.
  - 3. To review and establish guidelines and policies in the area of clinical privileges when requested to do so by the Medical Executive Committee.

### Section 4 OBSTETRICS AND GYNECOLOGY

- a. Any physician planning to perform a therapeutic abortion shall document the medical contraindication to pregnancy which constitutes a risk of grave and

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

permanent impairment of physical health to the woman involved. Severe fetal malformations may also be documented as a reason for the procedure.

- b. Elective abortions, interruption of pregnancy before viability at the request of the woman but not for reasons of impaired maternal health (as defined above) or fetal disease (as defined above), are not performed at this Hospital.
- c. The attending physician and two other members of the OB-Gyn Department, selected by the Chair of the OB-Gyn Department or his/her designee, will review the documentation before each such procedure. All three must agree that the above criteria have been met before the above mentioned procedure is performed.

### Section 5 BYLAWS COMMITTEE

- a. Composition: This committee shall consist of at least six members of the Medical Staff, to be selected annually by the Medical Executive Committee. The CMO will be an ex-officio member without vote.
- b. Duties: The duties of the Bylaws Committee shall be:
  - 1. To conduct reviews of the Medical Staff Bylaws and Rules and Regulations and to recommend to the Medical Executive Committee any necessary modifications to reflect current Medical Staff practices or new laws and regulations.
  - 2. To review and deliberate on proposals for Bylaws changes submitted by the Medical Executive Committee or Medical Staff and make recommendations on any proposed amendments.
- c. Meetings: The committee shall meet at least twice a year and as needed.

### Section 6 OTHER COMMITTEES

Medical Staff, through the action of the Medical Executive Committee, shall establish additional appropriate committees to monitor and review clinical services and Medical Staff functions on a regular basis. Such committees may also function as "Medical Review Committees" or committees conducting studies of morbidity or mortality as defined above. A description of each of these additional committees, its responsibilities and membership, shall be included or appended to the Medical Staff Policy Manual. Any proposed changes to such committee descriptions must be reviewed by the Medical Executive Committee and approved in accordance with Article XVI. Adoption and Amendment of Medical Staff Policies.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

**ARTICLE XII: MEDICAL STAFF MEETINGS**

Section 1      REGULAR MEETINGS

Regular Staff meetings shall be held a minimum of four times per year as denoted annually by the Medical Staff President. It is recommended that Active and Active Affiliate Staff members attend all Medical Staff meetings. An annual Staff meeting shall be held within 90 days of the end of the fiscal year. The agenda of such meeting shall include reports, or review and evaluation of the work done in the clinical Departments and the performance of the required Medical Staff functions, election of officers and representatives to the Executive Committee.

Section 2      SPECIAL MEETINGS

- a.      The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within 15 days after receipt of a written request stating the purpose of such meeting and signed by not less than twenty-five Members of the Active Staff. The President of the Medical Staff shall designate the time and place of any special meeting.
- b.      Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail or E-mail, to each member of the Active Staff not less than 10 days before the date of such meeting, by or at the direction of the President (or other persons authorized to call the meeting).

If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at the Member's address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such a meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3      QUORUM

A quorum for Medical Staff meeting will be defined as ten (10) members with voting privileges at any regular or special meeting of the Medical Staff.

Section 4      REFERENDUM VOTE

Any votes of the Medical Staff will be posted within seven (7) days. If within thirty (30) days of any vote twenty (20) members of the Medical Staff (eligible to vote) sign a request for a reconsideration of the vote, the issue will be presented again at the next regular meeting or a special meeting of the Medical Staff. A ballot will thereafter be sent to all voting members of the Medical Staff with information about the issues, both for and against, to be returned to the Medical Staff Office within thirty (30) days. A Bylaws amendment will require two-thirds majority of those voting to pass (see also Article XIX). Other votes may pass by a simple majority of those voting.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Section 5 ATTENDANCE REQUIREMENTS

Medical Staff Meetings are a responsibility of membership and attendance is strongly encouraged.

Section 6 AGENDA

- a. The agenda at any regular Medical Staff meeting shall be:
  - 1. Call to order
  - 2. Consideration of the minutes of the last regular and of all special meetings
  - 3. Introductions and announcements
  - 4. Communications
  - 5. Report from the President/CEO of the hospital
  - 6. Reports of committees
  - 7. New business (including elections, where appropriate)
  - 8. Adjournment
  
- b. The agenda at special meetings shall be:
  - 1. Reading of the notice calling the meeting
  - 2. Transaction of business for which the meeting was called
  - 3. Adjournment
  
- c. The procedure to be followed at all Staff meetings shall be in accordance with Robert's Rules of Order.

***ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS***

Section 1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings, without notice other than such resolution. Departments shall hold regular meetings at least nine times yearly, unless canceled by the Chair of the Department, to review and evaluate the clinical work of practitioners with privileges in the Department.

Section 2 SPECIAL MEETINGS

A special meeting of any committee or Department may be called by or at the request of the Chair or chief thereof, by the President of the Medical Staff, or by one-third of the group's then members, but not less than two members. In the event of special meetings, Members may participate by telephone or by other remote means of accessing the meeting; this shall be noted in the minutes.

Section 3 NOTICE OF MEETINGS

Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Department not less than five days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at the Member's address as it appears on the records of the hospital with postage prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

### Section 4 QUORUM

Thirty percent of the Active Medical Staff members of a committee or Department, but not fewer than two members, shall constitute a quorum at any meeting.

### Section 5 MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or Department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

### Section 6 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members will serve without vote unless otherwise specified; they shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

### Section 7 MINUTES

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

### Section 8 ATTENDANCE REQUIREMENTS

- a. Attendance at Department Meetings is encouraged. Participation on Medical Staff Committees is expected of all members of the Active Staff. Members assigned to committees are expected to attend at least 50% of the committee meetings. Physician attendance at Committee meetings will be considered at the time of Committee reappointments.
- b. A practitioner whose patient's clinical course is scheduled for discussion at a regular Departmental meeting, shall be so notified and shall be expected to attend such meeting. On request by a Medical Staff Committee reviewing the clinical course of a practitioner's patient, the practitioner shall be required to attend the committee meeting. The Chair of the respective meeting, shall give the practitioner at least five days advance written notice of the time and place of the meeting.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- c. Failure by a practitioner to attend any meeting with respect to which the practitioner was given notice that the Member's attendance was mandatory, unless excused by the appropriate Departmental Chair or committee Chair, for showing a good cause, shall result in an automatic suspension of all or such portion of practitioner's clinical privileges in compliance with corrective action as stated in Article VIII, Section 1.4 and Section 3.3 of the Medical Staff Bylaws.

***ARTICLE XIV: RULES AND REGULATIONS***

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws. **See Appendix B.**

***ARTICLE XV: ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES***

The Medical Staff shall adopt a Medical Staff Policy Manual that will contain policies to implement more specifically the general principles found within the Bylaws and Rules and Regulations. These shall include policies that relate to the proper conduct of the Medical Staff organizational activities as well as to the level of practice required of each Medical or Health Professional Affiliate staff member in the hospital. Such Medical Staff policies will be appended to the Bylaws. The method for introduction and implementation of new policies or the amendment or deletion of existing policies in this manual shall be delineated in the Bylaws of the Medical Staff. All such policies shall be considered to be implemented pursuant to written Bylaws.

1. New Medical Staff policies, or proposed changes to Medical Staff policies, may be introduced by any member of the Medical Staff or through the appropriate Medical Staff committee, Department, or service. Such proposals shall be submitted to the Medical Staff President.
2. These proposals shall be submitted to the Medical Executive Committee.
3. The Medical Executive Committee will discuss and act on the proposal. The sponsor of the policy may come to the Medical Executive Committee meeting and participate in the discussion. Medical Executive Committee action may include:
  - a. Adopting or rejecting the proposal;
  - b. Forwarding the proposal to a Department, service, or committee for discussion and comment prior to formal action;
  - c. Table proposal for further discussion and future action at the next Medical Executive Committee meeting.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

4. Before formal action by the Medical Executive Committee, the Medical Staff will be notified of the subject matter of the policy proposal.
5. Adoption of a proposed Medical Staff policy, or amendment or removal of an existing policy, by the Medical Executive Committee shall require a two-thirds majority vote of Medical Executive Committee members present and voting, excluding abstentions.
6. The Medical Staff will be notified within seven (7) days of the meeting. The policy will be implemented 21 days following such notice except as described in #7 below.
7. A letter signed by 20 members of the Active Staff prior to the end of the 21 day notice, shall be cause to bring the policy change before the entire Medical Staff at a regular or special Medical Staff meeting. In such a case, implementation of the policy shall be deferred until action of the Medical Staff.

