

MEDICAL STAFF

BYLAWS, RULES, & REGULATIONS

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**Preamble**

Johnson Memorial Hospital, Inc. (“JMH”) is a non-profit corporation organized under the laws of the State of Connecticut for the purpose of operating an acute-care Hospital, outpatient and long term care facilities, support personnel, other patient care services and education to patients in the local community. JMH strives to improve the well-being of the surrounding community. The Medical Staff of JMH is made up of health professionals who provide patient care, pursue enhancement of medical knowledge for themselves and the community, and share an interest in furthering education and research for the institution.

The Medical Staff members of JMH organize themselves in conformity with these Bylaws, Rules and Regulations for the purpose of providing a collegial body of health professionals who conform to the recognized professional standards that govern medical institutions and the delivery of high quality, cost effective health care. Its goal is to also allow for mutual support amongst health professionals in clinical and educational matters.

The Medical Staff, with the support of JMH’s Administration, is responsible for the medical care delivered at JMH in all of its locations. The Administration and Medical Staff are subject to the authority of the Board of JMH.

JMH recognizes that in order to serve its community best, dynamic discussion through a cooperative effort between its professional peers for improvement of quality of care will always be needed. Appropriate avenues of communication, responsibility and authority are defined through JMH’s organizational structure, its Bylaws, Policies and Procedures and through the Bylaws, Rules and Regulations and Policies of the Medical Staff, as may be modified from time to time.

Above all, the Bylaws, Rules and Regulations, were created for the health professionals of JMH to better serve the patients and surrounding community. The Bylaws, Rules and Regulations shall be applied in a consistent, fair and organized manner so that no person, member of the Medical Staff, applicant for membership, patient or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activity of JMH.

**DEFINITIONS**

1. **ADVANCED PRACTICE PROFESSIONALS** or APP shall mean those health care professionals described in Article Four of these Bylaws.
2. **BOARD** shall mean the Board of Johnson Memorial Hospital and shall mean the governing body of Johnson Memorial Hospital.
3. **CHIEF MEDICAL OFFICER** or **CMO** shall mean the physician employed by Johnson Memorial Hospital to fulfill those duties set forth in Article Seven and elsewhere in these Bylaws.
4. **CLINICAL PRIVILEGES** or **PRIVILEGES** shall mean the permission granted to a Practitioner or APP to provide specifically delineated diagnostic, therapeutic, medical, surgical, dental, podiatric or other health care services to patients in Johnson Memorial Hospital.
5. **EMERGENCY DEPARTMENT** or **ED** shall mean the Emergency Department and express care area of Johnson Memorial Hospital.
6. **EOPD** shall mean the Enfield Outpatient Department.
7. **EX OFFICIO** shall mean service as a member of a body by virtue of an office or position held.
8. **FPPE** shall mean Focused Professional Practice Evaluation.
9. **JMH** shall mean Johnson Memorial Hospital.
10. **HOSPITAL** shall mean Johnson Memorial Hospital, including its satellite Departments, locations and facilities.
11. **JMH FACILITIES** shall mean the Hospital and other such facilities as may be part of JMH.
12. **LOCUM TENENS** shall mean a practitioner with specific privileges who is serving within a specifically limited time frame as a member of the Medical Staff.
13. **MEDICAL EXECUTIVE COMMITTEE** or **MEC** shall mean the executive committee of the Medical Staff.
14. **MEDICAL REVIEW COMMITTEE** shall mean and include any committee or subcommittee referred to in or authorized under these Bylaws, including, but not limited to, the MEC, all committees referred to in or authorized under the provisions of Article Ten of these Bylaws, Departmental and Sectional committees, subcommittees or liaison committees, and meetings of any Department or Section or other entry established under these Bylaws including the entire Medical Staff. All the foregoing are intended to be “Medical Review Committees” within the meaning of that term as set forth in Chapter 368a of the Connecticut General Statutes, as amended from time to time.
15. **MEDICAL STAFF** or **STAFF** shall mean the formal organization of all physicians (M.D. or D.O.), dentists (D.D.S or D.M.D.), Advanced Practice Professionals (APRN, CRNA, NNP, or PA-C), and appropriately qualified podiatrists (D.P.M.) who are privileged to attend to patients or to provide other diagnostic, therapeutic, teaching or research services in Johnson Memorial Hospital, as provided in these Bylaws. The Staff shall be limited to these specialists. This Medical Staff is that of Johnson Memorial Hospital.
16. **MEMBERSHIP PREROGATIVE** shall mean a participatory right granted, by virtue of Staff category or otherwise, to a Staff member and exercised subject to the conditions and limitations imposed in these Bylaws and in other JMH or Medical Staff Policies.
17. **OPPE** shall mean Ongoing Professional Practice Evaluation.
18. **PHYSICIAN** shall mean an individual with an M.D. or D.O. degree who is licensed to practice medicine in the State of Connecticut.
19. **PRACTITIONER** shall mean any physician, dentist or appropriately licensed and qualified podiatrist applying for or exercising clinical privileges or providing other diagnostic, therapeutic, teaching or research services in JMH.
20. **PRESIDENT OF THE HOSPITAL** shall mean the individual appointed by the Board to act on its behalf in the overall administrative management of Johnson Memorial Hospital.
21. **PRESIDENT OF THE MEDICAL STAFF** shall mean the Officer elected by the Medical Staff to fulfill those duties and responsibilities set forth in Article Six and elsewhere in these Bylaws.
22. **RESPONSIBLE PHYSICIAN** shall mean the admitting, attending, or consulting physician making key decisions during that phase of care.
23. **SCOPE OF PRACTICE** shall mean the permission granted to an Advanced Practice Professional to provide specifically delineated services to patients under the supervision of a member of the Medical Staff.
24. **SPECIAL NOTICE** or **NOTICE** shall mean written notification sent by certified or registered mail, return receipt requested.

**ARTICLE ONE**

**NAME**

The name of this organization shall be “The Medical Staff of Johnson Memorial Hospital”.

**ARTICLE TWO**

 **PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF**

* 1. **PURPOSES**

The purposes of the Medical Staff shall be to:

2.1-1 Strive to ensure that all patients admitted to, or otherwise treated in or by, Johnson Memorial Hospital (“JMH”) receives appropriate medical care.

2.1-2 Constitute a professional, collegial body providing for its members’ mutual education, consultation, and professional support to the end that patient care provided by JMH shall be consistently maintained at the level of quality optimally achievable given the state of the healing arts and the resources locally available and leading to the continuous advancement of professional knowledge and skill.

2.1-3 Serve as the collegial body through which individual practitioners shall obtain Membership Prerogatives and clinical privileges at JMH.

2.1-4 To insure that all members of the Medical Staff and the Advanced Practice Professional Staff have appropriate education, training and experience and are credentialed, and to insure that appropriate health care is provided only by credentialed staff.

2.1-5 Promote a high level of professional performance by all practitioners through an ongoing review and evaluation of each practitioner’s performance at JMH.

2.1-6 Develop a self-governing organizational structure, reflected in the Staff’s Bylaws, rules and regulations and other related protocols which shall adequately define responsibility and concomitant authority and accountability of each Medical Staff member, Officer and committee and shall be designed to assure that each staff member, Officer and committee shall exercise the responsibility and authority commensurate with such individual’s or committee’s respective contributions to patient care and to the teaching and research needs of JMH and shall fulfill like accountability obligations.

2.1-7 Provide the primary mechanism for accountability to the Board, through defined Medical Staff components, for the appropriateness and quality of the patient care services and for the professional and ethical conduct and the teaching and research activities of each individual practitioner holding membership on the Medical Staff and/or exercising clinical privileges.

2.1-8 Provide a means or method by which members of the Medical Staff shall formulate recommendations for the JMH’s policy-making and planning processes and through which such Policies and plans shall be communicated to and observed by each member of the Staff. Communication between the Medical Staff and individual members may occur by distribution of meeting minutes and assorted correspondence.

2.1-9 Provide a means whereby issues concerning the Medical Staff and JMH may be presented to and discussed with the President of the Hospital and the Board by the Medical Staff. Communication will occur by reports, committee minutes and by Board and Administrative representatives on the Medical Executive Committee and Medical Staff representation on the Board.

**2.2 RESPONSIBILITIES**

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

2.2-1 Provide quality medical care to all patients admitted to, or otherwise treated in or by, Johnson Memorial Hospital.

2.2-2 Participate in JMH’s quality improvement program(s) by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided at JMH, including, without limitations:

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

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

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

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

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

2.2-3 Evaluate practitioner credentials for initial and continued membership on the Medical Staff and for the delineation of clinical privileges for Staff members and APPs, and to make recommendations to the Board concerning appointments and reappointments to the Staff, including membership category, Department and service assignments, clinical privileges, specified services for APPs, and corrective action.

2.2-4 Maintain sound professional practices and an atmosphere conducive to the diagnosis and treatment of illness, teaching and research.

2.2-5 Develop, administer, and recommend amendments to these Bylaws and the rules and regulations of the Staff and its various components.

2.2-6 Enforce compliance with the Bylaws and rules and regulations of the Staff
 and of its administrative and clinical components and with JMH’s Bylaws
 and Policies.

2.2-7 Participate actively in the Board’s short- and long-range planning processes, assist in identifying community health needs and suggest to the Board appropriate institutional Policies and programs to meet those needs.

2.2-8 Comply with federal regulations as may from time to time be enacted that pertain to credentials and Medical Staff membership. The provisions of the regulations, as they may be amended from time to time, are hereby incorporated into both the Bylaws and Policies and Procedures. To the extent possible, they shall be construed as being consistent with the provisions of these Bylaws and the rules and regulations of the Medical Staff.

2.2-9 Exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

**ARTICLE THREE**

**MEMBERSHIP**

* 1. **NATURE OF MEMBERSHIP**

Membership on the Medical Staff is a privilege that is granted by the Board after considering the recommendations of the Medical Staff, and that shall be extended only to professionally competent practitioners who continuously comply with and meet the qualifications, standards, and requirements set forth in these Bylaws, the rules and regulations of the Medical Staff and other Medical Staff Policies, including the directives and Policies of the MEC and other Medical Staff committees. Appointment to and membership on the Medical Staff shall confer on the staff member only such clinical privileges as have been specifically granted by the Board in accordance with these Bylaws.

An individual who fails to satisfy the membership qualifications, standards and requirements is ineligible to apply. A determination of eligibility shall be made prior to submitting the application to the Credentials Committee. A determination of ineligibility does not entitle the individual to the provisions of Article Twelve of these Bylaws.

* 1. **GENERAL QUALIFICATIONS**

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

**3.2-1 LICENSURE**

(a) A current, valid unrestricted license issued by the State of Connecticut to practice medicine, osteopathy, dentistry or podiatry; and

(b) A current, valid Federal DEA Registration with a Connecticut address to prescribe controlled substances except where the practitioner demonstrates that such registration is not required in order to exercise the practitioner’s current or requested clinical privileges (i.e. pathologists, teleradiologists, CRNAs); and

(c) A State of Connecticut Controlled Substance Registration to prescribe controlled substances except where the practitioner demonstrates that such registration is not required in order to exercise the practitioner’s current or requested clinical privileges (i.e. pathologists, teleradiologists).

**3.2-2 PERFORMANCE**

1. Professional education, training, experience, current competence and clinical results documenting a continuing ability to provide optimally achievable patient care services given the resources locally available.
2. With regard to board certification, all applicants to the Medical Staff, at the time of being granted privileges, shall:

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

(2) If not certified by a board that is a member of the American Board of Medical Specialties, by a board recognized by the American Board of Medical Specialties, by the American Osteopathic Association, by a board recognized by the American Osteopathic Association by the American Podiatric Medical Association or by the American Dental Association (limited to the American Board of Oral and Maxillofacial Surgery) be admissible for certification and become certified within the lesser of (i) the period of eligibility as defined by the respective board, or (ii) five years after initial appointment to the Medical Staff. Certification by the Royal College of Physicians and Surgeons of Canada may be accepted based upon a waiver recommended by the MEC and approved by the Board.

Furthermore, staff members whose board certificates bear an expiration date shall successfully complete recertification no later than three years following such date. Failure to obtain board certification or recertification shall result in automatic termination of all privileges accorded to such member and automatic termination of such practitioner’s Staff membership and are not subject to the provisions of Article Twelve of these Bylaws. However, the requirements to obtain board certification and/or recertification are not made retroactive for those Staff members who, prior to obtaining membership on the Medical Staff, had been members of the Medical Staff of JMH continuously since January 1, 1996 or for those Staff members, providing services specific to meeting a critical need recognized by the Hospital and approved by the Medical Executive Committee, who have been in practice continuously for over thirty years with evidence of good standing and quality performance from other institutions.

 **3.2-3 ATTITUDE**

A willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Staff members, members of other health disciplines, members of JMH management, employees, visitors, and the community in general, in a cooperative, professional manner conducive to the maintenance of an environment appropriate to quality patient care. The behavior of members of and applicants for membership on the Medical Staff, which includes APPs, constitutes an essential component of professional activity and personal relationships within JMH. Civil deportment fosters an environment conducive to excellent patient care. Accordingly, in addition to the other qualifications set forth in this Article Three, all members of Medical Staff, which includes APPs, at all times shall demonstrate an ability to interact on a professional basis with members of the Staff, patients, and others and to behave in a professional and civil manner in compliance with our Code of Conduct Policy.

**3.2-4 DISABILITY**

To be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a significant possibility of interfering with, the practitioner’s ability to perform the privileges requested or granted or ability to perform his/her duties or obligations in accordance with the Bylaws, rules and regulations of JMH.

 **3.2-5 PROFESSIONAL LIABILITY INSURANCE**

Practitioners having the privilege to admit or treat patients within JMH shall maintain professional liability insurance. Professional liability insurance is not less than the minimum amount, if any, as determined from time to time by resolution of the Board after consultation with the MEC or such other evidence of financial responsibility as the Board may from time to time establish. Practitioners shall show proof of such coverage annually and at reappointment in an appropriate format such as a certificate of insurance (“COI”) published by the carrier. COIs must state (i) the insured practitioner’s full name, (ii) coverage effective and expiration dates, (iii) limits of coverage, (iv) whether the policy is claims-made or occurrence, and (v) a retroactive date if applicable. Practitioners are expected to purchase tail coverage when terminating a claims-made policy. Practitioner shall inform the Medical Staff Office of any change in his/her professional liability insurance coverage, at the time of the change or upon notice or knowledge of a future change, including, but not limited to, a change in the policy limits or carrier, or the non-renewal or cancellation of coverage or any notice of such action.

**3.3 CORPORATION AND COMMUNITY; NEED AND ABILITY TO ACCOMMODATE**

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

**3.4 EFFECT OF OTHER AFFILIATIONS**

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

**3.5 NON-DISCRIMINATION**

All provisions of these Bylaws and the accompanying Rules and Regulations, including the granting or denying of Medical Staff membership or clinical privileges shall be interpreted and applied so that no person, member of the Medical Staff, applicant for membership, patient, or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination based on gender, race, creed or national origin.

**3.6 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP**

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

3.6-1 Provide patients with continuous care at the generally recognized
professional level of quality and efficiency;

3.6-2 Abide by the Medical Staff Bylaws, Rules and Regulations and Policies, the directives, Policies, protocols and Procedures established by the MEC and the other Medical Staff committees and all other standards, Policies, and rules of JMH;

3.6-3 Discharge such Staff, committee, Department, service, and JMH functions for which the practitioner shall be responsible by Staff category assignment, appointment, election, or otherwise;

3.6-4 Prepare and complete in a timely fashion the medical and other required records for all patients that the practitioner admits, or in any way provides care at JMH;

3.6-5 Abide and be governed by generally recognized standards of professional ethics;

3.6-6 Meet practitioner Continuing Education Requirements during each two-year reappointment period as follows:

* Each practitioner, with the exception of Podiatrists,shall maintain qualifyingcontinuing medical education consistent with the State of Connecticut Department of Public Health continuing medical education requirements for licensure and renewal.
* Each member of the Advanced Practice Professional Staff, with the exception of Psychologists, shall maintain qualifying continuing education consistent with that required by their respective governing bodies to maintain licensure and/or certification.
* Each Podiatrist shall complete fifty (50) hours of continuing medical education every two years.
* Each Psychologist shall complete twenty (20) hours of continuing education every two years.

Continuing Education documentation shall be as follows:

All new applicants will be required to submit a list of all continuing medical education courses taken in the previous two years. For reappointment, each practitioner will be required to submit a list of all continuing education courses taken during each credentialing cycle. The list is to be included with the completed credentialing paperwork for initial appointment and reappointment. Certificates of completion are not required to be submitted for initial appointment or reappointment unless the practitioner is specifically requested to do so by the Department Chairperson, the Credentials Committee, and/or regulatory agencies but may be submitted if the practitioner wishes to do so.

Continuing Education record retention shall be as follows:

Each practitioner shall retain records of attendance that demonstrate compliance with the continuing education requirements, and shall retain such documentation for a minimum of two years from the date of attestation.

Upon the request of the Department Chairperson, the Credentials Committee and/or regulatory agencies, a practitioner shall submit records or certificates of completion of continuing education within two (2) hours of such request, if not already submitted at the time of appointment or reappointment. A practitioner, who fails to comply with the continuing education requirements, including failure to maintain proof of course completion, may be subject to disciplinary action.

3.6-7 Meet the quality improvement standards established by the Joint Commission (“JC”) and JMH’s quality improvement plan(s) to include FPPE, OPPE and PQIC as appropriate based on membership.

3.6-8 Maintain the confidentiality of and not disseminate to any person other than as permitted or required by law, any health information submitted, collected, prepared or obtained by any member of the Medical Staff while (i) treating patients at JMH, (ii) obtaining payment for services rendered at JMH, or (iii) assisting with health care operations of JMH.

3.6-9 Comply with the JMH’s Notice of Privacy Practices and privacy Policies as well as with all applicable state and federal laws and regulations while providing services at JMH.

3.6-10 Provide the Medical Staff Office with a copy of his/her current professional liability insurance in an appropriate format such as a certificate of insurance (“COI”) published by the carrier as required in 3.2-5. Each applicant and member will also be required to provide the Medical Staff Office with a copy of his/her current medical license, Connecticut controlled substance registration, and Federal DEA registration (with Connecticut address) if copies of these documents are unable to be obtained on-line by the Medical Staff Office prior to the expiration date. If any changes occur regarding the status of medical license, insurance, Connecticut controlled substance registration, or Federal DEA registration, such change must be reported immediately to the Medical Staff Office. Members of the Emeritus/Inactive Staff are exempt from these requirements. Non-prescribing pathologists and teleradiologists will be exempt from maintaining Connecticut controlled substance registration and Federal DEA registration.Practitioners will also be required to inform the Medical Staff Office immediately of any changes regarding membership, employment, faculty status or clinical privileges at other institutions, facilities or organizations; malpractice claims (current and initiation of new claims); and participation in federally funded healthcare programs.

**3.7 TERM OF APPOINTMENT**

Appointments to the Medical Staff shall be for a period of two years except that upon the recommendation of the MEC, the Board may set a more frequent reappraisal period for exercise of particular Privileges.

**3.8 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

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

**3.8-1 APPLICATION FOR APPOINTMENT**

Applications for Medical Staff membership shall be issued by JMH’s Chief Medical Officer and completed and signed by the applicant.

