

THE MERCY HOSPITAL, INC.

**MEDICAL STAFF  
BYLAWS**

**JUNE 18, 2012**

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**THE MERCY HOSPITAL, INC.**  
**MEDICAL STAFF BYLAWS**

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## DEFINITIONS

“**Act**” means the Health Care Quality Improvement Act of 1986.

“**Administration**” means the executive members of the Hospital’s leadership team.

“**Adverse Action**” means an action taken or recommended by the Medical Executive Committee or the Governing Body that entitles the affected Practitioner to hearing and appellate review rights as set forth in Sections 5.2 or 5.6 of these Bylaws.

“**Adverse Action Notice**” means a Written Notice informing a Practitioner of an Adverse Action.

“**Affiliates**” means those entities owned, operated, or controlled, in whole or in part, by Sisters of Providence Health System, Inc.

“**Allied Health Professional**” or “**AHP**” means an individual, other than a Practitioner, who is licensed and/or certified to render health care services independently or under the supervision of a Medical Staff Member, and is credentialed and privileged in accordance with these Medical Staff Bylaws.

“**Appellate Review Request**” means a written request for an appellate review submitted in the manner set forth in these Bylaws by a Practitioner who is entitled to an appellate review under these Bylaws.

“**Applicant**” means a Practitioner who completes and submits an Application for or has been granted the following at the Hospital:

1. Appointment
2. Reappointment
3. Clinical Privileges (including initial, renewed, modified, temporary, disaster or emergency Privileges)
4. Modification of Medical Staff Category

“**Application**” means a written request for appointment, reappointment, modification of Medical Staff category, and/or Clinical Privileges (including initial, renewed, modified, and/or temporary Clinical Privileges). The application form utilized by the Hospital shall be reviewed by the Credentials Committee and the Medical Executive Committee and approved by the Governing Body.

“**Board of Registration**” means the Massachusetts Board of Registration in Medicine.

“**Certificate of Insurance**” means a current certificate of insurance or other evidence of professional liability insurance coverage acceptable to the Board of Registration and with limits not less than those specified by the Hospital.

“**Clinical Privileges**” or “**Privileges**” means permission granted by the Governing Body to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services at the Hospital.

“**CFR**” means the United States Code of Federal Regulations.

“**Clinical Service Chief**” means the Chief of a Medical Staff Clinical Service or his/her designee, and may also be known as the “Service Chief.”

**“Collaborative Practice Agreement”** means a written and signed agreement between an Allied Health Professional and one or more supervising Medical Staff Members that describes the collaborative relationship in which the Allied Health Professional and the supervising Medical Staff Member(s) propose to practice.

**“Collaborative Relationship”** means the relationship in which an Allied Health Professional works with one or more Medical Staff Members to deliver health care within the scope of the Allied Health Professional’s expertise and lawful practice, with medical direction and appropriate supervision in accordance with applicable law, Medical Staff Policies and Hospital Policies.

**“Credentials Verification Organization”** or **“CVO”** means a qualified organization with which the Hospital has contracted to perform certain credentials verification services.

**“Delivery Date”** means the date upon which any Written Notice is deemed to have been delivered to a Practitioner. The Delivery Date for Written Notices shall be as follows:

<b>Method of Delivery</b>	<b>Delivery Date</b>
Personal/Hand Delivery	Date of Delivery
Certified Mail, return receipt requested	Seventy-two (72) hours after deposit with the U. S. Postal Service, certified or registered with return receipt requested
Overnight Courier	Twenty-four (24) hours after deposit with a reputable overnight courier
Email	Date email sent to last address on file

**“Dentist”** means an individual who has received a doctorate in dental surgery or a doctorate in dental medicine degree and has a current license to practice dentistry in the Commonwealth of Massachusetts.

**“Department”** means a clinical grouping of Staff Members in accordance with their specialty or major practice interest, as specified in these Bylaws.

**“Department Chairperson”** means the Chairperson of a Medical Staff Department, or his/her designee, and may also be known as the “Department Director.”

**“Disciplinary action”** shall be defined in accordance with applicable law for purposes of reporting to the Board of Registration under M.G.L. c.111, §53B.

**“Ex Officio”** means service as a member of a committee or other body by virtue of an office or a position held. Unless otherwise specified in these Bylaws, an Ex Officio member shall serve as a non-voting member.

**“Focused Professional Practice Evaluation”** or **“FPPE”** means a time-limited study, review, investigation, evaluation, or assessment of the training, experience, skill, professional conduct, qualifications, current competence, and/or clinical judgment or expertise of a particular Staff Member. Relevant information obtained from a FPPE shall be integrated into performance improvement activities. The FPPE process is NOT part of the corrective action process, but is considered a medical peer review activity. If corrective action is indicated, the corrective action procedures outlined in these Bylaws must be followed.

**“Governing Body”** means the Board of Trustees or Board of Directors of the Hospital. As appropriate to the context and consistent with the Hospital’s corporate bylaws and delegations of authority made by the Governing Body, it may also mean any Governing Body committee or any individual authorized by the Governing Body to act on its behalf in certain matters.

**“Hearing Request”** means a written request for a hearing submitted in the manner set forth in these Bylaws by a Practitioner who is entitled to a hearing under these Bylaws.

**“Health Care Provider”** means any Medical Staff Member, any Independent Allied Health Professional Staff member; any intern, resident, fellow, or medical officer; and any employee or agent of the Hospital providing patient care.

**“History and Physical”** or **“H&P”** means a medical history and physical examination that is performed, in part, to determine whether any aspect of the patient’s condition or medical history would or should affect the planned course of the patient’s treatment (e.g., a medication allergy or a new or existing condition that requires additional interventions to reduce risk to the patient). An H&P must be performed or approved by an individual who has been privileged to perform or approve an H&P by the Medical Staff.

**“Hospital”** means **The Mercy Hospital, Inc., d/b/a Mercy Medical Center**. The Hospital is a “health care entity” as defined in 42 U.S.C. § 11151(4)(A) and a “hospital” as defined in 42 U.S.C. § 11151(5).

**“Hospital Policies”** means policies approved by the Governing Body or Hospital President.

**“Hospital President”** means the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital, or his/her designee.

**“Hospital Representative”** means, without limitation, the Hospital’s and its Affiliates’ staff members, medical staff members and officers, governing bodies, governing body members, officers, directors, medical executive committee, medical executive committee members, Hospital President, employees, agents, attorneys, and any outside reviewers who provide or evaluate information concerning any Applicant’s qualifications, clinical competency, character, professional conduct, mental or emotional stability, health, ethics or any other matter that might have an effect on patient care.

**“Joint Commission Standard”** or **“JCS”** means a standard set forth by The Joint Commission.

**“Licensed Health Care Professional”** means any person with employment, practice, association for the purpose of providing patient care, or privileges at the Hospital who has been issued any type of license, certificate or registration by an agency of the Commonwealth of Massachusetts authorizing the person to render or assist in rendering health care related services.

**“Licensee”** means a person licensed by the Massachusetts Board of Registration in Medicine.

**“Medical Director”** means a physician under contract with the Hospital to assume overall responsibility for a particular Service.

**“Medical Executive Committee”** or **“MEC”** means the executive committee of the Medical Staff, or its designee.

**“Medical Peer Review Committee”** means, as more fully set forth in Sections 7.2.4 and 10.4.3, Medical Staff committees, the Governing Body, committees of or established by the Governing Body, and their

respective agents and members (all of whom/which shall be deemed committees of the Medical Staff for this purpose) who are responsible for any activities related to: (1) the evaluation or improvement of the quality of health care rendered by providers of health care services; (2) the determination whether health care services were performed in compliance with the applicable standards of care; (3) the determination whether the cost of health care services rendered was considered reasonable by the providers of health services in the area; (4) the determination of whether a health care provider's actions call into question such health care provider's fitness to provide health care services; or (5) the evaluation and assistance of health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise, when they are conducting such activities.

**“Medical Staff”** means all Practitioners appointed to the Active, Associate, Courtesy, Honorary and Telemedicine Medical Staff by the Governing Body. The Medical Staff is a “Professional Review Body” as that term is defined below and in 42 U.S.C. § 11151(11), and is an integral part of the Hospital.

**“Medical Staff Policies”** means rules, regulations and policies which are approved by the Medical Executive Committee and the Governing Body.

**“Medical Staff President”** means the individual elected by the Medical Staff as its chief administrative officer, or his/her designee.

**“Medical Staff Services”** shall mean the Hospital’s designated administrative support personnel and/or a credentials verification service or telemedicine services organization.

**“Medical Staff Year”** means the calendar year.

**“Modification Request”** means a written request for modification of an individual’s Medical Staff Category and/or Clinical Privileges.

**“National Practitioner Data Bank”** or **“NPDB”** means the data bank established under the Act.

**“Ongoing Professional Practice Evaluation”** or **“OPPE”** means a continuous process in which certain data is evaluated to identify professional practice trends that impact quality of care and patient safety. OPPE activities may be assigned to a particular Department, Service or committee under the direction of the Patient Care Assessment Committee. Relevant information obtained from OPPE shall be integrated into performance improvement activities. The OPPE process is NOT part of the corrective action process, but is considered a medical peer review activity. If corrective action is indicated, the corrective action procedures outlined in these Bylaws must be followed.

**“Oral Surgeon”** means a Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education.

**“Patient Care Assessment Plan”** means the document which contains the policies, procedures, rules, regulations and standards for the Patient Care Assessment Program, which document and any amendments thereto are filed with the Board of Registration.

**“Patient Care Assessment Program”** or **“Program”** means the Hospital’s qualified patient care assessment program established pursuant to the Hospital’s corporate and Medical Staff Bylaws.

**“Patient Encounter”** means: (a) an inpatient or outpatient admission of a patient during which the Medical Staff Member has direct, in-person contact with the patient; (b) the performance of a procedure

at the Hospital or a Hospital-licensed facility; or (c) the provision of diagnostic or therapeutic services for a patient at the Hospital or a Hospital-licensed facility.

**“Physician”** means an appropriately licensed medical doctor (M.D.) or osteopathic physician (D.O.) who possesses an unlimited license to practice medicine in the Commonwealth of Massachusetts.

**“Podiatrist”** means an individual who has received a Doctorate of Podiatric Medicine (PM) and has a current license to practice podiatry in the Commonwealth of Massachusetts.

**“Practitioner”** means a Physician, Podiatrist, Dentist, Oral Surgeon or Allied Health Professional.

**“Professional Review Action”** means any action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity, which is based on the competence or professional conduct of a health care provider and which affects, or may affect such individual’s Staff Membership and/or Clinical Privileges.

**“Professional Review Activity”** means any activity which is undertaken to determine whether (a) a health care provider is eligible for Staff Membership or Clinical Privileges; (b) the scope or conditions of such Staff Membership or Clinical Privileges; or (c) if such Staff Membership or Clinical Privileges should be modified or terminated.

**“Professional Review Body”** means the Governing Body, Medical Executive Committee, Credentials Committee, Patient Care Assessment Committee, any Hearing or Appellate Review Committee, any subcommittee or member of the forgoing, and any other committee or entity which, or individual who, conducts or assists the Medical Staff and/or the Hospital in the performance of any Professional Review Activity and/or otherwise participates in a Professional Review Action. All Professional Review Bodies, regardless of whether established by the Governing Body or the Medical Staff, are designated as Medical Peer Review Committees as defined herein and under M.G.L. ch. 111, § 1.

**“Staff Member”** means a current appointee to the Active, Associate, Courtesy, Honorary or Telemedicine Medical Staff, or the Allied Health Professionals Staff.

**“Staff Membership”** means appointment to the Active, Associate, Courtesy, Honorary or Telemedicine Medical Staff, or the Allied Health Professionals Staff.

**“Telemedicine Service Organization”** or **“TSO”** means a Joint Commission-accredited ambulatory care organization that has contracted with the Hospital to provide telemedicine services through a telemedicine link.

**“Written Notice”** means a written notice that is delivered to the Practitioner via personal/hand delivery, or certified mail, return receipt requested to the Practitioner’s last known residential or office address. Notwithstanding the above, for purposes of Medical Staff meetings, Department meetings, and Medical Staff committee meetings (other than Medical Executive Committee meetings), the term “Written Notice” shall also include notice via email to the Practitioner’s last known email address on file with Medical Staff Services.



# ARTICLE 1. NAME, PURPOSES & RESPONSIBILITIES

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## 1.1 NAME

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The name of this medical staff organization shall be:

**“Medical Staff of the MERCY HOSPITAL”**

## 1.2 BYLAWS

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The purposes of these Bylaws are to: (1) describe the organization and structure of the Medical Staff and its relationship to the Governing Body; (2) establish a mechanism for the organized Medical Staff to carry out its responsibilities and govern the professional activities of its members and other individuals with Clinical Privileges, subject to the ultimate responsibility of the Governing Body; and (3) authorize the development and implementation of a Qualified Patient Care Assessment Program which includes, at a minimum, the written policies and procedures necessary to ensure compliance with 243 CMR 3.00, as may be amended.

## 1.3 ORGANIZED MEDICAL STAFF

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The purposes and responsibilities of the Organized Medical Staff are set forth in Section 6.2.

## 1.4 GOVERNING BODY

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The purposes and responsibilities of the Governing Body with regard to the Medical Staff are described in its Bylaws, these Medical Staff Bylaws, the Medical Staff Policies and the Hospital Policies.

### 1.4.1 Bylaws and Policies

The Governing Body reviews and approves these Bylaws, the Medical Staff Policies and the Hospital Policies.

### 1.4.2 Staff Membership and Clinical Privileges

The Governing Body determines, in accordance with applicable law, which categories of providers are eligible candidates for Staff Membership; makes final decisions with respect to requests for appointment and reappointment for Staff Membership after considering the recommendations of the Medical Executive Committee; and ensures that the criteria for Staff Membership and/or Clinical Privileges include individual character, competence, training, experience, professional conduct and judgment.

### 1.4.3 Communication with the Medical Staff

The Governing Body: (a) works with the Medical Staff to evaluate the Hospital’s performance in relation to its mission, vision, and goals; (b) ensures that the Medical Staff is accountable to the Governing Body for the quality of care provided to patients; and (c) provides the organized Medical Staff with the opportunity to participate in Hospital governance, and the opportunity to be represented at Governing Body meetings, by the Medical Staff President.

## **ARTICLE 2. STAFF MEMBERSHIP & CLINICAL PRIVILEGES**

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### **2.1 Generally**

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#### **2.1.1 No Entitlement**

An Applicant shall not be entitled to Staff Membership or to the exercise of Clinical Privileges at the Hospital merely by virtue of the fact that the Applicant: (a) is licensed to practice medicine, podiatry, or dentistry in this or in any other state; (b) is board certified or a member of any professional organization; or (c) had or currently has such privileges at another hospital. Individuals in administrative positions who desire Staff Membership or Clinical Privileges are subject to the same obligations and entitled to the same procedures (including but not limited to hearings and appellate reviews) as all other Applicants for Staff Membership or Clinical Privileges, unless otherwise stated in a written contract with the Hospital or a Hospital Affiliate.

#### **2.1.2 No Discrimination**

No Applicant who is otherwise qualified shall be denied Staff Membership and/or Clinical Privileges by reason of race, color, creed, age, sexual orientation, disability, gender, military status, national origin, or any other class protected by law, except as may be permitted by law. The criteria utilized to determine whether an Applicant is qualified to perform requested Clinical Privileges shall be consistently applied to all Applicants seeking such Clinical Privileges.

#### **2.1.3 Exercise of Clinical Privileges; Certain Restrictions**

Each Practitioner providing direct clinical services at the Hospital, by virtue of Staff Membership or otherwise, shall, in connection with such practice and except as provided in Section 2.9, be entitled to exercise only those Clinical Privileges that are within the scope of such Practitioner's licensure, certification, education, training and experience, and specifically granted to the Practitioner upon recommendation by the Medical Executive Committee and approval of the Governing Body. A Practitioner's authorization to exercise certain Clinical Privileges may be limited in accordance with applicable Medical Staff and Departmental practice and policies, or as specified by the Governing Body. The recommendation or implementation of restrictions on an individual Practitioner's Clinical Privileges may entitle the Practitioner to hearing and appeal rights in accordance with Article 5.

#### **2.1.4 Admitting and Prescribing Privileges**

The privilege to admit patients to the Hospital shall be specifically delineated. All prescribing practices and prescribing privileges must be in accordance with the Applicant's licensure and scope of practice, current clinical competence, accepted standards of good medical practice, applicable DEA and Massachusetts controlled substances registrations, and written prescriptive practice guidelines, if any (for Allied Health Professionals).

#### **2.1.5 Exclusive Contracts**

The Governing Body may, in the interest of quality patient care and as a matter of policy, authorize the Hospital's entry into exclusive contracts with qualified Practitioners/entities to manage and/or staff certain Hospital facilities and/or services, and/or perform certain coverage responsibilities. Such contracts may include provisions wherein the parties waive certain rights under these Bylaws. In the event of any conflict between the terms of any such contract and these Bylaws, the contract terms shall prevail and supersede. When practicable, the Hospital President shall request input from the Medical Executive Committee regarding the renewal of exclusive

contracts at the Hospital prior to the renewal of such contracts. Implementation of an exclusive contract for a particular Department or Service does not, in itself, terminate the clinical privileges of Medical Staff members in the Department or Service, but it can impact the ability of such members to exercise those clinical privileges while the exclusive contract is in effect.

### **2.1.6 Duration of Appointment, Reappointment and Clinical Privileges**

Initial appointment and reappointment to the Medical Staff and Clinical Privileges shall be granted for a specific period not to exceed two (2) years. Honorary Medical Staff Members are not eligible for Clinical Privileges. Honorary Medical Staff Members may be appointed for an indefinite term and are not required to complete the reappointment process.

### **2.1.7 Ongoing Evaluation of Qualifications and Competence**

Each Applicant's competence to perform Clinical Privileges shall be assessed and evaluated on an ongoing basis through, among other things, the Hospital's OPPE and FPPE processes (as further described in Medical Staff Policies). In addition, each Applicant must report any changes in the Applicant's qualifications in accordance with Section 2.4 of these Bylaws. If at any time, such information indicates that the Applicant is no longer competent to perform any or all of the Applicant's previously granted Clinical Privileges, such Clinical Privileges may be modified or terminated by the Governing Body, following the recommendation of the Medical Executive Committee.

## **2.2 Health Care Providers Eligible for Staff Membership & Clinical Privileges**

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### **2.2.1 Eligible Health Care Providers**

The following categories of Health Care Providers are eligible for Staff Membership and/or Clinical Privileges:

#### **Medical Staff**

- Medical Doctors
- Doctors of Osteopathic Medicine
- Dentists
- Oral Surgeons
- Doctors of Podiatric Medicine

### **Allied Health Professional Staff**

- Advanced Practice Registered Nurse (APRN)
  - Certified Registered Nurse Anesthetists
  - Certified Nurse Midwives
  - Nurse Practitioners
  - Psychiatric Mental Health Clinical Nurse Specialists
- Physician Assistants
- Licensed Independent Clinical Social Workers
- Licensed Mental Health Counselors
- Psychologists (Ph.D or Psy.D)

### **2.2.2 Available Clinical Privileges**

The Hospital, in consultation with the Medical Staff, shall determine which Clinical Privileges it has the space, equipment, personnel, and other necessary resources to support. No Applicant shall be granted Clinical Privileges if the Hospital does not have the necessary resources to support such Clinical Privileges. Lists of the specific Clinical Privileges available to each category of provider listed above are maintained by Medical Staff Services.

## **2.3 Qualifications for Staff Membership and Clinical Privileges**

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Only those Applicants who, at the time of application and following appointment to the Medical Staff, continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated Medical Staff and Hospital Policies (and provide documentation of the same) shall be eligible for initial and ongoing Staff Membership and Clinical Privileges.

Each Applicant shall have the burden of establishing that he or she is eligible for Staff Membership and Clinical Privileges and for resolving any doubts about such eligibility; and it is the sole responsibility of each Applicant to submit all of the information and supporting documentation requested by the Medical Staff on the forms and in the manner requested by the Medical Staff. Except as set forth in Section 2.9 (Temporary, Emergency and Disaster Privileges) and Section 2.6.8 (Honorary Medical Staff), such information and supporting documentation shall include the items listed below.

### **2.3.1 Current Competence**

Each Applicant must possess the individual character, current competence, training, skills, experience, judgment, background, and physical ability (with reasonable accommodation) needed to perform requested Clinical Privileges and provide quality patient care. Each Applicant must be able to demonstrate proficiency in the following six areas of general competencies:

- (a) Patient Care. Each Applicant is expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
- (b) Medical/Clinical Knowledge. Each Applicant is expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of such knowledge to patient care and the education of others.
- (c) Practice-Based Learning and Improvement. Each Applicant is expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- (d) Interpersonal and Communication Skills. Each Applicant is expected to demonstrate interpersonal and communication skills that enable the Applicant to establish and maintain professional relationships with patients, families, and other members of health care teams.
- (e) Professionalism. Each Applicant is expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward the Applicant's patients, profession, colleagues (both clinical and administrative), and society.
- (f) Systems-Based Practice. Each Applicant is expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

### **2.3.2 Complete Application and Fee**

Each Applicant must submit a complete, legible, signed Application and any applicable Application fee (such Application fee shall be established and modified by the Hospital President in consultation with the Medical Executive Committee). Except for Applicants to the Associate and Honorary Medical Staffs, who by virtue of Medical Staff category are not eligible for Clinical Privileges, each Application must be accompanied by a request for specific Clinical Privileges.

### **2.3.3 License/Registration**

Each Applicant must: (a) possess a current license to practice his/her profession in the Commonwealth of Massachusetts; (b) provide a copy of his/her most recent application for initial or renewal registration to practice medicine in the Commonwealth, including all attachments and other explanatory materials submitted with the application; (c) provide a list of all current and past licenses and certifications (in any state); (d) provide a list of any current or previous challenges to licensure or certification (including resolution), or voluntary relinquishment of licensure or certification (in any state). Medical Staff Services shall confirm the status of each Applicant's license/registration through primary source verification prior to appointment, reappointment, and modification of Clinical Privileges.

### **2.3.4 Residency/Training Program**

Medical Staff Services shall confirm each Applicant's residency and training history through primary source verification prior to initial appointment and whenever the Applicant provides information regarding training programs completed after initial appointment. If requested by Medical Staff Services, each Applicant must provide copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum, as applicable. If the Applicant is a foreign medical graduate, Medical Staff Services shall verify graduation through the Educational Commission for Foreign Medical Graduates.