When a policy is brought before the Medical Staff pursuant to this section:

- a. There must be at least two (2) weeks notice to the Medical Staff that the proposed policy will be discussed and acted upon.
  - b. Discussion and vote on the policy may be taken at the meeting following sufficient notice.
  - c. In the case of such policies, action at the full Medical Staff meeting shall require only a simple majority.
8. No Medical Staff policy may be passed or implemented in the manner described in this section if it contradicts, is inconsistent with, or is intended to replace any portion of the Bylaws of the Medical Staff. Prior to acting upon such a policy, the Bylaws must first be appropriately amended through the mechanism delineated in the Bylaws of the Medical Staff. **See Appendix C.**

### ***ARTICLE XVI: INDEMNIFICATION***

All Medical Staff officers, Department Chairs, section chiefs, committee chairs, committee members, and individual Staff members who act for and on behalf of the Hospital in performing functions pursuant to these Bylaws, shall be indemnified by the Hospital when acting in good faith in those capacities.

### ***ARTICLE XVII: PHYSICIAN EMPLOYMENT AND EXCLUSIVE SERVICES AGREEMENTS***

Whenever the Hospital intends to terminate any exclusive agreement with a group of hospital-based physicians for the providing of services to patients (such as agreements with anesthesiologists, pathologists, or radiologists), and whenever the Hospital intends to terminate

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

an employment relationship with any other Member of the Medical Staff, the Hospital first shall provide reasonable advance notice to and consult fully with the Medical Executive Committee provided that the group or individual in question requests such consultation with the Medical Executive Committee. In the event that the Medical Executive Committee is of the view that a termination is not appropriate and so advises the Hospital, but the Hospital continues to intend to terminate the agreement, the Medical Executive Committee's view on the matter and the view of Hospital Administration shall be presented to the Board of Directors for resolution.

The Medical Staff Membership and clinical privileges of physicians who are Hospital employees shall be governed by these Bylaws. These Bylaws shall not be interpreted to govern or control the employment relationship. Except for the consultation requirement set forth in this provision, employment matters shall be governed exclusively by the physician's employment agreement with the Hospital (if any), and/or the Hospital's applicable employment and personnel policies.

### ***ARTICLE XVIII: FAIR HEARING PLAN***

#### **INITIATION OF HEARING**

##### **Section 1 PRE AMBLE**

This Article sets forth the process and standards for the right to a hearing, scheduling a hearing, and an appeal to the Board of Directors.

##### **Section 2 RECOMMENDATIONS OR ACTIONS**

The following recommendations or actions shall, if deemed adverse pursuant to Section 3 of this Article, entitle a practitioner (Physician, Dentist, or Podiatrist) affected thereby to a hearing:

- a. Denial of appointment
- b. Denial of reappointment
- c. Suspension of Medical Staff membership other than an Automatic Suspension
- d. Suspension of Clinical Privileges including reduction or revocation other than minor administrative suspensions (e.g., failure to complete medical records)
- e. Mandatory Concurring Consultation Requirement Prior to Performing

No other recommendations or actions shall entitle a practitioner to a hearing or appellate review. For example, none of the following, or analogous actions, create any right to a hearing or appeal.

1. Issuance of a letter of guidance, warning, or reprimand
2. Imposition of conditions, monitoring, or a general consultation requirement (*i.e.*, the practitioner must obtain a consult but need not obtain prior approval for performing the procedure.)
3. Termination of temporary privileges
4. Automatic relinquishment of appointment or clinical privileges
5. Voluntary relinquishment of appointment or clinical privileges
6. Denial of a request for a leave of absence, or extension of a leave of absence

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

7. Determination that an application is incomplete
8. Determination that an application will not be processed due to a practitioner's misstatement or omission
9. Appointment or reappointment for less than two years.

### Section 3      WHEN DEEMED ADVERSE

A recommendation or action listed in Section 2 of this Article shall be deemed an adverse action only when it has been:

- a. Recommended by the Medical Executive Committee; or
- b. Taken by the Board of Directors contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing previously existed; or
- c. Taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

### Section 4      NOTICE TO PRACTITIONERS AND REQUESTS FROM PRACTITIONERS FOR HEARINGS/APPEALS

Whenever a practitioner is entitled to a hearing or appeal to the Board, the President/CEO shall give 10 business days written notice to the practitioner of such right. When relevant, the practitioner shall be advised by such notice of the practitioner's Medical Staff status pending further action. Such notice shall provide that a professional review action has been proposed to be taken against the practitioner, contain a concise statement of the reasons for the proposed action, explain that the practitioner has a right to request a hearing, and provide an explanation of the time limits set forth below. The notice also shall contain a summary of the practitioner's hearing rights under this Fair Hearing Plan.