By applying for appointment to the Medical Staff and/or for clinical privileges, each applicant, whether or not the application is accepted, thereby agrees to the provisions of Article Three and to all of the following:

(a) The applicant shall provide detailed information concerning professional qualifications, including the names of at least three peer references (i.e. appropriate practitioners in the same professional discipline as the applicant and at least one physician evaluation for members of the Advanced Practice Professional Staff who have extensive first-hand experience in observing and working with the applicant). The peer recommendations refer, as appropriate, to relevant training or experience; current competence; ethical conduct; fulfillment of obligations as a Medical Staff member; and any effects of health status on the privileges being recommended. One of these references shall have served in a Chief or supervisory capacity.

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

(c) The applicant shall disclose whether any malpractice or professional liability claim or claims against the applicant are pending and whether any previous claims have been settled or have resulted in a judgment. The applicant shall provide detailed information with respect to the circumstances of any of the foregoing.

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

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

(2) To delegate during absence(s) the responsibility for diagnosis or care of
 patients to a Connecticut Licensed practitioner in the same specialty
 who is qualified and has appropriate privileges within JMH;

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

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

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

(e) The applicant acknowledges that all the statements made and information given on the application are accurate and complete, that any misstatement in, or omission from, the application is grounds for the Medical Staff Office to stop processing the application, or if the application is for reappointment, then for non-renewal of appointment, or the termination or revocation of Staff membership and clinical privileges.

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

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

(h) The Applicant shall inform the Medical Staff Office of any change in his/her status or any change in the information provided on his/her application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other Hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment.

(i) The application shall be submitted to the Medical Staff Office for processing, including appropriate primary source verification of licensure, board certification, relevant training, experience, current competence, ability to perform privileges requested, professional liability insurance, and any other information deemed appropriate as identified in this Article. The application and verified information shall be reviewed by the Section Chief, if appropriate, and the Department Chair for recommendation to the Credentials Committee. The Credentials Committee shall review and evaluate the application and if complete, shall forward a recommendation to the Medical Executive Committee who shall then forward a recommendation to the Board. A final decision by the Board shall be made within 120 days of the recommendation of the Credentials Committee. If additional information is required, the application shall be deemed incomplete until such information is provided within a specified period of time. Once the required information is received, determination shall be made regarding the application’s completeness and a decision shall then be made within 120 days of the determination of completeness. If the recommendation of the Medical Executive Committee to the Board is adverse, a decision shall be made in accordance with the provisions of Article Twelve.

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

**3.8-2 REAPPOINTMENT PROCESS**

The provisions of Section 3.8-1 of these Bylaws also shall apply to the reappointment process in addition to the following additional provisions:

(a) Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon the same standards used for the evaluation of initial appointments and such additional standards relating to current competence as have been deemed relevant. The MEC shall make a reasonable inquiry into, and may require the applicant to submit reasonable evidence of, ability to perform the clinical privileges requested.

(b) The Credentials Committee and then the MEC shall review all pertinent information available on each applicant for the purpose of determining its recommendations for reappointment to the Medical Staff and for granting clinical privileges for the ensuing period. This information shall include a recommendation from the appropriate Department Chair or Section Chief and a reference by another peer. Where a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and explained to the applicant.

(c) The MEC shall make recommendations to the Board concerning the reappointment and/or clinical privileges of each applicant. Where a membership termination, a change in clinical privileges, or appointment for a period of less than two years is recommended, the reasons for such recommendation shall be stated and explained. In the event that reappointment is recommended for a period of less than two years, the applicant shall not have the right to a hearing or appellate review in accordance with the provisions of Article Twelve of these Bylaws.

Restriction on Reapplication: An applicant, who has previously received a final adverse decision concerning Clinical Privileges or appointment or re-appointment to the Medical Staff or, or who resigned or failed to apply for reappointment while under an investigation in order to avoid investigation or following an adverse recommendation by the Credentials Committee or MEC, shall not be eligible to reapply for appointment to the Medical Staff for a period of five years unless the Board expressly determines otherwise. Upon reapplication, the applicant shall submit, in addition to all of the other information required, specific information showing that the conditions or basis for the earlier adverse decision, recommendation or resignation no longer exists.

**3.9 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES**

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

**3.10 REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES**

A Staff member, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff Office. A modification request must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification request is processed in the same manner as a reappointment application. A Staff member who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice, through the Medical Staff Office and appropriate Department Chair. Such change shall be effective on the date indicated in the written notice or on the date received by the Medical Staff Office. A copy of such notice shall be forwarded to the Credentials Committee and the MEC and shall be included in the practitioner’s credentials file.

**3.11 RESIGNATION OF STAFF APPOINTMENT OR PRIVILEGES**

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide at least 30 days written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation and shall appropriately discharge or transfer responsibility for the care of any Hospitalized patient who is under the individual's care at the time of resignation.

**ARTICLE FOUR**

**MEDICAL STAFF CATEGORIES AND ADVANCED PRACTICE PROFESSIONALS**

**4.1 CATEGORIES**

There shall be four major categories of membership on the Medical Staff: Active Staff, Associate Staff, Advanced Practice Professional Active Staff, and Advanced Practice Professional Associate Staff. These categories establish and relate to the member’s level of involvement in the activities and self-governance of the organized Medical Staff of JMH. A provisional category is for all new appointments to the Medical Staff. With the exception of the Emeritus category, these categories do not in any way confer or preclude any specific clinical privileges. Such privileges must be granted as outlined in these Bylaws and the associated Medical Staff Policies, and Rules and Regulations. The granting of clinical privileges may impose certain other responsibilities in addition to those set forth by virtue of a member’s category of staff membership.

* 1. **ACTIVE STAFF**

**4.2-1 DEFINITION OF ACTIVE STAFF**

The Active Staff shall be composed of those physicians, dentists and podiatrists who have been members of the Staff for at least one year and who meet the qualifications for appointment set forth in Article Three of these Bylaws and in this Section.

**4.2-2 QUALIFICATIONS FOR ACTIVE STAFF**

An Active Staff member shall:

1. Be located close enough to where clinical privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Connecticut licensed physician having at least equivalent clinical privileges at JMH.
2. For the purpose of assuring that the highest quality of care is delivered to patients within JMH, the Active Staff member must perform at least 50 patient contacts in each two-year re-credentialing cycle at a JMH Facility.

“Patient contacts” are defined as:

* Inpatient, short stay, or observation encounters
* Surgical or invasive procedures, including surgical first assist
* Referral of patients from the member’s practice for admissions at a JMH Facility
* Inpatient and Emergency Department consults
* Evaluation and management of outpatients at a JMH facility

If the Active Staff member performs less than 50 patient contacts in two years, he/she may be recommended for the Associate Staff during the next re-credentialing period pending review by the Credentials Committee.

If the requirement for patient contacts as defined above is not met, exceptions as they relate to service to the institution may be determined by the Credentials Committee. The Credentials Committee reserves the right to request evidence of quality metrics.

**4.2-3 MEMBERSHIP PREROGATIVES OF ACTIVE STAFF**

Active Staff members may:

1. Admit patients without limitation, except as otherwise provided in the Medical Staff Rules and Regulations or his/her Delineation of Privileges.
2. Hold Staff Office.
3. Serve on all committees.
4. Participate in teaching programs.
5. Vote on all matters presented at all meetings of Staff, Departments, and Committees to which members are assigned.
6. Have the option to request exemption from the Emergency Department Call
Schedule if he/she has been a member of the Active Staff for 25 years or more.

**4.2-4 OBLIGATIONS OF ACTIVE STAFF**

1. Discharge its functions through the Medical Executive Committee and other
 committees of the Staff as described elsewhere in these Bylaws and as
 follows:
	1. Establish and maintain liaison with the Board, JMH Administration, and external agencies and institutions;
	2. Advise the Board on providing medical care to the people of the communities serviced by JMH;
	3. Inform the Board regularly and periodically of the quality of medical care being provided at JMH per JMH’s reporting structure;
	4. Advise the Board on the proper discharge of professional responsibilities within JMH;
	5. Evaluate the professional competence of the entire Staff membership and sponsor educational programs designed to promote said competence;
	6. Review regularly the performance of the entire Staff with a view toward the institution of new programs or revisions of existing ones;
	7. Devise and maintain its Bylaws and its Rules and Regulations by which its action shall be governed, subject to approval by the Board;
	8. Be responsible for review of and compliance with these Bylaws, Rules and
	Regulations; and
	9. Comply with the Hospital’s quality and performance improvement, claims review and risk management Policies;
	10. Actively participate in peer review, patient care audit, quality assurance programs and monitoring activities required of the Staff.
2. Individual obligations of the Active Staff are:
3. Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital and for which he/she is providing services or arranging suitable care and supervision by another qualified member of the Staff;
4. Shall be required to pay annual dues in an amount assessed by the majority vote of the Active Staff and the Advanced Practice Professional Active Staff membership;
5. Participate in Emergency Department Call Coverage as designated by the Chairperson of each Department.

Failure to meet any or all of the aforementioned obligations may result in conditional reappointment, change in Staff category, or removal from the Medical Staff.

* 1. **ASSOCIATE STAFF**

**4.3-1 DEFINITION OF ASSOCIATE STAFF**

The Associate Staff shall consist of physicians, dentists, podiatrists and optometrists who do not wish to assume the same level of involvement in Medical Staff activities and governance as the Active Staff, each of whom meets the qualifications set forth in Article Three of these Bylaws and in this Section. If a member of the Associate Staff desires to be a member of another category of the Medical Staff, such member must submit a request in writing to the Chair of his/her Department.

Any physician who was a member of the Medical Staff of the Johnson Surgery Center as of July 1, 2007, but who was not a member of the Medical Staff of the Hospital, shall automatically be a member of the Associate Staff with the physician’s existing delineation of privileges. Reappointment shall be in accordance with the provisions of these Bylaws.

**4.3-2 QUALIFICATIONS FOR ASSOCIATE STAFF**

An Associate Staff member shall:

1. Be located close enough to where clinical privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Connecticut licensed physician having at least equivalent clinical privileges.
2. For the purpose of assuring that the highest quality of care is delivered to patients within JMH, the Associate Staff member must perform at least 50 patient contacts in each two-year re-credentialing cycle at a JMH Facility. Groups with three or more practitioners will be considered as a single entity; therefore, the entity will be required to perform a combined total of 50 patient contacts in each two-year re-credentialing cycle. He/she must also allow JMH to access all quality and peer review data pertaining to the Associate Staff member at any facility where he/she has any patient contacts.

“Patient contacts” are defined as:

* Inpatient, short stay, or observation encounters
* Surgical or invasive procedures, including surgical first assist
* Referral of patients from the member’s practice for admissions at a JMH Facility
* Inpatient and Emergency Department consults
* Evaluation and management of outpatients at a JMH Facility

If the requirement for patient contacts as defined above is not met, exceptions as they relate to service to the institution may be determined by the Credentials Committee. The Credentials Committee reserves the right to request evidence of quality metrics.

**4.3-3 MEMBERSHIP PREROGATIVES OF ASSOCIATE STAFF**

 Associate Staff members may:

1. Not admit patients to the Hospital. If a patient that an Associate Staff member has performed a procedure on requires admission to the Hospital, that patient must be admitted by a member of the Active Staff. In the rare instance when there is no Active Staff member available to admit under a particular service, an Associate Staff member, designated by an Active Staff Member of that particular service, may admit the patient, pending approval of either the Chief Medical Officer or the President of the Medical Staff. The Associate Staff member may serve as a consultant on inpatients, including writing notes and orders in the chart as they pertain to the Associate Staff member’s area of expertise, and as they pertain to the initial procedure performed on the patient;
2. Perform procedures or see patients at the main Hospital or the Enfield Outpatient Department (“EOPD”); if more than 10% of the Associate Staff member’s total cases require admission, he/she may be recommended for the Active Staff during the next re-credentialing period pending review by the Credentials Committee.
3. Attend regular Medical Staff and Department meetings, but shall not have the right to vote; and
4. Serve on committees if invited to do so by the committee or by the MEC, and may have the right to vote on such committees.

**4.3-4 OBLIGATIONS OF ASSOCIATE STAFF**

1. Comply, as applicable, with the Bylaws, Rules and Regulations, and Policies of the Medical Staff, and the rules and regulations and Policies of the appropriate Department that they are a member of;
2. Comply with the Hospital’s quality and performance improvement, claims review and risk management Policies;
3. Actively participate in peer review, patient care audit, quality assurance programs and monitoring activities required of the Staff;
4. Discharge his/her functions, including peer review, through the Medical Executive Committee and other committees of the Staff as described elsewhere in these Bylaws; and
5. Pay the same amount of dues assessed the Active Staff and the Advanced Practice Professional Active Staff membership.

Failure to meet any or all of the aforementioned obligations may result in conditional reappointment or removal from the Medical Staff.

**4.4 EMERITUS STAFF**

**4.4-1 DEFINITION OF EMERITUS STAFF**

The Emeritus Staff shall be composed of those physicians, dentists and podiatrists who have been members of the Staff and who are 65 years old or over and who request transfer to the Emeritus Staff.

**4.4-2 MEMBERSHIP PREROGATIVES OF EMERITUS STAFF**

Emeritus Staff members:

1. May not admit or treat patients;
2. Are not required to maintain the following: licensure in the State of Connecticut, a current Connecticut Controlled Substance registration, a current Federal DEA registration, current professional liability insurance, a current delineation of privileges or evidence of continuing medical education;
3. Are not required to attend meetings of the general Staff and Department meetings as long as they remain on the Emeritus Staff;
4. Are not obligated to accept Staff or Departmental duties. They may from time to time be asked to serve on committees and shall have the right to vote on any Committee to which they are appointed; and
5. Will not be required to pay dues.
	1. **ADVANCED PRACTICE PROFESSIONAL (“APP)” STAFF**

**4.5-1 DEFINITION OF APP STAFF**

Advanced Practice Professionals shall be individuals, other than physicians, dentists and those podiatrists meeting the board certification and training requirements for podiatrist members of the Medical Staff, who are qualified to render patient care services within their areas of professional competence. APPs shall serve patients who are the primary responsibility of members of the Active and Associate Medical Staff but shall not have the privilege to admit patients independently. Advanced Practice Professionals include: (i) individuals, such as clinical psychologists, who are permitted by law and JMH to provide patient care services independently in JMH in accordance with delineated Clinical privileges; and (ii) individuals, such as physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives, permitted by law and by JMH in accordance with their scopes of practice under the supervision of a Medical Staff member. APPs shall not include other health professionals, such as audiologists, chemists, pharmacists, dietitians, physical therapists, etc., who are employed by JMH.

**4.5-2 QUALIFICATIONS OF APP STAFF**

Only an APP holding a license, certificate, or such other credentials as may be required by applicable state law and satisfying the basic qualifications as generally set forth in Article Three and other Sections of these Bylaws, shall be eligible to provide patient care services at JMH. The MEC may establish additional qualifications required of members of any particular APP discipline.

**4.5-3 GENERAL PROVISIONS**

1. APPs shall be appointed and reappointed to one of the Departments of the Medical Staff for periods not to exceed two years. In each category they shall be appointed and reappointed by the Board after submission of an application to the appropriate Chair, the Credentials Committee, and the MEC.
2. Guidelines for the scope of practice of supervised APPs shall be described in Departmental policy and, for the individual APP, shall be developed by the supervising Medical Staff member with approval by the Department Chair. Each APP is required to have a supervising Medical Staff member. In the event that such an APP no longer is supervised by a specific Medical Staff member, the Medical Staff member immediately shall notify the Chair of the Department.
3. For those APPs who practice independently, delineated clinical privileges shall be developed by the Department Chair and approved by the Credentials Committee, the MEC and the Board.
4. The appointment and clinical privileges of an APP shall automatically terminate in the event the APP’s employment by JMH terminates and such termination shall be without right of hearing or appellate review. In the event that an APP Staff member is no longer supervised by a Medical Staff member, the APP Staff member will be unable to practice at Johnson Memorial Hospital until a supervising Medical Staff member is assigned. If a supervising Medical Staff member is not assigned within one hundred twenty (120) days, the APP Staff member shall voluntarily resign appointment and clinical privileges from the Medical Staff.
5. Each APP shall maintain the confidentiality of and shall not disseminate to any person other than as permitted or required by law, any health information submitted, collected, prepared or obtained while (i) treating patients at JMH, (ii) obtaining payment for services rendered at JMH, or (iii) assisting with healthcare operations at JMH. Each APP shall comply with JMH’s Notice of Privacy Practices and privacy Policies as well as with all applicable state and federal laws and regulations while providing services at JMH. In the event that an APP fails to comply with this Section 4.6-3 (f), the President of the Medical Staff and Department Chair shall take all appropriate corrective action necessary to resolve the APP’s failure to comply under the procedures of Section 4.6-3 (d).

**4.5-4 APP ACTIVE STAFF**

* + 1. **QUALIFICATIONS FOR APP ACTIVE STAFF**

An APP Active Staff member shall:

1. Be located close enough to where clinical privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Connecticut licensed practitioner having at least equivalent clinical privileges at JMH.

**(b) MEMBERSHIP PREROGATIVES OF APP ACTIVE STAFF**

APP Active Staff members:

1. May Not admit patients to the Hospital. If a patient requires admission to the Hospital, that patient must be admitted by a member of the Active Staff.
2. May Not hold Staff Office (Medical Staff President, Medical Staff Vice President, or Department Chairperson).
3. Shall serve on Medical Staff Committees.
4. May participate in teaching programs.
5. May vote on all matters presented at all meetings of Staff, Departments, and Committees to which members are assigned.

**(c) OBLIGATIONS OF APP ACTIVE STAFF**

1. Comply, as applicable, with the Bylaws, Rules and Regulations, and Policies of the Medical Staff, and the rules and regulations and Policies of the appropriate Department that they are a member of;
2. Comply with the Hospital’s quality and performance improvement, claims review and risk management Policies;
3. Actively participate in peer review, patient care audit, quality assurance programs and monitoring activities required of the Staff;
4. Discharge his/her functions, including peer review, through the Medical Executive Committee and other Committees of the Staff as described elsewhere in these Bylaws;
5. Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patients in the Hospital and for which he/she is providing services or arranging suitable care and supervision by another qualified member of the Staff;
6. Shall be required to pay annual dues in an amount assessed by the majority vote of the Active Staff and the Advanced Practice Professional Active Staff membership;
7. Shall participate in some Emergency Department Call Coverage as determined by his/her supervising or collaborating physician.

Failure to meet any or all of the aforementioned obligations may result in conditional reappointment, change in Staff category, or removal from the Medical Staff.

**4.5-5 APP ASSOCIATE STAFF**

1. **QUALIFICATIONS FOR APP ASSOCIATE STAFF**

An Associate Staff member shall:

1. Be located close enough to where clinical privileges are held to provide continuous care to patients either directly or through coverage arrangements with another Connecticut licensed practitioner having at least equivalent clinical privileges at JMH.
2. **MEMBERSHIP PREROGATIVES OF APP ASSOCIATE STAFF**

APP Associate Staff members:

i. May Not admit patients to the Hospital. If a patient requires admission to the Hospital, that patient must be admitted by a member of the Active Staff.

1. May Not hold Staff Office (Medical Staff President, Medical Staff Vice President, or Department Chairperson).
2. May serve on Medical Staff Committees if invited to do so by the Committee or by the MEC, and may have the right to vote on such Committees.
3. May participate in teaching programs.
4. May attend regular Medical Staff and Department meetings, but shall not have the right to vote.