- (a) Physicians. A Physician must have successfully completed a residency program accredited by either: (i) the Accreditation Council for Graduate Medical Education (ACGME); (ii) the American Osteopathic Association; (iii) the Royal College of Physicians and Surgeons of Canada; or (iv) a program approved by the Medical Executive Committee and the Governing Body.
- (b) Podiatrists. A Podiatrist must have successfully completed a training program accredited by the Council on Podiatric Medical Education or approved by the Medical Executive Committee and the Governing Body.
- (c) Dentists. A Dentist must:

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- i. have successfully completed a training program at a school of dentistry that is either: (1) accredited by the American Dental Association; or (2) approved by the Medical Executive Committee and the Governing Body;
  - ii. have successfully completed at least one year of a post-graduate program that is approved by either: (1) the Commission on Dental Accreditation of the American Dental Association; or (2) the Medical Executive Committee and the Governing Body; and
  - iii. demonstrate the performance of at least 10 inpatient procedures in a hospital setting during such post-graduate training (which training occurred in the last two years or during the last two years of practice).
- (d) Oral and Maxillofacial Surgeons. An Oral Surgeon must have successfully completed a post-graduate residency program accredited by the Commission on Dental Accreditation of the American Dental Association, or an equivalent program approved by the Medical Executive Committee and the Governing Body.
- (e) Allied Health Professionals. Allied Health Professionals must have successfully completed a training program required for licensure or certification, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

### 2.3.5 Board Certification

Each Applicant must provide: (a) copies of certificates or letters from the appropriate specialty board confirming board status (i.e., board certification or evidence of board eligibility), if applicable; and (b) information regarding the Applicant's previous voluntary or involuntary termination of board certification, if any. Medical Staff Services shall confirm each Applicant's board status through primary source verification prior to initial appointment and reappointment.

- (a) Physicians. Except as provided in Section 2.3.5 below, a Physician must either:
- i. be board certified by one of the following: (1) the American Board of Medical Specialties; (2) the American Osteopathic Association; or (3) a specialty board approved by the Medical Executive Committee and the Governing Body; or
  - ii. be board eligible as defined by the applicable board and receive board certification by the time of the Physician's first reappointment Application following **five (5)** years of Staff Membership.

Physicians must maintain board certification for the duration of the Physician's Staff Membership.

- (b) Podiatrists. A Podiatrist must either:
- i. be board certified by one of the following: (1) the American Board of Podiatric Surgery; or (2) a specialty board approved by the Medical Executive Committee and the Governing Body; or
  - ii. be board eligible and receive board certification by the time of the Podiatrist's first reappointment Application following five (5) years of Staff Membership.

Podiatrists must maintain board certification for the duration of the Podiatrist's Staff Membership.

- (c) Oral and Maxillofacial Surgeons. An Oral Surgeon must either:

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- i. be board certified by one of the following: (1) the American Board of Oral and Maxillofacial Surgery; or (2) a specialty board approved by the Medical Executive Committee and the Governing Body; or
- ii. be board eligible and receive board certification by the time of the Oral Surgeon's first reappointment Application following five (5) years of Staff Membership.

Oral Surgeons must maintain board certification for the duration of the Oral Surgeon's Staff Membership.

- (d) Allied Health Professionals. Allied Health Professionals must have successfully obtained certification from the appropriate professional organization, as applicable.
- (e) Waiver. The Governing Body, following recommendation of the Credentials Committee and the Medical Executive Committee, may waive the board certification requirements described above for an individual Practitioner. The refusal of the Credentials Committee, Medical Executive Committee, or Governing Body to recommend or approve waiver of board certification requirements shall not entitle the Practitioner to any hearing or appeal rights under these Bylaws. The foregoing notwithstanding, individual Medical Staff Members who were appointed to or privileged on the Medical Staff as of February 13, 2007, are exempt from the board certification requirements described above.

### **2.3.6 Peer Recommendations**

Written peer recommendations from at least two (2) peers are required for all Applicants seeking: (a) initial appointment and/or Clinical Privileges; (b) renewed Clinical Privileges if there is insufficient professional practice review data generated at the Hospital to evaluate the Applicant's competence; and (c) modified Clinical Privileges if there is insufficient professional practice review data generated at the Hospital to evaluate the Applicant's competence. Such Applicants must provide the names and addresses of peers (individuals in the same professional discipline practicing in the same or similar field as the Applicant) who recently worked with the Applicant, directly observed the Applicant's professional performance over a reasonable period of time, and can and will provide reliable written information regarding the Applicant's proficiency in the following six areas of general competencies: (a) medical/clinical knowledge, (b) technical and clinical skills; (c) clinical judgment; (d) interpersonal skills; (e) communication skills; and (f) professionalism/professional conduct.

### **2.3.7 Professional Practice Evaluation Data**

Each Applicant seeking Clinical Privileges must provide or permit access to professional practice evaluation data (including morbidity and mortality data) generated at the Hospital and any other facility, entity or clinical practice that currently privileges the Applicant or reviews or evaluates the Applicant's professional practice, if available.

### **2.3.8 No Sanctions or Exclusion**

Each Applicant must be eligible for participation in the Medicare and Medicaid programs and may not (1) be currently excluded, suspended, debarred, or ineligible to participate in any health care program funded in whole or in part by the federal or state government; or (2) have been convicted of a criminal offense related to the provision of health care items or services and not reinstated in a health care program funded in whole or in part by the federal or state government after a period of exclusion, suspension, debarment, or ineligibility. Medical Staff Services shall confirm each Applicant's status through primary source verification prior to appointment and reappointment.

### **2.3.9 DEA Registration**

If the Applicant's practice will involve the prescription of controlled substances, the Applicant must (i) possess a current, unrestricted Drug Enforcement Agency (DEA) registration in each state in which the Applicant will prescribe medications; and (ii) a current, unrestricted Massachusetts Controlled Substances Registration. The Applicant must provide a copy of his/her current DEA registration certificate and current Massachusetts Controlled Substances Certificate, as well as previously successful or currently pending challenges to either registration, or voluntary or involuntary relinquishment of either registration, if any. Medical Staff Services shall confirm each Applicant's DEA registration and Massachusetts Controlled Substances Registration through primary source verification prior to appointment and reappointment.

### **2.3.10 Executed Acknowledgement, Authorization and Release**

Each Application must include the Applicant's specific, written acknowledgement that the Applicant agrees to the provisions set forth in Section 2.4.9 (Acknowledgment, Authorization and Release).

### **2.3.11 Current and Past Employment and Affiliations**

Each Applicant must provide contact names and addresses of all of the institutions, organizations and entities (including clinical practices) with which the Applicant is currently, or during the ten (10) years prior to the Application date was employed, affiliated, had staff membership, or held privileges. In addition; each Applicant must provide any information regarding: (1) the voluntary or involuntary termination of the Applicant's employment, affiliations, or staff membership, at any other institution, organization, or entity (including clinical practices); and (2) any investigation or disciplinary action by the Applicant's employer or other institution, organization, or entity, if such investigation or disciplinary action resulted in the limitation, reduction, denial, loss or relinquishment of clinical privileges or employment.

Medical Staff Services shall contact each entity with which the Applicant had employment, practice, association for the purpose of providing patient care, or clinical privileges during the past ten years to request: (a) an assessment of the Applicant's clinical skills; and (b) information regarding any pending or final disciplinary action, malpractice litigation, and any other information relevant to the Applicant's character, competence or professional behavior. For Applicants seeking reappointment or additional Clinical Privileges, Medical Staff Services shall contact each entity at which the Applicant had employment, practice, association for the purpose of providing patient care, or clinical privileges during the past three years to request: (a) an assessment of the Applicant's clinical skills; and (b) information regarding any pending or final disciplinary action, malpractice litigation, and any other information relevant to the Applicant's character, competence, or professional behavior.

### **2.3.12 Absence of Criminal Background**

Each initial Applicant will be requested to consent to and cooperate with the performance of a background check, including a criminal background CORI system check. If performed, the criminal background check must not disclose information that would disqualify the Applicant for Staff Membership and Clinical Privileges. Medical Staff Services will complete the criminal background check. Thereafter, Medical Staff Services will conduct an electronic background search for all reappointment Applicants who consent to a criminal background check (except reappointment Applicants to the Telemedicine Medical Staff) at least every five (5) years.

### **2.3.13 National Practitioner Data Bank Report**

Medical Staff Services will obtain an NPDB report for all Physicians who submit initial and reappointment/renewal applications, and all current Physician Staff Members seeking modified



Clinical Privileges. Such NPDB report must not contain information that would disqualify the Applicant for Staff Membership or Clinical Privileges.

**2.3.14 Proximity**

Each Applicant seeking Clinical Privileges (except Telemedicine Applicants) must practice and reside closely enough to the Hospital to ensure timely and continuous care of his/her patients and to ensure fulfillment of his/her responsibilities as a Staff Member.

**2.3.15 Telemedicine Services Agreement**

Each Telemedicine Medical Staff Applicant must be affiliated with a Telemedicine Service Organization (TSO) or a Distant Site Hospital. Such TSO or Distant Site Hospital must have a current, written Telemedicine Service Agreement with the Hospital. If the Applicant is affiliated with and has been granted privileges by a TSO or a Distant Site Hospital, the Applicant must be in good standing with such TSO or Distant Site Hospital and provide written documentation of his/her current privileges.

**2.3.16 Collaborative Practice Agreement; Written Practice Guidelines**

An Allied Health Professional must maintain a Collaborative Relationship with a Medical Staff Member and provide a copy of a written Collaborative Practice Agreement as requested by Medical Staff Services. The Collaborative Practice Agreement must be in a form acceptable to Medical Staff Services. Allied Health Professionals must also, as applicable, submit and maintain written practice and prescriptive practice guidelines in accordance with applicable regulations and Medical Staff and Hospital Policies. Advance Practice Registered Nurses must submit and practice in accordance with written practice guidelines that have been approved by the Medical Executive Committee and the Hospital's senior nursing leadership.

**2.3.17 TB and Immunization Status**

Each Applicant must provide documentation of the Applicant's TB and immunization status as requested by Medical Staff Services (not required for Telemedicine Medical Staff Applicants).

**2.3.18 Certification of Fitness; Physical and Psychological Examination**

Each Applicant must submit a statement that no health problems exist that would adversely affect the Applicant's ability to exercise requested Clinical Privileges and otherwise care for patients. Upon the request of the Credentials Committee, Medical Executive Committee or Governing Body, each Applicant agrees to undergo mental or physical examinations, tests and/or other evaluations deemed appropriate to evaluate the Applicant's ability to exercise requested Clinical Privileges. If there is a known mental or physical impairment, the Applicant will provide evidence that the impairment does not interfere with the Applicant's ability to exercise requested Clinical Privileges.

**2.3.19 Professional Liability Insurance**

Each Applicant must submit a current Certificate of Insurance evidencing professional liability insurance coverage with limits not less than those specified by the Governing Body or Medical Staff Bylaws and must maintain such insurance coverage.

**2.3.20 Claims and Settlements**

Each Applicant must provide a listing and description of all malpractice claims and lawsuits, pending or closed, which have been filed against the Applicant during the past ten (10) years. Each Applicant shall also authorize his/her malpractice insurance carrier(s) to release the following information relating to any claims or actions for damages against the Applicant

(pending or closed within the previous ten years), regardless of whether there has been a final disposition: (a) the Applicant's policy number; (b) the name, address and age of the claimant or plaintiff; (c) the nature and substance of the claim; (d) the date and place at which the claim arose; (e) the amounts paid (if any) and the date and manner of disposition, judgment, settlement, or otherwise; (f) the date and reason for final disposition, if no judgment or settlement; and (g) any additional information requested by the Credentials Committee, Medical Executive Committee, or Governing Body.

### **2.3.21 Confirmation of Identity**

Each initial Applicant (not required at reappointment/renewal or for Telemedicine Medical Staff Applicants) must provide:

- (a) Current Photograph. A head shot photograph of the Applicant, with a minimum size of 2” x 2” taken within the immediately preceding two (2) years, showing the Applicant’s current appearance in full face with a light background, either in color or black and white. The photograph must be on photo quality paper, not a copy. Note: The Applicant’s photograph is exclusively used to confirm the Applicant’s identity and the Applicant’s appearance on the photograph is not otherwise considered during the credentialing and privileging process.
- (b) Government-Issued Photo Identification. A copy of the Applicant’s driver’s license, passport or other U.S. government-issued photo identification. The copy must be clear enough to compare it with the head shot photograph described above.

Medical Staff Services shall compare each initial Applicant’s current photo to the copy of the Applicant’s government-issued photo identification. A copy of the current photo may also be sent to the Applicant’s peer references to confirm the Applicant’s identity.

### **2.3.22 Continuing Education**

Each Applicant must attest in writing that the Applicant has completed the number of qualifying continuing education program hours required under the Applicant’s licenses, and provide additional information about his/her participation in continuing education programs upon request.

### **2.3.23 Alternative Coverage**

Each Applicant must have alternate coverage available as required by Medical Staff Policies and applicable Departmental policies.

### **2.3.24 Other Information**

Each Applicant must provide other information requested and deemed by the Department Chairperson, Medical Executive Committee, and/or Governing Body to be relevant to the evaluation of the Applicant’s ability to exercise Clinical Privileges.

## **2.4 ONGOING OBLIGATIONS**

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By signing and submitting an Application, or requesting temporary or disaster Clinical Privileges, each Practitioner affirms his/her agreement to the ongoing obligations set forth below, which obligations shall remain in effect as long as the Practitioner is an Applicant or a Staff Member. For the purposes of this Section 2.4 the term “Practitioner” includes all Applicants.

### **2.4.1 Maintain Qualifications**

Each Practitioner agrees to maintain all necessary qualifications for Staff Membership and/or Clinical Privileges as set forth in Section 2.3 of these Bylaws.

**2.4.2 Provide Notice of Change in Qualifications**

Each Practitioner agrees (including but not limited to when applying for reappointment and/or modification of current Clinical Privileges) to inform Medical Staff Services of, and describe in writing, any changes to the Applicant's qualifications for Staff Membership and/or Clinical Privileges.

**2.4.3 Appear for Interview**

Each Practitioner agrees to appear for any requested interviews regarding his/her Application/request, and, subsequent to appointment or the granting of Clinical Privileges, to appear for any requested interviews related to questions regarding the Practitioner's qualifications, conduct or competence.

**2.4.4 Provide Continuous Care** *(Revised and approved December 8, 2016)*

Upon the granting of staff membership and clinical privileges, each Practitioner agrees to: (a) provide or arrange for continuous care *at the Mercy Medical Center* to his/her patients at the professional level of quality and efficiency established by the hospital; (b) delegate in his/her absence the responsibility for diagnosis and care of his/her patients *at the Mercy Medical Center* to a qualified Practitioner who possesses the Clinical Privileges necessary to assume care of such patients, *and who has agreed to cover their patients. Standing arrangements to transfer such patients to a covering practitioner at an outside institution, in the event of the absence of the Practitioner will not suffice.*

**2.4.5 Participate in Call Coverage Programs**

In order to meet the needs of Hospital inpatients and outpatients and ensure compliance with applicable regulatory requirements, the Medical Executive Committee and the Hospital President will determine whether certain programs and specialty services require on-call coverage, subject to the approval of the Governing Body. If the Medical Executive Committee and the Hospital President disagree on whether on-call coverage is needed in a specialty, or the extent of such needed coverage, then the matter shall be determined by the Governing Body. Active Medical Staff Members, Medical Staff Members who maintain admitting privileges, and Allied Health Professional Staff Members must participate in emergency department call and other call coverage programs to the extent required by the Medical Staff Bylaws, Medical Staff Policies, Hospital Policies, and other rules, policies, procedures, guidelines, and other requirements of the Medical Staff and the Hospital (unless waived by the Hospital). Call schedules shall be prepared by the applicable Department or Division Chairperson. If the Department or Division Chairperson, as applicable, fails to set the call schedule in the manner and to the extent approved by the Medical Executive Committee, then the Medical Executive Committee shall have the authority to set the call schedule in the manner and to the extent so approved. If the Medical Executive Committee fails to set the call schedule, then the Governing Body shall have the authority to set the call schedule in the manner and to the extent so approved by the Governing Body.

**2.4.6 Authorize Consultation and Review**

Each Practitioner authorizes Hospital Representatives to consult with others who are or have been associated with the Practitioner and who have information regarding the Practitioner's competence and qualifications, and consents to the Hospital's Representatives' inspection of all records and documents evaluating the Practitioner's professional qualifications and competence

to serve as a member of the Medical Staff and carry out the Clinical Privileges requested by Practitioner, including the Practitioner's moral and ethical qualifications. The Practitioner also agrees that the Medical Staff may obtain an evaluation of the Practitioner's performance by an outside consultant selected by the Medical Staff or the Hospital if the Medical Staff or the Hospital considers it appropriate. The Practitioner will cooperate with and receive a copy of any such evaluations.

**2.4.7 Participate in Staff Functions; Meeting Attendance**

As may be required by the Medical Executive Committee or the Governing Body, each Practitioner must actively participate in recognized functions of the Staff category, administrative position, and office to which he/she is appointed, elected or assigned. This includes, but is not limited to, participating in quality improvement and other monitoring activities. In accordance with applicable Medical Staff Policies, Active Medical Staff Members are expected to attend Medical Staff and Departmental Meetings, and such attendance may be considered in evaluating Active Medical Staff Members at the time of reappointment. All other Staff Members are strongly encouraged to attend Medical Staff and Departmental meetings.

**2.4.8 Participate in Quality Improvement and Other Initiatives**

The Practitioner agrees to participate in peer review (including OPPE and FPPE), quality assessment, performance improvement, risk management, case management/resource management, initiatives to promote high quality care, the appropriate utilization of Hospital resources, the Hospital's Qualified Patient Care Assessment Program, and other Hospital review and improvement initiatives.

**2.4.9 Acknowledgement, Authorization and Release**

Each Practitioner:

- (a) Acknowledges that the Practitioner has received and read copies of the Medical Staff Bylaws, Medical Staff Policies, and associated Hospital Policies, and agrees to be bound by and comply with the same;
- (b) Authorizes the Hospital and its Affiliates to release and exchange all information necessary for the review and evaluation of services provided by or conduct of the Practitioner, including any and all information related to the Practitioner's competence to practice his or her profession;
- (c) Authorizes the Hospital and its Affiliates to release and exchange all information necessary to facilitate credentialing of the Practitioner by third party payors and/or other hospitals or entities at which the Practitioner has or is seeking privileges or employment, including any and all information related to the Practitioner's competence to practice his or her profession;
- (d) Authorizes the release of information from any other health care facility where the Practitioner is or was affiliated or employed to Hospital and its Affiliates;
- (e) Authorizes the release of the following information from the Practitioner's medical malpractice carrier as to claims or actions for damages in the previous ten years: (1) policy number; (2) name, address and age of claimant/plaintiff; (3) nature and substance of the claim; (4) date and place at which the claim arose; (5) amounts paid, if any and the date and manner of disposition, judgment, or settlement; and (6) the date and reason for the final disposition, if no judgment or settlement;
- (f) Releases the Hospital, Hospital Representatives, and Hospital's Affiliates from liability related to acts reasonably undertaken in the furtherance of quality health care and

performed in good faith in connection with the Application and the Practitioner’s ongoing Staff Membership;

- (g) Acknowledges the Practitioner’s responsibility to promptly notify and provide information to the Hospital President regarding any changes to the Practitioner’s qualifications;
- (h) Authorizes the posting of the Practitioner’s affiliation with the Hospital on the Hospital’s website; and
- (i) Acknowledges that if the Practitioner participates in research activities that involve Hospital patients or the use of Hospital facilities, equipment or supplies, the Practitioner must perform such activities in accordance with applicable regulations and Hospital Policies, and must provide prior written notification of any research activities to the Hospital’s IRB.

#### **2.4.10 Comply with Ethical Guidelines**

Each Practitioner agrees to abide, as applicable, by the Principles of Medical Ethics of the American Medical Association, the American Podiatric Medical Association, Inc., the American Osteopathic Association, the Code of Ethics of the American Dental Association, or other ethical principles or codes for the appropriate professional association of the Practitioner, as if the same were appended to and made a part of these Bylaws. The Hospital shall provide a copy of applicable ethical principles or codes to the Members of the Medical Staff, or shall provide the Members information as to how to obtain access to such ethical principles or codes.

#### **2.4.11 Comply With Laws and Policies**

Each Practitioner agrees to strictly abide by: (a) all local, state and federal laws and regulations, Joint Commission standards, and professional review regulations and standards, as applicable to the Practitioner’s professional practice; and (b) these Bylaws, Medical Staff Policies, Hospital Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, including but not limited to the Hospital’s compliance plan and Code of Conduct. Each Practitioner who serves as a Medical Staff Officer, Medical Executive Committee Member, Department Chairperson, Clinical Services Chief, Medical Staff Committee Chairperson, or Medical Staff Committee member, agrees to comply with the Medical Staff’s and Hospital’s conflict of interest policies, including all applicable disclosure and recusal requirements. The Governing Body will determine whether a particular leader’s conflict(s) of interests are incompatible with the leadership position.

#### **2.4.12 Mandatory Self-Disclosure**

- (a) Notification to the Practitioner Health Committee. Each Practitioner agrees to notify the Practitioner Health Committee in writing promptly after he/she becomes aware (by the end of the next business day, if practicable) of any of the circumstances listed below:
  - i. The Practitioner enters, participates in, or, against medical advice, leaves or refuses any program of treatment prescribed or required by the Massachusetts Board of Registration in Medicine.
  - ii. The Practitioner is admitted for, seeks, or is undergoing treatment for substance or alcohol abuse or a behavioral health problem. “Substance abuse” shall include but not be limited to, use or ingestion of illegal drugs, or use or ingestion of prescription medications not prescribed in the ordinary course of treatment of injury or disease. “Behavioral health problem” shall mean any condition or disease of a psychiatric or psychological nature which, in the opinion of a qualified psychiatrist, adversely

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affects the practitioner’s ability to care for patients or practice his or her profession in accordance with the applicable prevailing standard of care.

- (b) Notification to the Medical Staff President. Each Practitioner agrees to notify the Medical Staff President in writing immediately after he/she becomes aware (in no event later than the end of the next business day) of any of the circumstances listed below (unless, where applicable, the circumstance is appropriately reported to the Practitioner Health Committee as set forth above). The Medical Staff President will immediately notify the Hospital President of:
- i. Any circumstance or condition which would affect or result in a change in status of any of the Practitioner’s qualifications for Staff Membership and/or Clinical Privileges as set forth in these Bylaws;
  - ii. Any disciplinary action or restriction related to the Practitioner’s professional practice by any entity (including but not limited to the Practitioner’s employer, other hospitals, health plans, and agencies);
  - iii. Criminal proceedings against the Practitioner, including arrest, arraignment, or indictment, even if the charges against the Practitioner were dropped, filed, dismissed or otherwise discharged. The Practitioner must also report: convictions for felonies and misdemeanors; nolo contendere pleas; matters where sufficient facts of guilt were pled or found; matters that were continued without a finding even if they were ultimately dismissed; and any other plea bargain. A charge of Driving Under the Influence is not a “minor traffic offense” and must also be reported; and
  - iv. The investigation of allegations (or a finding) related to the Practitioner’s professional practice by any governmental or regulatory agency, including but not limited to an investigation or finding related to the to the abuse or neglect of any person, or misappropriation (improperly taking or using) of the property of a patient or other person.

### **2.4.13 Immunity from Liability**

The Practitioner agrees and acknowledges that the Hospital, its Affiliates, Hospital Representatives, any Professional Review Body or Medical Peer Review Committee and its/their members, agents and representatives shall have absolute immunity from civil liability for actions performed in good faith in connection with providing, obtaining or reviewing information, and evaluating or making recommendations or decisions, concerning the following: (a) any Professional Review Activity; (b) any Professional Review Action; (c) any Adverse Action, corrective action, hearing or appellate review; (e) any FPPE, OPPE, or other evaluation of patient care services or qualifications; (f) any utilization review; and (g) other Hospital, Departmental or Committee activities related to patient care services and/or professional conduct. In furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute releases in favor of the Hospital, Hospital representatives and third parties from whom information has been requested, or who have provided information in connection with the above activities.