Any practitioner who has received notice of the practitioner's right to a hearing or Board appeal may request such hearing or appeal to the Board by giving written notice addressed to the President/CEO. Such request shall be made within 15 business days of the sending of the notice of such right; if not so made, the right to such hearing shall be deemed to have been permanently waived. Hearings or oral arguments should be scheduled as soon as possible subsequent to the receipt of the request by the practitioner, but in no event less than 30 days from the date of receipt of the practitioner's request. However, the practitioner shall be given at least ten (10) business days written notice of the date, time and place of said hearing or appeal to the Board. When the first notice is given, the practitioner shall be provided with a copy of these Bylaws.

### Section 5      APPOINTMENT OF HEARING COMMITTEE

Hearings shall be conducted by a Hearing Committee composed of at least three (3) members of the Medical Staff: (a) appointed by the CEO and the President of the Medical Staff, (b) none of whom are in direct economic competition with, professionally associated with, related to, or have any significant referral relationship with the practitioner, and (c) shall not have participated in the

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

formal investigation that led to the action, provided that knowledge of the matter involved shall not preclude any individual from serving as a Member of the Committee;. Whenever possible, at least one Member shall be of the same service as the practitioner. One of the members so appointed shall be designated by the President and CEO as the Chair. The President/CEO, Chief Medical Officer, and a member of the Board of Directors shall have a right to attend the Hearing, but not to participate or be part of the deliberations of the Committee.

In lieu of a Hearing Committee Chair, the CEO, in consultation with the President of the Medical Staff, may appoint a Presiding Officer, who may be an attorney. The Presiding Officer shall not act as an advocate for either side. The Presiding Officer may participate in the private deliberations of the Committee, but shall not be entitled to vote.

Any objection to the appointment of any Member of the Hearing Committee for cause, or to the appointment of the Presiding Officer, shall be made in writing to the CEO and the President of the Medical Staff within 10 business days of notice of the composition of the Committee, with a full written explanation of the basis for the objection. The CEO and the President shall have the discretion to accept or reject the objection. If the objection is accepted, an alternate shall be appointed in the same manner as the appointment of the rejected individual.

### Section 6 NOTICE OF HEARING AND STATEMENT OF REASONS

The CEO shall schedule the hearing and provide, by special notice, the following:

- The time, place, and date of the hearing;
- The names of the Hearing Committee Members and Chair (or and Presiding Officer) if known.

A statement of the reasons for the recommendation, including a list of patient records (If applicable), and information supporting the recommendation.

The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing.

### Section 7 WITNESS LIST

The practitioner and the body making the adverse recommendation are referred to in this Article from time to time as the “parties.”

At least 10 business days before the pre-hearing conference, both parties shall provide a written list of the names of proposed witnesses to the other party and to the Chair or Presiding Officer. The witness list shall include a brief summary of the anticipated testimony of the witnesses.

The witness list of either party may, in the discretion of the Chair or the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party, and that there is a complete written explanation as to why the name did not previously appear on the witness list.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

Section 8 RIGHT TO RELEVANT EVIDENCE

- (a) The practitioner requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained by the practitioner and the practitioner's representatives as confidential and not be disclosed for any purpose outside of the hearing:
- (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons for the hearing, at the practitioner's expense;
  - (2) written reports of experts relied upon by the Medical Staff;
  - (3) redacted copies of relevant minutes; and
  - (4) copies of any other written documents relied upon by the Medical Staff.

The providing of this information is not intended to waive any privilege under the CT Peer Review Act or the Connecticut statute protecting the proceedings of studies of morbidity and mortality.