**(c) OBLIGATIONS OF APP ASSOCIATE STAFF**

1. Comply, as applicable, with the Bylaws, Rules and Regulations, and Policies of the Medical Staff, and the rules and regulations and Policies of the appropriate Department that they are a member of;
2. Comply with the Hospital’s quality and performance improvement, claims review and risk management Policies;
3. Actively participate in peer review, patient care audit, quality assurance programs and monitoring activities requires of the Staff;
4. Discharge his/her functions, including peer review, through the Medical Executive Committee and other Committees of the Staff as described elsewhere in these Bylaws;
5. Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital and for which he/she is providing services or arranging suitable care and supervision by another qualified member of the Staff;
6. Shall be required to pay the same amount of dues as assessed by the Active Staff and the Advanced Practice Professional Active Staff; and
7. Shall not be required to participate in Emergency Department Call Coverage.

Failure to meet any or all of the aforementioned obligations may result in conditional reappointment or removal from the Medical Staff.

**4.6 RESIDENT PHYSICIANS**

**4.6-1 QUALIFICATIONS**

Resident physicians shall be members in good standing of an accredited residency or fellowship program. The Department Chair shall review resident physicians’ qualifications and approve the level of care the resident physician will provide.

**4.6-2 SUPERVISION**

Resident physicians shall perform under the direct supervision of a physician member of the Medical Staff. Orders issued by resident physicians will be in accordance with JMH policy. Medical procedures, duties and responsibilities of the resident physician shall be within the scope of privileges granted to the supervising practitioner.

**4.6-3 OBLIGATIONS**

Resident physicians are not deemed to be members of the Medical Staff.

Resident physicians shall abide by JMH Policies and clinical training agreements relevant to resident physicians.

The various provisions of these Bylaws and the accompanying Rules and Regulations shall apply to the resident physicians where specifically provided, or where the context requires application.

**4.7 LEAVE OF ABSENCE**

For adequate cause, a member of the Medical Staff shall apply for a leave of absence from sixty days to no more than one calendar year. A leave of absence is granted by the Board upon recommendation of the MEC. During the leave of absence period, Membership Prerogatives shall not be exercised. Decisions in regard to the granting or denial of leave of absence shall not be subject to the provisions of Article Twelve of these Bylaws or any other review and shall be final. A practitioner returning from a leave of absence may be fully reinstated to his/her previous status by the Board after consideration of the recommendation of the MEC providing that the practitioner has submitted the following: (i) evidence of current Connecticut medical license, (ii) evidence of current professional liability insurance coverage, (iii) evidence of current Federal DEA and State controlled substance registrations (if applicable), and a re-delineation of privileges. A practitioner returning from a medical leave of absence shall be required to provide a letter from the practitioner’s treating physician. The letter should state an approval to return to medical practice and any limitations related to performing the practitioner’s clinical privileges. Reapplication to the Medical Staff shall be required of any practitioner whose leave exceeds one calendar year. Any practitioner returning from a leave of absence in which the duration was six months or longer is subject to the FPPE process.

**4.8 GENERAL QUALIFICATIONS**

Each practitioner who seeks or holds Staff membership shall satisfy, at the time of appointment and continuously thereafter, all of the basic qualifications set forth in these Bylaws as well as any additional qualifications that attach to the Staff category to which such practitioner seeks appointment or in which membership exists. Under exceptional circumstances, the Board may waive any qualification when in its discretion such waiver will serve the best interests of patient care within JMH except where requirements are established by law.

**4.9 LIMITATION OF MEMBERSHIP PREROGATIVES**

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

**ARTICLE FIVE**

**DELINEATION OF CLINICAL PRIVILEGES**

**5.1 EXERCISE OF PRIVILEGES**

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

**5.2 BASIS FOR DETERMINATION OF PRIVILEGES**

Privileges governing clinical practice shall be granted in accordance with prior and continuing education, training, experience, demonstrated current competence, judgment, and ability to perform the clinical privileges requested as documented and verified in each practitioner’s credentials file and in accordance with the general qualifications set forth in Article Three. The basis for determination of privileges for current Staff members in connection with reappointment or a requested change in privileges shall include observed clinical performance and documented results of the Staff’s quality improvement program activities, as well as via the FPPE and OPPE processes as appropriate.

**5.3 SYSTEM AND PROCEDURE FOR DELINEATING PRIVILEGES**

Clinical privileging is performed in conjunction with the appointment and reappointment process. Additional privileges may be requested through the same procedure as prescribed for obtaining the original privileges.

**5.4 SPECIAL CONDITIONS FOR ADVANCED PRACTICE PROFESSIONAL SERVICES**

Requests to perform specified patient care services from APPs shall be processed in the manner specified in Section 4.5-3.

**5.5 EMERGENCY AND DISASTER PRIVILEGES**

**5.5-1 EMERGENCY PRIVILEGES**

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

**5.5-2 DISASTER PRIVILEGES**

In the case of a Federal or State government or Hospital declared emergency and when resources of existing Hospital Medical Staff have been, or are predicted to be exhausted, the President of the Hospital or his designee, upon approval by the Medical Staff President or his/her designee, may grant disaster privileges to volunteer practitioners in accordance with the Connecticut Statewide Credentialing Policy and/or Johnson Memorial Hospital Medical Staff Disaster Privileges Policy. The JMH Disaster Privileges Policy (as applicable) may be adopted and amended by the MEC. Privileges will terminate immediately upon identification of any adverse information about the practitioners, and, in any case, privileges will be granted only for the duration of the emergency.

**5.5-3 RECORDS**

In each instance, a list of those practitioners granted emergency or disaster privileges shall be reported to the MEC at the next regular meeting of the Medical Executive Committee, and then subsequently reported to the Board, and a record of such privileges shall be maintained.

**5.6 TEMPORARY PRIVILEGES**

**5.6-1 CONDITIONS**

Temporary privileges may be granted only in the circumstances described in Section 5.6-2, only to an appropriately licensed practitioner, only when the information available shall support a favorable determination regarding the requesting practitioner’s qualifications, ability, and judgment to exercise the privileges requested, and only after verification that the practitioner has satisfied the applicable licensure requirements and the professional liability insurance requirement, if any, of these Bylaws, and has demonstrated current competence and ability to perform the clinical privileges requested. Special requirements of consultation and reporting shall be imposed by the Department Chair or Chief of services responsible for supervision. Temporary Privileges shall not be granted unless the practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations, and Policies of the Staff of JMH in all matters relating to the temporary privileges granted. Said Bylaws, Rules and Regulations, and Policies shall control in all matters relating to the exercise of temporary privileges. All temporary privileges of applicants shall be specifically delineated.

**5.6-2 CIRCUMSTANCES**

Upon written concurrence of the Chair of the Department where the privileges will be exercised, and the President of the Medical Staff, the President of JMH or designees, after appropriate verification, may grant temporary privileges in the following circumstances:

 I. Temporary Privileges to Fulfill an Important Patient Care Need:

* In this circumstance, temporary privileges may be granted upon verification of the following:
* Current Connecticut licensure
* Current competence
* A query and evaluation of the National Practitioner Data Bank (NPDB) information
* These temporary privileges are granted by the President of the Hospital (or authorized designee), upon the written concurrence of the Chairperson of the Department(s) where the privileges will be exercised (or authorized designee) and of the President of the Medical Staff (or authorized designee). The temporary privileges must define the important patient care need.
* These temporary privileges are granted for a maximum of 120 days.

II. Temporary Privileges Granted to New Applicants with a Complete, Clean Application Awaiting Review and Approval by the Medical Executive Committee and the Board:

* In this circumstance, temporary privileges may be granted upon verification of the following:
	+ Current Connecticut licensure.
	+ Relevant training or experience.
	+ Current competence.
	+ Ability to perform the privileges requested
	+ A query and evaluation of the National Practitioner Data Bank (NPDB) information.
	+ Appropriate professional liability insurance.
	+ At least two evaluative medical references must be received from the physician’s current or most recent appointment, at least one of which must be from the physician’s supervisor.
	+ A complete application.
	+ No current or previously successful challenge to licensure or registration.
	+ No subjection to involuntary termination of Medical Staff membership at another organization.
	+ No subjection to involuntary limitation, reduction, or denial, or loss of clinical privileges.
* Upon verification of the above, temporary privileges may be granted for the following:
1. Applicants: An applicant to the Active, Associate, Advanced Practice Professional Active Staff, or Advanced Practice Professional Associate Staff with a complete, clean application that raises no concerns and upon meeting the verification criteria listed above may be granted temporary privileges for a maximum of 120 consecutive days.
2. Proctoring for Specific Procedure(s): Upon receipt of a written request by a Medical Staff member, for proctoring for specific procedure(s) by a Practitioner who is not an applicant for Staff membership. Such Privileges shall be restricted to the specific procedure(s) requested and may not last more than 12 months.
3. Locum Tenens: Upon receipt of a written request for specific temporary Privileges, to a Practitioner who is serving as a Locum Tenens for a member of the Medical Staff. Locum Tenens Privileges may be granted for a period not to exceed six months and may be renewed, if required, to fulfill an important patient care need. These Privileges shall not exceed the services as Locum Tenens, shall be limited to treatment of patients of the Staff member for whom the Practitioner is serving as Locum Tenens, but shall not entitle the Locum Tenens to admit patients other than patients of the Medical Staff member to JMH. The qualifications of a Locum Tenens shall not be greater than those of the Staff member being replaced by the Locum Tenens.

**5.6-3 SUPERVISION REQUIREMENT**

In exercising temporary privileges, the practitioner shall act under the supervision of the Department Chairperson or Section Chief. Special requirements of supervision and reporting may be imposed on any practitioner granted temporary clinical privileges.

**5.6-4 TERMINATION OF TEMPORARY PRIVILEGES**

The granting of temporary privileges is a courtesy and may be terminated for any reason by those individuals authorized to grant such privileges. The President of the Hospital or designee shall, on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner’s professional qualifications or ability to exercise all or any of the temporary privileges granted, and may at any other time after consultation with the Chair or Chief responsible for supervision, terminate all or any of a practitioner’s temporary privileges. In addition to the foregoing, where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspensions under these Bylaws. In the event of any termination of temporary privileges, the practitioner’s patients then in a JMH Facility shall be assigned to another practitioner by the Chair or Chief responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

**5.6-5 RIGHTS OF THE PRACTITIONER**

A practitioner shall not be entitled to the procedural rights afforded by the Bylaws in the event that the Practitioner’s request for temporary privileges is refused or terminated.

**ARTICLE SIX**

**STAFF OFFICERS**

* 1. **GENERAL OFFICERS OF THE STAFF**

**6.1-1 IDENTIFICATION**

The general Officers of the Staff shall be a President and a Vice President.

**6.1-2 QUALIFICATIONS**

Each general Officer shall be a member of the Active Staff at the time of nomination and election, shall remain a member in good standing continuously during the term of the office, and shall be willing and able to discharge the duties of the particular office faithfully. Each Officer shall have demonstrated executive ability, be recognized for his/her high level of clinical competencies, be a member of the Active Staff and have demonstrated active participation in Medical Staff, Department, service and committee functions and a commitment to maintaining excellence of the Medical Staff. No individual may hold two general Staff offices concurrently.

**6.2 TERM OF OFFICE**

The term of office of general Staff Officers shall be one Medical Staff year (November 1st through October 31st). Officers shall assume office on the first day of the Medical Staff year following their election or appointment except that an Officer elected to fill a vacancy shall assume office immediately upon election. Each Officer shall serve until the end of the term or until a successor is elected, unless the Officer sooner resigns or is removed from office.

**6.3 HONORARIUM**

A yearly honorarium shall be provided to the President and Vice President of the Medical Staff as determined by Medical Staff Policy #7: Medical Staff Leadership Stipends.

**6.4 ATTAINMENT OF OFFICE**

The Officers of the Medical Staff shall be elected at the Annual Meeting of the Medical Staff. They shall be elected by a majority vote on a closed ballot of the Active Staff and the Advanced Practice Professional Active Staff. Eligible voting members, who are unable to attend the meetings, may cast their vote via absentee ballot within seven days of the election meeting. They may be re-elected for one (1) additional consecutive term. The term shall be for one (1) year.

**6.5 NOMINATIONS**

The Administrative Affairs Committee shall convene 40 days prior to the Annual Meeting and after appropriate consultation with members of the Staff, shall select names for each of the two offices. The names of these nominees shall be reported to the Staff by the President of the Medical Staff at least 30 days prior to the Annual Meeting.

Nominations may also be made from the floor according to ROBERTS RULES OF ORDER as they may be revised from time to time.

**6.6 VACANCIES**

**6.6-1 REMOVAL OF OFFICERS**

In the event that an Officer of the Medical Staff dies, resigns, takes a leave of absence, loses his Medical Staff membership, or loses his license to practice medicine in Connecticut, such Officer shall be deemed to have been removed from office and the vacancy shall be filled in accordance with the provisions of 6.6-2 below.

In the event that an Officer becomes disabled or incapable of fulfilling the requirements of his office, or is convicted of a crime reflecting negatively on the character of the Officer such as a morals crime or a crime relating to the improper practice of medicine, or has been subject to disciplinary action by the Medical Staff as a result of a matter deemed to be serious and to reflect negatively on the character or ability of the Officer, then the Medical Staff by a 2/3 vote of all voting members present at the meeting at which a quorum has been established may remove such Officer. The vacancy then shall be filled in accordance with the provisions of 6.6-2 below.

**6.6-2 VACANCIES**

Vacancies in the office of President will be filled by the Vice President after the term has exceeded ninety (90) days and shall subsequently be eligible for election and reelection as described above. The Immediate Past-President may serve as President if the new President is unable to perform duties during the first ninety (90) days of the term and may request to the Medical Executive Committee a stipend to cover time served.

Vacancies in the office of Vice President will be filled by proper election at the next regular or special meeting of the full Medical Staff following the vacancy. Nominations may be made from the floor according to ROBERTS RULES OR ORDER as they may be revised from time to time.

In the event of vacancies in the offices of both the President and Vice President, the senior member in years of service of the current Medical Executive Committee shall temporarily assume the office of President and convene within thirty days a special meeting of the Medical Staff for purposes of filling the vacant offices. Individuals so elected may be reelected to two full terms following the partial one.

**6.7 DUTIES OF THE OFFICERS**

**6.7-1 DUTIES OF THE PRESIDENT**

The President shall serve as the Chief Medical Officer of the Hospital and as the principal elective official of the Staff, and shall be furnished with work space within the Hospital and clerical assistance, as needed. Duties are as follows:

* 1. Preside at the Annual and all special meetings of the Staff;
	2. Call special meetings of the Staff;
	3. Be Chairperson of the Medical Executive Committee;
	4. Direct the organizational functions of the Medical Staff in accordance with the terms of the Medical Staff Bylaws, Rules and Regulations and Medical Staff Policies.
	5. Implement sanctions where these are indicated and assure Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
	6. Be responsible for the functioning of the clinical organizations of the Staff, keeping or causing to keep careful supervision over the clinical work in all Departments;
	7. Serve as a member of the Quality Committee of the Board and as an ex‑officio member with vote of all other staff committees as necessary;
	8. Be empowered in matters deemed most urgent, to act on behalf of the Medical Executive Committee in response to a request or petition from the Board, the President of the Hospital, a Departmental Chairperson or an external agency. Such action by the President shall be reported by him to the Medical Executive Committee at its next meeting, when it shall be presented for review or approval. Modification or verification of this action shall require majority vote of the Medical Executive Committee;
	9. Be empowered to grant temporary privileges as described in the Medical Staff Bylaws;
	10. Represent the Staff at meetings and functions with such representation as proper or requested;
	11. Principal point of contact and liaison with the President of the Hospital and the Board.

**6.7-2 DUTIES OF THE VICE PRESIDENT**

 The Vice President shall:

* 1. Succeed to the presidency in the event of an unexpired term of that office and shall subsequently be eligible for election and reelection as described above;
	2. Assume the presidency at the conclusion of the current President’s term;
	3. Act upon designation by the President or notification by the Chairperson of the Medical Executive Committee in case of illness or absence from the community by the President;
	4. Be responsible for the review of the Medical Staff Bylaws every two years and the revision function of the Medical Staff Bylaws by serving as Chairperson of the Administrative Affairs Committee;
	5. Be a member of the Medical Executive Committee;
	6. Collect the authorized dues of the Medical Staff and properly disburse authorized monies from the Staff Treasury. Present a financial report at the Annual Meeting;

Pertaining to the disbursement of Medical Staff funds, proposed expenses of $500 or less may be approved by the President of the Medical Staff or the Vice President of the Medical Staff. Proposed expenses in the amount of $500 to $2,000 must be presented as an agenda item and voted on by the Medical Executive Committee. Proposed expenses greater than $2,000 must be presented as an agenda item and voted on at a Quarterly Staff meeting.

The final bill on all disbursements over $2,000, when the first request was just an estimate, must also be reviewed by the Medical Executive Committee and Quarterly Staff.

* 1. Perform such additional duties as are assigned to him by the President of the Medical Staff or the Medical Executive Committee.

**ARTICLE SEVEN**

**CHIEF MEDICAL OFFICER**

* 1. **SELECTION**

The Chief Medical Officer (CMO) shall be appointed by the President of the Hospital, following consultation with a committee appointed by the President of the Hospital, such committee to include but not be limited to members of the Medical Executive Committee. The committee will identify individuals who possess the abilities and interests required to discharge successfully the responsibilities of this office. Suitable candidates will be those who have demonstrated outstanding clinical skills, competent administrative performance, and an ability to work successfully with Practitioners, APPs and Administrators, and a master’s degree in Medical Management, Business Administration or other relevant healthcare degree is preferred.

**7.2 DUTIES**

The CMO functions as the senior administrative Officer of the Medical Staff. Successful performance of this key position will help assure effective Medical Staff functioning. This result will be accomplished by maintaining broad participation in Medical Staff affairs, by frequent interaction with all elements of the Staff, especially those in leadership positions, i.e., Chairs, Chiefs and elected Officers, and by closely monitoring areas of special sensitivity. The CMO functions as a liaison for the Medical Staff to the administrators of JMH and as a communicator for such administrators to the Medical Staff. Specific responsibilities shall include:

1. Management of Medical Staff Affairs: Medical Staff application process, committee performance, compliance with the Joint Commission and licensure requirements as they pertain to medical practice, and patient concerns and complaints regarding medical service.
2. Advocate for the Medical Staff: as a member of JMH management, and to various organizations locally and statewide.
3. Administrative supervision of functioning of medical services through the Chairs and Chiefs.
4. Assistance to elected Medical Staff Officers in the discharge of their duties.
5. Management of the appointment and reappointment process for Practitioners applying to the Medical Staff.
6. Other responsibilities as further elaborated in the CMO Job Description.

**7.3 REPORTING**

The CMO reports to the President of the Hospital and also has responsibility to report to the Board regarding medical practice. The CMO’s performance will be reviewed annually by the President of the Hospital following consultation with the President of the Medical Staff.

The CMO shall be an ex officio member without vote of the MEC and the other Medical Staff Committees identified in these Bylaws and such additional committees as may be designated.