### **2.4.14 Cooperate With Hospital**

The Practitioner agrees to cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including matters relating to payment or reimbursement by governmental and third party payers (to the extent such policies are consistent with applicable standards of care).

#### **2.4.15 Exhaust Remedies**

The Practitioner agrees that, if an Adverse Action is taken or recommended against him or her, the Practitioner will exhaust the remedies afforded by these Bylaws before resorting to legal action.

#### **2.4.16 Pay Medical Staff Dues**

The Practitioner agrees to pay Annual Medical Staff or Allied Health Professional Staff dues, if any, upon request. Applicable Medical Staff and Allied Health Professional Staff dues shall be set forth in a Medical Staff Policy. Failure to pay dues may result in a request for corrective action and/or be the basis upon which to deny reappointment and/or renewal of clinical privileges.

### **2.5 Obtaining and Submitting an Application**

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#### **2.5.1 Obtaining an Application**

Individuals seeking appointment, reappointment, Clinical Privileges (including initial or modified Clinical Privileges), and/or modification of Medical Staff category must submit a complete written Application.

- (a) Initial Appointment and Clinical Privileges. A prospective Applicant for initial Medical Staff Membership and Clinical Privileges must contact Medical Staff Services to obtain an Application. Unless the Applicant is seeking Honorary Staff Membership, Medical Staff Services personnel may contact the prospective Applicant to confirm that the prospective Applicant meets the following basic criteria:
- i. Possesses a current license to practice his/her profession in Massachusetts;
  - ii. Can provide peer recommendations as provided in Section 2.3 of these Bylaws;
  - iii. Is eligible for participation in state and federal reimbursement programs as provided in Section 2.3;
  - iv. Can provide a current certificate of insurance evidencing professional liability coverage with limits not less than those specified by the Governing Body;
  - v. Practices in a specialty that is open to new Applicants (certain specialties, such as anesthesiology and radiology, may be closed to new Applicants if the Hospital enters into an exclusive contractual arrangement to secure such specialty services in accordance with Section 2.1.5).
  - vi. Satisfies the board certification or board eligibility requirements of Section 2.3.5.

If the prospective Applicant confirms that he/she meets the foregoing criteria, Medical Staff Service personnel shall provide the Applicant with an Application. Medical Staff Services shall send the appropriate Application to the potential Applicant, or make the Application available to the potential Applicant electronically. If a CVO or TSO will participate in the credentials verification process, the Application or a portion of the Application may be sent to the Applicant by the CVO or TSO. Applicants to the Honorary or Telemedicine Medical Staff may receive an abbreviated Application. If the prospective Applicant does not meet the basic qualifications above, Medical Staff Service personnel shall inform the Applicant that the Hospital will not provide or process an Application unless all such criteria are met. The failure to meet the criteria above and refusal of

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Medical Staff Services to provide an Application on that basis shall not entitle a prospective Applicant to hearing or appeals rights under these Bylaws.

- (b) Reappointment and Renewal of Clinical Privileges. Medical Staff Services will send to each Applicant for reappointment/renewal the appropriate Application at least one hundred twenty (120) days prior to the Applicant's reappointment/renewal date. If a CVO or a TSO will participate in the credentials verification process, the Application or a portion of the Application may be sent by the CVO or TSO. Honorary Medical Staff Members do not need to complete the reappointment application/review process.
- (c) Modification of Medical Staff Category or Clinical Privileges. An individual seeking to modify his/her Medical Staff category or his/her current Clinical Privileges must request the appropriate Application from Medical Staff Services. Medical Staff Services shall send the appropriate Application to the prospective Applicant, or make the Application available to the prospective Applicant electronically, unless the particular Clinical Privileges sought are not available to the Applicant.
- (d) Previously Denied or Terminated Applicants. An individual whose Application for Staff Membership and Clinical Privileges has been denied or whose Staff Membership and Clinical Privileges have been terminated, shall not be permitted to submit the same or a similar Application for at least two (2) years after notice of such Adverse Action, unless the notice of Adverse Action provides otherwise. Applications submitted during this two (2) year period shall be returned to the Applicant, and no right of hearing or appellate review shall be available in connection with the return of such Application. An Application submitted subsequent to the two year period shall be processed as an initial Application.

### 2.5.2 Application Submission

- (a) Initial Appointment. Initial Applicants must submit a complete Application (including required supporting documentation specified in the Application) to Medical Staff Services within ninety (90) days of the Applicant's receipt of the Application. If a complete Application is not submitted within ninety (90) days of the Applicant's receipt of the initial Application, the Application will be considered withdrawn, no further processing will take place, and the Applicant shall not be entitled to hearing and appellate review rights in connection with such withdrawal.
- (b) Reappointment/Renewal. In order to allow for an adequate amount of time to process the Application, reappointment/renewal Applicants must submit a complete Application (including required supporting documentation specified in the Application) to Medical Staff Services at least ninety (90) days prior to the expiration of the Applicant's then current term of appointment. If an Applicant fails to timely submit a reappointment/renewal Application, the Applicant will be deemed to have voluntarily relinquished his/her Staff Membership and all Clinical Privileges upon expiration of the Applicant's then current term, unless good cause is shown for the late submission. Refusal to process an Application that is not submitted in a timely manner shall not entitle the reappointment/renewal Applicant to hearing or appellate review rights. If an Applicant fails to timely submit a reappointment/renewal Application and the processing of the application is refused, the Applicant must, if he/she desires appointment and Clinical Privileges, complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable initial appointment Application fee.



- (c) Modification of Medical Staff Category or Clinical Privileges. Requests for modification of Medical Staff category or current Clinical Privileges may be submitted to Medical Staff Services at any time; except that such requests will not be accepted or considered within the twelve (12) month period following an Adverse Action regarding a similar request, unless the Adverse Action provides otherwise.

### **2.5.3 Applicant's Burden**

Each Applicant shall have the burden of producing complete, accurate and adequate information to allow a proper evaluation of, and to resolve any doubts related to, his/her qualifications for Staff Membership and Clinical Privileges. This burden may include completion of a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the Medical Executive Committee or Governing Body, which shall also designate two physicians, either of whom may serve as the examining physician. The Applicant may then select one of the two physicians to serve as the examining physician. The Applicant's failure to sustain his/her burden hereunder, or the Applicant's submission of information which is either inaccurate or incomplete, may be grounds for denial of an Application.

## **2.6 REVIEW AND EVALUATION PROCESS**

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### **2.6.1 Generally**

Prior to making a recommendation or decision regarding an Application for Active, Associate, Courtesy or Telemedicine Medical Staff Membership, or Allied Health Professional Staff Membership, Medical Staff Services, the appropriate Department Chairperson, the Credentials Committee, the Medical Executive Committee, and the Governing Body will review all relevant information regarding the Applicant and verify that the Applicant meets the qualifications for Staff Membership and Clinical Privileges set forth in these Bylaws. The Department Chairperson, the Credentials Committee, the Medical Executive Committee, and/or the Governing Body may contact any of the Applicant's peer references, educational institution references or clinical settings where the Applicant had or has employment or privileges for additional information, and/or may request an interview with the Applicant. Applications for Honorary Medical Staff Membership shall be reviewed and approved as set forth in Section 2.6.8. In the event that a Medical Staff Member submits an application which seeks to relinquish a portion of his/her clinical privileges, the Department Chairperson, Medical Executive Committee, and Governing Body may, in reviewing such application, take into account whether the requested relinquishment would create an unreasonable burden for other Members of the Medical Staff or the Hospital in connection with, e.g., on-call rotations and regulatory requirements (such as the Emergency Medical Treatment and Active Labor Act or "EMTALA").

### **2.6.2 Anticipated Time Periods for Application Processing**

All individuals and groups required to act on an Application shall do so in a timely and good faith manner and, except for good cause (including but not limited to a delay on the part of the Applicant), each Application should be processed within the time periods set forth below, measured from the receipt of a completed Application. These time periods are deemed guidelines, not requirements, and do not create any right to have an Application processed within these precise periods. If the provisions of the corrective action, or hearing and appellate review processes specified in these Medical Staff Bylaws are initiated, the time requirements provided therein shall govern the continued processing of the Application.

<b>Individual/Group</b>	<b>Time Period</b>
Medical Staff Services (and CVO or TSO)	90 days
Department Chairperson	Prior to next Credentials Committee Meeting, provided that the next meeting is at least fourteen days after the Chairperson’s receipt of the Application
Credentials Committee	Next Scheduled Meeting, provided that the next meeting is at least fourteen days after the Committee’s receipt of the Application
Medical Executive Committee	Next Scheduled Meeting, provided that the next meeting is at least fourteen days after the Committee’s receipt of the Application
Governing Body	Next Scheduled Meeting, provided that the next meeting is at least fourteen days after the Governing Body’s receipt of the Application

**2.6.3 Initial Review by Medical Staff Services**

- (a) Initial Review. Medical Staff Services shall maintain a separate credentials file for each individual Applicant. Medical Staff Services will perform an initial review of each Applicant’s credentials file to ensure that it includes: (a) a complete Application; (b) verification of the Applicant’s credentials (including primary source verification of certain qualifications as set forth in Section 2.3); and (c) all other required documentation. If the Applicant’s credentials file is deemed complete, it will be forwarded to the appropriate Department Chairperson for review.
- (b) Incomplete Application. It is the sole responsibility of each Applicant to submit all of the required information and supporting documentation described in these Bylaws, or as otherwise requested by the Medical Staff, on the approved forms and in the manner requested. The Hospital is under no obligation to act on an Application until all such information and supporting documentation has been received (even if the missing information is to be provided by a third party). If the required information and documentation have not been submitted, the Applicant’s file will be deemed incomplete. Medical Staff Services will notify the Applicant of the deficiencies and that the Applicant’s failure to correct such deficiencies within thirty (30) days may be deemed a voluntary withdrawal of the Application. The Applicant shall not be entitled to hearing or appellate review rights in connection with such voluntary withdrawal.

**2.6.4 Department Chairperson Review and Recommendation**

The Department Chairperson shall determine whether the Applicant’s peer recommendations and professional practice review data is sufficient to assess the Applicant’s competence to perform the requested Clinical Privileges. If not, the Department Chairperson shall refer the Applicant’s credentials file back to Medical Staff Services and Medical Staff Services shall request that the Applicant provide additional information or peer recommendations. If the Department Chairperson determines that the Applicant’s peer recommendations and professional practice review data are sufficient, the Department Chairperson shall complete the evaluation described in

Section 2.6.1 and submit a written recommendation to the Credentials Committee that includes the following:

- (a) Staff Membership. Whether the Applicant's request should be approved or disapproved, the appropriate Medical Staff category (as applicable), and the appropriate Department to which the Applicant should be assigned. If the recommendation regarding Staff Membership or Medical Staff category is adverse to the Applicant, the written recommendation shall clearly state the reason(s) for such Adverse Action.
- (b) Clinical Privileges. Whether the Applicant's request should be approved or disapproved, in whole or in part, and whether there are any recommended conditions or restrictions. If the recommendation regarding Clinical Privileges is adverse to the Applicant, in whole or in part, the written recommendation shall clearly state the reason(s) for such Adverse Action.
- (c) Written Guidelines. For Allied Health Professionals, whether the Applicant's written practice guidelines, if any, should be approved or disapproved, in whole or in part, and whether there are any recommended conditions or restrictions, including in connection with the scope of practice requested.

### **2.6.5 Credentials Committee Review and Recommendation**

Upon completion of the evaluation described in Section 2.6.1 and review of the Department Chairperson's written recommendation, the Credentials Committee will submit a written recommendation to the Medical Executive Committee that includes the information set forth in Section 2.6.4. If the Credentials Committee disagrees with the recommendation of the Department Chairperson or the recommendation is adverse to the Applicant, in whole or in part, the Credentials Committee's written recommendation shall include the reason(s) for the disagreement or the adverse recommendation. The foregoing notwithstanding, in the case of an application for reappointment to the Medical Staff, if during the Credentials Committee review of such application, it is determined that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Credentials Committee shall so notify the affected applicant in writing. The applicant shall be informed of the general nature of the evidence supporting the contemplated recommendation and shall be offered the opportunity to explain or refute the evidence. The applicant may, but need not, be invited to meet with the Credentials Committee and discuss the matter prior to a final recommendation being made by the Committee. If the applicant is invited to meet with the Committee, such meeting shall not constitute a hearing, and none of the procedural rules set forth in these Bylaws relating to hearings shall apply; nor need minutes of the discussion at the meeting be kept. However, the Credentials Committee shall indicate as part of its recommendation to the Medical Executive Committee whether such a meeting occurred.

### **2.6.6 Medical Executive Committee Review and Recommendation**

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Department Chairperson and the Credentials Committee, the Medical Executive Committee will draft a written recommendation that includes the information set forth in Section 2.6.4.

- (a) Favorable Recommendation. If the Medical Executive Committee disagrees with the recommendations of the Department Chairperson or the Credentials Committee, in whole or in part, or the recommendation is adverse to the Applicant, the Medical Executive Committee's proposed recommendation shall include the reason(s) for the disagreement or

the adverse recommendation. If the proposed recommendation is favorable to the Applicant, the Medical Executive Committee will submit its recommendation to the Governing Body.

- (b) Unfavorable Recommendation. If the proposed recommendation is deemed an Adverse Action in accordance with these Medical Staff Bylaws, the Hospital President will provide the Applicant with Written Notice of the Adverse Action (including the reasons for such recommendation) and advise the Applicant of his/her hearing rights (if any) in accordance with Article 5. In the case of an application for initial appointment to the Medical Staff, only an adverse recommendation which is based primarily on issues of professional competence or conduct shall be considered an Adverse Action which entitles the Applicant to hearing and appellate review rights under these Medical Staff Bylaws. The Medical Executive Committee shall not submit the proposed Adverse Action to the Governing Body until the Applicant has had an opportunity to exercise his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

### **2.6.7 Governing Body Review, Conflict Resolution, and Decision**

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Department Chairperson, the Credentials Committee, and the Medical Executive Committee, and following the Applicant's exercise of hearing and/or appeal rights, if applicable, the Governing Body will take action on the matter. If the Governing Body determines that its action will be contrary to the recommendation of the Medical Executive Committee, the matter will be submitted to a committee of an equal number of (a) medical staff members of the Medical Executive Committee and (b) Governing Body members for review and recommendation before the Governing Body takes final action. The committee will deliberate and provide its recommendation to the Governing Body within thirty (30) days of a request for review submitted to the Medical Executive Committee from the Governing Body. Following receipt of the recommendation of the committee, if applicable, the Governing body will take action on the matter, and following final Governing Body action, the Governing Body will issue a written decision that includes the information set forth in Section 2.6.4. The written decision may precondition appointment or reappointment, and the granting or continued exercise of Clinical Privileges, upon the Applicant undergoing mental or physical examinations and/or such other evaluations as it may deem appropriate at that time or at any intervening time, to evaluate the Applicant's ability to exercise Clinical Privileges.

### **2.6.8 Applicants to the Associate and Honorary Medical Staffs**

Associate and Honorary Medical Staff Members are not eligible for Clinical Privileges. An Applicant to the Associate or Honorary Medical Staff need not meet the qualifications set forth in Section 2.3, nor complete the submission and review process set forth above. An Applicant to the Associate or Honorary Medical Staff must: (a) be recognized for his/her reputation and contributions to the health and medical sciences, as well as his/her contributions to the Hospital; (b) continue to exemplify high standards of professional and ethical conduct; (c) complete the appropriate Application; (d) be recommended for Associate or Honorary Medical Staff Membership by at least two (2) Active Medical Staff appointees; and (e) be approved for membership on the Associate or Honorary Medical Staff by the Medical Executive Committee and the Governing Body.

## **2.7 PRIVILEGING BY PROXY PROCESS – TELEMEDICINE PRIVILEGES**

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### **2.7.1 Minimum Qualifications for Use of Privileging By Proxy Process**

## ARTICLE 2 – STAFF MEMBERSHIP & CLINICAL PRIVILEGES

Provided that doing so then comports with applicable Massachusetts law, the Medical Staff may utilize the privileging by proxy process set forth in this Section 2.7 to approve an Application for Telemedicine Medical Staff Membership and Telemedicine Clinical Privileges from an Applicant who wishes to provide services to Hospital patients from a distant site if all of the following qualifications are met:

- (a) Complete Application and Fee. The Applicant must submit a complete, legible, signed Application and any applicable Application fee. The Application must be accompanied by a request for specific Clinical Privileges.
- (b) Telemedicine Services Agreement. The Applicant agrees to and does provide services in accordance with a written Telemedicine Services Agreement between the Hospital and another Medicare participating hospital (the “Distant Site Hospital”) that includes the following:
  - i. A statement that it is the responsibility of the Distant Site Hospital’s governing body to meet all of the requirements set forth in 42 CFR § 482.12 (a)(1)-(a)(7) with regard to all Applicants;
  - ii. A statement that the Distant Site’s governing body will ensure that each Applicant providing services pursuant to the Telemedicine Services Agreement meets the qualifications for staff membership and clinical privileges at the Distant Site Hospital and will promptly notify the Hospital of any changes to such qualifications, membership or clinical privileges.
- (c) Credentialing and Privileging Information. The Distant Site Hospital provides Medical Staff Services with a current list of the Applicant’s clinical privileges at the Distant Site Hospital, which includes at least those clinical privileges which Applicant is seeking at the Hospital.
- (d) License/Registration. The Applicant has and must maintain licensure/registration as described in Section 2.3 of these Bylaws. A Practitioner whose licensure or registration is or has been denied, limited, or challenged in any way, is not eligible for Telemedicine Clinical Privileges using this alternative process.
- (e) No Sanctions or Exclusion. As described in Section 2.3 of these Bylaws.
- (f) Signed Acknowledgement. As described in Section 2.3 of these Bylaws.
- (g) National Practitioner Data Bank Report. As described in Section 2.3 of these Bylaws.
- (h) Professional Liability Insurance. As described in Section 2.3 of these Bylaws.

### **2.7.2 Initial Review by Medical Staff Services**

- (a) Initial Review. Medical Staff Services shall maintain a separate credentials file for each Telemedicine Applicant. Medical Staff Services will perform an initial review of each Telemedicine Applicant’s credentials file to ensure that it includes documentation evidencing that the Applicant meets the qualifications set forth in Section 2.6.1: (i) a complete Application; (ii) a copy of the applicable Telemedicine Service Agreement; and (iii) primary source verification of the Applicant’s license and registration. If the Applicant’s credentials file is deemed complete, it will be forwarded to the appropriate Department Chairperson for review.
- (b) Incomplete Credentials File. It is the sole responsibility of each Applicant to submit all the required information and supporting documentation described in these Bylaws, or as

otherwise requested by the Medical Staff, on the approved forms and in the manner requested. The Hospital is under no obligation to act on an Application until all such information and supporting documentation has been received (even if the missing information is to be provided by a third party). If the required information and documentation have not been submitted, the Applicant's file will be deemed incomplete. Medical Staff Services will notify the Applicant of the deficiencies and that the Applicant's failure to correct such deficiencies within thirty (30) days may be deemed a voluntary withdrawal of the Application. The Applicant shall not be entitled to hearing or appellate review rights in connection with such voluntary withdrawal.

### **2.7.3 Department Chairperson Review and Recommendation**

The Department Chairperson shall review all relevant information regarding the Applicant and verify that the Applicant meets the qualifications set forth in Section 2.6.1. and submit a written recommendation to the Medical Staff President that includes the following:

- (a) Staff Membership. Whether the Applicant's request for Telemedicine Medical Staff Membership should be approved or disapproved and the appropriate Department to which the Applicant should be assigned. If the recommendation regarding Staff Membership is adverse to the Applicant, the written recommendation shall clearly state the reason(s) for such Adverse Action.
- (b) Clinical Privileges. Whether the Applicant's request for Telemedicine Clinical Privileges should be approved or disapproved, in whole or in part, and whether there are any recommended conditions or restrictions. If the recommendation regarding Clinical Privileges is adverse to the Applicant, in whole or in part, the written recommendation shall clearly state the reason(s) for such Adverse Action.

### **2.7.4 Medical Staff President Review and Recommendation**

Upon review of the credentials file and the written recommendations of the Department Chairperson, the Medical Staff President will draft a written recommendation that includes the information set forth in Section 2.6.4.

- (a) Favorable Recommendation. If the Medical Staff President disagrees with the recommendations of the Department Chairperson, in whole or in part, or the recommendation is adverse to the Applicant, the Medical Staff President's proposed recommendation shall include the reason(s) for the disagreement or adverse recommendation. If the proposed recommendation is favorable to the Applicant, the Medical Staff President will submit its recommendation to the Governing Body.
- (b) Unfavorable Recommendation. If the proposed recommendation is deemed an Adverse Action in accordance with these Medical Staff Bylaws, the Hospital President (or his or her designee) will notify the Applicant of the proposed Adverse Action (including the reasons for such recommendation) and advise the Applicant of his/her hearing rights (if any) in accordance with these Medical Staff Bylaws. The Medical Staff President shall not submit the proposed Adverse Action to the Governing Body until the Applicant has had an opportunity to exercise his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

### **2.7.5 Governing Body Review and Decision**

Upon review of the credentials file, and review of the written recommendations of the Department Chairperson and the Medical Staff President, and following the Applicant's exercise of hearing and/or appeal rights, if applicable, the Governing Body will issue a written decision

that includes the information set forth in Section 2.6.4. The written decision may precondition appointment or reappointment, and granting or continued exercise of Clinical Privileges, upon the Applicant undergoing mental or physical examinations and/or such other evaluations as it may deem appropriate at that time or at any intervening time, to evaluate the Applicant's ability to exercise Clinical Privileges.

## **2.8 NOTIFICATION OF MEMBERSHIP AND CLINICAL PRIVILEGING DECISIONS**

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### **2.8.1 Notification of Applicant**

- (a) Favorable Decision. If the Governing Body's decision is favorable to the Applicant, the Hospital President shall notify the Applicant in writing of the Governing Body's final decision. The written notification will include, as applicable:
  - i. that the Governing Body has approved the Applicant's request for appointment/reappointment or change in Medical Staff category;
  - ii. the Medical Staff Category to which the Applicant is appointed or reappointed;
  - iii. the Department assignment;
  - iv. the delineation of Clinical Privileges granted;
  - v. any special conditions or restrictions that apply; and
  - vi. for all Applicants seeking initial or additional Clinical Privileges, a description of the focused professional practice evaluation method that will be used to evaluate the Applicant's ability to perform the privileges, and a copy of the focused professional practice evaluation policy and orientation packet.
- (b) Unfavorable Decision. If Governing Body's decision is deemed an Adverse Action, the Hospital President will provide the Applicant with Written Notice of the Adverse Action and, if the Applicant is entitled to hearing and/or appellate review rights in accordance with Article 5, advise the Applicant of those rights.

### **2.8.2 Communication with Hospital Departments**

Medical Staff Services will ensure that the appropriate Departments and other Hospital patient care areas are informed of the Clinical Privileges granted to an Applicant, as well as of any revisions or revocations of an Applicant's Clinical Privileges.