- (b) No information shall be provided regarding the practices of other individual practitioners.
- (c) Prior to the pre-hearing conference, on dates set by the Chair/Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. Objections must be based on consideration of lack of relevancy. The Chair or Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause for not previously making the objection.
- (d) Evidence unrelated to the reasons for the recommendation or to the practitioner's qualifications for appointment or the relevant clinical privileges (such as evidence relating to the practices of other individual practitioners) shall be excluded.
- (e) Neither the practitioner, nor the practitioner's attorney, nor any other person acting on behalf of the practitioner shall contact Hospital employees appearing on the Medical Staff or Board's witness list concerning the subject matter of the hearing, unless specifically agreed upon by the parties' respective legal counsel.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 9 PRE-HEARING CONFERENCE; SIDE BAR CONFERENCES

The Chair or Presiding Officer shall require representatives of the parties (who may be legal counsel) to participate in a pre-hearing conference. At the pre-hearing conference, the Chair or Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

If a procedural question could have been presented at the pre-hearing conference, the Chair of Presiding Officer may refuse to subsequently consider the matter.

Each party may prepare a pre-hearing statement, which shall be provided to the other party and to the Committee and Chair or Presiding Officer prior to the hearing.

At the discretion of the Hearing Committee, the Chair or Presiding Officer may entertain argument by legal counsel on procedural matters outside the presence of the Hearing Committee.

The Chair or Presiding Officer, the Medical Staff, and the Board, may be advised by legal counsel to the Hospital throughout the proceeding.

### Section 10 RECORD OF HEARING

An accurate record of the hearing shall be kept. The Hearing Committee may select the method to be used, such as court reporter, electronic recording unit, or detailed minutes of the proceedings. A practitioner may, no later than 10 days prior to the pre-hearing conference, elect an alternate method from among the foregoing methods and a practitioner electing such alternate method shall bear the cost. Nothing herein shall preclude a hearing record by more than one method at the discretion of the Hearing Committee.

### Section 11 HEARING PROCEDURE

The Hearing Committee, in its discretion, may postpone or adjourn a hearing. The Medical Executive Committee or the Board of Directors, whichever made the decision being heard, shall designate a representative or representatives (who may include consultants or attorneys) to present information in support of the adverse decision.

Failure by a practitioner, without good cause shown to the Hearing Committee, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

At the hearing, each party shall have the right:

- (1) to call and examine witnesses,
- (2) to introduce exhibits;
- (3) to cross-examine any witness;

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

- (4) to have representation by legal counsel who may call, examine, and cross-examine witnesses and present the case; and
- (5) to submit a written statement at the close of the hearing.

The Hearing Committee may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

### Section 12 PERSONS TO BE PRESENT; NO “GUESTS”

The hearing shall be restricted to those individuals directly involved in the proceeding. “Guests,” including the media, family members, and Medical Staff Members who are not formally representing the practitioner, are not permitted to attend hearing or appeal sessions.

### Section 13 QUORUM AND VOTING

Attendance by all Members of the Hearing Committee shall be mandatory and constitute a quorum. Recommendations to the MEC/Board shall be by a majority of the Committee.

### Section 14 HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

#### Order of Presentation:

The Executive Committee/Board shall first present evidence in support of its recommendation. Thereafter, the practitioner who requested the hearing will present their response.

#### Basis of Hearing Committee’s Recommendation:

The Hearing Committee shall uphold the adverse recommendation if it finds by a preponderance of the evidence that:

- The action was taken in the reasonable belief that it was in the furtherance of quality health care;
- It was taken after a reasonable effort to obtain the facts of the matter;
- Adequate notice was provided to the practitioner and the procedures were fair; and
- the action was taken in the reasonable belief that the action was warranted by the facts known

In arriving at this determination, the Hearing Committee shall consider the evidence presented to it, provided that members of the Committee may take into account and refer to their own professional expertise, experience, and knowledge.

#### Deliberations and Recommendation of the Hearing Committee:

Within 20 business days after final adjournment of the hearing (which may be designated as the time the Hearing Committee receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Committee shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Committee shall render a

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

recommendation, accompanied by a written report, which shall contain a concise statement of the basis for its recommendation.

### Section 15 NOTICE OF THE REPORT OF THE HEARING COMMITTEE AND EFFECT OF RESULT

The President/CEO shall within 7 days send a copy of the report of the Hearing Committee, to: (a) the practitioner, (b) the President of the Medical Staff, and (c) the Chief Medical Officer. The President/CEO shall within 7 days sent a copy of the final decision of the MEC to the practitioner, the President of the Medical Staff, the Chief Medical Officer and the Board of Directors.

### Section 16 ACTION ON THE REPORT OF THE HEARING COMMITTEE

Within 15 business days after receipt of the report of the Hearing Committee, or, at its discretion, at its next regularly-scheduled meeting, the Medical Executive Committee shall consider the same and confirm, modify or reverse its recommendation in the matter. It shall then promptly transmit its decision together with the hearing record and the report of the Hearing Committee and all other documentation considered, to the President/CEO for prompt consideration by the Board of Directors.