**ARTICLE EIGHT**

**CLINICAL DEPARTMENTS**

* 1. **CLINICAL DEPARTMENTS AND SECTIONS**

The eight clinical Departments are: Anesthesiology, Emergency Medicine, Family Medicine and Pediatrics, Medicine, Pathology, Psychiatry, Radiology and Surgery. Each Department includes services as necessary for proper patient care, and as determined by each Department.

 **8.1-1 DEPARTMENTS**

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine and Pediatrics
4. Medicine
5. Pathology
6. Psychiatry
7. Radiology
8. Surgery

 **8.1-2 SECTIONS**

1. Cardiology (Department of Medicine)
2. Endocrinology (Department of Medicine)
3. Gastroenterology (Department of Medicine)
4. General Surgery (Department of Surgery)
5. Hematology/Oncology (Department of Medicine)
6. Hospitalist Medicine (Department of Medicine)
7. Infectious Disease (Department of Medicine)
8. Nephrology (Department of Medicine)
9. Neurology (Department of Medicine)
10. Pulmonary Medicine (Department of Medicine)
11. Obstetrics & Gynecology (Department of Surgery)
12. Ophthalmology (Department of Surgery)
13. Orthopedic Surgery (Department of Surgery)
14. Otolaryngology (Department of Surgery)
15. Urology (Department of Surgery)
16. Vascular Surgery (Department of Surgery)
	1. **REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS AND SECTIONS**

Each Department and Section shall be a separate organizational component of the Medical Staff, and all Staff members shall be a member of the Department and Section (if applicable) which most closely reflects their professional training and experience and the clinical area in which their practices are concentrated. A practitioner may be granted clinical privileges in one or more of the other Departments or Sections; the exercise of clinical privileges within the jurisdiction of any Department or Section shall always be subject to the rules and regulations of that Department and Section and the authority of the Department Chair and Section Chief.

**8.3 FUNCTIONS OF DEPARTMENTS**

 **8.3-1 MEETING AND GENERAL FUNCTIONS**

 All Departments shall each hold regular meetings of the Department no less than quarterly, depending on the needs of the Department. Departments fulfill administrative, collegial and quality-of-care maintenance and improvement functions. Through election to Departmental offices and Departmental representation on committees, the Staff members affiliated with each Department shall perform these same functions on a multidisciplinary, Staff and Hospital-wide basis.

  **8.3-2 ADMINISTRATIVE FUNCTIONS**

 Each Department shall assure that its members contribute their professional views and insights to the formulation of Medical Staff and JMH Policies and Plans, shall communicate formulated Policies and Plans back to its members for implementation, and shall coordinate the professional services of its members with those of other Departments and services and with JMH and Medical Staff support services.

 **8.3-3 QUALITY IMPROVEMENT FUNCTIONS**

 Each Department shall discharge the following quality improvement and accountability functions, either alone or in concert with other organizational components of the Medical Staff and JMH.

1. Conduct special studies of the inputs, processes and outcomes of care and specified monitoring activities, including mortality and invasive procedure reviews, which will reference the required data collection points per the Joint Commission, for the purpose of evaluating the clinical work performed under its jurisdiction.
2. Establish minimum requirements for the clinical privileges that may be exercised by its members and others exercising clinical privileges within its jurisdiction, review the demonstrated results of privileges so exercised, and frame recommendations for future privileges.
3. Monitor its members’ performance, on a continuing and concurrent basis, for adherence to Staff and Department Policies and Procedures, including requirements for alternate coverage and for obtaining consultation; for adherence to sound principles of clinical practice; for appropriate surgical and other procedures; for unexpected clinical occurrences; and for patient safety via the OPPE process.
4. Establish such committees or other mechanisms as are necessary and desirable to properly perform the quality improvement functions assigned to it.

 **8.3-4 COLLEGIAL FUNCTIONS**

 Each Department shall serve as the most immediate peer group for providing clinical and emotional support among and between peers, for teaching, continuing education, research and sharing of new knowledge, and for providing consultation within the Department and throughout JMH in its specialty area.

**8.4 FUNCTIONS OF SECTIONS**

Each Section shall perform the functions assigned to it by the Department in which it is under and/or the MEC. Such functions may include, without limitation, any of the functions described above for Departments. A Section shall transmit an annual report at the Annual Staff meeting and reports on the conduct of its assigned functions to the Department Chair upon request.

**ARTICLE NINE**

**DEPARTMENT AND SECTION CHAIRPERSONS**

**9.1 DEPARTMENT CHAIRPERSONS**

1. Chairpersons of the Departments will be elected by their respective Departments at their Annual Meeting, and will be recommended to the Board for approval. They will supervise the quality of care provided within their Department at the Hospital. Such Chairpersons shall be recognized by their peers as holding qualities of professional abilities and leadership which will assure both the Medical Staff and the Board of competent supervision. In the event that there is not an Active Staff member who is eligible to fulfill this role, while continuing the search, an Interim Chairperson may be selected to fill in temporarily. The expectation would be as soon as a suitable candidate is found within the Active Medical Staff; that candidate would assume the role of Department Chairperson.
2. Each Department Chairperson shall be a member of the Active Staff, shall be certified by an appropriate specialty board, with demonstrated ability in at least one of the clinical areas covered by the Department.

Any member of the Medical Staff who has served Johnson Memorial Hospital in the past or is currently serving in the capacity of Chairperson of a Department and/or Section shall be allowed to hold either or both positions in the future independent of their board certification status.

1. Each Department Chairperson unless otherwise ineligible (i.e. Officer of either JMH or JMH) will be a voting member of the Medical Executive Committee.
2. A Department Chairperson shall serve a one‑year term commencing on his/her appointment. The number of years is consistent with the rules governing MEC membership.
3. The MEC, or a 50% plus one or a majority vote of the Department members eligible to vote on Departmental matters, may recommend removal of a Departmental Chairperson.
4. Duties:
	1. Shall conduct no less than the required meetings annually of his/her Department, as listed in Article Eight Section 8.3-1 and be accountable to the MEC and to the President of the Medical Staff for all professional and administrative activities within his/her Department; particularly for the quality of patient care rendered by the members of his/her Department;
	2. Shall be responsible for the effective conduct of all clinically related activities of the Department;
	3. Shall develop in conjunction with his/her Department all administrative related activities of the Department and shall administer them unless otherwise provided for by the Hospital;
	4. Shall give guidance on the overall Medical Policies of the Hospital, making specific recommendations and suggestions regarding his/her own Department;
	5. Shall maintain continuing review of the professional performance of all practitioners with clinical privileges and of all Advanced Practice Professionals with specified services in his/her Department and report regularly thereon to the MEC;
	6. Shall transmit to the appropriate authorities his/her Department's recommendation concerning appointments and classification, reappointment, delineation of clinical privileges or specified services, or corrective action with respect to practitioners in his/her Department;
	7. Shall enforce the Hospital and Medical Staff Bylaws, Rules and Regulations within his/her Department;
	8. Implement within his/her Department actions taken by the MEC and by the Board;
	9. Shall perform such other duties commensurate with his/her office as may from time to time be reasonably requested by the MEC, by the President of the Hospital, or by the Board.
	10. Shall be responsible for recommending criteria for clinical privileges in the Department to the Credentials Committee;
	11. Shall recommend privileges for all members of the Department;
	12. Shall recommend all off site services using Medical Staff approved criteria.
	13. Shall develop annual quality improvement goals for his/her Department.

**9.2 SECTION CHAIRPERSONS**

1. Chairpersons of the Sections of the Medical Staff shall be elected by their respective Sections (or Departments, if applicable) to supervise and control the quality of care provided within the Hospital. Such Chairpersons shall be recognized by their peers as holding qualities of professional abilities and leadership which will assure both the Medical Staff and the Board of competent medical supervision.
2. A Section Chairperson shall serve a one‑year term commencing on his/her appointment.
3. Each Section Chairperson shall be a member of the Active Staff, shall be certified by an appropriate specialty board, and be a member of the Section which he/she is to head and shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by his/her Section. In the event that there is no Active Staff member who is eligible to serve as Section Chairperson, an Associate Staff member may fulfill this role.
4. The MEC, or a 50% plus one or a majority vote of the Section members eligible to vote on Section matters, may recommend removal of a Section Chairperson.
5. Duties:
	1. Each Section Chairperson shall account to his/her Department Chairperson and to the MEC for the effective operation of his/her Section and for his/her Section's discharge of all tasks delegated to it;
	2. Shall act as presiding Officer at all Section meetings which will be held as needed at the call of the respective Section Chairperson or respective Department Chairperson;
	3. Shall develop and implement in cooperation with his/her Department Chairperson programs to carry out the quality review, evaluation, and monitoring functions assigned to his/her Section;
	4. Shall exercise general supervision over all clinical work performed within his/her Section;
	5. Shall perform such other duties commensurate with his/her office as may from time to time be reasonably requested by his/her Department Chairperson, by the MEC, by the President of the Hospital, or by the Board; and
	6. Shall be responsible for recommending criteria for clinical privileges within his/her Section to the respective Department Chairperson.

**ARTICLE TEN**

**COMMITTEES**

**10.1 MEDICAL STAFF**

The Medical Staff shall be assisted in its activities by Committees whose Chairperson and Membership shall be appointed by the President of the Medical Staff. The Committee minutes shall be regularly reviewed by the MEC and any other Committees as appropriate.

**10.2 STANDING COMMITTEES**

**10.2-1 STANDING COMMITTEES OF THE STAFF**

* Administrative Affairs Committee
* Advanced Practice Professional Committee
* Ethics Committee
* ICU Committee
* Investigational Review Committee
* Palliative Care Committee
* Perinatal Committee
* Perioperative Committee
* Radiation Safety Committee
* Utilization Management Committee

 **10.2-2 PEER REVIEW COMMITTEES OF THE STAFF**[[1]](#footnote-1)

* Credentials Committee
* Infection Prevention Committee
* Pharmacy and Therapeutics Committee
* Physician Quality Improvement Committee

**10.2-3 OTHER COMMITTEES**

* Quality Committee of the Board

**10.2-4 NON MEDICAL STAFF MEMBERS**

Other members of these Committees, when appropriate to the functions necessary, such as from Patient Care Services (Nursing), Health Information Services (Medical Records), Pharmaceutical Services, Social Services, and Facility Engineering Services, shall be appointed by the President of the Hospital and shall not have a vote.

**10.2-5 PRESIDENT OF THE MEDICAL STAFF**

The President of the Medical Staff or his/her designee may serve as an ex-officio member with a vote on all Committees.

**10.2-6 PRESIDENT OF THE HOSPITAL**

The President of the Hospital or his/her designee may serve as an ex‑officio member without a vote on all Committees.

**10.3 MEDICAL EXECUTIVE COMMITTEE (“MEC”)**

 **10.3-1 COMPOSITION**

The Executive Committee of the Medical Staff shall consist of the following members: the President of the Medical Staff, the Vice President of the Medical Staff, the Chairperson of the Department of Anesthesiology, the Chairperson of the Department of Emergency Medicine, the Chairperson of the Department of Family Medicine and Pediatrics, the Chairperson of the Department of Medicine with one additional Representative from the Department of Medicine, the Chairperson of the Department of Pathology, the Chairperson of the Department of Psychiatry, the Chairperson of the Department of Radiology, the Chairperson of the Department of Surgery with one additional Representative from the Department of Surgery, and the Chairperson of the Advanced Practice Professional Committee. A member of the Credentials Committee shall not simultaneously be a member of the Executive Committee. The President of the Hospital shall be an ex‑officio member without vote. The Chief Medical Officer or his/her alternate as designated by Hospital Administration shall be an ex‑officio member without vote.

Each Department Chairperson, and additional Department Representatives from Medicine and Surgery, would have to be elected at the Annual Meetings of their respective Departments. A member of the MEC may be removed for cause upon the vote of a majority of all of the members of the Medical Staff entitled and eligible to vote.

The Executive Committee shall meet at least once per month and maintain a permanent record of its proceedings and actions. When necessary, the Executive Committee shall initiate peer review sessions during regular business meetings to review minutes or other matters. The record of such sessions shall be marked “PEER REVIEW”.

**10.3-2 PURPOSE AND DUTIES**

The Executive Committee is empowered by the Medical Staff:

1. To receive and act upon reports and recommendations from the Departments, Committees, and Officers of the Staff concerning the patient care audit and other quality review, evaluation, and monitoring functions and recommend to the Board specific programs and systems to implement these functions;
2. To enforce the Bylaws, and Rules and Regulations of the Medical Staff and recommend to the Board of the Hospital appropriate action for infraction of these Bylaws, and Rules and Regulations;
3. To discharge the business of the Staff and report appropriate recommendations for approval at the regular Staff meetings;
4. To serve as Medical Staff representative on the Quality Committee of the Board;
5. To hold meetings monthly and at other times as it may be necessary. Meetings shall also be called by the Chairperson at the request of the President of the Hospital or of any three members of the Medical Staff;
6. To recommend to the Board all matters related to Staff appointments, reappointments, Staff categorization, Department assignment, clinical privileges, and corrective action;
7. To account to the Board and the Staff for the overall efficiency of patient care in the Hospital;
8. To inform the Medical Staff of the accreditation program and accreditation status of the Hospital;
9. To make recommendations on Medical, Administrative, and Hospital matters;
10. To represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws;
11. To take reasonable steps to insure professional and ethical performance on the part of the Staff members as defined in the Medical Staff Code of Conduct Policy; and
12. To act for the Medical Staff in the interval between Staff meetings, the acts of which are subject to the approval of the Medical Staff.

 Any changes to, including addition or removal, of the authority given to the MEC hereunder must be approved by an amendment to these Medical Staff Bylaws approved by the Active Medical Staff and the Advanced Practice Professional Active Staff as provided in Article Seventeen.

**10.4 ADMINISTRATIVE AFFAIRS COMMITTEE**

 **10.4-1 COMPOSITION**

The Administrative Affairs Committee shall consist of four members of the Staff and its Chairperson shall be the Vice President of the Medical Staff. The members will be appointed by the President of the Medical Staff.

 **10.4-2 PURPOSE AND DUTIES**

This Committee shall act on directives given to it by the Executive Committee and on recommendations from the President of the Hospital or Staff Members on motions for Bylaw changes passed by the Staff at a regular Staff meeting. It shall conduct an annual review of the Bylaws and of the Rules and Regulations of the Staff and shall present to the Medical Executive Committee recommendations for additions to, revisions of, and deletions from the Bylaws as indicated from time to time.

This Committee shall present the list of nominees for the elective offices of the Staff at least thirty days before the Annual Meeting. This Committee shall also present to the Staff nominees for vacant positions as they occur.

**10.5 CREDENTIALS COMMITTEE**

 **10.5-1 COMPOSITION**

The Credentials Committee shall consist of five members, from the Active Medical Staff and the Advanced Practice Professional Active Staff, appointed annually by the President of the Medical Staff. No member of the Credentials Committee shall simultaneously be a member of the Medical Executive Committee.

 **10.5-2 PURPOSE AND DUTIES**

This Committee shall meet monthly. This Committee shall investigate the credentials of all applicants for admission to the Medical Staff in conformity with the procedure for Staff appointments provided for in Article Three of these Bylaws, andshall review all information regarding the competence of Staff members and as a result of such reviews shall make recommendations for the granting of privileges, reappointments, and assignment of members to various Departments.

This Committee shall advise the Medical Executive Committee on means for determining the status of physical and mental health of each member of the Staff with specific relation to reappointment and renewal of privileges.

This Committee shall meet monthly or as frequently as needed, and maintain a permanent record of its proceedings and actions; all meetings of the Credentials Committee shall be conducted as peer review sessions. The record of such sessions shall be marked “PEER REVIEW”.

 **10.5-3 APPLICANT CREDENTIALING PROCESS**

* 1. The Applicant Credentialing Process is delineated in the Credentialing Policy/Procedure Manual. The MEC shall have authority to adopt and amend the Credentialing Policy/Procedure Manual and shall communicate any new additions or amendments to the Medical Staff within thirty days of adoption of such changes.
	2. The basic steps of the credentialing process are as follows, and are subject to the further details provided for in the Credentialing Policy/Procedure Manual:
		1. A complete application, along with all necessary documentation, professional references, and completed primary source verifications shall be reviewed by the Section Chief (if applicable) and Department Chief for recommendation to the Credentials Committee;
		2. The Credentials Committee shall review and evaluate the application;
		3. The Credentials Committee may request additional information, documentation or investigation related to review of the application;
		4. The Credentials Committee may request an interview with any applicant after review of the applicant’s application for privileges and related documentation;
		5. Following the Credentials Committee's review and possible interview, the applicant's credentials will be approved or disapproved by a majority vote;
		6. The Credentials Committee's recommendation will be reported in the minutes to the Medical Executive Committee for review and recommendation to the Board;
		7. The MEC shall review the recommendation from the Credentials Committee, the application and all other materials for recommendation to the Board for the Board’s final decision.
	3. The above process will apply to all applicants for Staff privileges in the following Staff categories (Active, Associate, Advanced Practice Professional Active, Advanced Practice Professional Associate, and Emeritus).

**10.6 INFECTION PREVENTION COMMITTEE**

 **10.6-1 COMPOSITION**

This Committee shall consist of three members from the Medical Staff appointed annually by the President of the Medical Staff, the Nurse Epidemiologist, the Vice President of Patient Care Services, the Director of Pharmacy, and consulting members from all Departments and Sections of the Hospital may be invited to attend meetings, as a guest, whenever it is deemed necessary.

 **10.6-2 PURPOSE AND DUTIES**

The Infection Prevention Committee shall establish procedures to investigate Hospital infections in all areas of the Hospital and offsite ambulatory campuses and take measures to prevent and control them.

This Committee shall hold at least six meetings annually and maintain a record of all its activities, and submit same to the Medical Executive Committee and any other Committees as appropriate.

**10.7 PHARMACY & THERAPEUTICS COMMITTEE**

 **10.7-1 COMPOSITION**

This Committee shall consist of three members from the Medical Staff appointed by the President and any other members of the Medical Staff and Hospital personnel as deemed necessary.

 **10.7-2 PURPOSE AND DUTIES**

This Committee shall review the use of pharmaceutical materials and therapeutic agents within the Hospital and shall make observations and recommendations based thereon. It shall also maintain an ongoing review of the use of antibiotics in the Hospital, performing audits from time to time when deemed necessary.

This Committee shall advise on the content of the Hospital formulary and shall make recommendations on additions thereto, changes therein, or deletions there from.

This Committee shall meet no less than quarterly and meet more often as needed depending on the needs of the Committee and maintain a record of all its activities, and submit same to the Medical Executive Committee and any other Committees as appropriate.

**10.8 QUALITY COMMITTEE OF THE BOARD (“QCOB”)**

 **10.8-1 COMPOSITION**

The QCOB is comprised of not fewer than two Directors of the Board in addition to the Board Chair, Hospital President, and Medical Staff President. Other members shall be determined by the Johnson Board of Directors. Non-Board Directors may serve on the Committee as non-voting members. The Board Chairman and the Medical Staff President shall serve as co-Chairs of the Committee and will run meetings on an alternating basis.