## **2.9 TEMPORARY, EMERGENCY, AND DISASTER PRIVILEGES**

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### **2.9.1 Minimum Qualifications for Temporary Clinical Privileges**

All Applicants for temporary Clinical Privileges must meet the minimum qualifications set forth below:

- (a) Current Competence. As described in Section 2.3 of these Bylaws.
- (b) License/Registration. As described in Section 2.3 of these Bylaws. A Practitioner whose licensure or registration is or has been denied, limited, or challenged in any way, is not eligible for temporary Clinical Privileges.
- (c) Board Status and Residency/Training Program. As described in Section 2.3 of these Bylaws.

## ARTICLE 2 – STAFF MEMBERSHIP & CLINICAL PRIVILEGES

- (d) No Sanctions or Exclusion. As described in Section 2.3 of these Bylaws.
- (e) DEA Registration. As described in Section 2.3 of these Bylaws.
- (f) Signed Acknowledgement. As described in Section 2.3 of these Bylaws.
- (g) Current and Past Affiliations. As described in Section 2.3 of these Bylaws. A Practitioner whose staff membership and/or clinical privileges have been involuntarily terminated, limited, reduced, or denied by the Hospital or any other institution, organization, or entity is not eligible for temporary Clinical privileges.
- (h) National Practitioner Data Bank Report. As described in Section 2.3 of these Bylaws.
- (i) Professional Liability Insurance. As described in Section 2.3 of these Bylaws.
- (j) Completed Background Disclosure Form. As described in Section 2.3 of these Bylaws. Temporary privileges may be granted while Medical Staff Services awaits the results of the background check.
- (k) Telemedicine Services Agreement. As described in Section 2.3 of these Bylaws.

### 2.9.2 Request for Temporary Clinical Privileges

The following practitioners may request temporary Clinical Privileges by submitting a Clinical Privileges request to Medical Staff Services and providing the information necessary for verification of the minimum qualifications set forth in Section 2.9.1:

- (a) A practitioner (including a locum tenens Practitioner) who has not submitted a complete Application for Staff Membership, but is seeking temporary Clinical Privileges in order to fulfill an important care, treatment or services need.
- (b) An Applicant (including a locum tenens Practitioner) who has submitted a complete Application that raises no concerns and is awaiting review and approval of the Medical Executive Committee and the Governing Body.

### 2.9.3 Granting of Temporary Clinical Privileges

- (a) Credentials Verification. Medical Staff Services (or a qualified CVO or TSO) will verify the practitioner's credentials and forward the Clinical Privileges request and the credentials file to the Department Chairperson.
- (b) Review by Department Chairperson. The Department Chairperson shall review the Clinical Privileges request and the credentials file. If the Department Chairperson approves the request, he/she shall submit a written recommendation to the Medical Staff President and the Hospital President. If the Department Chairperson disapproves the request, Medical Staff Services shall notify the Practitioner of the denial.
- (c) Review by Medical Staff President and Hospital President. Upon receipt of a recommendation from the Department Chairperson, the Medical Staff President and the Hospital President shall each review the Clinical Privileges request, the credentials file, and the Department Chairperson's recommendation. The Hospital President, after consulting with the Medical Staff President, may grant temporary Clinical Privileges for a specified period not to exceed one hundred-twenty (120) days). If the Medical Staff President or the Hospital President disapproves the request, Medical Staff Services shall notify the Practitioner of the denial.



#### **2.9.4 Emergency Privileges**

In an emergency situation (defined as a circumstance in which immediate action is necessary to prevent serious harm or death), any Staff Member with Clinical Privileges may provide any type of patient care, treatment, or services necessary to prevent serious harm or death, regardless of the Staff Member's Medical Staff category or designated Clinical Privileges, as long as such care, treatment or services is within the scope of the Staff Member's license. If time permits, such Staff Member, or other Hospital staff members in attendance, shall attempt to locate an appropriately privileged Practitioner.

#### **2.9.5 Disaster Privileges**

Disaster privileges may be granted to volunteer Practitioners only when the Hospital's Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs. Such disaster privileges may only be granted by the Hospital President or the Medical Staff President in accordance with the Hospital's policy regarding disaster privileges. Requests for disaster privileges will not be accepted or considered within the twelve (12) month period following the denial or termination of a similar request, unless the denial or termination decision provides otherwise.

#### **2.9.6 Monitoring and Review**

Individuals exercising temporary or disaster Clinical Privileges shall act under the supervision and observation of the Department Chairperson of the Department to which he/she is assigned. The Medical Staff President or the Hospital President may impose special requirements in order to monitor and assess the quality of care rendered by the Practitioner exercising temporary or disaster Clinical Privileges.

#### **2.9.7 Termination of Temporary and Disaster Privileges**

Temporary and disaster privileges shall automatically terminate at the end of the specific period for which they were granted. In addition, temporary and disaster privileges shall be immediately terminated by the Hospital President upon notice of any failure by the Practitioner to comply with any special requirements. The Hospital President may at any time, upon the recommendation of the Medical Staff President or the appropriate Department Chairperson, terminate a Practitioner's temporary or disaster privileges, effective upon the discharge of the Practitioner's patient(s) from the Hospital. However, if the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, any person authorized to impose a summary suspension in accordance with Section 4.3 of these Bylaws may terminate the Practitioner's temporary privileges, effective immediately. The Medical Staff President shall assign a Medical Staff appointee to assume responsibility for the care of such terminated Practitioner's patient(s) until discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of an alternative Practitioner.

#### **2.9.8 Hearing and Appellate Review Rights**

An individual who requests temporary or disaster Clinical Privileges shall not be entitled to the hearing and appellate review rights afforded by these Bylaws as the result of a denial of temporary or disaster Clinical Privileges and/or the termination of such temporary or disaster Clinical Privileges.

## **2.10 LEAVE OF ABSENCE; VOLUNTARY RESIGNATION**

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### **2.10.1 Leave of Absence**

- (a) Request for Leave. A Staff Member may obtain a leave of absence from the Medical Staff for a period not to exceed one (1) year by submitting a written request to the Medical Executive Committee which explains the reason for the requested leave. A leave shall be granted if approved by the Medical Executive Committee and the Governing Body. The Medical Executive Committee and Governing Body may, in their discretion, extend a Staff Member's leave of absence for a period not to exceed one (1) additional year.
- (b) Scheduled Reappointment. During the leave of absence, the Staff Member will be required to complete the reappointment process as scheduled. If the Staff Member fails to do so, the Staff Member will be required to submit a new initial appointment application upon return.
- (c) Reinstatement.
  - i. *Request for Reinstatement*. At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Staff Member may request reinstatement of Staff Membership and Clinical Privileges by submitting a written request to the Medical Staff President. The written request for reinstatement shall include an attestation that no adverse changes have occurred in the status of any of the Practitioner's qualifications for Staff Membership or Clinical Privileges since the Practitioner's last Application, or, if changes have occurred, a detailed description of the nature of the changes and any additional information requested by the Medical Staff President, Hospital President, Department Chairperson, Credentials Committee, Medical Executive Committee, and/or the Governing Body.
  - ii. *Review Process*. The Medical Staff President will forward the request for reinstatement to the member's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation and forward it to the Governing Body for approval. The refusal of the Governing Body to reinstate a Practitioner following an approved leave of absence shall entitle the Practitioner to hearing and appellate review rights as provided in these Bylaws.
- (d) Failure to Request Reinstatement. If a Practitioner fails to complete the reappointment process during his/her leave of absence, the Practitioner shall be deemed to have voluntarily resigned from the Medical or Allied Health Professional Staff at the end of the Practitioner's then current term and such resignation shall not entitle the Practitioner to hearing or appellate review rights under these Bylaws. If a Practitioner fails to submit a request for reinstatement prior to the end of his/her approved leave of absence, the Practitioner shall be deemed to have voluntarily resigned from the Medical or Allied Health Professional Staff at the end of the Practitioner's then current term and such resignation shall not entitle the Practitioner to hearing or appellate review rights. A Practitioner who seeks to regain his/her Staff Membership or Clinical Privileges following such voluntary resignation must complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.

### **2.10.2 Voluntary Resignation**

Resignations from the Medical Staff must be submitted in writing to Medical Staff Services and must state the date the resignation becomes effective. The Practitioner's Department Chairperson, the Hospital President, the Medical Executive Committee, and the Governing Body shall be informed of all resignations.

## **2.11 MEDICO-ADMINISTRATIVE APPOINTMENTS**

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### **2.11.1 Appointment**

A Staff Member who is appointed, employed, or under contract to perform administrative duties and who also renders clinical care at the Hospital must meet the qualifications for Staff Membership and necessary Clinical Privileges.

### **2.11.2 Termination of Administrative Functions**

The Governing Body may terminate the administrative functions of a Practitioner who is appointed, employed, or under contract to perform administrative duties by providing notice to the Practitioner (or the entity with which the Hospital contracts to provide such administrative services). Such termination shall not affect such Practitioner's Staff Membership or Clinical Privileges except as provided in these Bylaws and/or in any contract with the Practitioner (or the entity with which the Hospital contracts to provide such administrative services). If the termination is deemed an Adverse Action, the Hospital President will provide Practitioner with Written Notice of the Adverse Action in accordance with these Medical Staff Bylaws (except as otherwise provided in any contract between the Hospital and such Practitioner, or between the Hospital and the entity with which the Hospital contracts to obtain such administrative services). A Practitioner may waive any right or privilege under these Bylaws in a contract between the Practitioner and the Hospital, or a contract between the Practitioner and an entity with which the Hospital has contracted and by which the Practitioner is bound. In the event of any conflict or inconsistency between the terms of any such contract and these Bylaws, the terms of the contract shall supersede and prevail.

## ARTICLE 3. STAFF CATEGORIES

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### 3.1 GENERALLY

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#### 3.1.1 Designation; Modification

Each Staff Member shall be designated as a member of one of the staff categories set forth below. At the time of appointment and each reappointment, each Staff Member's staff category shall be recommended by the Medical Executive Committee and approved by the Governing Body. A Medical Staff Member seeking to change his/her current Medical Staff category must submit the appropriate Application to Medical Staff Services. Such requests shall be reviewed and approved or denied using the same process as is set forth herein for Medical Staff appointment/reappointment.

### 3.2 CATEGORIES

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#### 3.2.1 Medical Staff

Each Practitioner shall be designated as a member, as applicable, of one of the Medical Staff categories set forth below, or of the Allied Health Professionals Staff, as set forth in Section 3.2.2. The composition, duties and privileges related to each Medical Staff category and the Allied Health Professionals Staff are described in Section 3.3.

**Active:** Practitioners with admitting privileges; and all Hospital-Based Practitioners (e.g., Anesthesiologists, Pathologists, Radiologists, Radiation Oncologists, Emergency Department Physicians)

**Courtesy:** (i) Practitioners with less than 30 Patient Encounters annually; (ii) Locum Tenens Practitioners; and (iii) Moonlighting Practitioners

**Associate:** No Patient Encounter requirements; not eligible for admitting or clinical privileges; membership without delineated privileges

**Consulting** No Patient Encounter requirements; clinical privileges but not eligible to admit patients

**Honorary:** No Patient Encounter requirements; not eligible for admitting or clinical privileges

**Telemedicine:** Practitioners who possess telemedicine privileges only

#### 3.2.2 Allied Health Professionals Staff

Each Allied Health Professional shall be designated as a member of the Allied Health Professionals Staff.

**3.3 RIGHTS AND OBLIGATIONS**

Rights/Obligations	Active	Courtesy	Associate	Consulting	Honorary	Telemed.	AHP
Patient Encounters	NA	<30 <sup>1</sup>	NA	NA	NA	NA	NA
Must meet the qualifications set forth in §:	2.3	2.3	2.6.8	2.3	2.6.8	2.3 or 2.7	2.3
Eligible for admission privileges	YES	YES <sup>2</sup>	NO	NO	NO	NO	NO
Eligible for Clinical Privileges	YES	YES	NO	YES	NO	TM Only	YES
Subject to FPPE/OPPE	YES	YES	NO	YES	NO	YES	YES
Eligible for privileges to enter patient orders	YES	YES	NO	YES	NO	YES	YES
Eligible for access to Medical Records	YES	YES	YES	YES	NO	YES	YES
Supervise AHPs	YES	NO	NO	YES	NO	NO	NO
Serve as Medical Staff Officer	YES	NO	NO	NO	NO	NO	NO
Serve on the MEC	YES	YES	YES	NO	NO	NO	NO
Serve on other Medical Staff Committees	YES	YES	YES	YES	NO	NO	YES
Serve as a Medical Staff Committee Chair	YES	NO	NO	YES	NO	NO	NO
Serve on a Departmental Committee	YES	YES	YES	YES	NO	NO	YES
Serve as a Department Chair	YES	NO	NO	NO	NO	NO	NO
Serve as a Clinical Service Chief	YES	NO	NO	NO	NO	NO	NO
Attendance at Medical Staff meetings	Expected	Encouraged	Encouraged	Encouraged	Encouraged	Encouraged	Encouraged
Attendance at Department meetings	Expected	Encouraged	Encouraged	Encouraged	Encouraged	Encouraged	Encouraged
Vote in Med. Staff Officer & Dept. Chair elections	YES	YES	YES	NO	NO	NO	NO
Vote in other medical staff matters	YES	YES	YES	NO	NO	NO	NO
Vote in medical staff Departmental matters	YES	YES	YES	YES	NO	NO	Per Dept. <sup>3</sup>
Must participate in call coverage programs <sup>4</sup>	YES	YES <sup>4</sup>	NO	NO	NO	NO	YES
May attend CME	YES	YES	YES	YES	YES	YES	YES
Must pay annual dues (may vary by category)	YES	YES	YES	YES	NO	YES	YES

<sup>1</sup> Locum Tenens and Moonlighting Practitioners may have more than 30 patient encounters. All other Practitioners with 30 or more patient Encounters may be required to submit a request for change in Medical Staff category.

<sup>2</sup> If necessary to perform services, the Governing Body may grant admitting privileges to Moonlighting and Locum Tenens Practitioners in accordance with Sections 2.5 to 2.6 of these Medical Staff Bylaws. Practitioners with admitting privileges must participate in call coverage programs (unless waived, see Section 2.4.5).

<sup>3</sup> The Department Chairperson may permit Allied Health Professionals to vote on Departmental Matters.

<sup>4</sup> In order to meet the needs of Hospital inpatients and outpatients and ensure compliance with applicable regulatory requirements, the Medical Executive Committee and the Hospital President will determine whether certain programs and specialty services require on-call coverage, subject to the approval of the Governing Body. Active Medical Staff Members, Staff Members with admitting privileges, and Allied Health Professionals must participate in call coverage programs (see Section 2.4.4). Individual Staff members may request a waiver of on-call program participation requirements. Refer to Section 2.4.5 of these Medical Staff Bylaws.

*Revised and approved by MEC 11/6/2013*

## ARTICLE 4. CORRECTIVE ACTIONS

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### 4.1 COMMUNICATION OF PRACTICE AND CONDUCT CONCERNS

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The Medical Staff actively encourages any individual (including a Staff Member, Hospital employee, patient, visitor, vendor or other person) who has or becomes aware of any question or concern related to the professional practice or conduct of any individual Staff Member, to promptly communicate such question or concern in accordance with the applicable Medical Staff Policies and/or Hospital Policies. In the event the Quality and Professional Affairs Committee (or other Hospital committee functioning as the Patient Care Assessment Committee) determines that a Staff Member should be subject to corrective action, the chairperson of such committee shall immediately initiate the corrective action process set forth in Section 4.2.

### 4.2 CORRECTIVE ACTION PROCESS

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#### 4.2.1 Application

The procedures set forth in this Article 4 are applicable to all Medical Staff and Allied Health Professional Staff Members.

#### 4.2.2 Written Request for Corrective Action

Whenever information indicates that a Staff Member's acts, omissions, demeanor, conduct or professional performance inside or outside of the Hospital may be:

- (a) Below the standards of the Medical Staff, including applicable professional standards of care;
- (b) Detrimental to patient safety or to the delivery of quality care;
- (c) Unethical, disruptive or harassing; and/or
- (d) In violation of these Bylaws, Medical Staff Policies, Hospital Policies, or applicable laws, regulations or accreditation standards,

the Board Chairperson, the Hospital President, a Department Chairperson, or the Medical Staff President may submit a written request for corrective action ("Corrective Action Request") to the Medical Executive Committee. A Corrective Action Request must be based on a reasonable belief that the action is in furtherance of quality health care and/or to limit or stop unprofessional or disruptive conduct, and such action shall be supported by reference to the specific acts or omissions which constitute the grounds for the Corrective Action Request. The Medical Staff President shall notify the Hospital President and the applicable Department Chairperson in writing within seven (7) business days of the Medical Executive Committee's receipt of a Corrective Action Request, and will continue to keep the Hospital President and the Department Chairperson fully informed of all action taken in connection therewith.

#### 4.2.3 Written Notice of Corrective Action Request

The Hospital President shall provide the affected Staff Member with Written Notice of the Corrective Action Request. The Written Notice shall:

- (a) Advise the Staff Member of the Corrective Action Request and the general nature of the acts or omissions underlying the request; and

- (b) Advise the Staff Member that he/she may request a preliminary interview with the Medical Executive Committee by submitting a written interview request (“Interview Request”) to the Medical Staff President via personal/hand delivery or certified mail, return receipt requested within five (5) business days of the Delivery Date of the Notice of Corrective Action Request.

#### **4.2.4 Preliminary Interview**

A Staff Member who timely submits an Interview Request shall be afforded an informal preliminary interview (without representation by legal counsel) with the Medical Executive Committee to be held within such reasonable time period as the Medical Executive Committee shall determine. The informal interview shall include at least: (a) a review of the Corrective Action Request, and (b) an opportunity for the Staff Member to discuss the matter with the Medical Executive Committee. During such interview, the Staff Member shall be invited to discuss, explain or refute the allegations against the Staff Member. The Medical Executive Committee may request further information as required to make a recommendation regarding the Corrective Action Request. This informal interview shall be preliminary in nature and none of the procedural rules provided in Article 5 with respect to hearings shall apply, except that a record of the interview shall be made in the minutes of the Medical Executive Committee.

#### **4.2.5 Medical Executive Committee Investigation and Action**

The Medical Executive Committee (or its designee) shall investigate the acts or omissions described in the Corrective Action Request and any other concerns or issues that arise during the course of its investigation, and shall make a reasonable attempt to obtain the facts related to such acts or omissions. The Medical Executive Committee may request the assistance of Hospital administration or departmental peer review committees. Following such investigation, including the informal interview with the Staff Member, if requested, the Medical Executive Committee’s action on the Corrective Action Request may include, but is not limited to, one or more of the following:

- (a) Rejection or modification of the Corrective Action Request;
- (b) Issuance of a warning;
- (c) Issuance of a letter of reprimand;
- (d) Requirement to complete specific education;
- (e) Imposition of a term of monitoring;
- (f) Requirement to seek consultations;
- (g) Recommendation for reduction, suspension or revocation of Clinical Privileges;
- (h) Recommendation that the Staff Member’s Staff Membership be revoked; and/or
- (i) Any other action that may be appropriate under the circumstances.

#### **4.2.6 Written Notice of Adverse Action**

Before any action of the Medical Executive Committee that may be deemed an Adverse Action is forwarded to the Governing Body, the Hospital President shall notify the Staff Member of the Adverse Action as set forth in Article 5 and the Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5.

### **4.3 SUMMARY SUSPENSION**

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#### **4.3.1 Authority and Indications**

A Staff Member's Clinical Privileges may be summarily suspended if such action is taken in the reasonable belief that the suspension is warranted by the facts known and that the failure to take such action may result in imminent danger to the health, safety or welfare of any individual, or result in significant disruption to the operation of the Hospital. Summary suspensions imposed pursuant to this Section 4.3.1 need not follow the procedures set forth in Section 4.2. The following individuals or groups shall each have the authority to summarily suspend Staff Membership and all or any portion of a Staff Member's Clinical Privileges:

- (a) Medical Staff President;
- (b) Medical Staff Vice President (in the absence of the Medical Staff President);
- (c) Hospital President, or in his/her absence, a designee (in consultation with the Medical Staff President and Department Chairperson, if available);
- (d) a majority of the Medical Executive Committee; or
- (e) a majority of the Governing Body.

#### **4.3.2 Communication with the Medical Executive Committee and the Governing Body.**

In the event of a summary suspension, the individual or group imposing the summary suspension shall promptly contact the Hospital President. The Hospital President shall inform the Medical Executive Committee and the Governing Body of the summary suspension, and provide notice to the affected Staff Member as set forth in Section 4.3.3 below.

#### **4.3.3 Written Notice of Summary Suspension**

The Hospital President shall contact the affected Staff Member as soon as reasonably possible to inform him/her of the summary suspension and shall thereafter provide the affected Staff Member with Written Notice of the summary suspension which describes the basis for the summary suspension ("Summary Suspension Notice"). The contact may be verbal, in person or by telephone, and the person contacting the affected Staff Member shall record the date and time of the contact. Such summary suspension shall become effective upon the earlier of: (a) the date and time the Hospital President contacted the affected Staff Member; or (b) the Delivery Date of the Summary Suspension Notice. A copy of the Summary Suspension Notice shall be submitted to the Medical Executive Committee and the Governing Body by the Hospital President as soon as reasonably possible.

#### **4.3.4 Preliminary Interview**

A Staff Member whose Clinical Privileges have been summarily suspended shall be entitled to request (in a writing received by the Hospital President within five (5) business days of the Delivery Date of the Summary Suspension Notice) an informal preliminary interview (without representation by legal counsel) with the Medical Executive Committee to be held within such reasonable time period thereafter as the Medical Executive Committee shall determine. The informal interview shall include at least: (a) a review of the Summary Suspension Notice, and (b) an opportunity for the Staff Member to discuss the matter with the Medical Executive Committee. During such interview, the Staff Member shall be invited to discuss, explain or refute the allegations against the Staff Member. The Medical Executive Committee may request further information as required to make a recommendation regarding the summary suspension. This informal interview shall be preliminary in nature and none of the procedural rules provided in



Article 5 with respect to hearings shall apply, except that a record of the interview shall be made in the minutes of the Medical Executive Committee.

#### **4.3.5 Medical Executive Committee Investigation and Action**

Within forty-eight hours of the imposition of a summary suspension, the Medical Staff President shall convene an ad hoc investigating committee which includes at least three (3) Medical Staff Members to investigate the action and report back to the Medical Executive Committee within seven (7) days of the imposition of the summary suspension. Upon receipt of the report of the ad hoc investigating committee, the Medical Executive Committee may request further information as it deems appropriate. The Medical Executive Committee shall promptly convene to consider the summary suspension, taking into account the information obtained through the informal interview, if any. In the event the Medical Executive Committee elects to terminate, revoke or void the summary suspension and reinstate the Staff Member's Clinical Privileges, the Hospital President will contact the Staff Member. The Medical Executive Committee may also recommend that the summary suspension continue (with or without modification). Before any action of the Medical Executive Committee that may be deemed an Adverse Action is forwarded to the Governing Body, the Hospital President shall notify the affected Staff Member of the Adverse Action as set forth in Article 5 and the Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5. The terms of the summary suspension shall remain in effect pending completion of the hearing and appellate review process set forth in Article 5.