#### 16.1 Effect of Favorable Result

- a. Adopted by the Board: If the Board's decision is favorable to the practitioner, such result shall become the final decision of the Board, and the matter shall be considered finally closed.
- b. The final action of the Medical Executive Committee shall promptly be forwarded to the Board by the CEO together with all supporting documentation, for final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's decision in whole or in part, or by referring the matter back to the Medical Executive Committee for it to consider the same again. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President/CEO shall promptly give the practitioner written notice informing the practitioner of each action taken pursuant to this Section. Favorable action by the Board shall become the final decision of the Board, and the matter shall be considered finally closed.

### Section 17 EFFECT OF ADVERSE RESULT

If the decision of the Board continues to be adverse to the practitioner in any of the respects listed in Section 2 of this Article, the President/CEO shall give written notice to the practitioner of the practitioner's right to request an appeal to the Board by requesting it in writing within 10 business days of receipt of said notice.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### Section 18 APPEAL TO THE BOARD OF DIRECTORS

Within 40 days of its receipt of a request by written notice for appeal to the Board, the Board shall convene to reconsider the matter. The practitioner may appear on the practitioner's own behalf and/or be represented by the practitioner's Medical Staff or Medical Society representative or the practitioner's attorney, who shall be entitled to present written and/or oral arguments. This appearance shall be analogous to an appellate court hearing and no new evidence may be presented.

In its sole discretion, the Board may specify the amount of time for oral argument by the practitioner and by the spokesman for the adverse decision. The Board of Directors shall render a final decision no later than its next regularly-scheduled meeting. Written notice of such decision shall be given by the President/CEO to the practitioner within seven business days of such decision.

Notice of the same shall also be given to the President of the Medical Staff. Such decision by the Board following the appeal to the Board shall be deemed final for purposes of these Bylaws.

Grounds for an appeal to the Board are limited to the following:

- The assertion that there was a substantial failure to comply with the Bylaws during the hearing, so as to deny a fair hearing; and/or
- The assertion that the recommendation of the Hearing Committee was made arbitrarily or capriciously, or was not supported by evidence.

### Section 19 WRITTEN NOTICE

Written notice in all instances under this Article shall be given by mailing the same by certified mail, return receipt requested, or by using a recognized courier service, such as Federal Express; provided, however, that the requirement of written notice also may be satisfied by actual notice acknowledged in writing by the intended recipient or witnessed by a Member of the Medical Staff or a Hospital employee or agent.

### Section 20 RIGHT TO ONE HEARING AND ONE APPEAL ONLY; NO FURTHER ACTION

No practitioner shall be entitled to more than one hearing and one appellate review on any matter.

If a hearing or appeal is pending at the time of re-appointment, the re-appointment shall be conditional and subject to the outcome of the hearing or appeal. The fact of such limited re-appointment shall not entitle the practitioner to more than one hearing or appellate review, or a new hearing and appellate review in regard to all matters being decided by the Board in its final decision.

The Final Action of the Board of Directors may not be the subject of any further administrative in-house proceeding.

## *Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

### **ARTICLE XIX: AMENDMENTS**

#### **Section 1. PROPOSING AMENDMENTS**

Proposed amendments to the Medical Staff Bylaws and Rules & Regulations are referred to the Medical Executive Committee or Bylaws Committee of the Medical Executive Committee.

If 10% of the voting members of the Medical Staff sign a petition to do so, they may propose amendments to the Bylaws or Rules & Regulations 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 2. 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 seven (7) days in advance of the meeting at which they will be considered.

A simple majority 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 3. VOTING BY THE MEDICAL STAFF**

All amendments approved by the Medical Executive Committee shall be submitted to the voting members of the Medical Staff. Voting members shall be allowed a minimum of fourteen (14) calendar days to consider the proposed amendments. Notifications shall be sent electronically. The notification shall include a date, time and location of a Medical Staff Meeting at which the amendments will be discussed.

In the event that 10% or more of voting members signify disagreement with any of the proposed amendments, either via expression at the Medical Staff Meeting or in discussion with an elected medical staff officer, these concerns will be transmitted to the Bylaws Committee of the Medical Executive Committee for review and consideration. One or more representative from the dissenting group will be invited to participate in the Bylaws Committee.