 **10.8-2 PURPOSE AND DUTIES**

This Committee shall:

1. Meet at least quarterly. The Committee shall meet bi-monthly and as needed.
2. Record and maintain minutes of all meetings and submit to the Johnson Board of Directors for approval.
3. Identify, prioritize and implement quality and safety goals for the calendar year.
4. Assess Quality Committee of the Board goals at the end of each calendar year, and make recommendations regarding goals for the next calendar year.
5. Review reports and make recommendations with regard to quality indicators in dashboard format, including roll-up measures of clinical quality, patient safety and patient experience.
6. Review of Casual Analysis/Root Cause Analysis.
7. Review of Regulatory Corrective Action Plan compliance and regulatory survey updates.
8. Review regular reports on mortality, morbidity, adverse events and peer review activities.
9. Review and recommend for approval the reports of the Credentials Committee of the Medical Staff regarding privileging and credentialing.
10. Review and recommend for approval any policies and procedures pertaining to the Medical Staff.
11. Review and recommend for approval any changes to the Bylaws, Rules and Regulations of the Medical Staff.
12. Inform members of the Board of Directors of any issues concerning quality of care, patient safety, patient experience, accreditation, adverse events and the Medical Staff.

**10.9 PHYSICIAN QUALITY IMPROVEMENT COMMITTEE (“PQIC”)**

 **10.9-1 COMPOSITION**

The PQIC is a multi-disciplinary committee and shall consist of: the President of the Medical Staff; the Vice President of the Medical Staff; the Chair of the Department of Surgery; the Chair of the Department of Medicine; the Chair of the Department of Emergency Medicine, and the Chair of any additional Department or Subsection, appointed by the Medical Staff President or his/her designee. The Committee Chair shall be the President of the Medical Staff or the President’s designee. The CMO shall serve ex-officio without vote. A member of the JMH QI team may also serve as ex-officio without vote. As appropriate, the Committee may act through subcommittees or committee members, and may retain consultants or experts from time to time as needed for a particular task or review.

 **10.9-2 PURPOSE AND DUTIES**

The Physician Quality Improvement Committee (PQIC) shall coordinate and monitor the peer review activities conducted by the Medical Staff, its Departments and services.

This Committee shall meet monthly as needed and maintain a record of all its activities, and submit same to the Medical Executive Committee.

In addition the PQIC shall coordinate peer review activities undertaken by and may work jointly in such peer review activities with the MEC, the Organizational Process Improvement and Safety Committee, and any other quality improvement committees within JMH or the Medical Staff (i.e. Credentials Committee, Infection Prevention Committee, Pharmacy & Therapeutics Committee).

Specifically, the PQIC shall:

(a) Review and oversee the peer review activities of all Medical Staff Departments and services throughout JMH including evaluating the quality and efficiency of services ordered or performed.

(b) The Committee shall request and receive reports from all Medical Staff Departments, services and Sections and shall authorize the collection and analyses of pertinent information. The Committee minutes shall reflect its findings on the quality of care provided by Departments and services.

(c) The Committee shall highlight exemplary performance and/or recommend corrective action for identified problems regarding clinical competence and may make recommendations for further activities taken by Departments and services.

**10.10 PALLIATIVE CARE COMMITTEE**

 **10.10-1 COMPOSITION**

This Committee shall consist of at least one member from the Medical Staff appointed annually by the President of the Medical Staff (a Pain Management and Palliative Care Specialist Physician/APRN if available), a Social Worker, a Case Management Representative, a Hospice Home and Community Nurse, and a Representative from Executive Leadership. Consulting members from all Departments and Sections of the Hospital, including Pharmacy, Clergy, Psychiatry, Clinical Nutrition and Rehabilitation, may be invited to attend meetings, as a guest, whenever it is deemed necessary.

 **10.10-2 PURPOSE AND DUTIES**

The Palliative Care Committee shall provide the inpatient, outpatient or nursing home resident with a multidisciplinary team, who can help with difficult decisions, assist in communications and provide expertise in the areas of pain and symptom control.

This Committee shall hold meetings as often as necessary to fulfill its responsibilities and maintain a record of all its activities, and submit same to the Medical Executive Committee and any other Committees as appropriate.

**10.11 ADVANCED PRACTICE PROFESSIONAL COMMITTEE**

 **10.11-1 COMPOSITION**

This Committee shall consist of all Advanced Practice Professional Staff Members (Active and Associate) and the physician liaison for this Committee would be the Chief Medical Officer or designee. Its Chairperson would be elected by the members of the Committee.

 **10.11-2 PURPOSE AND DUTIES**

The Advanced Practice Professional Committee would address matters that pertain to the Advanced Practice Professional Staff. The Chairperson of the Committee would be a member of the Medical Executive Committee and will serve as an advisory member of the Credentials Committee.

The Committee shall hold meetings as often as necessary to fulfill its responsibilities and maintain a record of all its activities, and submit same to the Medical Executive Committee.

**10.12 OTHER COMMITTEES**

All other committees deemed essential for the proper functioning of the Medical Staff shall be appointed by the President of the Medical Staff with approval of the Medical Executive Committee. Committees also may undertake any additional duties required of them by other provisions of these Bylaws and Rules and Regulations.

**ARTICLE ELEVEN**

**CORRECTIVE ACTION**

This Article addresses the types of intervention which may be undertaken to address attitude, behavior and/or professional conduct or clinical performance out of compliance with these Bylaws. The medical staff leadership will select the most appropriate intervention(s) depending upon the facts and circumstances.

**11.1 COLLEGIAL INTERVENTION**

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

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders. The President of the Medical Staff in conjunction with the Chief Medical Officer shall determine whether to direct a matter to be handled in accordance with another Section of the Bylaws, such as the Corrective Action process or the Policy on Physician Health. The collegial intervention provided in this Section 11.1 is not a procedural right of the Practitioner and shall not be conducted according to the procedural rules provided in Article Twelve of these Bylaws. The Practitioner shall not be permitted to bring an attorney or other representative to any meetings or interviews. All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional peer review activities.

The CMO, in consultation with the applicable Department Chief shall determine whether it is appropriate to include documentation of the collegial intervention efforts in the Practitioner’s confidential peer review file. If documentation of collegial efforts is included in an individual’s file, it shall include information about the resolution of the collegial intervention and the individual shall have an opportunity to review it and respond in writing. The response shall be maintained in the file along with the original documentation.

**11.2 DISCRETIONARY INTERVIEW PRIOR TO CORRECTIVE ACTION**

Prior to initiating corrective action against a member of the Medical Staff, the initiating party may, but is not obligated to, afford the Practitioner a formal interview at which the circumstances prompting the corrective action shall be discussed and the Practitioner shall be permitted to present relevant information in the Practitioner's own behalf. A formal interview shall be initiated by Special Notice to the Practitioner from the Chair of the appropriate Department or President of the Medical Staff. A copy of the Special Notice shall be sent to each of the following: the President of the Medical Staff, the appropriate Department Chair, the President of the Hospital and the CMO. The President of the Medical Staff and the President of the Hospital may, at their option, be present as observers at a formal interview. If the Practitioner fails to respond to the Special Notice or declines to participate in the interview, corrective action shall immediately proceed in accordance with these Bylaws. The formal interview provided in this Section 11.2 is not a procedural right of the Practitioner and shall not be conducted according to the procedural rules provided in Article Twelve of these Bylaws. The Practitioner shall not be permitted to bring an attorney or other representative to formal interviews.

**11.3 ROUTINE CORRECTIVE ACTION**

Whenever the acts, statements, demeanor, clinical conduct or professional conduct of a member of the Medical Staff with Clinical Privileges, either within or outside of the JMH Facilities, are, appear to be, or are reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, a reason for serious concern as to the member’s clinical competence, disruptive to the JMH Facilities or day-to-day operations, or the operations of the JMH Facilities, or an impairment to the community's confidence in the Hospital or the JMH Facilities, then any one of the following: an Officer of the Medical Staff, the Chair of any Department or Chief of any service in which the Practitioner holds membership or exercises Clinical Privileges, the President of the Hospital, the CMO or the Board, may, in his/her or its discretion, request that the MEC review, investigate and/or discuss such conduct or behavior for the purpose of evaluation of the need for corrective action against the Practitioner and determination of the recommended scope of corrective action, if any.

**11.3-1 REQUESTS AND NOTICES**

All requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct constituting the grounds for the request. The President of the Medical Staff shall promptly notify the President of the Hospital in writing of all requests.

The MEC shall inform the Practitioner that an investigation has begun. However, notification may be delayed if, in the MEC’s sole discretion, informing the individual promptly would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

**11.3-2 INVESTIGATION**

After review and consideration of a request for corrective action, the MEC shall either act on the request or direct that an investigation concerning the grounds for the corrective action request be undertaken. The MEC shall conduct such investigation itself or assign this task to a Medical Staff Officer, Department or service, standing or ad hoc committee, or other organizational component of the Staff. The investigation begins when the MEC so designates. Expert assistance may be obtained to assist in an investigation. The investigating committee may require a physical and/or mental examination of the Practitioner by a health care professional acceptable to it if the circumstances indicate that such examination would be appropriate or necessary. The Practitioner being investigated shall execute a release allowing the investigating committee to discuss with the health care professional the reasons for the examination and for such health care professional to provide a report of the results of the examination to the investigating committee. This investigative process is not a "hearing" as that term is used for purposes of hearing and appellate review. It may include a consultation with the Practitioner involved and with the individuals who may have knowledge of the events involved. If the investigation is conducted by a group or individual other than the MEC, that group or individual shall forward a written report of the investigation to the MEC as soon as is practicable. Failure of the Practitioner to submit information requested by the MEC (or a Medical Staff Officer, Department or service, standing or ad hoc committee, or other organizational component of the Staff) as part of an investigation within the time specified in the request shall result in voluntary relinquishment of privileges and staff membership. The MEC may at any time within its discretion terminate the investigative process and proceed with action as provided below. If an investigation is conducted by the MEC pursuant to a request or inquiry by the Board, the results of such investigation and recommendation shall be forwarded to the Board. The Practitioner shall not be permitted to bring an attorney or other representative to any consultation, meeting or interview with the investigating committee.

**11.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION**

The MEC shall act upon a request for corrective action at the regular meeting of the MEC next occurring after the conclusion of the investigative process, but in any event not more than thirty days from the conclusion of the investigative process, or if no investigation was done, then not more than thirty days after receipt of the request for corrective action, unless deferred as provided below. The action of the MEC may, without limitation, recommend:

1. Rejection of the request for corrective action.
2. A warning or formal letter of counsel or reprimand.
3. Imposition of a requirement for additional training or continuing education.
4. A probationary period with monitoring of cases but without special
 requirements of prior or concurrent consultation, direct supervision or prior
 approval of the plan of treatment.
5. Suspension of some or all of Membership Prerogatives that do not affect
 Clinical Privileges.
6. Individual requirements of mandatory consultation or supervision, with
 requirement of prior approval of the course of treatment.
7. Reduction, restriction, suspension, denial or revocation of Clinical Privileges.
8. Reduction of Staff category or suspension or limitation of any Membership
 Prerogatives directly related to the Practitioner's provision of patient care.
9. Suspension or revocation of Staff membership.
10. Further inquiry or other appropriate action.

**11.3-4 DEFERRAL**

If additional time is needed to complete the investigative process, the MEC may defer action on the request for good cause. A subsequent recommendation for any one or more of the actions provided in Section 11.3-3 shall be made as promptly as possible.

**11.3-5 PROCEDURAL RIGHTS**

A Practitioner shall be entitled to the procedural rights and hearing process contained in Article Twelve only when the recommendation by the MEC or the decision by the Board is adverse in accordance with the list in Section 12.2-1. Any other recommendation or action by the MEC or decision by the Board, including the actions listed in Section 12.2-2, shall be deemed non-adverse and the Practitioner shall not be entitled to any hearing or appellate review.

**11.4 SUMMARY SUSPENSION**

**11.4-1 SUMMARY SUSPENSION**

Any two of the following, the President of the Hospital, the Chief Medical Officer, the President of the Medical Staff, the Chief of the Practitioner’s Department or the MEC, shall have the authority to summarily suspend all or a portion of the Clinical Privileges or the Medical Staff membership of a Practitioner where the failure to take such an action could result in an imminent danger to the health of any individual. A summary suspension can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following an adverse recommendation of the MEC that would entitle the individual to request a hearing. Such suspension shall become effective immediately upon imposition. The President of the Hospital shall promptly notify the Practitioner of the summary suspension via certified mail and provide a brief description of the reasons for such action.

**11.4-2 CARE OF PATIENTS**

Immediately upon the imposition of a summary suspension, the President of the Medical Staff, or his or her designee, shall have authority to provide alternate coverage for the Practitioner’s patients who are admitted in the Hospital at the time of the summary suspension. The wishes of the patient shall be considered in the selection of such alternative coverage where feasible.

**11.4-3 MEDICAL EXECUTIVE COMMITTEE ACTION**

As soon as possible, but in not less than fourteen days after a summary suspension is imposed, the MEC shall convene to review the matter and consider the action taken. Prior to, or as part of, this review, the Practitioner may, in the discretion of the MEC, be given the opportunity to meet with the MEC to discuss, explain or refute the information that gave rise to the summary suspension. Any such meeting shall not constitute a “hearing” under Article Twelve and none of the procedural rights thereunder shall apply to such meeting. The MEC shall determine whether there is sufficient information to warrant a final recommendation, or whether an investigation in accordance with Section 11.3-2 is necessary or appropriate. The MEC shall also determine whether the summary suspension should be continued, modified or terminated. If the summary suspension is continued, the MEC shall indicate the time period for continuation, which may include continuation until completion of the investigation and its further review of the matter, or until completion of the hearing and appeal process, if applicable.

**11.4-4 PROCEDURAL RIGHTS**

(a) If the MEC determines that an investigation is necessary or appropriate, then Section 11.3-2 shall apply. The Practitioner shall not be entitled to a hearing or any of the procedural rights set forth in Article Twelve with respect to the MEC’s action to conduct an investigation or to the imposition or continuation of a summary suspension pending any investigation.

(b) If the MEC makes a final recommendation that is adverse to the Practitioner, as listed in Section 12.2-1, then the Practitioner shall be entitled to the procedural rights contained in Article Twelve. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board, unless otherwise modified or terminated by the MEC. The MEC’s recommendation shall be promptly transmitted, together with all supporting documentation, to the Chair of the Board and the President of the Hospital. The Practitioner shall be entitled to a single hearing and review process with respect to review of the summary suspension and the adverse recommendation of the MEC.

(c) If the MEC makes a final recommendation to terminate the summary suspension or to modify the suspension to an action that is non-adverse to the Practitioner, as listed in Section 12.2-2, then the procedural rights contained in Article Twelve shall not apply. The terms of the summary suspension as originally imposed may be modified or terminated as determined by the MEC. The MEC’s recommendation and decision shall be promptly transmitted, together with all supporting documentation, to the Chair of the Board and the President of the Hospital.

**11.5 AUTOMATIC REVOCATION, RESTRICTION, SUSPENSION, OR PROBATION**

**11.5-1 LICENSE**

1. Revocation or Relinquishment: Whenever a Practitioner's license to practice in Connecticut is revoked or voluntarily relinquished, the Practitioner's Staff membership and Clinical Privileges shall be immediately and automatically revoked without resort to the provisions of Article Twelve. If the license subsequently is restored or a new license is issued, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.
2. Restriction: Whenever a Practitioner's license is limited or restricted in any way, those Clinical Privileges which had been granted that are within the scope of the limitation or restriction shall be similarly limited or restricted automatically, effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation until reinstatement is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-1(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
3. Suspension: Whenever a Practitioner's license is suspended, Staff membership and Clinical Privileges shall be automatically suspended effective upon and for at least the term of the suspension until reinstatement is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-1(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
4. Probation: Whenever a Practitioner is placed on probation by a licensing authority, the Practitioner's voting and office-holding Membership Prerogatives shall be automatically suspended effective upon and for at least the term of the probation until reinstatement is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-1(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
5. Non-Renewal: Whenever a Practitioner's license is declared void because of non-renewal, as defined by the State of Connecticut, Department of Public Health, the Practitioner's Staff Membership and Clinical Privileges shall be automatically suspended. Presentation of a valid license within six (6) months shall allow reinstitution of Staff Membership and Clinical Privileges if reinstatement is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-1(f) hereof. Further action on the matter shall proceed under Section 11.5-4. After six (6) months, the Practitioner's Staff membership and Clinical Privileges shall automatically terminate and upon reinstitution of the Practitioner's license, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.
6. Upon the renewal of a Practitioner's license or the termination of a restriction, suspension or probation of a Practitioner's license, the Practitioner may request in writing to the President of the Medical Staff and the Chief Medical Officer for reinstatement of Staff membership, Membership Prerogatives and Clinical Privileges, as applicable. The President of the Medical Staff or the Chief Medical Officer shall review the request for reinstatement and if such license has been renewed or the restriction, suspension or probation has been terminated, the Practitioner's Staff membership, Membership Prerogatives and Clinical Privileges, as applicable, shall be so reinstated unless further action is or has been taken pursuant to Section 11.5-4. Notwithstanding the foregoing, in the event that the Practitioner's term of appointment expires during a suspension or period of nonrenewal of the Practitioner's license, the Practitioner's Staff membership and Clinical Privileges shall automatically terminate and upon termination of such suspension, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.
7. In the event of a restriction, revocation, suspension or probation of Membership Prerogatives, Staff membership or Clinical Privileges pursuant to this Section 11.5-1, the provisions of Article Twelve of these Bylaws shall not apply.

**11.5-2 CONTROLLED SUBSTANCE REGISTRATION OR PRESCRIBING
 AUTHORITY**

1. Revocation or Relinquishment: Whenever a Practitioner's controlled substance registration or prescribing authority is revoked or voluntarily relinquished, the Practitioner shall be immediately and automatically divested of the right to prescribe medications covered by the registration or prescribing authority without resort to the provisions of Article Twelve, until reinstatement of the right to prescribe medications is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-2(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
2. Restriction: Whenever a Practitioner's controlled substance registration or prescribing authority is restricted or limited in any way, the Practitioner's right to prescribe medications covered by the registration or prescribing authority, shall be similarly restricted or limited automatically, effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation until reinstatement of the right to prescribe medications is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-2(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
3. Suspension: Whenever a Practitioner's controlled substance registration or prescribing authority is suspended, the Practitioner shall be divested of the right to prescribe medications covered by the registration or prescribing authority effective upon and for at least the time of the suspension until reinstatement of the right to prescribe medications is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-2(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4.
4. Probation: Whenever a Practitioner is placed on probation, insofar as the use of the controlled substance registration or prescribing authority is concerned, the Practitioner’s right to prescribe medications covered by the registration or prescribing authority shall automatically become subject to the same terms of probation effective upon the effective date of such probation and for at least the time of the probation until reinstatement of the right to prescribe medications is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-2(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4 below.
5. Non-Renewal: Whenever a Practitioner's controlled substance registration or prescribing authority expires due to non-renewal, the Practitioner shall be divested of the right to prescribe medications covered by the controlled substance registration or prescribing authority effective upon the date of expiration and for at least the duration of time until a valid controlled substance registration or prescribing authority is reinstated and until reinstatement of the right to prescribe medications is requested by the Practitioner and granted by the President of the Medical Staff or the Chief Medical Officer in accordance with Section 11.5-2(f) hereof. Further action on the matter may at the discretion of the MEC proceed under Section 11.5-4 below.
6. Upon the renewal or the termination of a restriction, suspension or probation of a Practitioner's controlled substance registration or prescribing authority, the Practitioner may request in writing to the President of the Medical Staff and the Chief Medical Officer for reinstatement of the Practitioner's right to prescribe medications, as applicable. The President of the Medical Staff or the Chief Medical Officer shall review the request for reinstatement and if such registration or authority has been renewed or the restriction, suspension or probation has been terminated, the Practitioner's right to prescribe medications, as applicable, shall be so reinstated unless further action is or has been taken pursuant to Section 11.5-4.
7. In the event of revocation, restriction, suspension or probation of a Practitioner's right to prescribe medications pursuant to any provision of this Section 11.5-2, the provisions of Article Twelve of these Bylaws shall not apply.
	* 1. **EXCLUSION FROM PARTICIPATION IN FEDERALLY FUNDED
		 HEALTHCARE PROGRAMS**
8. Whenever a Practitioner is listed as being barred or excluded from participation in any federally-funded healthcare program, the Practitioner's Staff Membership and Clinical Privileges shall automatically be revoked as of the date such action became effective.
9. In the event of a revocation of a Practitioner's Staff Membership or Clinical Privileges pursuant to this Section 11.5-3, the provisions of Article Twelve of these Bylaws shall not apply. If the Practitioner becomes no longer barred or excluded, the Practitioner may, if eligible, apply for initial appointment to the Medical Staff in the same manner as other new applicants.