#### **4.3.6 Enforcement and Alternative Coverage**

The Medical Staff President shall take all steps necessary to effectuate the summary suspension with the assistance of the Hospital President and the applicable Department Chairperson(s). Immediately upon imposition of a summary suspension, the Medical Staff President shall have authority to appoint an alternative Staff Member to provide medical coverage for the suspended Staff Member's patients who remain at the Hospital at the time of such suspension. Unless otherwise decided by the Medical Staff President, such alternative coverage shall be the responsibility of the Staff Member who agreed, by signing the applicable form, to serve as the suspended Staff Member's alternate for coverage. The wishes of the patients shall be considered in the selection of such alternative Staff Member. The suspended Staff Member shall confer with the alternative Staff Member to the extent necessary to ensure continuous quality care.

#### **4.3.7 Communication with Hospital Departments**

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any summary suspension of a Staff Member's Clinical Privileges.

### **4.4 AUTOMATIC SUSPENSIONS AND/OR TERMINATIONS**

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#### **4.4.1 Generally**

Automatic suspensions and/or terminations may or may not be reportable to the Massachusetts Board of Registration in Medicine, depending on whether the automatic suspension or termination is a "disciplinary action" within the meaning of 243 CMR 3.02.

#### **4.4.2 Failure to Complete Medical Records or to Provide Requested Information**

Whenever a Staff Member fails to complete medical records in accordance with the standards set forth in the applicable Medical Staff or Hospital Policies, the Staff Member shall be subject to automatic suspension as further described in the applicable Medical Staff Policy. When a Staff Member fails to provide information pertaining to said individual's qualifications for appointment

or clinical privileges, a quality or peer review issue, in response to a written request from the Credentials or Medical Executive Committee or other committee of the Medical Staff or Hospital, or in response to the Hospital President, the Staff Member's clinical privileges may be automatically relinquished at least until the information is provided.

#### 4.4.3 Adverse Change in Licensure or Certification

- (a) Revocation. If a Staff Member's license, certification or other credential authorizing professional practice in Massachusetts is revoked by the applicable licensing or certifying authority, such Staff Member's Staff Membership and Clinical Privileges shall be automatically terminated as of the date such revocation becomes effective.
- (b) Suspension and Restriction. If a Staff Member's license, certification or other credential authorizing practice in Massachusetts is suspended, limited, restricted or made subject to certain conditions (including without limitation, probation) by the applicable licensing or certifying authority, any of the Staff Member's Clinical Privileges that are within the scope of the suspension, limitation, restriction, or condition shall be automatically suspended, limited, restricted or conditioned by the Hospital in a similar manner, as of the date such action becomes effective and throughout the term thereof.

#### 4.4.4 Exclusion from Health Care Program

If a Staff Member is involuntarily excluded or suspended from participation in Medicare, Medicaid or any health care program funded in whole or in part by the federal or state government, such Staff Member's Staff Membership and Clinical Privileges shall be automatically terminated or suspended as of the date such exclusion becomes effective.

#### 4.4.5 Adverse Change in DEA Certification

If a Staff Member's Drug Enforcement Administration (DEA) certification is revoked, suspended or voluntarily relinquished, or whenever such certification is subject to probation, the Staff Member shall immediately and automatically be divested of the right to prescribe medications covered by such certification. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA certification was revoked, suspended, relinquished, or made subject to probation. The Medical Executive Committee may then take such further corrective action as may be appropriate under the circumstances.

#### 4.4.6 Failure to Maintain Professional Liability Insurance

- (a) Written Notice. If a Staff Member fails to submit a Certificate of Insurance as required under these Bylaws or as otherwise requested, Medical Staff Services shall notify the Hospital President and the Hospital President shall send a Written Notice to the Staff Member. The Written Notice shall inform the Staff Member that:
  - i. If the Staff Member fails to submit a Certificate of Insurance within seven (7) business days after the Delivery Date of the Written Notice, the Staff Member's Clinical Privileges shall be automatically **suspended** effective as of 11:59 p.m. on the seventh (7<sup>th</sup>) day after the Delivery Date, and remain suspended until the Certificate of Insurance is received; and
  - ii. If the Staff Member fails to submit a Certificate of Insurance within three (3) months after the automatic suspension, the Staff Member's Staff Membership and Clinical Privileges shall be automatically **terminated**, effective as of 11:59 p.m. on the day three (3) months after the automatic suspension. If the Staff Member wishes to

## ARTICLE 4 – CORRECTIVE ACTIONS

reestablish Staff Membership, the Staff Member shall be required to complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.

- (b) Submission of Certificate. If the Staff Member submits a Certificate of Insurance prior to the automatic termination of Staff Membership and/or Clinical Privileges, the Staff Member's Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Hospital President when the Certificate of Insurance has been received.

### 4.4.7 Failure to Pay Dues

- (a) Written Notice. If a Staff Member fails to pay Medical Staff dues as required under these Bylaws, Medical Staff Services shall notify the Medical Staff President. The Medical Staff President shall send a Written Notice to the Staff Member. The Written Notice shall inform the Staff Member that:
  - i. If the Staff Member fails to submit the appropriate Medical Staff Dues within the time period specified in the Written Notice (which shall be at least sixty (60) days), the Staff Member's Clinical Privileges may be automatically **suspended** effective as of 11:59 p.m. on date specified in the Written Notice, and remain suspended until the Staff Member submits the required dues; and
  - ii. If the Staff Member fails to submit a Medical Staff Dues within three (3) months after the automatic suspension, the Staff Member's Staff Membership and Clinical Privileges shall be automatically **terminated**, effective as of 11:59 p.m. on the day three (3) months after the automatic suspension (requiring the Staff Member to complete an initial Application if he/she wishes to re-establish Staff Membership, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee).
- (b) Submission of Dues. If the Staff Member submits the required Medical Staff dues prior to the automatic termination of Staff Membership and/or Clinical Privileges, the Staff Member's Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Hospital President when the Medical Staff dues have been received.

### 4.4.8 Failure to Maintain Collaborative Relationship

If an Allied Health Professional (i) fails to maintain a Collaborative Relationship and/or Collaborative Practice Agreement with one or more Medical Staff Members (e.g., the collaborating physician terminates the Collaboration Agreement, leaves the Hospital or his/her Clinical Privileges are reduced or revoked) in accordance with these Bylaws and the applicable Medical Staff Policies; or (ii) fails to comply with the terms of his/her Collaborative Practice Agreement, the Allied Health Professional's Clinical Privileges shall be automatically suspended and shall remain suspended until the Allied Health Professional provides Medical Staff Services with adequate evidence that an appropriate Collaborative Relationship and Collaborative Practice Agreement exists. A failure to provide Medical Staff Services with adequate evidence that an appropriate Collaborative Relationship and Collaborative Practice Agreement exists within one (1) month after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the Allied Health Professional's Staff Membership and a relinquishment of all Clinical Privileges.

**4.4.9 Enforcement and Alternative Coverage**

The Medical Staff President shall take all steps necessary to effectuate all automatic suspensions/terminations with the assistance of the Hospital President and the applicable Department Chairperson(s). Immediately upon imposition of an automatic suspension or termination, the Medical Staff President shall have authority to appoint an alternative Staff Member to provide medical coverage for the suspended/terminated Staff Member's patients who remain at Hospital at the time of such suspension or termination. Unless otherwise decided by the Medical Staff President, such alternative coverage shall be the responsibility of the Staff Member who agreed, by signing the applicable form, to serve as the suspended/terminated Staff Member's alternate for coverage. The wishes of the patients shall be considered in the selection of such alternative Staff Member. The suspended/terminated Staff Member shall confer with the alternate Staff Member to the extent necessary to ensure continuous quality care.

**4.4.10 Communication with Hospital Departments**

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any automatic suspension/termination of a Staff Member's Clinical Privileges.

## **ARTICLE 5. HEARING & APPELLATE REVIEW PROCEDURE**

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### **5.1 GENERAL PROVISIONS**

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#### **5.1.1 Purpose**

The hearing and appellate review processes described herein are designed to ensure that: (1) Adverse Actions are issued or imposed in furtherance of quality health care and only after full consideration of all relevant quality and safety issues; and (2) any Practitioner who is subject to an Adverse Action has a fair opportunity to appeal such action.

#### **5.1.2 Application**

For purposes of this Article 5, the term “Practitioner” may include “Applicant,” if applicable under the circumstances. The procedures and rights set forth in this Article 5 are applicable to Allied Health Professionals who maintain Clinical Privileges.

#### **5.1.3 Exhaustion of Remedies; Right to One Hearing/Appellate Review**

If an Adverse Action is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action. No Practitioner shall be entitled to more than one hearing and one appellate review on any matter which shall have been the subject of an Adverse Action.

#### **5.1.4 Construction of Time Periods; Waiver**

Failure by any Hearing Committee or Appellate Review Committee, the Medical Executive Committee, or the Governing Body, to comply with time limits specified in this Article 5 shall not be deemed to invalidate their actions, or give rise to any claim or cause of action by the affected Practitioner. Notwithstanding the above, where these Bylaws specifically provide that any right shall be waived as a result of the failure to act within a specified time period, such provisions shall be strictly applied.

### **5.2 GROUNDS FOR A HEARING**

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#### **5.2.1 Adverse Actions**

Except as otherwise specified in these Bylaws, the following actions shall be deemed Adverse Actions. A Practitioner shall be entitled to a hearing if the Medical Executive Committee or the Governing Body recommends or implements any of the following Adverse Actions:

- (a) Denial of Medical Staff or Allied Health Professionals Staff appointment or reappointment (provided that denial of Medical Staff or Allied Health Professionals Staff initial appointment which is not based primarily on issues of professional competence or conduct shall not be considered an Adverse Action);
- (b) Revocation of Staff Membership;
- (c) Refusal to reinstate a Practitioner following an approved leave of absence;
- (d) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial results in the denial, reduction, or termination of Clinical Privileges;

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- (e) Denial of requested Clinical Privileges under circumstances that would be reportable to the Board of Registration or the NPDB;
- (f) Letters of warning, reprimand, censure or admonition, if such letters require a report to the Board of Registration;
- (g) A required course of education, training, counseling, or monitoring, if the requirement arose out of the filing of a formal complaint or other allegations related to the Staff Member's competence to practice his/her profession;
- (h) Reduction or suspension of Clinical Privileges under circumstances that would be reportable to the Board of Registration or the NPDB;
- (i) Termination of current Clinical Privileges under circumstances that would be reportable to the Board of Registration or the NPDB; and/or
- (j) Any other action that, if finalized, would be reportable to the Board of Registration, the NPDB, or any other state or federal agency.

### **5.2.2 Actions Which are Not Considered Adverse Actions**

The following actions shall not be deemed Adverse Actions and shall not constitute grounds for a hearing and/or appellate review rights:

- (a) Any automatic suspension or termination imposed in accordance with Section 4.4 of these Bylaws;
- (b) The expiration, termination, or non-renewal of Staff Membership and/or Clinical Privileges that results from the termination of any contract with the Hospital, if the contract authorizes such expiration, termination or non-renewal of Staff Membership and/or Clinical Privileges;
- (c) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial does not result in the denial, reduction or termination of Clinical Privileges;
- (d) The denial or refusal to accept an incomplete Application;
- (e) The denial of Medical Staff or Allied Health Professionals Staff initial appointment which is not based primarily on issues of professional competence or conduct;
- (f) The refusal to recommend waiver of board certification requirements;
- (g) The recommendation or imposition of monitoring, supervision, proctoring, review or consultation requirements that affect all similarly situated Practitioners (e.g., required by Departmental policy);
- (h) Appointment, reappointment or Clinical Privileges which are granted for a period of less than two (2) years;
- (i) Failure to place a Practitioner on any on-call or interpretation roster, or removal of any Practitioner from any such roster;
- (j) Denial or revocation of membership on the Honorary Medical Staff; and/or
- (k) The removal of a Staff Member from any medico-administrative position, including removal from a Medical Staff Member's position as a Medical Staff Officer, Department Chairperson, or Clinical Service Chief.

### 5.3 PRE-HEARING PROCESS

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#### 5.3.1 Written Notice of Adverse Action

The Hospital President shall be responsible for giving prompt Written Notice of any Adverse Action (“Adverse Action Notice”) to any affected Practitioner. The Adverse Action Notice shall:

- (a) Advise the Practitioner of the Adverse Action;
- (b) Contain a brief statement identifying the acts and/or omissions upon which the Adverse Action is based;
- (c) Advise the Practitioner that he/she may request a hearing to review the Adverse Action by submitting a written hearing request (“Hearing Request”) to the Hospital President via personal/hand delivery or certified mail, return receipt requested within thirty (30) days of the Practitioner’s receipt of the Adverse Action Notice;
- (d) State that the Practitioner’s failure to submit a Hearing Request within the specified time, or to personally appear at the scheduled hearing, shall constitute a waiver of the Practitioner’s right to the hearing and subsequent appellate review;
- (e) Advise the Practitioner that the Practitioner has the right to be represented at the hearing by a Medical Staff Member, legal counsel, or any other individual chosen by the Practitioner; and (ii) if the Practitioner intends to be represented by legal counsel, the Practitioner’s Hearing Request should include the name and contact information for such counsel, if available;
- (f) Advise the Practitioner that the Practitioner may: (i) call, examine and cross-examine witnesses, present evidence deemed relevant by the Hearing Committee Chairperson or the Chairperson’s designee (regardless of its admissibility in a court of law); and (ii) submit a written statement at the close of the hearing;
- (g) Advise the Practitioner that a record of the hearing, shall be made, and that the Practitioner has a right to receive a copy of such hearing record upon payment of reasonable charges for the preparation thereof; and
- (h) State that upon completion of the hearing procedure, the Practitioner will receive a copy of the Hearing Committee Report, which shall include its recommendations and the basis therefor.

#### 5.3.2 Hearing Request; Failure to Request Hearing

A Practitioner who is entitled to a hearing under these Bylaws shall have thirty (30) days following the Delivery Date of the Adverse Action Notice to submit a Hearing Request to the Hospital President via personal/hand delivery or by certified mail, return receipt requested. The Practitioner’s failure to submit a Hearing Request 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. If the Adverse Action was *issued* by the Medical Executive Committee, it shall remain effective pending the Governing Body’s action. If the Adverse Action was *recommended* by the Medical Executive Committee, it shall not become effective until the Governing Body takes action on the matter.

#### 5.3.3 Appointment of Hearing Committee

- (a) Medical Executive Committee Review. Except as provided below, when a hearing relates to an Adverse Action of the Medical Executive Committee, the matter shall be heard by a Hearing Committee selected by the Medical Staff President, in consultation with the

Hospital President, in accordance with the terms of the Medical Staff Policies. The Medical Staff President, in consultation with the Hospital President, shall designate one of the Hearing Committee members to serve as the Hearing Committee Chairperson; provided, however, that, in lieu of a Hearing Committee Chairperson, the Hospital President, in consultation with the Medical Staff President, may appoint a Presiding Officer, who may be an attorney, to preside over the hearing. Any such Presiding Officer (who may be referred to herein as the Hearing Committee Chairperson) shall not act as an advocate for either side at the hearing.

- (b) Governing Body Review. When a hearing relates to an Adverse Action of the Governing Body that is not based on a prior Adverse Action of the Medical Executive Committee, the Governing Body shall appoint a Hearing Committee that includes at least three (3) Active Medical Staff Members. The Governing Body shall designate one of the Hearing Committee members to serve as the Hearing Committee Chairperson.
- (c) Generally. Hearing Committee members may not: (i) have participated in the Adverse Action decision (other than providing information); or (ii) be in direct economic competition with the affected Practitioner. Prior to the hearing, the Hospital President shall make the names of Hearing Committee members available to the Practitioner and the affected Practitioner shall notify the Hospital President if he or she has questions regarding the ability of any Hearing Committee member to be objective or impartial. Any objection to a member of the Hearing Committee, or to the Presiding Officer or Hearing Officer, if selected, shall be made by the Practitioner in writing to the Hospital President within ten (10) days of the Practitioner's receipt of the names of the Hearing Committee, Presiding Officer or Hearing Officer. A copy of the written objection must be provided to the Medical Staff President and must include the basis for the objection. The Hospital President shall give due consideration to the questions raised and to the input of the Medical Staff President, consistent with the provisions of this section and general considerations of fairness.
- (d) Alternative to Hearing Committee. As an alternative to a Hearing Committee, the Hospital President, after consulting with the Medical Staff President, may appoint a hearing officer (the "Hearing Officer"), preferably an attorney, to perform the functions of a Hearing Committee. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing. If a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Hearing Committee Chairperson shall be deemed to refer to the Hearing Officer.

#### **5.3.4 Scheduling of Hearing; Postponement**

Within ten (10) days after receipt of a Hearing Request, the Medical Executive Committee or the Governing Body, as applicable, shall schedule and arrange for such hearing. The hearing date shall be at least thirty (30), but not more than sixty (60), days from the date of the Hospital President's receipt of the Hearing Request, unless otherwise agreed by the Practitioner and the Hearing Committee Chairperson. In the event the Practitioner's Clinical Privileges are subject to a summary suspension, the Practitioner may request an expedited hearing, in which case the Hearing Committee Chairperson will schedule the hearing within ten (10) days of the Hearing Request, if reasonably possible. The approval or disapproval of rescheduling requests made by the Practitioner is within the sole discretion of the Hearing Committee Chairperson.



### **5.3.5 Written Notice of Hearing**

The Hospital President shall be responsible for giving prompt Written Notice of the hearing (“Hearing Notice”) to the affected Practitioner. The Hearing Notice shall:

- (a) State the time, place and date of the hearing;
- (b) Provide a list of witnesses (if any) who may testify on behalf of the Medical Executive Committee or the Governing Body (depending on which body's action prompted the Hearing Request);
- (c) Inform the Practitioner that the Practitioner must provide the Hearing Committee with the following :
  - i. a list of witnesses the Practitioner intends to call at the hearing (at least fifteen (15) days prior to the hearing or as otherwise agreed by the parties);
  - ii. access to written materials that the Practitioner intends to present at the hearing (at least fifteen (15) days prior to the hearing or as otherwise agreed by the parties); and
  - iii. the name and address of the Practitioner’s legal counsel (if the Practitioner intends to be represented by legal counsel at the hearing).

### **5.3.6 Representation**

The Practitioner may appoint a Medical Staff Member, legal counsel, or any other individual chosen by the Practitioner to represent the Practitioner at the hearing, present facts in opposition to the Adverse Action, and cross-examine witnesses. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the hearing, present facts in support of the Adverse Action, and examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one or more of its members, and/or legal counsel to represent it at the hearing, present the facts in support of the Adverse Action, and examine witnesses. The Medical Executive Committee or Governing Body representative shall not simultaneously serve as a Hearing Committee member. If any party will be represented by legal counsel, that party shall inform the other parties of the name and address of such counsel.

### **5.3.7 Access to Information**

The parties shall cooperate in good faith to (within a reasonable period prior to the hearing date):

- (a) exchange lists of expected witnesses and written materials to be presented at the hearing; and
- (b) inform the other party of any changes to the lists of expected witnesses, and/or the written materials to be presented at the hearing. The Practitioner shall have access to the written materials that will be considered by the Hearing Committee during the hearing. The Medical Executive Committee or Governing Body, as applicable, shall provide prompt Written Notice of any subsequent modifications to the grounds for the Adverse Action.

## **5.4 HEARING PROCEDURE**

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### **5.4.1 Presiding Officer**

The Hearing Committee Chairperson (or the Chairperson’s designee), shall preside over the hearing to: (a) determine the order of procedure during the hearing, (b) assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and (c) maintain decorum.

**5.4.2 Personal Presence Required**

The Practitioner for whom the hearing has been scheduled must be personally present during the hearing. A Practitioner who fails without good cause to appear and participate at such hearing shall be deemed to have waived such Practitioner’s hearing and appellate review rights and to have accepted the Adverse Action, and the same shall thereupon become and remain in effect.

**5.4.3 Submission of Written Statements**

Prior to or during the hearing, the Practitioner and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the hearing record. Written statements may be submitted to the Hearing Committee Chairperson by personal/hand delivery or by certified mail, return receipt requested, or brought to the hearing.

**5.4.4 Hearing Record**

An accurate record of the hearing must be kept. Participants in the hearing shall be informed of all matters noticed and those matters shall be noted in the hearing record. The mechanism by which the hearing is recorded shall be established by the Hearing Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. A Practitioner desiring an alternate method of recording the hearing shall bear the cost thereof.

**5.4.5 Evidence; Witnesses**

At the hearing, the affected Practitioner (or his/her appointed representative), the Medical Executive Committee or Governing Body representative, and any member of the Hearing Committee (or its appointed representative) shall each have the right to: (a) call and examine witnesses, (b) introduce written evidence, (c) cross-examine any witness on any matter relevant to the issue of the hearing, (d) challenge any witness, and (e) rebut any evidence. If the Practitioner does not testify on such Practitioner’s own behalf, the Practitioner may be called and examined as if under cross-examination. The Hearing Committee may order that oral evidence be taken only upon oath or affirmation administered by any person entitled to notarize documents in the Commonwealth of Massachusetts. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible in a civil or criminal action. The Hearing Committee may impose, in advance, reasonable time limits on examination and cross-examination of witnesses.

**5.4.6 Standard of Proof**

It shall be the obligation of the Medical Executive Committee/Governing Body representative to present appropriate evidence in support of the Adverse Action. The affected Practitioner shall thereafter be responsible for supporting such Practitioner’s challenge to the Adverse Action by an appropriate showing that the charges or grounds lack substantial factual basis, or that such basis or any action based thereon is either unreasonable, arbitrary, or capricious. The parties to the hearing shall be given the opportunity, on request, to refute officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

**5.4.7 Recess; Conclusion; Deliberations**

The Hearing Committee may, in its sole discretion and without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining

new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Within ten (10) days after the hearing is closed, the Hearing Committee shall conduct its deliberations. The Hearing Committee may: (a) conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the Practitioner prior to or during the hearing. A Hearing Committee member who failed to attend the hearing may not participate in deliberations or voting on the matter.

#### **5.4.8 Hearing Committee Report**

Upon the conclusion of its deliberations, the Hearing Committee shall issue a written Hearing Committee Report, which (a) shall include the Hearing Committee's recommendations, including confirmation, modification, or rejection of the original Adverse Action and the basis therefore, and (b) may include the Hearing Committee's official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the Massachusetts courts. Within twenty (20) days after the hearing, the Hearing Committee shall: (a) submit the Hearing Committee Report, the hearing record, and all other related documentation, to the Medical Executive Committee or the Governing Body, whichever appointed it, and (b) deliver a copy of the Hearing Committee Report to the Practitioner through the Hospital President by personal/hand delivery or certified mail, return receipt requested.

### **5.5 MEC / GOVERNING BODY REVIEW AND RECOMMENDATION**

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#### **5.5.1 Review and Recommendation**

The entity that appointed the Hearing Committee (the Medical Executive Committee or the Governing Body) shall review the Hearing Committee Report, the hearing record and all other documentation considered by the Hearing Committee, and shall make a recommendation.

#### **5.5.2 Favorable Recommendation**

If the Medical Executive Committee's reconsidered recommendation is favorable to the Practitioner, the recommendation shall be forwarded to the Governing Body for action at its next regularly scheduled meeting. If the Governing Body's reconsidered recommendation is favorable to the Practitioner, it shall be the final decision in the matter and the Hospital President shall provide the affected Practitioner with Written Notice of the Governing Body's decision.