If fewer than 10% of voting members voice objection, the amendments shall be recommended for approval and forwarded for action to the Governance Committee of the Board.

#### **Section 4. GOVERNANCE COMMITTEE OF THE BOARD OF TRUSTEES**

Amendments approved by the Medical Executive Committee and the voting members of the Medical Staff shall be forwarded to the Governance Committee of the Board.

If the Governance Committee of the Board recommends the amendments, they shall be forwarded to the Board for final approval.

In the event that the Governance Committee of the Board or the Board modifies or disapproves any amendments proposed by the Medical Executive Committee and the voting members of the

## ***Bylaws of the Medical Staff of Lawrence & Memorial Hospital***

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 Medical Staff as outlined in Section 3. above.

If the Medical Executive Committee rejects the modifications, the amendment and arguments against the modifications shall be resubmitted to the Governance Committee of the Board or the Board.

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

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

### **Section 5: APPROVAL REQUIREMENTS**

The Bylaws, which include the accompanying Rules and Regulations and, to the extent required by regulatory requirements, medical staff policies, may be changed or amended as described in Sections 1 through 4 above.

In addition, the Governance Committee of the Board or the Board itself may initiate such changes.

### **Section 6: EFFECTIVE DATE**

Amendments shall be considered effective as of the date approved by the Board.

### **Section 7: 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 Medical Staff.

## ***ARTICLE XX: CONFLICT RESOLUTION***

The Medical Staff and the Board of Directors will make best efforts to address and resolve all conflicts in the best interests of patients, L&M Hospital and the Medical Staff.

When the MEC, the Medical Staff, or the Board of Directors acts, or considers acting in a manner contrary to a recommendation made by the MEC, the Medical Staff, or the Board, the Medical Staff officers shall meet as soon as possible with the Board, or a designated committee of the Board and Administration, to seek to resolve the conflict through informal discussions.

If these formal discussions fail to resolve the conflict, the Medical Staff President, a majority of the voting members of the Medical Staff, the President of the Hospital, or the Chair of the Board may request initiation of a formal conflict resolution process.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within 30 calendar days of the initiation of the formal process. The Medical Staff representatives to this Committee shall at a minimum include the three officers of the Medical Staff and three other Medical Staff members, recommended by the officers and elected by the Medical Staff.

If, after 60 days from the date of the initial request for the formal conflict resolution process, the Joint Conference Committee is unable to resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue which gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken in a shorter time period than that allowed through this formal conflict resolution process due to an urgent issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take action that will remain in effect until the conflict resolution process is completed. This Article XX shall not be construed to constitute a waiver by any party of any remedies otherwise available under applicable law.

***ARTICLE XXI: SUCCESSOR IN INTEREST***

In the event In the event that the Hospital is contemplating merging with, or being consolidated into any other corporation(s), or in the event that it contemplates selling or transferring substantially all of its assets to another corporation, or in the event that it contemplates coming under the control of another entity or corporation, then (1) the Medical Staff leadership will be notified of any situation where such a transaction is likely; (2) there will be full consultation with the Medical Staff before any contemplated transaction is finalized, and (3) at least one Member of the Board of Directors of the Hospital, who also is a Medical Staff Member, will be involved in the committee or group that finalizes the transaction.”

In the event that the Hospital merges with, or is consolidated into, any other corporation(s), or in the event that it sells or transfers substantially all of its assets to another corporation, or in the event that it comes under the control of another entity or corporation, the terms of these Bylaws shall inure to the benefit of the Members of the Medical Staff at the time of such event, and these Bylaws shall be assumed insofar as possible by the corporation or entity (1) resulting from such merger or consolidation, or (2) to which the Hospital’s assets are sold or transferred, or (3) which assumes control of the business of the Hospital.

***ARTICLE XXII: BYLAWS ADOPTION***

These Bylaws, together with the appended Rules & Regulations, shall replace any previous Bylaws, Rules & Regulations and shall become effective once approved by the Board consistent with the process described in Article XIX.

ADOPTED by the Active Medical Staff on May 28, 1978.

original on file  
William J. Murray, M.D.

*Bylaws of the Medical Staff of Lawrence & Memorial Hospital*

President of the Staff

original on file

Daniel E. Moalli, M.D.

Secretary of the Staff

APPROVED by the Board on June 26, 1978

original on file

William M. Miner

Secretary of the Board