**11.5-4 MEDICAL EXECUTIVE COMMITTEE DELIBERATION**

As soon as practicable (a) after Practitioner's license is revoked, restricted, suspended, placed on probation or not renewed, or (b) after a Practitioner's controlled substance registration or prescribing authority is revoked, restricted, suspended, placed on probation or not renewed, the MEC shall convene to review and consider the facts upon which such action was taken. The MEC may initiate an investigation in accordance with Section 11.3-2 if it determines necessary or appropriate. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in its review or in any investigation, including without limitation, limitation of Membership Prerogatives. Thereafter, the procedure in Section 11.3-5, as applicable, shall be followed.

**11.5-5 MEDICAL RECORDS**

1. Timely Preparation and Completion: After written warning for failure to complete medical records in timely fashion, as provided in the Rules and Regulations of the Staff (except for current inpatients, patients already scheduled for procedures within thirty days, assist in emergency surgery cases and emergency Department call), (a) Practitioner's right to admit patients, to schedule procedures, to assist in surgery and to consult with respect to patients, and (b) a Practitioner's voting and office-holding Membership Prerogatives shall be automatically suspended effective on the date specified in the written warning and continuing until the delinquent medical records are completed. The Practitioner shall be notified of the suspension by a Staff Officer, the Department Chair or the CMO. The provisions of Article Twelve shall not apply.
2. Referral to MEC: After the third suspension in any six-month period or fourth suspension within any twelve month period for failure to complete or prepare medical records, or for any suspension greater than thirty (30) days, the CMO shall report the Practitioner's deficiencies to the President of the Medical Staff who shall request an investigation by the MEC. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation. Thereafter, the procedure in Section 11.3-5 shall be followed.

**11.5-6 PROFESSIONAL LIABILITY INSURANCE**

For failure to maintain the minimum amount of professional liability insurance, required in accordance with these Bylaws, a Practitioner's membership and Clinical Privileges shall be immediately suspended. In the event of such suspension, the provisions of Article Twelve of these Bylaws shall not apply, and the Practitioner's Staff membership and Clinical Privileges shall remain suspended until such time as the Practitioner obtains the specified minimum amount of professional liability insurance and provides proof thereof to the CMO. Notwithstanding the foregoing, the MEC may investigate and then recommend such further action as is appropriate to the facts disclosed in the investigation. Thereafter, the procedure in Section 11.3-5 shall be followed. If a suspension under this Section is in effect at the time of reappointment, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate and the provisions of Article Twelve shall not apply.

**11.5-7 FAILURE TO MAINTAIN THE CONFIDENTIALITY OF HEALTH
 INFORMATION**

1. In the event that a Practitioner fails to comply with the confidentiality of health information requirements set forth in Sections 3.6-9 and 3.6-10 of these Bylaws, the President of the Medical Staff, Department Chair, service Chief or CMO shall issue a written warning to the Practitioner. If after receipt of a written warning, the Practitioner fails to comply with the confidentiality of health information requirements, the Practitioner's (a) Clinical Privileges, (b) right to admit patients and to consult with respect to patients, and (c) voting and office-holding Membership Prerogatives shall be suspended by the President of the Medical Staff, Department Chair, service Chief or CMO effective immediately and continuing until the earlier of thirty days from the effective date of the suspension or such date on which the Practitioner agrees in writing to comply with the confidentiality of health information requirements. Except as provided in Section 11.5-7(b) the provisions of Article Twelve shall not apply.
2. In the event that a Practitioner fails to agree in writing to comply with the confidentiality of health information requirements of Sections 3.6-9 and 3.6-10 as permitted by Section 11.5-7(a), or concurrent with the second suspension of a Practitioner pursuant to Section 11.5-7(a) for failure to comply with the confidentiality of health information requirements of Sections 3.6-9 and 3.6-10, the President of the Medical Staff, Department Chair, service Chief or CMO shall request an investigation by the MEC pursuant to Section 11.3-2. Thereafter, the procedures for corrective action set forth in Section 11.3 shall apply.

 **11.5-8 CRIMINAL INDICTMENT OR CONVICTION**

If a Practitioner is convicted of, or enters a plea of “guilty or “no contest” to, a felony or misdemeanor involving a charge of moral turpitude (wrongful or depraved conduct), violence against another person, use of illegal drugs, or insurance or health care fraud or abuse, in any jurisdiction, then the Practitioner’s Medical Staff membership and Clinical Privileges shall be immediately and automatically revoked and the provisions of Article Twelve shall not apply. In the event of an indictment or charges filed against a Practitioner involving any of the foregoing charges, then the MEC will review the circumstances to determine if immediate suspension is warranted or if other correction action should be taken in accordance with Section 11.3 of these Bylaws.

 **11.5-9 FAILURE TO PROVIDE REQUESTED INFORMATION**

Failure of a Practitioner to execute a general or specific release and/or to provide information or documents for the evaluation of his or her clinical competency and qualifications for appointment to the Staff or clinical privileges in response to a written request from the Credentials Committee, the MEC, the CMO, the President of the Hospital, or any other committee authorized to request such information, shall result in automatic suspension of all Clinical Privileges until the information, documents or release is provided to the satisfaction of the requesting party. However, the Practitioner’s failure to comply with such request within thirty calendar days will be considered a voluntary resignation of Staff membership and all Clinical Privileges. The provisions of Article Twelve shall not apply to a suspension or voluntary resignation pursuant to this provision.

**ARTICLE TWELVE**

**PROCEDURAL RIGHTS**

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

**12.1 STANDARDS FOR PROFESSIONAL ACTIONS**

 **12.1-1 IN GENERAL**

All professional review actions shall be taken:

1. In the reasonable belief that the action was in furtherance of quality health care.
2. After a reasonable effort to obtain the facts of the matter.
3. In the case of adverse professional review actions, after adequate notice and hearing procedures are afforded to the Practitioner, as set forth in these Bylaws, or after such other procedures as are fair to the Practitioner under the circumstances.
4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of subparagraph (c), above.

**12.1-2 DEFINITION OF PROFESSIONAL REVIEW ACTION**

For purposes of Section 12.1-1, the term "professional review action" shall mean an action or recommendation of the Medical Executive Committee, the Credentials Committee, any ad hoc investigation committee, any hearing committee, the Board, or other Hospital professional review body (including the President of the Hospital, the President of the Medical Staff and the Chief of a Department) which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of a Practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) the Practitioner's Medical Staff membership or Clinical-Privileges. Such term includes: (a) determination of whether to approve an application for appointment (or reappointment); (b) determination of the scope of or conditions for Clinical Privileges or Medical Staff membership; (c) any change or modification to Clinical Privileges or Medical Staff membership; or (d) a formal decision to take or not to take any corrective action.

**12.2 ADVERSE ACTIONS**

**12.2-1 ADVERSE RECOMMENDATIONS AND DECISIONS DEFINED**

A recommendation or decision by the MEC or a decision by the Board under circumstances where no prior right to request a hearing existed shall be deemed adverse only where the recommendation or decision made is one of the following:

1. Denial of initial Medical Staff appointment, except where the application does not meet the minimum objective requirements for appointment to the Medical Staff set forth in the Medical Staff Bylaws.
2. Denial of reappointment.
3. Suspension of Staff membership.
4. Revocation of Staff membership.
5. Denial of requested appointment to or advancement in Staff category.
6. Reduction in Staff category.
7. Denial or restriction of requested Clinical Privileges.
8. Reduction in, restriction of, or failure to renew Clinical Privileges.
9. Suspension of Clinical Privileges.
10. Revocation of Clinical Privileges.
11. Individual application of or individual changes in mandatory consultation requirements (i.e. consultant must approve the course of treatment in advance).

 **12.2-2 ACTIONS NOT DEEMED ADVERSE**

Only actions specified in Section 12.2-1 shall entitle the Practitioner to any hearing or appellate review rights. Furthermore, the following actions or circumstances shall not entitle the Practitioner to any hearing or appellate review rights:

1. The issuance of a warning, admonition or formal letter of reprimand.
2. The imposition of educational or training requirements.
3. The imposition of a probationary period with monitoring of practices but without special requirements of consultation or supervision.
4. The imposition of any other monitoring, proctoring or consultation requirements, where approval before proceeding with plan of treatment is not required.
5. The Practitioner's failure to maintain professional liability insurance as required by Section 3.2-5.
6. The Practitioner's failure to maintain a currently valid Connecticut license to practice medicine, osteopathy, dentistry, or podiatry as required by Section 3.2-1 or a currently valid registration to prescribe controlled substances if required by Section 3.2-1.
7. The Practitioner's failure to achieve board certification or recertification within the time frames specified in Section 3.2-2.
8. Any automatic action, including revocation, termination, restriction, suspension or probation, taken with regard to Practitioner’s Clinical Privileges or Staff membership in accordance with the provisions of Section 11.5.
9. Exclusion or debarment from participation in federally funded healthcare programs, in accordance with Section 11.5-3.
10. The suspension of Clinical Privileges for a period not to exceed thirty Days for failure to comply with the confidentiality of health information requirements of Sections 3.6-9 and 3.6-10 in accordance with Section 11.5-7(a).
11. The suspension or restriction of Clinical Privileges, for a period of no longer than fourteen days, during which time an investigation is being conducted to determine the need for corrective action.
12. Appointment or reappointment for a period of less two years.
13. The suspension of Clinical Privileges for no more than thirty days for failure to comply with the Verification of Patient/Invasive Procedure/Site Policy in accordance with IV. Other Rules and Regulations.
14. Any other actions not specifically subject to hearing and appellate review under this Article Twelve.

**12.3 PROCEDURES FOR HEARINGS AND APPELLATE REVIEWS**

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

**12.3-1 RIGHT TO HEARING AND TO APPELLATE REVIEW**

1. When any Practitioner receives Special Notice of a recommendation by
the MEC that, if ratified by decision of the Board, will adversely affect the Practitioner's appointment to or status as a member of the Medical Staff or the Practitioner's exercise of Clinical Privileges as provided in Section 12.2-1, the Practitioner shall, upon proper and timely request, be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the MEC following such hearing is still adverse, the Practitioner shall, upon proper and timely request, then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.
2. When any Practitioner receives Special Notice of a decision by the Board
that will adversely affect the Practitioner's appointment or status as a member of the Medical Staff or the Practitioner's exercise of Clinical Privileges as provided in Section 12.2-1, and such decision is not based on or related to a prior adverse, recommendation by the MEC with respect to which the Practitioner was entitled to a hearing and appellate review, the Practitioner shall, upon proper and timely request, be entitled to a hearing before an ad hoc committee. If the decision of the Board following such hearing is still adverse, the Practitioner shall, upon proper and timely request, be entitled to an appellate review by the Board, before the Board makes a final decision on the matter. Such appellate review shall be conducted by Board members who did not participate in the hearing or on the hearing committee.

 **12.3-2 REQUEST FOR HEARING**

1. The President of the Hospital shall be responsible for giving prompt Special Notice of an adverse recommendation or decision to the affected Practitioner who shall be entitled to a hearing or to an appellate review. Such Special Notice shall state (1) that a professional review action has been proposed to be taken against the Practitioner and the reasons for the proposed action; (2) that the Practitioner has a right to request a hearing on the proposed action and that a request for a hearing must be made within thirty days; and (3) a summary of the Practitioner's rights in the hearing. A copy of Article Twelve of these Bylaws with regard to hearing and appellate review shall accompany this Special Notice.
2. The Practitioner has thirty days following receipt of the Special Notice to request a hearing. The request shall be in writing and sent to the President of the Hospital. The failure of a Practitioner to request a hearing to which the Practitioner is entitled by these Bylaws within thirty days and in the manner herein provided shall be deemed a waiver of the Practitioner's right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled on the matter.
3. When the waived hearing or appellate review relates to an adverse recommendation of the MEC or of a hearing committee appointed by the Board, the same shall become and remain effective against the Practitioner pending the Board's final decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall become and remain effective against the Practitioner in the same manner as a final decision of the Board provided for in Section 12.3-8 of this Article. In either of such events, the President of the Hospital shall promptly notify the affected Practitioner of the Practitioner's status by Special Notice.

 **12.3-3 NOTICE OF HEARING**

1. Within thirty days after receipt of a request for a hearing from a Practitioner entitled to the same, the MEC or the Board, as the case may be, shall schedule and arrange for such a hearing and shall, through the President of the Hospital, notify the Practitioner by Special Notice of the time, place and date scheduled. The hearing date shall be not less than thirty days or more than ninety days from the date of the Special Notice to the Practitioner. Granting of an earlier hearing or a postponement shall be made in the sole discretion of the hearing committee.
2. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned or the other reasons or subject matter that was considered in making the adverse recommendation or decision. Such notice shall contain a list of the witnesses (if any) expected to testify at the hearing on behalf of the MEC or the Board. Additional witnesses may be called as necessary and notice that they will be called shall be provided whenever possible.

**12.3-4 COMPOSITION OF HEARING COMMITTEE**

 When a hearing relates to an adverse recommendation of the MEC, such hearing shall be conducted by an ad hoc hearing committee of not less than three members of the Medical Staff appointed by the President of the Medical Staff in consultation with the MEC and one of the members so appointed shall be designated as Chair. No Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff. However, mere knowledge of the existence of a peer review action or the matter involved shall not preclude a staff member from serving on the hearing committee. No individual who is in direct competition with the Practitioner involved shall be appointed a member of the hearing committee. The hearing committee shall not include any individual who is demonstrated to have an actual bias, prejudice or conflict of interest that would prevent the individual from fairly and impartially considering the matter. Employment by, or other contractual arrangement with, the Hospital or an affiliate, in and of itself, shall not present a conflict of interest and shall not preclude a Staff member from serving on the hearing committee.

 When a hearing relates to an adverse decision of the Board that is not based upon or related to a prior adverse recommendation of the MEC, the Board, in consultation with the President of the Medical Staff and the President of the Hospital, shall appoint a hearing committee of not less than three members to conduct such hearing and shall designate one of the members of this committee as Chair. A majority of the hearing committee appointed under this Section shall be members of the Medical Staff, but other qualified persons may also be appointed to serve on this hearing committee. However, where the issue before the hearing committee is a question of clinical competence, all of the hearing committee members shall be clinical practitioners. No individual who is in direct economic competition with the Practitioner involved shall be included on this hearing committee. The hearing committee shall not include any individual who is demonstrated to have an actual bias, prejudice or conflict of interest that would prevent the individual from fairly and impartially considering the matter. Employment by, or other contractual arrangement with, the Hospital or an affiliate, in and of itself, shall not present a conflict of interest and shall not preclude a Staff member from serving on the hearing committee.

 The President of the Hospital shall notify the Practitioner of the appointed members of the Ad Hoc Hearing Committee and if the Practitioner has any objection to any proposed member, the Practitioner shall within ten calendar days after notification, state the objection in writing and provide specific detailed reasons for such objection. The President of the Medical Staff and the President of the Hospital shall, after considering such objections, decide in their discretion whether to replace any person objected to and the Practitioner shall be notified of the final members of the hearing committee.

**12.3-5 HEARING OFFICER**

The President of the Hospital shall appoint a Hearing Officer to preside at the hearing in lieu of the hearing committee Chair. The Hearing Officer shall be an attorney or other individual familiar with the fair hearing process. The Hearing Officer shall not act as an advocate for either side at the hearing. The Hearing Officer may participate in the private deliberations of the hearing committee and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendations. The Hearing Officer shall:

* 1. determine the order of procedure;
	2. maintain decorum throughout the hearing;
	3. allow the participants in the hearing to have a reasonable opportunity to present relevant oral and documentary evidence;
	4. set reasonable limits of the number of witnesses and duration of direct and cross-examination of witnesses;
	5. rule on all matters of procedure and the admissibility of evidence, including whether evidence has sufficient relevance and reliability to be submitted to the hearing committee for consideration;
	6. prohibit conduct, testimony or presentation of evidence that is cumulative, excessive, irrelevant, abusive or that causes undue delay;
	7. have authority to recess and reconvene the hearing and to rule on requests for postponements or extensions of time in consultation with the hearing committee Chair; and
	8. may require any person who does not comply with the orders or rulings of the Hearing Officer or who ignores such orders or rulings, for example, continues to submit repetitive testimony, to leave the hearing.