#### **5.5.3 Unfavorable Recommendation**

If the Medical Executive Committee's or Governing Body's reconsidered recommendation is an Adverse Action or, if the Governing Body's recommendation following a Medical Executive Committee favorable reconsidered recommendation is an Adverse Action, the Hospital President shall promptly provide Written Notice of the Adverse Action, as provided in Section 5.7 of these Bylaws.

### **5.6 GROUNDS FOR APPELLATE REVIEW**

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A Practitioner shall be entitled to an appellate review for any matter which was subject to a hearing under Section 5.2.1.

## **5.7 PRE-APPEAL PROCESS**

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### **5.7.1 Written Notice of Adverse Action**

The Hospital President shall be responsible for giving prompt Written Notice of an Adverse Action to any affected Practitioner who is entitled to appellate review. The Written Notice shall:

- (a) Advise the Practitioner of the Adverse Action;
- (b) Contain a brief statement identifying the acts and/or omissions upon which the Adverse Action is based;
- (c) Advise the Practitioner of the Practitioner's right to request an appellate review of the Adverse Action in accordance with this Article 5, and specify that the Practitioner shall have ten (10) days within which to submit a written Appellate Review Request to the Hospital President via personal/hand delivery or certified mail, return receipt requested;
- (d) Inform the Practitioner that unless the Practitioner's Appellate Review Request specifically requests the opportunity for oral argument, the appellate review shall be held only on the record on which the Adverse Action is based, supplemented by written statements of the parties (Practitioner and Medical Executive Committee or Governing body) if the party(ies) so desire(s);
- (e) State that the Practitioner's failure to submit an Appellate Review Request within the specified time and/or to include a request for the opportunity to present an oral argument in such Appellate Review Request, shall constitute a waiver of the Practitioner's right to appellate review and/or the Practitioner's right to present an oral argument (as applicable);
- (f) Advise the Practitioner that: (i) the Practitioner has the right to be represented at the appellate review by a Medical Staff Member, legal counsel, or any other individual chosen by the Practitioner; (ii) if the Practitioner intends to be represented by legal counsel, the Practitioner's Hearing Request should include the name and contact information for such counsel, if available;
- (g) Advise the Practitioner of the Practitioner's right to submit a written statement at, or at the close of, the appellate review;
- (h) Advise the Practitioner that a record of the appellate review shall be made, and of the Practitioner's right to receive a copy of the record upon payment of reasonable charges for the preparation thereof; and
- (i) State that upon completion of the appellate review the Practitioner shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

### **5.7.2 Appellate Review Request; Failure to Request Appellate Review**

A Practitioner who is entitled to an appellate review under these Bylaws shall have ten (10) days following the Delivery Date of the Adverse Action Notice to submit an Appellate Review Request to the Hospital President via personal/hand delivery or by certified mail, return receipt requested. The Practitioner's failure to timely submit an Appellate Review Request shall be deemed a waiver of the Practitioner's right to such appellate review and the Adverse Action shall thereupon become and/or remain effective pending the Governing Body's final decision on the matter. The Practitioner shall be notified of the Governing Body's final decision as set forth in Section 5.9 of these Bylaws.

**5.7.3 Appointment of Appellate Review Committee and Chairperson**

Following receipt of a timely Appellate Review Request, the Governing Body shall: (a) appoint an Appellate Review Committee that includes at least three (3) Governing Body members, none of whom are in economic competition with the affected Practitioner; and (b) designate one Governing Body member to act as the Appellate Review Committee Chairperson.

**5.7.4 Scheduling / Rescheduling of Appellate Review**

Within ten (10) days after receipt of a Practitioner's written Appellate Review Request, the Appellate Review Committee shall schedule a date for such appellate review, including a time and place for oral argument (if requested). The date of the appellate review shall be at least fifteen (15) days, but not more than thirty (30) days, from the date of receipt of the affected Practitioner's Appellate Review Request, unless otherwise agreed by the affected Practitioner and the Appellate Review Committee Chairperson. The approval or disapproval of rescheduling requests made by the Practitioner is within the sole discretion of the Appellate Review Committee Chairperson.

**5.7.5 Written Notice of Appellate Review**

The Appellate Review Committee Chairperson shall, through the Hospital President, be responsible for giving prompt Written Notice of the appellate review to the Practitioner. The Written Notice shall:

- (a) State the time, place and date of the appellate review;
- (b) Contain a concise statement which identifies the acts, omissions or transactions upon which the Adverse Action is based;
- (c) Advise the Practitioner of the Practitioner's right to submit a written statement at the close of the appellate review, if the opportunity for oral argument has been requested;
- (d) If the Practitioner requested the opportunity for oral argument, the Written Notice shall inform the Practitioner that the Practitioner's failure to personally appear to present such oral argument shall constitute a waiver of the Practitioner's right to present an oral argument;
- (e) If the Practitioner has not requested the opportunity for oral argument, the Written Notice shall inform the Practitioner that the appellate review shall be held only on the record on which the Adverse Action is based, supplemented by a written statement by the Practitioner, if the Practitioner so desires, and a responsive statement by the Medical Executive Committee or Governing Body, as applicable. Such a written statement must be submitted by the Practitioner to the Hospital President by personal/hand delivery or certified mail, return receipt requested at least ten (10) days before the appellate review, and the responsive statement must be submitted at least five (5) days prior to the appellate review;
- (f) Advise the Practitioner that a record of the appellate review shall be made, and of the Practitioner's right to receive a copy of the record upon payment of reasonable charges for the preparation thereof; and
- (g) State that upon completion of the appellate review the Practitioner shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

### **5.7.6 Representation**

The Practitioner may appoint a Medical Staff Member, legal counsel, or any other individual chosen by the Practitioner to represent the Practitioner at the appellate review, present facts in opposition to the Adverse Action, and cross-examine witnesses. The Medical Executive Committee, when its action has prompted the appellate review, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the appellate review, present facts in support of the Adverse Action, and examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one or more of its members, and/or legal counsel to represent it at the appellate review, present the facts in support of the Adverse Action, and examine witnesses. The Medical Executive Committee or Governing Body representative shall not serve on the Appellate Review Committee. If the Practitioner or the party that imposed the Adverse Action will be represented by legal counsel, that party shall inform the other party of the name and address of such counsel.

### **5.7.7 Access to Information**

The parties shall cooperate in good faith (within a reasonable period prior to the appellate review) to exchange information and written materials that will be presented at the appellate review and any changes to the same. The Practitioner shall have access to:

- (a) the Hearing Committee Report;
- (b) the hearing record (and transcript, if any); and
- (c) all other written material, favorable or unfavorable, that: (i) was considered by the Hearing Committee in the development of the Hearing Committee Report; (ii) was considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action; and (iii) will be considered by the Appellate Review Committee during the appellate review.

## **5.8 APPELLATE REVIEW PROCEDURE**

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### **5.8.1 Presiding Officer**

The Appellate Review Committee Chairperson shall preside over the appellate review to: (a) determine the order of procedure during the appellate review, (b) assure that all participants in the appellate review have a reasonable opportunity to present relevant oral (if oral argument has been requested) and documentary evidence, and (c) maintain decorum.

### **5.8.2 Quorum; Personal Presence of Practitioner Not Required**

All Appellate Review Committee members must be present when the appellate review takes place and no member may vote by proxy. The personal presence of the Practitioner for whom the appellate review has been scheduled is not required, unless the Practitioner has requested the opportunity to present an oral argument. A Practitioner who requested the opportunity for an oral argument but fails without good cause to appear and participate, shall be deemed to have waived such Practitioner's right to present an oral argument.

### **5.8.3 Submission of Written Statements**

Prior to or during the appellate review, the Practitioner and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the appellate review record. Written statements may be submitted to the Appellate Review Committee through the

Hospital President by personal/hand delivery or by certified mail, return receipt requested, or brought to the appellate review.

#### **5.8.4 Review of Records; Standard of Proof**

The Appellate Review Committee shall act as the appellate body for the purpose of determining whether the Adverse Action against the affected Practitioner is supported by reasonable evidence and is not arbitrary or capricious. It shall review and consider:

- (a) the Hearing Committee Report;
- (b) the hearing record (and transcript, if any);
- (c) all other material, favorable or unfavorable, that was considered by the Hearing Committee in the development of its report, or considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action;
- (d) any written statements submitted pursuant to Section 5.8.3 of these Bylaws; and
- (e) any oral argument.

New or additional matters not raised during the original hearing or in the Hearing Committee Report and not otherwise reflected in the hearing record may only be introduced at the appellate review with the approval of the Appellate Review Committee.

#### **5.8.5 Oral Argument**

The Practitioner (or his/her representative) may present an oral argument against the Adverse Action and any member of the Appellate Review Committee may direct questions to the Practitioner. The representative of the entity that imposed the Adverse Action (the Medical Executive Committee or the Governing Body) shall be permitted to speak in favor of the Adverse Action recommendation and any member of the Appellate Review Committee may direct questions to such representative.

#### **5.8.6 Record of Oral Argument**

An accurate record of the appellate review oral argument (if any) must be kept. Participants in the oral argument shall be informed of all matters noticed and those matters shall be noted in the record. The mechanism by which an oral argument is recorded shall be established by the Appellate Review Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. A Practitioner desiring an alternate method of recording the appellate review shall bear the primary cost thereof.

#### **5.8.7 Recess; Deliberations**

The Appellate Review Committee may, in its sole discretion and without special notice, recess the appellate review and reconvene the same for the convenience of the participants or for consultation. Upon conclusion of the appellate review, the appellate review shall be adjourned (the “Adjournment Date”). Within ten (10) days after the Adjournment Date, the Appellate Review Committee shall complete its deliberations. The Appellate Review Committee may: (a) conduct its deliberations outside the presence of the Practitioner for whom the appellate review was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the Practitioner prior to or during the hearing and appellate review process.

#### **5.8.8 Appellate Review Committee Report**

Within twenty (20) days after the Adjournment Date, the Appellate Review Committee shall issue a written Appellate Review Committee Report, which (a) shall include the Appellate Review Committee’s recommendations, including confirmation, modification, or rejection of the original

Adverse Action and the basis therefore, and (b) may include the Appellate Review Committee's official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the appellate review and of any facts which may be judicially noticed by the Massachusetts courts. The Appellate Review Committee shall: (a) submit such Appellate Review Committee Report, the appellate review and hearing record, and all other documentation, to the Governing Body; and (b) deliver a copy of the Appellate Review Committee Report to the Practitioner through the Hospital President by personal/hand delivery or certified mail, return receipt requested.

## **5.9 FINAL DECISION BY GOVERNING BODY**

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### **5.9.1 Final Decision**

At its next meeting after receipt of the Appellate Review Committee Report and the other documentation described in Section 5.7 of these Bylaws, the Governing Body shall make a final decision in the matter and shall send notice thereof to the Medical Executive Committee and the Hospital President. The Hospital President shall send Written Notice of the Governing Body's final decision to the affected Practitioner and such decision shall become effective upon the Delivery Date of such Written Notice.

### **5.9.2 Communication with Hospital Departments**

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any revisions or revocations of a Practitioner's Clinical Privileges.



## **ARTICLE 6. ORGANIZED MEDICAL STAFF**

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### **6.1 COMPOSITION**

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The Hospital has a single, self-governing organized Medical Staff, composed of current Medical Staff Members.

### **6.2 PURPOSES & RESPONSIBILITIES**

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The purposes and responsibilities of the organized Medical Staff are as described below. Provision shall be made in these Bylaws or by resolution of the Medical Executive Committee, approved by the Governing Body, either through assignment to Departments, to Medical Staff committees, to Medical Staff Officers or officials, or to interdisciplinary Hospital committees, for the effective performance of Medical Staff functions set forth in these Bylaws and Medical Staff Policies, and such other Medical Staff functions as the Medical Executive Committee or the Governing Body shall reasonably require.

#### **6.2.1 Administration and Enforcement of Bylaws and Policies**

The organized Medical Staff develops, adopts, reviews, amends, complies with, monitors and enforces compliance with these Bylaws and the Medical Staff Policies necessary for the proper functioning of the Medical Staff and the integration and coordination of Staff Members with the functions of the Hospital.

#### **6.2.2 Communication With and Accountability to the Governing Body**

The organized Medical Staff is accountable to the Governing Body for the quality of medical care provided to Hospital's patients, assists the Governing Body by serving as a Professional Review Body, and cooperates with the Governing Body, Administration, and Hospital staff to resolve conflicts with regard to issues of mutual concern.

#### **6.2.3 Recommendations for Staff Membership and Clinical Privileges**

The organized Medical Staff: (i) develops criteria for Staff Membership and Clinical Privileges that are designed to assure the Medical Staff and the Governing Body that patients of the Hospital will receive quality care, treatment, and services; (ii) utilizes the criteria to evaluate and recommend individuals for Staff Membership and Clinical Privileges; and monitors and evaluates the ethical and professional practice of individuals with Clinical Privileges in order to make recommendations regarding such individuals' continued Staff Membership and Clinical Privileges.

#### **6.2.4 Quality Assurance and Performance Improvement**

The organized Medical Staff provides leadership in, participates in, conducts, oversees, and/or coordinates Hospital activities related to quality assurance, performance improvement, patient safety, patient satisfaction, risk management, case management, utilization review and resource management, including the following:

- (a) Assists in establishing and maintaining patient care standards and in ensuring that all Hospital patients receive care that is commensurate with applicable standards of care and available community resources;

- (b) Monitors the quality of care, treatment and services provided by individuals with Clinical Privileges, including the performance and appropriateness of medical record documentation, the performance of invasive procedures, blood usage, and drug usage;
- (c) Measures, assesses, and improves processes that primarily depend on the activities of individuals credentialed and privileged through the Medical Staff process;
- (d) Pursues corrective actions with respect to Staff Members with Clinical Privileges when warranted;
- (e) Communicates findings, conclusions, recommendations, and actions to improve performance to the Medical Executive Committee and the Governing Body;
- (f) Assists the Hospital in identifying community health needs and establishing services or programs to meet such needs and other institutional goals; and
- (g) Coordinates the care, treatment and services provided by individuals with Clinical Privileges with those provided by the Hospital's nursing, technical, and administrative staff.

### **6.2.5 Continuing Education**

The organized Medical Staff: (a) provides continuing education opportunities to promote current best practices, encourage continuous advancement in professional knowledge, and complement quality assessment/improvement activities; and (b) supervises the Hospital's professional library services.

### **6.2.6 Compliance with Laws, Regulations, and Accreditation Standards**

The organized Medical Staff assists the Hospital in reviewing and maintaining Hospital accreditation and ensuring compliance with applicable accreditation standards and federal, state, and local laws and regulations.

### **6.2.7 Other**

The organized Medical Staff:

- (a) Monitors the Hospital's infection control program and investigates and controls nosocomial infections;
- (b) Monitors pharmacy and therapeutic policies and practices within the Hospital;
- (c) Assists in developing a response plan for fire and other disasters; and
- (d) Engages in other functions reasonably requested by the Medical Executive Committee or the Governing Body.

## **6.3 MEDICAL STAFF OFFICERS**

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### **6.3.1 Medical Staff Officers**

The officers of the Medical Staff shall be:

- Medical Staff President
- Immediate Past Medical Staff President
- Medical Staff Vice President
- Medical Staff Secretary/Treasurer

### 6.3.2 Duties and Responsibilities

- (a) Medical Staff President. The Medical Staff President shall serve as the organized Medical Staff's chief administrative officer and shall:
- i. fulfill those duties specified in these Medical Staff Bylaws and the Medical Staff Policies;
  - ii. collaborate with the Hospital President in all matters of mutual concern within the Hospital;
  - iii. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Medical Executive Committee;
  - iv. serve as ex officio member of all other Medical Staff committees without vote;
  - v. be responsible for the enforcement of these Bylaws, Medical Staff Policies, and associated policies, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against an appointee to the Medical Staff;
  - vi. make recommendations to the Medical Executive Committee regarding Staff Members qualified to serve as Medical Staff committee members (except the Medical Executive Committee);
  - vii. appoint Medical Staff committee chairpersons;
  - viii. present the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Hospital President;
  - ix. receive, and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on quality improvement review with respect to the Medical Staff's delegated responsibility to provide medical care;
  - x. be primarily responsible for the educational activities of the Medical Staff;
  - xi. be responsible for the management of Medical Staff funds; and
  - xii. attend to all correspondence and perform such other duties as ordinarily pertain to such office.
- (b) Immediate Past Medical Staff President. The Immediate Past Medical Staff President shall:
- i. be a member of the Medical Executive Committee;
  - ii. assist the Medical Staff President in the transition into his/her new role as Medical Staff President; and
  - iii. perform such duties as may be delegated to the Immediate Past Medical Staff President by the Medical Staff President;
- (c) Medical Staff Vice President. The Medical Staff Vice President shall:
- i. be a member of the Medical Executive Committee;
  - ii. perform such duties as may be delegated to the Medical Staff Vice President by the Medical Staff President;

## ARTICLE 6 – ORGANIZED MEDICAL STAFF

- iii. in the absence of the Medical Staff President, assume all the duties and have the authority of the Medical Staff President;
  - iv. serve as the Medical Staff President in any circumstance in which the Medical Staff President is not able to serve;
  - v. serve as chairperson of the Credentials Committee; and
  - vi. attend to and perform such other duties as ordinarily pertain to such office.
- (d) Medical Staff Secretary/Treasurer.
- i. The Medical Staff Secretary/Treasurer shall be a member of the Medical Executive Committee;
  - ii. The Medical Staff Secretary/Treasurer shall ensure that attendance is taken and accurate and complete minutes are kept of all Medical Executive Committee meetings;
  - iii. The Medical Staff Secretary/Treasurer shall be accountable for all Medical Staff funds, arrange for and present an audit upon request by the Medical Executive Committee, and authorize expenditures in accordance with these Bylaws; and
  - iv. The Medical Staff Secretary/Treasurer shall attend to and perform such other duties as ordinarily pertain to the such office.

### 6.3.3 Qualifications

At the time of nomination and election, and throughout his or her term of office, each Medical Staff Officer must:

- (a) Be an Active Medical Staff Member;
- (b) Be eligible to serve as a Medical Staff Officer in accordance with Medical Staff and Hospital conflict of interest policies;
- (c) Demonstrate an interest in maintaining quality patient care at the Hospital; and
- (d) Constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees.

### 6.3.4 Nomination

Medical Staff Officer candidates shall be nominated by the Nominating Committee, which shall convene at least ninety (90) days prior to the regular Medical Staff meeting that is referred to as the “annual meeting” and shall submit to the Medical Staff President a list of one or more qualified nominees for each office (all of whom must have agreed to stand for election to the office). The names of the nominees shall be made available to the voting members of the Medical Staff at least thirty (30) days prior to the annual meeting. Nominations may also be made by petition signed by at least twenty (20) members of the Active Medical Staff (provided that such nominees have agreed to stand for election) and filed with the President of the Medical Staff at least seven (7) days prior to the annual meeting. The names of nominees by petition shall be made available to voting members of the Medical Staff as soon as practicable after filing with the President of the Medical Staff. If all of the nominees for an office are disqualified from, or otherwise unable to accept nomination prior to the annual meeting, the Nominating Committee shall submit one or more substitute nominees for such office at the annual meeting.

### 6.3.5 Election

Except for the Immediate Past Medical Staff President (who serves by virtue of his/her past service as Medical Staff President), Medical Staff Officers shall be elected every other year at the annual meeting of the Medical Staff. Only those who are appointed to a Medical Staff category which entitles them to vote for Medical Staff Officer positions shall be eligible to vote. Election by the Medical Staff for each office shall be by a ballot vote requiring a simple majority for election. If, during the voting for a particular office, a candidate does not receive a simple majority to elect such candidate to office, successive balloting shall ensue with the name of the candidate receiving the fewest votes being omitted from the next ballot until a majority is obtained by one candidate.

### 6.3.6 Term

A Medical Staff Officer shall serve for a term of two (2) years and may stand for re-election. Medical Staff Officers shall take office on the first day of the Medical Staff year.

### 6.3.7 Vacancies in Office

Vacancies in office during a Medical Staff Officer's two (2) year term, except for the Medical Staff President, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the Medical Staff President, the Medical Staff Vice President shall serve as the Medical Staff President for the remainder of his or her term.

### 6.3.8 Removal from Office

- (a) Automatic Removal. The Medical Executive Committee shall automatically remove from office any Medical Staff Officer upon verification of such Medical Staff Officer's: (i) revocation or suspension of license to practice medicine, podiatry or dentistry in the Commonwealth of Massachusetts; or (ii) revocation or denial of Active Medical Staff Membership. There shall be no right of appellate review or hearing in connection with removal from a Medical Staff Officer position.
- (b) Discretionary Removal. Grounds for removal of a Medical Staff Officer may include, but shall not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic relinquishment or restriction or suspension of privileges; and conduct or statements damaging to the Hospital or Medical Staff.
  - i. *Suspension of Appointment*. Upon the suspension of any Medical Staff Officer's Medical Staff appointment, the Medical Executive Committee shall consider the removal of such Medical Staff Officer, pending the results of the hearing and appellate review procedures provided in these Bylaws.
  - ii. *Request for Removal*. The Medical Executive Committee shall consider the removal of a Medical Staff Officer from office in the event:
    - the Medical Executive Committee receives a written request to consider such removal signed by at least one-quarter (1/4) of the Active Medical Staff or signed by the Hospital President (any such request shall include a list of the allegations or concerns precipitating the request of removal);
    - the Medical Executive Committee receives written certification by two (2) physicians with special qualification in the appropriate medical field(s) that the Medical Staff Officer, to a reasonable medical certainty, cannot be expected to

## ARTICLE 6 – ORGANIZED MEDICAL STAFF

perform the duties of the office because of illness for a minimum of three (3) months;

- iii. *Removal by Active Medical Staff.* A Medical Staff Officer may be removed by a vote by ballot of two-thirds (2/3) of the Active Medical Staff present at a special meeting of the Medical Staff at which the question is considered.

(c) Removal Procedure for Removal by Medical Executive Committee.

- i. *Medical Executive Committee Meeting.* A meeting of the Medical Executive Committee shall be called within seven (7) days of a suspension or request for removal, as set forth in Section 6.3.8, to consider the removal of the Medical Staff Officer. A quorum of the Medical Executive Committee must be present to act on the removal. The Medical Staff Officer in question shall have no vote on his or her removal, and may be excluded from the meeting except as provided in (ii) below.
- ii. *Appearance of Officer.* The Medical Staff Officer in question shall be permitted to make an appearance before, and make a statement to, the Medical Executive Committee prior to the Medical Executive Committee taking a final vote on the Medical Staff Officer's removal.
- iii. *Vote.* A Medical Staff Officer may be removed by an affirmative vote by ballot of two-thirds (2/3) of the Medical Executive Committee members present at a meeting of the Medical Executive Committee at which there is a quorum present. The Medical Staff Officer who is subject to the removal process may not participate or be present during the vote.
- iv. *Notification.* The Hospital President shall provide the Medical Staff Officer with written notification of the Medical Executive Committee's final decision.
- v. *Hearing and Appeal Rights.* There shall be no right of hearing or appellate review in connection with a removal from a Medical Staff Officer position.

## 6.4 MEDICAL STAFF MEETINGS

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### 6.4.1 Purpose

The primary objective of Medical Staff meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda.