**12.3-6 CONDUCT OF HEARING**

1. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy. The hearing committee may make a recommendation as long as a majority of the panel members have attended all the hearing sessions or read the transcript of any hearing session for which a member was not in personal attendance. A majority of the members shall constitute a quorum for purposes of conducting a hearing.
2. An accurate record of the hearing shall be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. The Practitioner for whom the hearing is held has the right to obtain copies of the records upon payment of any reasonable charges; provided that Practitioner shall have no right to receive a copy during the hearing or to delay continuation of the hearing pending completion of a transcript.
3. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the rights herein provided in the same manner as provided in Sections 12.3-2 (b) and (c) of this Article and to have accepted the adverse recommendation or decision involved and the same thereupon shall become and remain in effect as provided in said Sections.
4. The affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by an attorney or other person of the Practitioner's choice. If the Practitioner is accompanied or represented at the hearing, the practitioner shall still be required to respond personally to any questions directed to the Practitioner. The Practitioner shall notify the President of the Medical Staff and the President of the Hospital of the name of his or her attorney or other representative not less than fifteen calendar days prior to the commencement of the hearing. Failure to provide such notice shall result in the Practitioner not being permitted to be accompanied by counsel or another representative. Practitioner shall pay his or her own attorney’s fees and costs.
5. The MEC, when its action has prompted the hearing shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendations and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision. The presenter of the adverse recommendation or decision may be represented by counsel at the hearing.
6. The Practitioner shall have no right to formal discovery in connection with the hearing. The Practitioner requesting a hearing shall be provided with a copy of, or reasonable access to, the medical records and documents relied on by the MEC or the Board in making its adverse recommendation or decision or to be submitted as exhibits to the hearing committee, including any written reports from an investigation committee or expert; provided that, such documents shall be provided only after the Practitioner, and his or her attorney or other representative, provide a written statement agreeing to maintain the confidentiality of such documents, to maintain the privacy of any patient Protected Health Information in compliance with state and federal laws, and not to disclose the documents for purposes other than the hearing. Practitioner shall not be entitled to receive copies of any minutes relating to the peer review session of MEC meetings or to any information or records regarding other practitioners on the Medical Staff. The provision of any documents is not intended to waive any privilege under the state peer review protection statute.
7. At least seven calendar days prior to the hearing, each party shall provide the other party and the hearing committee with a written list of all witnesses and expert witnesses, a copy of the curriculum vitae and written report of any expert, and a copy of any documentary evidence such party intends to submit to the hearing committee. The Hearing Officer may within his or her discretion refuse to allow the presentation of any witness testimony or documentary evidence by either party that was not disclosed prior to the hearing, unless the Hearing Officer determines that such failure to disclose was unavoidable, unanticipated or there is otherwise good cause shown to permit such additional testimony or documents.
8. The hearing shall be conducted in an informal manner and the rules of evidence shall not apply. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make the evidence inadmissible over objection in civil or criminal action.
9. At a hearing both sides shall have the following rights, in addition to other rights specifically set forth in this Section 12.3-6, subject to reasonable limits determined by the Hearing Officer:
10. to call and examine witnesses, to the extent they are available and willing to testify;
11. to cross-examine any witness on matters relevant to the issues;
12. to introduce exhibits; and
13. to submit a written statement at the close of the hearing.
14. If the Practitioner does not testify in the Practitioner’s own behalf, the Practitioner may be called and examined as if under cross-examination.
15. Each side shall be permitted to make an opening statement to the hearing committee. The MEC or the Board, depending on whose recommendation or decision prompted the hearing, shall present evidence first in support of its recommendation or decision. Thereafter, the burden shall shift to the Practitioner who requested the hearing to present evidence. The Hearing Officer may in his or her discretion modify such order of presentation.
16. The hearing committee may question the witnesses, call additional witnesses or request additional documentary evidence.
17. Both sides are required to prepare their cases, including an allowance of time for questions by the hearing committee, so that a hearing shall be concluded after a maximum of nine hours of hearing in no more than three three-hour hearing sessions. Hearing sessions shall generally be held on weekdays and shall start in the evening hours. The Hearing Officer, in consultation with the hearing committee, may under extraordinary circumstances and for good cause shown depart from these requirements, provided that the Hearing Officer shall not permit a hearing to be extended due to delay, repetition or lack of appropriate deportment in the course of presentation of a case.
18. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations off the record and outside the presence of the Practitioner for whom the hearing was convened.
19. It is the burden of the Practitioner under review to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial reappointment, reappointment and clinical privileges and fully complies with all Medical Staff and Hospital Bylaws, Rules and Regulations and Code of Conduct. The Practitioner shall have the burden of proving by clear and convincing evidence that the adverse recommendation lacks reasonable factual basis or that the conclusions and recommendation or decision drawn therefrom are arbitrary, unreasonable or capricious.
20. After final adjournment of the hearing, the hearing committee shall promptly prepare a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the MEC or to the Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC or decision of the Board, and shall include a statement of the basis for the recommendation. The Practitioner shall be given a copy of the report and shall be advised of the Practitioner's right to request an appellate review in accordance with these Bylaws.
21. The MEC, when its action has prompted the hearing, shall consider the recommendations of the hearing committee and may accept, modify, or reject such recommendations. The MEC shall then make written recommendations to the Board which shall include a statement of the basis for its recommendations. The Practitioner shall be given by Special Notice a copy of the written recommendation of the MEC and written notice of the Practitioner's right under these Bylaws to request, within ten calendar days of the date of said Special Notice, an appellate review.
22. The Board, when its action has prompted the hearing, shall consider the recommendations of the hearing committee and may accept, modify, or reject such recommendations. The Board shall notify the Practitioner by Special Notice of its decision and of the Practitioner's right under these Bylaws to request within ten calendar days of the date of receipt of the Special Notice an appellate review by the Board.

 **12.3-7 APPEAL TO THE BOARD**

1. Within ten calendar days after the date of receipt of the Special Notice to the affected Practitioner of an adverse recommendation or decision made after a hearing as above provided, the Practitioner may, by written request to the Board delivered to the President of the Hospital, request an appellate review by the Board. The Practitioner may file a written statement and/or request that oral argument be permitted.
2. If such appellate review is not requested within such ten days, the affected Practitioner shall be deemed to have waived the Practitioner's right to such appellate review. If the appeal is waived as to an adverse recommendation of the MEC after a hearing, then the adverse recommendation shall become effective immediately and forwarded to the Board for final action. If the appeal is waived as to a decision of the Board after a hearing, then the Board’s decision shall become effective immediately as provided in Section 12.3-8 of this Article Twelve.
3. Promptly after receipt of such request for appellate review, the Board shall schedule a date for such appellate review, including a time and place for oral argument if such request has been made and granted, and shall, through the President of the Hospital by Special Notice, notify the affected Practitioner of the same. The date of the appellate review ordinarily shall be not less than thirty days nor more than sixty days from the date of receipt of the request for appellate review, except that if the Practitioner requesting the review is under a suspension which is then in effect, then upon the request of the Practitioner, such review shall be scheduled as soon as arrangements for it may reasonably be made. For good cause shown, the Board or a duly appointed appellate review committee may, in its sole discretion, extend the time period for appellate review.
4. The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than three members. If the adverse recommendation being reviewed was made by a hearing committee appointed by the Board, the appellate review shall be by a committee of the Board made up of members who did not participate in the hearing or on the hearing committee.
5. To the extent such documents have not been previously provided, the affected Practitioner shall have access to a copy of the written report of the hearing committee, any available transcription of the hearing and all other written material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against the Practitioner. However, the Practitioner shall not be entitled to copies of any meeting minutes of the MEC, the Board, or other peer review committee related to any confidential deliberations for the adverse recommendation or decision regarding the Practitioner.
6. The Practitioner shall have the opportunity to submit a written statement in the Practitioner's behalf, in which those factual and procedural matters with which the Practitioner disagrees, and the Practitioner's reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted by the Practitioner at least fifteen days prior to the scheduled date for the appellate review to the Board or the Chair of the appellate review committee through the President of the Hospital; a copy shall also be sent to the MEC, the Chair of the hearing committee appointed by the Board, and to such party’s attorney. A similar statement, which may include a response to Practitioner’s statement, may be submitted by the MEC or by the hearing committee appointed by the Board. Copies of the written statement shall be provided to the President of the Hospital and the Practitioner at least 5 days prior to the date of such appellate review.
7. If a request for oral argument was granted, then both parties and their representatives or legal counsel shall appear and may make an oral statement regarding the adverse recommendation or decision. The Practitioner must be present if he or she requested oral argument. Failure of the Practitioner to appear shall be deemed a waiver of the requested oral argument. Any party or representative appearing shall answer questions raised by any member of the appellate review body.
8. The Board or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements and oral arguments submitted pursuant to sub-Sections (f) and (g) of this Section for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was supported by the evidence and was not arbitrary or capricious.
9. New or additional matters not raised during the original hearing or in the hearing committee report, or otherwise reflected in the record, shall only be introduced at the appellate review under extraordinary circumstances as determined in the sole discretion of the Board or its appointed appellate review committee.
10. At the next regular meeting of the Board occurring after the Board either (i) completes the appellate review, or (ii) receives the written recommendation from the appellate review committee appointed by the Board, the Board shall consider the matter and take action. The Board may review any information that it deems relevant, including any part of the record and the findings and recommendations of the MEC, the ad hoc hearing committee, and the appellate review committee (as applicable). The Board may adopt, modify or reverse any recommendation that it receives; may in its sole discretion refer the matter for further investigation, review or hearing to the MEC or the hearing committee with instructions; or may make its own decision based upon the Board’s ultimate legal authority for decisions regarding Staff membership or Clinical Privileges. If the Board refers the matter to either the MEC or the hearing committee, it should specify the review or action requested and the period of time for such body to provide a written report of such further review or action to the Board. After the Board’s receipt of a report of such further review, the Board shall take final action as provided in Section 12.3-8.
11. Where permitted by the Hospital's Bylaws, all action required of the Board may be taken by a committee of the Board.

**12.3-8 FINAL DECISION BY THE BOARD**

After completion (or waiver) of the appellate review, the Board shall render its final decision in the matter in writing, including a statement of the basis for its decision. The Board shall send a Special Notice of its decision to the MEC, and through the President of the Hospital to the affected Practitioner. The decision of the Board shall be immediately effective and final and shall not be subject to further hearing or appellate review.

 **12.3-9 RIGHT TO ONE HEARING AND ONE APPEAL**

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

 **12.3-10 GENERAL PROVISIONS**

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

(b) When Special Notice is required to be given under any provision of Article Eleven or Article Twelve, such notice shall be deemed adequately given if hand delivered or mailed by certified mail, return receipt requested to the Practitioner’s last office address shown in the records of the Medical Staff Office of the Hospital. Any written notice required to be sent to the Hospital, the Board or any committee under a provision of Article Eleven or Article Twelve, shall be deemed adequately given if hand delivered or mailed by certified mail, return receipt requested to President of the Hospital, Johnson Memorial Hospital, 201 Chestnut Hill Road, Stafford Springs, CT 06076.

(c) If the last day for performing any act required under Article Eleven or Article Twelve falls on a Saturday, Sunday or legal holiday, then the period for performing the act shall be extended to the end of the next day which is not a Saturday, Sunday or legal holiday.

(d) Any member of the Board or the MEC that recuses himself/herself from participation or voting due to an actual or potential conflict of interest shall not be counted in the determination of presence of a quorum or any required vote.

**ARTICLE THIRTEEN**

 **MEETINGS**

**13.1 MEDICAL STAFF YEAR**

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

**13.2 MEDICAL STAFF MEETINGS**

**13.2-1 REGULAR STAFF MEETINGS**

The regular meetings of the Medical Staff shall be held at least on a quarterly basis during the months of January, April, June and October at the call of the President. The October meeting shall serve as the Annual Meeting of the Medical Staff.

The MEC may authorize the holding of additional Medical Staff meetings by resolution. The resolution authorizing any such additional meeting(s) shall require notice specifying the place, date and time for the meeting, and that the meeting can transact any business as may come before it.

**13.2-2 REGULAR STAFF MEETINGS – ORDER OF BUSINESS/AGENDA**

The order of business at a Quarterly or Annual Meeting shall be determined by the President. The agenda shall include at least:

(a) Reading and acceptance of the minutes of the last Quarterly or last Annual Meeting and of all special meetings held since the last Quarterly meeting;

(b) Review of Medical Executive Committee summaries and actions of the Medical Executive Committee;

(c) Administrative reports from the President of the Hospital, the President of the Staff, and the CMO;

(d) The election of Officers and of representatives to Staff and Hospital committees, when required by these Bylaws;

(e) Reports by Medical Staff Officers, Chairmen of Committees and Departments on the overall results of patient care audit and other quality review, evaluation and monitoring activities of the Staff and on the fulfillment of any other required Staff functions (Annual Meeting only);

(f) New Business; and

(g) Adjournment.

 **13.2-3 SPECIAL MEETINGS**

Special meetings of the Staff may be called at any time by its President, by the Medical Executive Committee, by the Board, or by any ten Staff members with written notification of at least thirty days. No business shall be transacted at any special meeting except that stated in the notice.

**13.3 DEPARTMENT, SECTION AND COMMITTEE MEETINGS**

 **13.3-1 DEPARTMENT MEETINGS**

The Departments of Anesthesiology, Emergency Medicine, Family Medicine and Pediatrics, Medicine, Pathology, Psychiatry, Radiology and Surgery shall hold regular meetings no less than quarterly, depending on the needs of the Department, and meet more often as needed to consider both patient care outcomes and business issues. Department meetings shall be for educational and administrative purposes including ongoing auditing of the work done in the Department and those aspects of patient care relating quality improvement.

**13.3-2 COMMITTEE MEETINGS**

See Article Ten for requirements for each respective Committee.

 **13.3-3 SECTION MEETINGS**

The Sections comprising the Medical Staff Departments shall meet as needed at the call of their respective Chairperson or as directed by their respective Department Chairperson. Section meeting attendance shall count towards meeting requirements.

**13.3-4 SPECIAL DEPARTMENT OR SECTION MEETINGS**

Special Department or Section meetings may be called at any time with at least 48 hour notice by the Chairperson of the Department or Section, or by the President of the Medical Staff.

**13.4 ATTENDANCE EXPECTATIONS**

**13.4-1 ACTIVE STAFF AND ADVANCED PRACTICE PROFESSIONAL ACTIVE STAFF**

Each member of the Active Medical Staff and the Advanced Practice Professional Active Staff shall be expected and encouraged to attend Staff, Department and Section meetings. Each member of the Active Medical Staff and the Advanced Practice Professional Active Staff shall be appointed to serve on those Committees listed under Article Ten, Committees.

**13.4-2 ASSOCIATE STAFF AND ADVANCED PRACTICE PROFESSIONAL ASSOCIATE STAFF**

Members of the Associate Staff and the Advanced Practice Professional Associate Staff are encouraged to attend Staff, Department, Section and Committee meetings.

 **13.4-3 SPECIAL APPEARANCES**

A member of any category of the Medical Staff who has attended a case that is to be presented for discussion at a Department, Section or Committee meeting shall be notified at least two weeks in advance of the meeting and shall be required to attend. If excused for just cause, the presentation may be held over until the following meeting, but no longer. In the event the notified member fails to attend without prior excuse, the case shall be presented in his absence.

**13.5 MEETING PROCEDURES**

**13.5-1 NOTICE OF MEETINGS**

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

 **13.5-2 QUORUM AND ACTION**

 **(a) MEDICAL STAFF MEETINGS**

At any regular or special meeting of the Medical Staff, a quorum shall be 20% of the qualified members of the Active Medical Staff and the Advanced Practice Professional Active Staff.Eligible voting members, who are unable to attend the meeting, may cast their vote via absentee ballot no later than six (6) hours prior to the start of the meeting. Vote shall be decided by simple majority of those present at the time of the vote as well as the votes received via absentee ballot. Should a quorum not be present at a meeting, the action of two-thirds (2/3) majority of the voting members present, including all votes via absentee ballot, shall be the action of the Medical Staff.

At any regular or special meeting of the MEC, a quorum shall be 50% of the qualified members of the MEC. Vote shall be decided by simple majority of those present at the time of the vote.

 **(b) DEPARTMENTS, SECTION SERVICES AND COMMITTEE MEETINGS**

At any Department, Section or Committee meeting, except the MEC and the Advanced Practice Professional Committee, the quorum shall be defined 1/3 of the voting members present or five voting members, but not less than two voting members as applicable for Department size. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a Committee, Department or Section. Action may be taken without a meeting by two-thirds unanimous consent in writing, setting forth the action so taken signed by each member entitled to vote. Each voting member must be given an opportunity to vote.

At any regular or special meeting of the Advanced Practice Professional Committee, a quorum shall be five members of the Committee. Vote shall be decided by simple majority of those present at the time of the vote.

 **13.5-3 RIGHTS OF EX OFFICIO MEMBERS**

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

 **13.5-4 MINUTES**

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

**ARTICLE FOURTEEN**

**CONFIDENTIALITY, IMMUNITY AND RELEASES**

**14.1 SPECIAL DEFINITIONS**

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

(a) INFORMATION shall mean records or proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in Section 14.5.

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

(c) PRACTITIONER shall mean, for purposes of this Article Fourteen, a Medical Staff member or applicant.

(d) REPRESENTATIVE shall mean the Board of JMH and any director, trustee or committee of JMH; the President of the Hospital or any designee; registered nurses and other employees of JMH, the Medical Staff organization and any member, Officer, Department, Section or Committee thereof; and any individual authorized by any of the foregoing to perform specific Information gathering, analysis, use or disseminating functions.

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

**14.2 AUTHORIZATIONS AND CONDITIONS**

By submitting an application for Medical Staff membership or by applying for or exercising clinical privileges or providing specific patient care services within JMH, a practitioner shall be deemed to:

(a) Authorize any Representative of JMH and the Medical Staff to solicit, provide, and act upon Information including otherwise privileged or confidential information bearing on the practitioner’s professional ability, character, conduct and other matters relating to his/her qualifications.

(b) Authorize any Third Party to release or provide Information, including otherwise privileged or confidential information, bearing on the practitioner’s professional ability, character, conduct and other matters relating to his/her qualifications.

(c) Agree to be bound by the provisions of this Article and to absolutely and unconditionally release from all liability and waive all legal claims against any Representative who acts in accordance with the provisions of this Article.

(d) Acknowledge that the provisions of this Article are express conditions to the practitioner’s application for, or acceptance of, Medical Staff membership and to the exercise of clinical privileges or provision of specified patient services within JMH.

(e) Agree that, if any adverse decision is made with respect to practitioner’s staff membership or clinical privileges, he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the hearing procedures therein before resorting to formal legal action.

**14.3 CONFIDENTIALITY OF INFORMATION**

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

**14.4 IMMUNITY FROM LIABILITY**

 **14.4-1 FOR ACTION TAKEN**

No Representative or Third Party shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of such Representative or Third Party’s duties or participation related to the activities described in Section 14.5 below, if the Representative or Third Party acts in good faith and without Malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

 **14.4-2 FOR PROVIDING INFORMATION**

No Representative and no Third Party shall be liable to a practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to any Representative, health care system, or facility, organization of health professionals, licensing boards, the National Practitioner Data Bank or any other healthcare organization concerning a practitioner who is or has been an applicant to or member of the Medical Staff or who did or does exercise clinical privileges or provide specified services within JMH, provided that such Representative or Third Party acts in good faith and without Malice and provided further that such Information is related to the performance of the duties and functions of the recipient.

**14.5 ACTIVITIES AND INFORMATION COVERED**

 **14.5-1 ACTIVITIES**

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

(a) Applications for Medical Staff appointment, clinical privileges or specified services.

(b) Periodic reappraisals for reappointment or changes in clinical privileges or specified services.

(c) Corrective or disciplinary action.

(d) Hearings and appellate reviews.

(e) Quality improvement program activities.

(f) Utilization reviews.

(g) Claims reviews.

(h) Profiles and profile analyses.

(i) Malpractice loss prevention.

(j) Other JMH and Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

(k) Reports to and from the National Practitioner Data Bank.

 **14.5-2 INFORMATION**

The Information referred to in this Article may relate to a practitioner’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or that are otherwise related to practitioner’s qualifications for staff membership or clinical privileges.

**14.6 RELEASES**

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

**14.7 CUMULATIVE EFFECT**

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

**ARTICLE FIFTEEN**

**GENERAL PROVISIONS**

**15.1 STAFF RULES AND REGULATIONS**

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

**15.2 DEPARTMENT AND SECTION POLICIES**

Subject to approval of the MEC, each Department and Section shall formulate its own written Policies for the conduct of its affairs and the discharge of its responsibilities. Such written Policies shall be consistent with these Bylaws and the Rules and Regulations of the Medical Staff.

**15.3 RELATIONSHIP OF STAFF WITH THE BOARD**

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

 **15.3-1 CREDENTIALS OVERSIGHT**

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

 **15.3-2 EVALUATION AND MONITORING OVERSIGHT**

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

 **15.3-3 ADMINISTRATIVE OVERSIGHT**

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

 **15.3-4 ORGANIZATIONAL OVERSIGHT**

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

 **15.3-5 OTHER**

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

**15.4 CONSTRUCTION OF MEDICAL STAFF AND JMH BYLAWS**

When construing these Bylaws, the following principles shall apply.