### 6.4.2 Scheduling and Notice

- (a) Regular Meetings. The Medical Staff shall meet at least once each year.
- (b) Special Meetings. The Medical Staff President, the Medical Executive Committee, the Governing Body, or the Hospital President may call a special meeting of the Medical Staff at any time. In addition, the Medical Staff President must call a special meeting within twenty (20) days after receipt of a written request signed by at least twenty voting members of the Active Medical Staff which states the purpose of such special meeting.  
The Medical Staff President shall designate the time and place of any special meeting.
- (c) Notice. Written Notice of each regular Medical Staff meeting shall be sent to all Medical Staff Members and conspicuously posted (such Written Notice may be posted online).

## ARTICLE 6 – ORGANIZED MEDICAL STAFF

Written Notice stating the time, place and purposes of any special Medical Staff meeting shall be sent to each member of the Medical Staff at least five (5) days before the date of such meeting and conspicuously posted (such Written Notice may be posted online). No business shall be transacted at any special meeting, except that stated in the notice of such special meeting. The attendance of a Medical Staff Member at a meeting shall constitute a waiver of notice of such meeting.

### **6.4.3 Minutes**

Written minutes of each Medical Staff meeting shall be prepared and recorded, made accessible to Medical Staff Members, and approved by the Medical Staff at its next regular or special Medical Staff meeting.

### **6.4.4 Attendance Requirements**

In accordance with applicable Medical Staff Policies, Active Medical Staff Members are expected to attend Medical Staff Meetings and such attendance may be considered in evaluating Active Medical Staff Members at the time of reappointment. All other Staff Members are strongly encouraged to attend Medical Staff meetings.

### **6.4.5 Telecommunication**

Medical Staff members may participate in regular or special Medical Executive Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.

### **6.4.6 Voting Requirements and Quorum**

A quorum for Medical Staff meetings shall be at least twenty (20) members of the Active Medical Staff. If a quorum exists, unless otherwise stated in these Bylaws, action on a matter shall be approved if approved by a majority of those entitled to vote on the matter.

## ARTICLE 7. MEDICAL STAFF COMMITTEES

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### 7.1 MEDICAL EXECUTIVE COMMITTEE

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#### 7.1.1 Composition

The Medical Executive Committee shall include the members listed below. A majority of Medical Executive Committee members must be Physicians. Notwithstanding the number of offices held by any individual, each Medical Executive Committee member shall have only one vote.

#### **Voting Members:**

1. Medical Staff President (who shall serve as the Medical Executive Committee Chairperson)
2. Medical Staff Vice President
3. Medical Staff Secretary/Treasurer
4. Immediate Past Medical Staff President
5. At least two (2) and no greater than six (6) Staff Members, selected by the Medical Executive Committee for two year terms
6. Each Department Chairperson
7. One Active Staff Member appointed by and from Mercy Inpatient Medical Associates.

#### **Non-Voting Members:**

1. Hospital President
2. Vice President of Medical Affairs
3. Vice President of Patient Care Services

The Medical Executive Committee, by majority vote, may elect to appoint additional non-voting administrative members to serve two year terms, subject to the approval of the Hospital President.

#### 7.1.2 Duties and Responsibilities

The Medical Executive Committee is authorized to represent and act of behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws. The Medical Executive Committee acts on behalf of the Organized Medical Staff between meetings of the Organized Medical Staff, within the scope of its responsibilities as described in these Bylaws. The authority delegated to the Medical Executive Committee by the Medical Staff may be limited or removed by the Organized Medical Staff by amending these Medical Staff Bylaws in accordance with Section 9.1. The duties and responsibilities of the Medical Executive Committee include the following:

- (a) Coordinate the activities and general policies of the Departments;
- (b) Receive, review and act upon Department and Medical Staff committee reports;
- (c) Develop, approve, implement, and monitor Medical Staff Policies not otherwise the responsibility of the Departments;
- (d) Provide liaison between the Medical Staff, the Hospital President and the Governing Body;



## ARTICLE 7 – MEDICAL STAFF COMMITTEES

- (e) Make recommendations to the Hospital President on matters of a medico-administrative nature;
- (f) Make recommendations to the Governing Body and the Hospital President on matters concerning the management of the Hospital (the Medical Executive Committee may recommend to the Governing Body and the Hospital President specific physicians to fill the ex officio Medical Staff positions on the Governing Body);
- (g) Fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital and participation in quality improvement activities;
- (h) Ensure that the Medical Staff actively participates in the Hospital's accreditation program and assists the Hospital in maintaining its accreditation status;
- (i) Review and act on the credentials and qualifications of all Applicants and make recommendations to the Governing Body for staff appointment, assignments to Departments and delineation of Clinical Privileges;
- (j) Review periodically all information available regarding the performance and clinical competence of Staff Members and other individuals with Clinical Privileges, and as a result of such reviews, make recommendations to the Governing Body for reappointments and renewal of or changes in Clinical Privileges;
- (k) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all appointees to the Medical and Allied Health Professional Staffs, including the initiation of and/or participation in corrective action and/or review measures when warranted;
- (l) Appoint Medical Staff committee chairpersons and members;
- (m) Report at each general Medical Staff meeting;
- (n) Make recommendations relating to changes to the Medical Staff structure; and revisions to and updating of the Medical Staff Bylaws and Medical Staff Policies;
- (o) Provide for the consideration of differing points of view when conflicts arise between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt a rule, regulation, or policy (or an amendment thereto), and report on such consideration and the Medical Executive Committee's determination relating thereto to the Medical Staff, as appropriate; and
- (p) Review, recommend, and support Hospital sponsored educational activities that are relevant to the Medical Staff and to the nature and type of care offered by the Hospital. When applicable, these educational activities shall relate to performance improvement activities.

### 7.1.3 Medical Executive Committee Meetings

- (a) Scheduling and Notice.
  - i. Regular Meetings. The Medical Executive Committee shall meet as often as necessary, but in no event less than quarterly, to fulfill its duties and responsibilities.
  - ii. Special Meetings. The Medical Staff President, the Governing Body or the Hospital President may call a special meeting of the Medical Executive Committee at any time.

## ARTICLE 7 – MEDICAL STAFF COMMITTEES

- iii. Notice. Medical Staff Services shall send Written Notice of each regular and special Medical Executive Committee meeting to all Medical Executive Committee members.
- (b) Telecommunication. Medical Executive Committee members may participate in regular or special Medical Executive Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.
- (c) Quorum and Voting Requirements. A quorum shall consist of at least fifty percent (50%) of the Medical Executive Committee's voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.
- (d) Attendance Requirements. Medical Executive Committee members are expected to attend at least seventy percent (70%) of the meetings held.
- (e) Minutes. Minutes (written or recorded) of each regular and special Medical Executive Committee meeting shall be prepared and shall include a record of the attendance of Medical Executive Committee members and the vote taken on each matter. The minutes shall be approved by the Medical Executive Committee at the next regular or special meeting of the committee and copies thereof shall be made available to the Governing Body. Minutes of each Medical Executive Committee meeting shall be maintained in a permanent Medical Staff file by Medical Staff Services.

### 7.1.4 Removal of Medical Executive Committee Members

- (a) Automatic Removal. The status as members of the Medical Executive Committee of individuals who serve as such members by virtue of ex officio status shall automatically terminate at such time as they cease to serve in such ex officio capacity. Members of the Medical Executive Committee shall also cease to serve as such members upon verification of their: (i) revocation or suspension of license to practice medicine, podiatry or dentistry in the Commonwealth of Massachusetts; or (ii) revocation or denial of Active Medical Staff Membership. There shall be no right of appellate review or hearing in connection with removal as a member of the Medical Executive Committee.
- (b) Discretionary Removal. Grounds for removal of a Medical Executive Committee member may include, but shall not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic relinquishment or restriction or suspension of privileges; and conduct or statements damaging to the Hospital or Medical Staff.
  - i. *Suspension of Appointment*. Upon the suspension of any Medical Executive Committee member's Medical Staff appointment, the Medical Executive Committee (not including the member in question) shall consider the removal of the member, pending the results of the hearing and appellate review procedures provided in these Bylaws.
  - ii. *Request for Removal*. The Medical Executive Committee (not including the member in question) shall consider the removal of an elected or appointed member of the Medical Executive Committee in the event:
    - the Medical Executive Committee receives a written request to consider such removal signed by at least one-quarter (1/4) of the Active Medical Staff or

## ARTICLE 7 – MEDICAL STAFF COMMITTEES

signed by the Hospital President (any such request shall include a list of the allegations or concerns precipitating the request of removal);

- the Medical Executive Committee receives written certification by two (2) physicians with special qualification in the appropriate medical field(s) that the Medical Executive Committee member, to a reasonable medical certainty, cannot be expected to perform the duties of the office because of illness for a minimum of three (3) months;
- iii. *Vote of Active Medical Staff.* An elected or appointed member of the Medical Executive Committee may be removed by a vote by ballot of two-thirds (2/3) of the Active Medical Staff present at a special meeting of the Medical Staff at which the question is considered.

### (c) Removal Procedure for Removal by Medical Executive Committee.

- i. *Medical Executive Committee Meeting.* A meeting of the Medical Executive Committee shall be called within seven (7) days of a suspension or request for removal, as set forth in this Section 7.1.4, to consider the removal of the Medical Executive Committee member. A quorum of the Medical Executive Committee must be present to act on the removal. The Medical Executive Committee member in question shall have no vote on his or her removal, shall not be counted when determining a quorum, and shall be excluded from the meeting except as provided in (ii) below.
- ii. *Appearance of Member.* The Medical Executive Committee member in question shall be permitted to make an appearance before, and make a statement to, the Medical Executive Committee prior to the Medical Executive Committee taking a final vote on the Medical Staff Officer's removal.
- iii. *Vote.* An elected or appointed Medical Executive Committee member may be removed by an affirmative vote by ballot of two-thirds (2/3) of the Medical Executive Committee members present at a meeting of the Medical Executive Committee at which there is a quorum present. The Medical Executive Committee member who is subject to the removal process may not participate or be present during the vote.
- iv. *Notification.* The Hospital President shall provide the Medical Executive Committee member in question with written notification of the Medical Executive Committee's final decision.
- v. *Hearing and Appeal Rights.* There shall be no right of hearing or appellate review in connection with a removal from the Medical Executive Committee.

## 7.2 OTHER MEDICAL STAFF COMMITTEES

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### 7.2.1 Medical Staff Committees

At a minimum the Medical Executive Committee shall establish the following standing Medical Staff Committees, in addition to the Medical Executive Committee:

- **Credentials Committee**
- **Bylaws Committee**
- **Nominating Committee**

- **Practitioner Health Committee**

### **7.2.2 Formation, Composition and Dissolution**

The Medical Executive Committee may, without amendment of these Bylaws: (a) establish additional standing and ad hoc Medical Staff committees to perform one or more Medical Staff functions, (b) determine the Medical Staff composition of such Medical Staff committees; (c) appoint Staff Members and other individuals to serve as committee members and chairpersons; and (d) dissolve or rearrange the Medical Staff committee structure or composition, provided no such action taken with respect to items (a)-(c) is inconsistent with these Bylaws, including Section 7.2.1. Medical Staff Committee members must be eligible to serve as Medical Staff Committee members in accordance with Medical Staff and Hospital conflict of interest policies. Committee chairs are subject to approval by the Governing Body, and Hospital personnel on committees shall be appointed by the Hospital President. Except as provided herein, Medical Staff Committee composition, other qualifications for membership, and the process for election or appointment (if any) shall be set forth in Medical Staff Policies.

### **7.2.3 Duties and Responsibilities**

The Medical Executive Committee shall describe the duties and responsibilities of each Medical Staff committee (except the Medical Executive Committee) in the applicable Medical Staff Policy(ies). Medical Staff committees (other than the Medical Executive Committee) shall: (1) confine their activities to the purposes for which they are appointed; (2) ensure compliance with all applicable Medical Staff and Hospital Policies; and (3) provide regular written reports of their activities, findings, recommendations and actions to the Medical Executive Committee.

### **7.2.4 Medical Peer Review Committees: Proceedings, Reports and Records**

Consistent with the terms of Section 10.4.3 of these Bylaws, Medical Staff committees, the Governing Body, committees of and established by the Governing Body, and their respective agents and members who are responsible for any activities related to: (1) the evaluation or improvement of the quality of health care rendered by providers of health care services; (2) the determination whether health care services were performed in compliance with the applicable standards of care; (3) the determination whether the cost of health care services rendered was considered reasonable by the providers of health services in the area; (4) the determination of whether a health care provider's actions call into question such health care provider's fitness to provide health care services; or (5) the evaluation and assistance of health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise; are, when conducting such activities, deemed to be Medical Staff committees and "medical peer review committees", as such term is defined herein, in M.G.L. ch. 111, and in the Massachusetts Board of Registration in Medicine regulations. The proceedings, reports and records of all medical peer review committees shall be confidential in accordance with state and federal law and regulation.

### **7.2.5 Medical Staff Committee Meetings**

(a) Scheduling and Notice.

- i. Regular Meetings. Medical Staff Committees shall meet as often as necessary to fulfill their duties and responsibilities, as may be further described in the Medical Staff Policies.
- ii. Special Meetings. The Committee Chairperson, the Medical Staff President, the Governing Body, the Hospital President or one-third of the current members of a committee may call a special meeting of a Medical Staff Committee at any time.

ARTICLE 7 – MEDICAL STAFF COMMITTEES

- iii. Notice. Notice provided to Committee members shall be as set forth in the applicable Medical Staff Policy.
- (b) Telecommunication. Medical Staff Committee members may participate in regular or special Medical Staff Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.
- (c) Quorum and Voting Requirements. A quorum shall consist of at least fifty percent (50%) of the Medical Staff Committee's voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.
- (d) Attendance Requirements. Attendance requirements for Medical Staff Committees shall be as set forth in the applicable Medical Staff Policy.
- (e) Minutes. Minutes (written or recorded) of each regular and special Medical Staff Committee meeting shall be prepared and shall include a record of the attendance of Medical Staff Committee members and the vote taken on each matter. The minutes shall be made available to Medical Staff Committee members and approved by the Medical Staff Committee members at the next regular or special meeting. Copies of the minutes shall be made available to the Medical Executive Committee and the Governing Body. Minutes of each Medical Staff Committee meeting shall be maintained in a permanent file by Medical Staff Services.

## **ARTICLE 8. DEPARTMENTS & CLINICAL SERVICES**

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### **8.1 ESTABLISHMENT OF DEPARTMENTS & CLINICAL SERVICES**

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The Medical Executive Committee, with the approval of the Governing Body, may establish Clinical Departments, and Clinical Services within such Departments. Such Departments and Clinical Services shall be set forth in a Medical Staff Policy.

### **8.2 ASSIGNMENT TO DEPARTMENTS & CLINICAL SERVICES**

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#### **8.2.1 Assignment**

The Medical Executive Committee will, after consideration of the recommendations of the applicable Department Chairperson(s), recommend Department and Clinical Service assignments for each Staff Member in accordance with the Staff Member's qualifications. Each Staff Member shall be assigned to at least one Department, but may also be assigned to and/or granted Clinical Privileges in one or more other Departments. The exercise of Clinical Privileges or the performance of specified services within any Department shall be subject to the policies of that Department.

#### **8.2.2 Multiple Departments**

A Staff Member who wishes to be assigned to more than one Department must declare which Department shall be designated as his/her major affiliation. A Medical Staff Member who meets the qualifications in Section 8.3.1 of these Bylaws shall be eligible for nomination as Department Chairperson only in that Department which he/she has declared as his/her major Department affiliation. Membership in Departments other than the declared major Department does not confer the privilege to be nominated for the position of Department Chairperson, but does confer all other privileges of discussion, voting and appointment to committees which may be established by the Department.

### **8.3 DEPARTMENT CHAIRPERSONS**

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#### **8.3.1 Qualifications**

At the time of appointment or election, and throughout his or her term of office, a Department Chairperson must:

- (a) Be and remain a member of the Active Medical Staff;
- (b) Be and remain board certified in his/her specialty;
- (c) Be eligible to serve as a Department Chairperson in accordance with Medical Staff and Hospital conflict of interest policies;
- (d) Demonstrate an interest in maintaining quality patient care at the Hospital and in the Department; and
- (e) Constructively participate in Medical Staff affairs, including by actively participating in peer review activities and on Medical Staff committees.

### **8.3.2 Appointment/Election of Department Chairperson**

Unless the selection of a Department Chairperson is governed by a contract between the Hospital and a medical group or practitioner (in which case the selection and/or removal may be governed by the terms of the contract), the Chairperson of each Department shall be selected as follows. At least ninety (90) days prior to the annual meeting of the Medical Staff in each odd calendar year, each Department shall convene a Department meeting to elect a Department Chairperson for the subsequent two years. Medical Staff Members of the Department who are entitled to vote for the Department Chairperson shall nominate one or more members of the Department with the requisite qualifications to serve as Department Chairperson. Each nominee must sign a statement agreeing to stand for election as Chairperson prior to the election. The election of a Department Chairperson requires the affirmative vote of a majority of those voting members of the Department who are present at the meeting at which the vote is taken, and must be affirmed by the Medical Executive Committee and the Governing Body. In the event that either the Medical Executive Committee or the Governing Body does not approve the elected Chairperson, the Medical Executive Committee, in consultation with the applicable Department, shall make an alternate recommendation to the Governing Body for its approval.

### **8.3.3 Term**

Appointed Department Chairpersons shall serve for the term specified by the Hospital President. Elected Department Chairpersons shall serve two year terms. All Department Chairpersons shall be subject to periodic review and may be removed from their position as set forth in Section 8.3.5.

### **8.3.4 Duties and Responsibilities**

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

- (a) Be a member of the Medical Executive Committee.
- (b) Report to the Medical Executive Committee and the Vice President of Medical Affairs regarding professional and administrative activities within the Department.
- (c) Cooperate with Administration and the Vice President of Medical Affairs in connection with all operations of the Department.
- (d) Serve as Chairperson of the Department's meetings.
- (e) Establish, when appropriate, Clinical Services within the Department, and appoint Chiefs thereof, subject to approval by the Medical Executive Committee and the Governing Body in accordance with Section 8.1.
- (f) Be responsible for the enforcement within the Department of actions taken by the Medical Executive Committee and the Governing Body.
- (g) Be responsible for the enforcement within the Department of these Medical Staff Bylaws, Medical Staff Policies and Hospital Policies.
- (h) Recommend to the Medical Executive Committee the criteria for Clinical Privileges that are relevant to the care provided by the Department.
- (i) Establish guidelines for the granting of Clinical Privileges and the performance of specified services within the Department.

## ARTICLE 8 – DEPARTMENTS & CLINICAL SERVICES

- (j) Make recommendations to the Medical Executive Committee regarding Staff Membership (e.g. appointment and reappointment) and Clinical Privileges for Department members.
- (k) Be responsible for all clinical and administrative activities of the Department (including maintaining quality and medical records), unless otherwise provided for by the Hospital.
- (l) Maintain or provide for the continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges, and report thereon to the Medical Executive Committee as part of the reappointment process and at other such times as may be indicated.
- (m) Be primarily responsible for the integration of the Department into the primary functions of the Hospital and for the coordination and integration of interdepartmental and intradepartmental services.
- (n) Develop and implement Departmental Policies to guide and support the provision of care, treatment and services within the Department. Such Departmental Policies are subject to the approval process set forth in Section 9.3.
- (o) Make recommendations for a sufficient number of qualified and competent Practitioners to provide care, treatment and services within the Department.
- (p) Make recommendations regarding the qualifications and competence of Department or service personnel who are not Practitioners and who provide care, treatment, and services.
- (q) Be responsible for the continuous assessment and improvement of the quality of care, treatment, and services provided within the Department.
- (r) Be responsible for the maintenance of quality control programs, as appropriate.
- (s) Be responsible for the orientation and continuing education of Department members, including but not limited to education on fire and other regulations designed to promote safety.
- (t) Make recommendations for space and other resources needed by the Department.
- (u) Report and recommend to Administration when necessary with respect to matters affecting patient care in the Department such as personnel, budget planning, supplies, space, special regulations, standing orders and techniques.
- (v) Be responsible for arranging and securing appropriate Departmental emergency service on-call coverage in accordance with the needs of the Hospital.
- (w) Coordinate the patient care provided by the Department's appointees with nursing and ancillary patient care services and with administrative support services.
- (x) Submit written reports to the Medical Executive Committee on such matters as may be requested from time to time by the Medical Executive Committee.
- (y) Conduct meetings of the Department, including for the purpose of performing the functions described herein.
- (z) Establish Departmental committees or other mechanisms as are necessary and desirable to properly perform Department functions.

### **8.3.5 Removal of a Department Chairperson**

Unless otherwise provided by contract, a Department Chairperson may be removed from office by the Governing Body acting upon its own recommendation, or acting on the recommendation of a simple majority of the Medical Staff Members of the Department who are entitled to vote, for



reasons including, but not limited to: mental or physical impairment or inability; unwillingness to perform duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic relinquishment or a suspension of privileges; and conduct or statements damaging to the Hospital, the Medical Staff or their goals or programs. When practicable, the Governing Body shall consult with the Medical Executive Committee prior to such removals when the removals are on the Governing Body's own recommendation. In the event a Department Chairperson is removed, the Medical Staff President and the Hospital President shall appoint an Active Medical Staff Member of the applicable Department to serve as the interim Department Chairperson until another Department Chairperson is appointed or elected in accordance with Section 8.3.2. If the Medical Staff President and Hospital President cannot agree on the interim Department Chairperson, then the interim Department Chairperson may be appointed by the Governing Body. A Practitioner shall not be entitled to hearing or appellate review rights in connection with his or her removal as a Department Chairperson.

## **8.4 CLINICAL SERVICE CHIEFS**

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### **8.4.1 Appointment/Election**

Unless the selection of a Service Chief is governed by a contract between the Hospital and a medical group or practitioner (in which case the selection and/or removal may be governed by the terms of the contract), the Chief of each Service shall be selected as follows. At least ninety (90) days prior to the annual meeting of the Medical Staff in each odd calendar year, each Service shall convene a Service meeting to elect a Service Chief for the subsequent two years. Medical Staff Members of the Service who are entitled to vote for the Service Chief shall nominate one or more members of the Service with the requisite qualifications to serve as Service Chief. Each nominee must sign a statement agreeing to stand for election as Chief prior to the election. The election of a Service Chief requires the affirmative vote of a majority of those voting members of the Service who are present at the meeting at which the vote is taken, and must be affirmed by the Medical Executive Committee and the Governing Body. In the event that either the Medical Executive Committee or the Governing Body does not approve the elected Chief, the Medical Executive Committee, in consultation with the applicable Service, shall make an alternate recommendation to the Governing Body for its approval.

### **8.4.2 Qualifications of Clinical Service Chiefs**

At the time of appointment, and throughout his or her term of service, a Clinical Service Chief must:

- (a) Be an Active Medical Staff Member;
- (b) Be and remain board certified in his/her specialty;
- (c) Be eligible to serve as a Clinical Service Chief in accordance with Medical Staff and Hospital conflict of interest policies;
- (d) Demonstrate an interest in maintaining quality patient care at the Hospital, including in the applicable Department and Clinical Service; and
- (e) Constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees.