 **15.4-1 WAIVER**

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

 **15.4-2 SEVERABILITY**

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

 **15.4-3 COMPLIANCE WITH LAWS, ETC.**

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

 **15.4-4 CONSTRUCTION**

To the extent possible, these Bylaws, the Medical Staff Rules and Regulations, Policies of Departments and Sections, and agreements between JMH and members of the Medical Staff shall be construed as being consistent with each other. If consistent construction is not possible, then provisions which specifically provide that they supersede inconsistent provisions shall be given effect. This Section 15.4 is not intended to alter or supersede other interpreted, construed or applied.

 **15.4-5 JMH BYLAWS**

Nothing contained in these Bylaws shall be deemed to supersede, waive or otherwise affect the corporate Bylaws of Johnson Memorial Hospital and if there be any conflict between these Bylaws and the corporate Bylaws of JMH, as applicable, then the corporate Bylaws of JMH shall govern.

 **15.4-6 NON-DISCRIMINATION**

In accordance with the Policies of JMH, all provisions of these Bylaws and the accompanying rules and regulations shall be interpreted and applied so that no person, member of the Medical Staff, applicant for membership, patient or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activities of JMH or the Medical Staff.

 **15.4-7 HEADINGS**

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

 **15.4-8 REVIEW**

The Medical Staff Bylaws, and Rules and Regulations shall be reviewed every two years by the Administrative Affairs Committee. The report of its review shall be forwarded to the Medical Executive Committee with appropriate recommendations.

**ARTICLE SIXTEEN**

**MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS**

**16.1 MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS**

An appropriate history and physical examination shall be recorded by a physician within twenty-four hours. All histories and physical examinations performed by physician assistants must be co-signed by an attending physician of the service within twenty-four hours of dictation. This H&P should include the chief complaint, history of present illness, personal history, psycho-social assessment, family history, review of systems (includes functional status; nutritional and hydration status), physical examination, special reports such as consultations, clinical laboratory and radiology services, a provisional diagnosis, and a medical/surgical treatment plan. For patients receiving end of life care, social, spiritual, cultural and family/significant other perceptions should be documented whenever possible.

Outpatient procedures shall require a focused H&P based on chief complaint, relevant history and procedure being performed. For all cases involving surgery or a procedure requiring anesthesia services, an H&P must be completed within thirty days prior to the surgery or procedure. An updated examination of the patient, including any changes in the patient’s condition, shall be completed and documented within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty days before admission or registration.

Any chart without a report of history and physical examination within twenty-four hours following admission shall be reported to the appropriate Department Chair and action will be taken in accordance with Rule & Regulation B. 12.

A history and physical completed within thirty days prior to admission is acceptable as long as clinical changes were noted according to acceptable practices.

**ARTICLE SEVENTEEN**

**ADOPTION AND AMENDMENT**

**17.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

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

**17.2 ADOPTION**

These Bylaws, together with the appended Rules and Regulations, shall be adopted by the Medical Staff to serve as the Bylaws for the Medical Staff of Johnson Memorial Hospital and shall be approved by the Board.

**17.3 AMENDMENT**

**17.3-1 STANDARD PROCESS**

A proposed amendment to the Bylaws or the Rules and Regulations shall be submitted either to the Administrative Affairs Committee directly, or to any regular or special meeting of the Medical Staff and referred to the Administrative Affairs Committee, which shall make its recommendation to the MEC. The MEC shall report its recommendations to the Staff within thirty days before a regular meeting or special meeting at which the proposed amendment will be discussed and either approved or rejected. A copy of proposed documents or amendments shall be delivered personally or by mail or through accepted electronic means to Staff members entitled to vote thereon with the notice of the meeting. Adoption or amendment of these Bylaws or rules and regulations shall require the affirmative vote of at least two-thirds of the Medical Staff members present, eligible and qualified to vote on Bylaws, at a regular or special Staff meeting at which a quorum is present. In the event approval of amendments needs to be accomplished in the period of time between regularly scheduled annual meetings and a special meeting is not planned, a mail ballot may be employed. Each use of a mail ballot must be specifically approved by a vote of at least two-thirds of the membership of the MEC present and voting at a meeting at which a quorum is present. The ballot, the proposed amendment(s) and a summary of the issues will be mailed to each Medical Staff member eligible and qualified to vote. The ballot must be returned to the Medical Staff Office by the date specified in the ballot but shall not be less than fifteen days of the date mailed. Approval by mail ballot requires a two-thirds majority of those responding and a response of greater than 50% of the members eligible and qualified to vote. The Medical Staff’s action shall be forwarded to the Board for its action.

**17.3-2 ADDITIONAL PROCESS BY THE MEDICAL STAFF**

In addition to the foregoing standard process, the Medical Staff shall also be permitted to adopt and propose directly to the Board Bylaws, Rules and Regulations, and Policies, and amendments thereto. When the proposal by the Medical Staff under this paragraph relates to a policy that the MEC has been delegated the authority to adopt and/or make amendments to, then the Medical Staff shall first communicate the proposal to the MEC before proposing to the Board. The Board may, upon receiving any proposal from the Medical Staff hereunder, consult with the MEC, the Administrative Affairs Committee and the Medical Staff, as appropriate and necessary for its review of and decision with respect to the proposed bylaw, rule and regulation, or policy or amendment thereto.

In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the Medical Executive Committee, if delegated to do so by the voting members of the organized Medical Staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

**17.3-3 TECHNICAL REVISIONS**

The Administrative Affairs Committee, with the approval of the MEC, shall have the authority to adopt such non-substantive technical revisions or amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling or other errors of grammar or expression.

**17.4 BOARD ACTION**

In accordance with the corporate Bylaws of JMH, Medical Staff recommendations concerning adoption or amendment of these Bylaws are effective upon the affirmative vote of the Board.

**17.5 RELATED POLICIES AND PROTOCOLS**

Department and Section Policies and other Medical Staff Policies and protocols that are not part of the Medical Staff Bylaws or Rules and Regulations must be consistent with such Bylaws and Rules and Regulations and shall be effective upon adoption by the MEC. The MEC shall notify the Medical Staff of the adoption of such Policies and protocols or amendments thereto.

Rules & Regulations

**RULES & REGULATIONS**

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**Johnson Memorial Hospital**

**Rules and Regulations**

**of the Medical Staff**

**A. Admission and Discharge of Patients**

1. A patient may be admitted to JMH only by a member of the Active Medical Staff. In the rare instance when there is no Active Staff member available to admit under a particular service, an Associate Staff member may admit the patient.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in JMH, for prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner. Whenever these responsibilities are transferred to another Staff member, an order covering the transfer of responsibility shall be entered on the order sheet of the medical record.

A member of the Staff may admit a patient to his/her service only, and is responsible for that patient unless he/she formally transfers the patient to another physician. The physician to whom he/she transfers the patient to must be available to attend the patient at the time of transfer. No transfer of patients shall occur unless ordered or approved by the attending physician.

3. No patient should be admitted to JMH unless a provisional diagnosis or a valid reason for admission has been stated and documented in the medical record. Appropriate treatment and/or diagnostic examinations at an acute level, related to the physician’s reason for admission, should be documented at the time of admission.

The Medical Staff shall define the categories of medical conditions (Observation or Inpatient Admission status) and criteria to be used in order to implement patient admission priorities and the proper review thereof (through InterQual criteria). In the event of conflict or disagreement, intervention will be sought through the Chief Medical Officer or designee.

4. A patient without an established or assigned JMH physician to be evaluated on an emergency basis shall be referred to the physician on back-up call for follow-up needs or inpatient care. If the patient prefers, he/she may select another physician on Active Staff with mutual agreement.

5. For the protection of patients, the Medical and Nursing Staffs and JMH, potentially suicidal or homicidal patients should not routinely be admitted to the Medical Surgical Unit of JMH unless the patient requires acute medical / surgical care. Any patient suspected to being suicidal, homicidal, inducing self-injury or having taken a chemical overdose must have consultation by a member of the Psychiatric Staff.

6. All admissions to the Intensive Care Unit will be in accordance with the ICU standard operating practices**.** If any questions as to the validity or admission to or discharge from the ICU should arise, that decision is to be made through consultation with the Medical Director of the ICU. In any case, the Medical Director of the ICU will have the final determination after reviewing all facts and having had the opportunity to consult with the attending. Patients admitted to the ICU are considered severely ill and will be seen by their attending physician (or his/her covering physician) in a time frame consistent with the patient’s illness severity and that which would be consistent with Standards of Good Clinical Practice but not to exceed four (4) hours. All previous orders are canceled when patients go to surgery and into and out of the ICU.

7. The attending practitioner is required to document on a daily basis the need for continued hospitalization. This documentation must contain an adequate record of the reason for continued hospitalization; a simple reconfirmation of the patient’s diagnosis is not sufficient. No transfer of patients shall occur within the Hospital or outside of the Hospital without expressed permission or a good faith attempt to contact the attending physician.

8. Patients shall be discharged only on an order of the attending practitioner or similarly privileged physician or his/her designee. Should a patient leave JMH against medical advice or without proper discharge, a signed release shall be made in the patient’s medical record.

9. In the event of a JMH death, the deceased shall be pronounced dead by the attending practitioner or his/her designee and the practitioner will be responsible for signing the death certificate, both within a reasonable time.

10. It shall be the duty of all Staff members to secure meaningful autopsies whenever possible. An autopsy may be performed either with a written or witnessed telephone consent, granted by a person over eighteen years of age who has assumed custody of the body for purposes of burial. The appropriate individual and the witness will document the consent. All autopsies shall be performed by the JMH Pathologist. The pathologist must notify the attending physician that the autopsy is being performed.

**B. Medical Records**

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification date, a complete history and physical, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary, and autopsy report when performed.

All clinical entries in the patient’s medical record must be accurately dated, timed and signed. They must be legible. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the medical record department. Copies are distributed to all clinical areas.

2. A medical record shall be started for each patient within twenty-four hours. Complete identification data, a nurse’s notation of condition on admission, and admission orders by the attending physician or physician designee should be documented as soon as received. A brief and concise admission note providing pertinent information relating to history, physical examination, and plan for treatment shall be made on all patients at the time of admission in the progress notes or on the standard Short Stay H&P/Admission Progress Notes form.

3. An appropriate history and physical examination shall be recorded by a physician within twenty-four hours. All histories and physical examinations performed by physician assistants must be co-signed by an attending physician of the service within twenty-four hours of dictation. This H&P should include the chief complaint, history of present illness, personal history, psycho-social assessment, family history, review of systems (includes functional status; nutritional and hydration status), physical examination, special reports such as consultations, clinical laboratory and radiology services, a provisional diagnosis, and a medical/surgical treatment plan. For patients receiving end of life care, consideration for social, spiritual, cultural and family/significant other perceptions should be documented whenever possible.

 Outpatient procedures shall require a focused H&P based on chief complaint, relevant history and procedure being performed. For all cases involving surgery or a procedure requiring anesthesia services, an H&P must be completed within thirty days prior to the surgery or procedure. An updated examination of the patient, including any changes in the patient’s condition, shall be completed and documented within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty days before admission or registration.

Any chart without a report of history and physical examination within twenty-four hours following admission shall be reported to the appropriate Department Chair and action will be taken in accordance with Rule/Regulation 12.

A history and physical completed within thirty days prior to admission is acceptable as long as clinical changes were noted according to acceptable practices.

4. Pertinent progress notes shall be recorded daily sufficient to permit continuity of care. These include an account of the patient’s progress, exam findings, labs / diagnostic findings, summary of consultant recommendations, other pertinent findings, current diagnosis and a treatment plan consistent with current documentationguidelines. In addition, an estimate of the time the patient will need to remain in JMH and plans for post-JMH care should be included.

Any attending physician not having a progress note completed, including signature, date and time on the chart within twenty-four hours of admission and daily thereafter shall be referred to the appropriate Department Chairperson and the Chief Medical Officer.

5. Operative reports include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated within twenty-four hours following surgery and the report promptly signed by the surgeon and made a part of the patient’s current medical record. In addition to this dictation, a brief note to summarize the operative procedure is required immediately following surgery.

Any physician not having the summary completed immediately or the operative report dictated within twenty-four hours, shall be reported to the appropriate Department Chair and action will be taken in accordance with Rule/Regulation B. 12 below.

6. Any qualified practitioner with clinical privileges can be called for consultation within his/her area of expertise. The attending practitioner is primarily responsible for requesting consultation when indicated. He/she will provide written authorization including the reason for the evaluation to permit another practitioner to attend or examine his/her patient (waived in cases of emergency) and shall act to coordinate care with other practitioners and personnel as relevant to the care of the individual patient.

Consultations shall show evidence of a review of the patient’s record or communication of the case by the consultant, pertinent findings on examination of the patient, and the consultant’s opinions and recommendations. This report shall be made part of the patient’s medical record. All consults should be addressed either by telephone or in person within twenty-four hours. Patients should be seen in a time frame which would be consistent with Standards of Good Clinical Practice.

7. A practitioner’s routine, telephone and/or verbal orders, when applicable to a given patient, shall be reproduced in detail on the order, dictated to a duly authorized person functioning within his/her sphere of practice (i.e. Respiratory Therapist, Pharmacist, Licensed Practical Nurse, Registered Nurse) and signed by the responsible practitioner or his/her designee within twenty-four hours.

All telephone orders will be flagged in the chart and must be signed by the physician or his/her designee the next business day; otherwise this will trigger an incomplete chart. A request for a forty-eight hour extension under the current medical record suspension policy as written in the Medical Staff Bylaws, Rules & Regulations, applies.

8. Orders for the following will expire and will be automatically discontinued when the time indicated has elapsed unless the responsible physician renews them. A notation will be attached to the chart forty-eight hours prior to this expiration.

 (a) Schedule II Controlled Substances – seven days

 (b) Schedule III, IV, V Controlled Substances – ten days

 If the physician is unreachable, the renewal will be carried over to the next day. Orders and reorders shall be specific as to name of drugs, dose, strength and route of administration.

9. Final diagnosis shall be recorded in full at the time of discharge of all patients as well as the physician discharge order, medication reconciliation and W-10 Interagency Referral forms. These are to be completed in their entirety prior to the discharge of any patient from JMH. The form should be completed by the attending physician or his/her designee.

10. A Discharge Summary shall be dictated on all medical records of patients hospitalized over twenty-four hours, including those patients in observation, or in cases of a death or surgery in less than twenty-four hours of admission. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

The Discharge Summary should include a final diagnosis, essential elements of the History and Physical exam, clinical course, operative interventions, special reports such as consultations, clinical laboratory, radiology services and others, and condition at discharge, medications, home care, diet and first follow-up appointment. All summaries shall be signed by the responsible practitioner or similarly privileged physician.

Any physician not having completed the patient record including the Discharge Order or Discharge Summary within two weeks shall be reported to the appropriate Department Chair and action will be taken in accordance with Rule/Regulation B. 12 below.

11. A medical record shall not be permanently filed until it is completed by the responsible practitioner.

12. The Chairperson of the appropriate Department or his/her designee, upon notification of infractions, may decide to grant an additional forty-eight hours to complete any incomplete chart or have the provider placed immediately on medical records suspension. If granted the additional forty-eight hours and the charts remain incomplete, the physician in question shall automatically be placed on medical record suspension. The granting of any additional forty-eight hours will be documented in the practitioner’s OPPE report. The Director of Health Information Services or the Chair of the appropriate Department or designee shall release such affected physicians from suspension as soon as the deficient records are completed.

13. Once a physician is placed on medical record suspension, he/she is not allowed to admit new patients, perform new consults, perform surgeries, or perform procedures except in emergency or life threatening situations. They are allowed to continue to care for patients already in his/her care in JMH. Medical records suspension does not affect Emergency Department back-up schedules.

**C. GENERAL CONDUCT OF CARE**

1. Informed Consent - Except in emergency situations, the responsible practitioner, covering practitioner, or Advanced Practice Professional under the direct supervision of the responsible practitioner, shall obtain proper informed consent as a prerequisite for any procedure or treatment (i.e. blood transfusion) for which it is appropriate and provide evidence of consent by a form signed by the patient or, when the patient is incapable of consenting, by the patient’s representative. In cases of emergency, or whenever appropriate, the physician also shall write an explanatory note concerning consent in the patient’s medical record. The extent of information to be supplied by the practitioner, covering practitioner, or Advanced Practice Professional under the direct supervision of the responsible practitioner, to the patient shall include the specific procedure or treatment or both, the reasonably foreseeable risks, and the known alternatives for care and treatment. If the procedure and/or treatment is to be performed by a practitioner who did not obtain consent, the performing practitioner must also co-sign the consent at the time of procedure and/or treatment.

2. Pharmacy Standards – All drugs and medications administered to patients shall be FDA approved and meet the standards set by the United States Pharmacopeia/National Formulary. Drugs for bona fide clinical investigations may be exceptions as well as new drugs that will be added to the next addition of USP/NF. These shall be used in full accordance with the Statement of Principles Involved in the use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. Only those pharmaceuticals currently approved by the Medical Staff shall be included in the Formulary.

The Pharmacy will dispense the brand stocked for a medication order regardless of the brand actually ordered unless the physician states on the medication order that the specific brand is medically necessary. In this case, the pharmacy will make every reasonableeffort to obtain the desired brand within twenty-four hours. Stocked brand will be dispensed until desired brand can be obtained.

If the physician orders a non-formulary drug that is not covered by the automatic substitution Formulary, he/she will be contacted to determine if a Formulary drug in the same class might be substituted. If not, the Pharmacy will make every effort to obtain the non-formulary drug as soon as possible. The Pharmacy will inform the physician of the expected arrival of the medication for potential substitution in the interim.

A physician may request a non-formulary drug be added and must document the rational for including the drug, addressing the question as to why this drug product should be used in place of the therapeutically equivalent product. Requests will be considered at the next scheduled Pharmacy & Therapeutics Committee meeting and a recommendation made to the Medical Executive Committee.

New drug products which have not been considered for inclusion in the Formulary will be treated as a non-formulary drug until a trial is requested through the Pharmacy & Therapeutics Committee. Trial medications will be stocked by the Pharmacy for a period of three months then evaluated for possible addition to the Formulary.

**D. Amendments**

These Rules and Regulations may be amended at any regular meeting of the Staff by a majority vote, and such an amendment shall be effective when approved by the Medical Executive Committee and the Board.

**BYLAWS, RULES AND REGULATIONS**

**OF**

**JOHNSON MEMORIAL HOSPITAL**

**MEDICAL STAFF**

Adopted by the Active Medical Staff and the Board of Directors of Johnson Memorial Hospital effective August 2, 2019.

/s/ Patrick Mahon

Mr. Patrick Mahon

Chairman, Board of Directors

/s/ Robert P. Dudek, M.D.

Robert P. Dudek, M.D.

President, Medical Staff

1. This is not intended to suggest that other committees and subcommittees cannot function as “medical review committees” that are conducting “peer reviews” within the meaning of those terms as defined by the Connecticut Peer Review Act, as amended from time to time. The Medical Executive Committee and the Board, for example, perform various peer review functions as do many Departmental committees and subcommittees, ad hoc committees, or individual delegates of such committees or subcommittees. [↑](#footnote-ref-1)