### **8.4.3 Duties and Responsibilities**

The primary responsibility delegated to each Clinical Service Chief is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in his/her Clinical Service. To carry out this

responsibility, each Clinical Service Chief shall act in accordance with all applicable Medical Staff and Hospital Policies, and under the direction of the applicable Department Chairperson and appropriate senior administrators.

#### **8.4.4 Removal of Clinical Service Chief**

Unless otherwise provided by contract, a Service Chief may be removed from office by the Governing Body acting upon its own recommendation, or acting on the recommendation of a simple majority of the Medical Staff Members of the Service who are entitled to vote, for reasons including, but not limited to: mental or physical impairment or inability; unwillingness to perform duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic relinquishment or a suspension of privileges; and conduct or statements damaging to the Hospital, the Medical Staff or their goals or programs. When practicable, the Service Chief who is subject to removal pursuant to the preceding sentence will be notified in advance of a recommended removal and given the opportunity to respond to the grounds for removal prior to the taking of final action with respect to the removal. In the event a Service Chief is removed, the Medical Staff President and the Hospital President shall appoint an Active Medical Staff Member of the applicable Service to serve as the interim Service Chief until another Service Chief is appointed or elected in accordance with Section 8.4.1. If the Medical Staff President and Hospital President cannot agree on the interim Service Chief, then the interim Service Chief may be appointed by the Governing Body. A Practitioner shall not be entitled to hearing or appellate review rights in connection with his or her removal as a Service Chief.

### **8.5 DEPARTMENTAL MEETINGS**

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#### **8.5.1 Scheduling and Notice**

- (a) Regular Meetings. Each Department may set the time for holding the Department's regular meetings by resolution. Departmental meetings shall be held as reasonably required to perform the Departmental functions described in these Bylaws.
- (b) Special Meetings. A special meeting of a Department may be called at any time by or at the request of the Department Chairperson thereof, the Medical Staff President, or the Hospital President.
- (c) Telecommunication. Department members may participate in regular or special Departmental meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.
- (d) Notice. Written Notice stating the place, day, and hour of any special meeting or of any regular Departmental meeting not held pursuant to resolution shall be delivered or sent to each Department member at least five (5) business days before the time of such meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

#### **8.5.2 Attendance Requirements**

In accordance with applicable Medical Staff Policies, Active Medical Staff Members are expected to attend Medical Staff Department Meetings and such attendance may be considered in

evaluating Active Medical Staff Members at the time of reappointment. All other Staff Members are strongly encouraged to attend Medical Staff Department meetings.

**8.5.3 Participation by Hospital President**

The Hospital President may attend any Medical Staff Department meeting. The Department may request that the Hospital President recuse him/herself from part or all of a Department meeting in order to allow discussion of issues which may impact the relationship between the Department and Hospital administration, but the decision to leave any meeting shall be up to the Hospital President, in his/her discretion.

**8.5.4 Minutes**

Minutes of each regular and special Department meeting shall be prepared and shall include a record of the Department members in attendance and the vote taken on each matter. The minutes shall be signed by the Department Chairperson and copies thereof shall be submitted to the Medical Executive Committee. Minutes of Department meetings shall be maintained in a permanent file by Medical Staff Services.

**8.5.5 Quorum and Voting Requirements**

For Department meetings, a quorum shall consist of those present and voting. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action.

## ARTICLE 9. MEDICAL STAFF BYLAWS & POLICIES

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### 9.1 MEDICAL STAFF BYLAWS – ADOPTION & AMENDMENT

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#### 9.1.1 Adoption

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff and shall become effective only when approved by the Governing Body. These Medical Staff Bylaws contain a description of the basic steps associated with processes listed below. Additional procedural details associated with these basic processes may be placed in these Bylaws, a Medical Staff Policy or a Hospital Policy approved by the Medical Executive Committee. Additional procedural details may be adopted or amended by the Medical Executive Committee as provided in Section 9.2 of these Bylaws.

(a) Privileging/Credentialing/Appointment

- i. Medical Staff appointment and reappointment.
- ii. Credentialing and re-credentialing of Staff Members.
- iii. Privileging and re-privileging of Staff Members.

(b) Adverse Actions

- i. Automatic suspension of Staff Membership and/or Clinical Privileges.
- ii. Summary suspension of Staff Membership and/or Clinical Privileges.
- iii. Recommending termination or suspension of Staff Membership and/or termination, suspension or reduction of Clinical Privileges.
- iv. Fair hearing and appeal process, including the process for scheduling and conducting hearings and appeals.

(c) Medical Staff/Medical Executive Committee Functions

- i. Selection and removal of Medical Staff officers.
- ii. How the Medical Executive Committee's authority is delegated or removed.
- iii. Selection and removal of Medical Executive Committee members.

(d) Adoption, Approval of Documents

- i. Adopting and amending these Medical Staff Bylaws.
- ii. Adopting and amending Medical Staff Policies.

#### 9.1.2 Periodic Review

These Bylaws shall be reviewed periodically by the Bylaws Committee.

#### 9.1.3 Amendment of Bylaws

Neither the Medical Staff, nor the Governing Body, may unilaterally amend these Medical Staff Bylaws. All amendments to these Bylaws must be approved by both the Medical Staff and the Governing Body. The Medical Executive Committee will ensure that approved amendments are communicated to the Medical Staff. Any Department, Staff Member, Medical Staff Committee or Departmental Committee may submit a request for amendment of these Bylaws to the Medical Executive Committee at any time.

## ARTICLE 9 – MEDICAL STAFF BYLAWS & POLICIES

- (a) Amendments Proposed to the Governing Body by the Medical Staff. An amendment to these Medical Staff Bylaws which has been approved by the Medical Staff as provided in Section 9.1.3(d) shall be forwarded to the Governing Body for approval and shall be effective if and when such amendment is approved by the Governing Body.
- (b) Amendments Proposed by the Medical Executive Committee. The Medical Executive Committee may submit a proposed amendment to these Medical Staff Bylaws to the Medical Staff President. The Medical Staff President shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, or at a special Medical Staff meeting called for such purpose, or by mail vote as provided in Section 9.1.3(d). An amendment approved by the Medical Staff as provided in Section 9.1.3(d) shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body.
- (c) Amendments Proposed by the Governing Body. Amendments proposed by the Governing Body shall be submitted to the Medical Staff President. The Medical Staff President shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, or at a special Medical Staff meeting called for such purpose, or by mail vote as provided in Section 9.1.3(d). An amendment approved by the Medical Staff as provided in Section 9.1.3(d) shall be returned to the Governing Body for its final approval and shall become effective if and when it is approved by the Governing Body.
- (d) Medical Staff Vote Required for Amendments. A vote to approve an amendment to the Medical Staff Bylaws shall require one of the following:
  - (i) Notice of the Medical Staff meeting at least fifteen (15) days prior to the meeting, including a summary of the amendment(s) to be considered, and the affirmative vote of at least two-thirds of the Active Medical Staff members present, provided that at least twenty-six (26) Active Staff Members vote in the affirmative; or
  - (ii) In lieu of a meeting of the Medical Staff, notice of the proposed amendment(s), including the full text thereof, is distributed to all members of the Active Medical Staff at least fifteen (15) days prior to the deadline for receipt of votes on the amendment(s), and the affirmative vote of a majority of all members of the Active Medical Staff are received in Medical Staff Services on or before the deadline by mail or electronic mail.
- (e) Status of Medical Staff Bylaws. The Medical Staff will cooperate with the Hospital to resolve any conflict or inconsistency between these Bylaws and the Hospital Bylaws or Policies.

### 9.1.4 Technical Modifications of Bylaws

Modifications to these Bylaws that do not materially change any Bylaw provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations, shall not be considered an amendment of the Medical Staff Bylaws and shall not require approval as described above.

## 9.2 MEDICAL STAFF POLICIES – ADOPTION AND AMENDMENT

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The Medical Executive Committee shall adopt and amend Medical Staff Policies as may be necessary to implement more specifically the general principles found within these Bylaws and guide and support the provision of care, treatment and services at the Hospital, subject to the approval of the Governing Body. Medical Staff Policies must be consistent with these Medical Staff Bylaws and applicable Hospital Policies.

### 9.2.1 Adoption

Any Medical Staff Member, Medical Staff committee (including the Medical Executive Committee), Department, of the Medical Staff as a body may submit a proposal to adopt a Medical Staff Policy to the Medical Staff President. The Medical Staff President shall submit the proposed Policy to the Medical Executive Committee for approval at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. If the proposed Policy was proposed initially by the Medical Executive Committee, it shall also be communicated to the Medical Staff. To be approved by the Medical Executive Committee, a proposed Policy must be approved by a majority (51%) vote of the Medical Executive Committee. A Policy approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed Policy is not approved by the Medical Executive Committee, the Medical Staff may submit the proposed Policy directly to the Governing Body if two-thirds (2/3) of the Active Medical Staff Members vote to submit such proposed Policy directly to the Governing Body. Such a proposed Policy shall become effective if and when it is approved by the Governing Body.

### 9.2.2 Amendment

Medical Staff Policies may be amended or repealed upon recommendation of the Medical Executive Committee and approval of the Governing Body. The Medical Executive Committee will ensure that amendments to Medical Staff Policies which are approved by the Medical Executive Committee and the Governing Body are communicated to the Medical Staff.

- (a) Amendments Proposed by the Medical Executive Committee. An amendment to Medical Staff Policies proposed by the Medical Executive Committee shall be communicated to the Medical Staff, and, if approved by the Medical Executive Committee, forwarded to the Governing Body for its approval and shall become effective if and when approved by the Governing Body. The foregoing notwithstanding, in cases of a documented need for an urgent amendment to Medical Staff Policies necessary to comply with law or regulation, the Medical Executive Committee may provisionally approve such amendment without prior notification to the Medical Staff. In such cases, the Medical Staff shall immediately be notified of the provisional approval by the Medical Executive Committee, and the Medical Staff shall have the opportunity for retrospective review and comment on the provisionally approved amendment. If there is no conflict over the provisional amendment, the provisional amendment shall stand. If there is conflict between the Medical Executive Committee and Medical Staff regarding the provisional amendment, the conflict will be addressed by the Medical Executive Committee in accordance with the terms of Section 7.1.2(o) of these Bylaws.
- (b) Amendments Proposed by a Medical Staff Member, Committee, or Department. Any Medical Staff Member, Medical Staff committee, Department, or the Medical Staff as a body may submit a proposed amendment to Medical Staff Policies to the Medical Staff President. The Medical Staff President shall submit the proposed amendment to the

Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, an amendment proposed by a Medical Staff Member, Committee, Department or Medical Staff shall require a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed amendment is not approved by the Medical Executive Committee, the Medical Staff may submit the proposed amendment directly to the Governing Body if two-thirds (2/3) of the Active Medical Staff Members vote to submit such proposed amendment directly to the Governing Body. Such a proposed amendment shall become effective if and when it is approved by the Governing Body.

- (c) Amendments Proposed by the Governing Body. An amendment to the Medical Staff Policies proposed by the Governing Body shall be submitted to the Medical Staff President for consideration by the Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, an amendment proposed by the Governing Body shall require a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be returned to the Governing Body for its final approval and shall become effective if and when it is approved by the Governing Body.
- (d) Status of Medical Staff Policies. In the event of any conflict or inconsistency between these Bylaws and Medical Staff Policies, these Bylaws shall supersede and prevail. In the event of any conflict or inconsistency between Medical Staff Policies and Department policies, Medical Staff Policies shall supersede and prevail. In the event of conflict or inconsistency between Medical Staff Policies and Hospital Policies, Hospital Policies shall supersede and prevail. In the event of conflict or inconsistency between Hospital Bylaws and Hospital Policies, Hospital Bylaws shall supersede and prevail.

### **9.2.3 Technical Modifications of Medical Staff Policies**

Modifications that do not materially change any Medical Staff Policy provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations, shall not be considered an amendment of the Medical Staff Policies and shall not require approval as described above.

## **9.3 DEPARTMENTAL POLICIES – ADOPTION & AMENDMENT**

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Each Department may develop and propose amendments to Department policies intended to guide and support the provision of care, treatment and services in such Department, or govern the administration of such Department. Such policies or proposed amendments must: (1) be consistent with these Medical Staff Bylaws, Medical Staff Policies, and applicable Hospital Policies; and (2) be approved by the Department Chairperson, the Medical Executive Committee, and the Hospital President. If the Medical Executive Committee or Hospital President declines to approve a Department policy or proposed amendment to such a policy recommended by the relevant Department Chairperson, the Medical Executive Committee or Hospital President shall provide a written explanation of its action to the Department Chairperson.

## **9.4 HISTORY AND PHYSICAL EXAMINATIONS**

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A medical history and physical examination (H&P) must be performed and documented by a Physician, Oral Surgeon, or other qualified licensed individual (as identified in applicable Medical Staff Policies), no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services (as described in the Medical Staff Policies). If the H&P is performed within thirty (30) days prior to the patient's admission or registration, a Physician, Oral Surgeon, or other qualified licensed individual (as identified in the Medical Staff Policies) must complete and document an updated examination of the patient, including any changes in the patient's condition, within 24 hours after the patient's admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services (as described in Medical Staff Policies). Additional information regarding H&P documentation requirements shall be included in the Medical Staff Policies.



## **ARTICLE 10. PATIENT CARE ASSESSMENT PROGRAM**

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### **10.1 ESTABLISHMENT OF PROGRAM**

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The Hospital shall establish, and the Governing Body of the Hospital shall be responsible for, a Patient Care Assessment Program designed to provide effective quality assurance, risk management, peer review, identification and prevention of substandard practice by licensed health care professionals, and minimization of claims losses, which Program shall comply with applicable policies, rules, regulations, procedures and standards of professional review organizations and accrediting agencies, and with the requirements for designation as a qualified Program under applicable law. All Health Care Providers (including all Staff Members) shall participate in the Patient Care Assessment Program.

### **10.2 STRUCTURE OF PROGRAM**

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#### **10.2.1 Patient Care Assessment Committee**

The Governing Body shall serve as part of or shall establish one or more Patient Care Assessment Committees responsible for carrying out those patient care assessment functions required by the Governing Body of the Hospital or by applicable law from time to time. The Governing Body of the Hospital shall assure the adequacy of resources and support systems for the functions of the Patient Care Assessment Committee(s). The Patient Care Assessment Committee(s) is(are) a Governing Body level medical peer review committee that is also a Medical Staff committee. The Hospital's senior quality and safety officer shall serve on the Patient Care Assessment Committee.

#### **10.2.2 Patient Care Assessment Coordinator**

The Chairperson of the Governing Body with concurrence of the Medical Executive Committee shall appoint one or more individuals, such as the Vice President of Medical Affairs, to serve as the Hospital's Patient Care Assessment Coordinator. The Patient Care Assessment Coordinator shall serve as the formal administrative link among the separate committees performing patient care assessment functions within the Hospital. The Patient Care Assessment Coordinator shall be responsible for implementing, by delegating, overseeing, facilitating, coordinating or otherwise, the Hospital's Patient Care Assessment Program.

### **10.3 ELEMENTS OF PATIENT CARE ASSESSMENT PROGRAM**

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The Hospital is authorized through its designees to establish such elements of a Patient Care Assessment Program as may be required for the Program to be designated as a qualified Program under applicable law. The structure, policies, procedures, rules, regulations and standards for the Patient Care Assessment Program shall be detailed in the Patient Care Assessment Plan.

### **10.4 MISCELLANEOUS**

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The following provisions shall also be part of the Hospital's Patient Care Assessment Program:

#### **10.4.1 Disciplinary/Corrective Actions**

Whenever, following review by any committee of the Medical Staff, a determination is reached that a Staff Member should be subject to disciplinary action, the committee shall communicate its concern in accordance with Section 4.1.

#### **10.4.2 Reporting of Alleged Substandard Conduct of Licensed Health Care Professionals**

To the extent required by applicable law, any conduct by a licensed health care professional that is alleged to: (a) indicate incompetency in his or her specialty; or (b) be inconsistent with or harmful to good patient care, shall be reported to the Patient Care Assessment Coordinator. Reports pertaining to Medical Staff Members shall be investigated, reviewed and resolved in accordance with the procedures specified in these Medical Staff Bylaws. Reports pertaining to licensed health care professionals who are not members of the Medical Staff shall be investigated, reviewed and resolved in accordance with the Patient Care Assessment Plan as amended from time to time by the Governing Body of the Hospital.

#### **10.4.3 Medical Peer Review Committee Activities**

For purposes of peer review, confidentiality and immunity from liability, the Governing Body, when performing medical peer review functions, and any committee designated or established by the Governing Body under the Hospital's corporate Bylaws as a Patient Care Assessment Committee, shall be a committee of the Medical Staff and a medical peer review committee, and the proceedings, reports and records of such Committee(s) are hereby deemed to be proceedings, reports and records of medical peer review committee(s). To the extent that any individual Patient Care Assessment Coordinator is responsible for, and engaged in, medical peer review activities under the Patient Care Assessment Program, such activities are performed on behalf of a Patient Care Assessment Committee, which is a committee of the Medical Staff and a Medical Peer Review Committee, and activities of the Coordinator are hereby deemed to be activities of a Medical Peer Review Committee. In addition, to the extent that Department Chairpersons, Medical Staff Officers and other individual Medical Staff members are responsible for, and are engaged in, medical peer review activities under these by-laws, such activities are performed on behalf of the Medical Executive Committee, which is a committee of the Medical Staff and a Medical Peer Review Committee, and the activities of such individuals are hereby deemed to be activities of a Medical Peer Review Committee. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings of that process. However, all of the facts obtained for and in the peer review process shall be available to the subject physician. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution, while excluding direct economic competitors, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed, and their activities and their proceedings, reports and records shall be deemed those of a Medical Peer Review Committee.

### **10.5 IMPAIRED PROFESSIONALS**

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#### **10.5.1 Practitioner Health Committee**

The Practitioner Health Committee (PHC) exists to: (i) evaluate and assist in the supervision and rehabilitation of Staff Members who may suffer with physical or mental health problems which affect their professional responsibilities; and (ii) educate Staff Members and Hospital employees regarding the nature of practitioner health issues and the purpose of the PHC. The PHC will function as a medical peer review committee and is separate from the Medical Staff disciplinary functions. The Medical Executive Committee shall describe, or ensure that the Medical Staff Policies describe, the PHC's functions and appoint PHC members. PHC members should not

have responsibilities or duties within the Hospital that discourage self-referral or referral from others to the PHC. The PHC will accept and review referrals concerning any Staff Member. Confidentiality of the Staff Member seeking referral or referred for assistance shall be maintained, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

### **10.5.2 Evaluation and Intervention**

The PHC shall, upon obtaining a self-referral or referral from others, gather information, evaluate the credibility of issues and discuss the issues with the Staff Member in question. The PHC may obtain a consultation and possible referral of the affected Staff Member to appropriate professional internal or external resources, including the Physician Health Services of the Massachusetts Medical Society (Physicians Health Services is available to all physicians regardless of membership in the Society), for evaluation, diagnosis and treatment of the condition or concern. Physician Health Services is available to assist in the education, assessment of issues, and determination of the appropriateness of intervention, treatment and/or monitoring. The affected Staff Member will be monitored and the safety of patients will be assured until the rehabilitation or any disciplinary process is complete. To the extent required by law and consistent with patient safety, reasonable accommodations shall be made for impaired practitioners. The PHC will consider and make recommendations regarding appropriate accommodations for impaired practitioners. Monitoring may take place periodically thereafter, if required. The PHC shall report to the Medical Staff President or Medical Executive Committee any unsafe treatment instances or recommendations that require action.

### **10.5.3 Reports and Records.**

The reports, records, and proceedings of the PHC are confidential with the following exceptions: (i) proceedings conducted by the boards of registration in medicine, social work, and psychology; (ii) documents, incidents, reports or records otherwise available from original sources; (iii) in an action against a committee member for bad faith or unreasonable action, and (iv) testimony where information is known to an individual independently of committee proceedings.

## **10.6 COMPLIANCE WITH REPORTING REQUIREMENTS**

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As part of the Hospital's Patient Care Assessment Program, each Staff Member shall follow procedures adopted by the Hospital to ensure compliance with such Staff Member's obligation to report to the Board of Registration whenever the Staff Member has reason to believe that a Licensee has violated any of the Board of Registration's disciplinary standards, including disciplinary standards pertaining to impaired Licensees. In certain circumstances and in accordance with applicable statutes and regulations, Hospital policies and procedures may permit a Staff Member to refrain from reporting a physician who is in compliance with the requirements of a drug or alcohol program satisfactory to the Board of Registration, or who has successfully concluded such a program subsequent to the actions or circumstances as to which reporting would otherwise be required.

## **ARTICLE 11. MISCELLANEOUS**

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### **11.1 COMPLIANCE WITH LAWS AND REGULATIONS**

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Any act or omission that may be considered inconsistent with the provisions set forth in these Medical Staff Bylaws, but which was undertaken in order to comply with applicable federal or state statutes or regulations, shall not be considered a violation of these Medical Staff Bylaws. In the event these Medical Staff Bylaws are inconsistent with such statutes or regulations, the Medical Executive Committee shall initiate the amendment process set forth in these Bylaws in a timely manner.

### **11.2 GOVERNING LAW; VENUE; WAIVER OF JURY TRIAL**

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The validity, construction, and enforcement of these Bylaws shall be construed and enforced solely in accordance with the laws of the Commonwealth of Massachusetts. The parties agree that jurisdiction and venue for any dispute shall be in Hampden County, Commonwealth of Massachusetts and no party or person may object to personal jurisdiction in, or venue of such courts or assert that such courts are not a convenient forum. Both parties waive trial by jury in any action hereunder.

### **11.3 ELECTRONIC RECORDKEEPING**

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Wherever these Bylaws call for the maintenance of written records, such records may be recorded and/or maintained in electronic format.

### **11.4 HEADINGS**

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The captions or headings used in these Medical Staff Bylaws are for convenience only and are not intended to limit or otherwise define the scope of effects of any provisions of these Medical Staff Bylaws.

### **11.5 IDENTIFICATION**

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Although the masculine gender and the singular are generally used throughout these Bylaws and associated policies for simplicity, words which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

### **11.6 SEVERABILITY**

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In the event that any provision of these Bylaws shall be determined to be invalid, illegal, or unenforceable, the validity and enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

### **11.7 RULES OF ORDER**

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The latest edition of ROBERT'S RULES OF ORDER shall prevail at all Medical Staff, Medical Executive Committee, and other Medical Staff Committee meetings except: (1) the Medical Staff President may vote at Medical Staff meetings; (2) the Medical Staff President may vote at Medical Executive Committee Meetings, (3) the Department Chairperson may vote at Departmental meetings; and (4) in the event that a specific provision of these Bylaws is in conflict with Robert's Rules of Order, the provision contained in these Bylaws shall supersede and control (e.g., specific quorum requirement set forth in these Bylaws).

**ADOPTED BY THE VOTING MEMBERS OF THE MEDICAL STAFF ON June 14, 2012**

\_\_\_\_\_  
(Signature on file)  
President of the Medical Staff Date

\_\_\_\_\_  
(Signature on file)  
Secretary/Treasurer of the Medical Staff Date

APPROVED BY THE BOARD OF TRUSTEES ON JUNE 18, 2012

\_\_\_\_\_  
(Signature on file)  
Chairperson of the Board of Trustees Date

\_\_\_\_\_  
(Signature on file)  
Secretary of the Board of Trustees Date

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**Revision Dates:**

