MEDICAL STAFF BYLAWS

September 24, 2020

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BYLAWS OF THE MEDICAL STAFF OF THE ANNA JAQUES HOSPITAL

PREAMBLE

The Anna Jaques Hospital is a non-profit corporation organized and existing under the laws of the Commonwealth of Massachusetts, whose purpose is to serve as a licensed hospital providing acute patient care. The Medical Staff of the Anna Jaques Hospital is responsible for the quality and appropriateness of the medical and dental care at the Anna Jaques Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Hospital's Governing Body.

These Bylaws are adopted to provide for the organization of the medical staff of Anna Jaques Hospital and to establish a framework for self-governance enabling the medical staff to discharge its responsibilities in overseeing care, treatment and services provided by practitioners with privileges at the hospital. Besides providing the professional and legal structure for medical staff operations, these bylaws govern organized medical staff relations with the Board and with applicants to and members of the medical staff and those holding or seeking delineated clinical privileges. These bylaws are not subject to waiver by contract or otherwise between Anna Jaques Hospital and other parties. These bylaws constitute a contract between the medical staff and the Anna Jaques Hospital, and also a contract between those two entities, each individually, and the individual members of the medical staff and are respectfully, mutually binding, and shall be binding, on any and all successors and interest of the Hospital. The Governing Body and the Medical Staff shall comply with these bylaws, upon their adoption and approval.

These Bylaws shall be subject to the Laws and Statutes of the Commonwealth of Massachusetts and to the Articles of Organization, Corporate Bylaws and Rules and Regulations of the Anna Jaques Hospital. The Executive Committee shall be notified of any proposed or impending changes in the hospital/corporate bylaws, and rules and regulations, so that members of the medical staff and applicants to the medical staff can be informed of the effect of these changes.

All members of the Medical Staff and all practitioners who have privileges at the Anna Jaques Hospital, by virtue of accepting such membership or privileges, shall demonstrate their voluntary intention to practice their profession at the Anna Jaques Hospital in accordance with these Bylaws.

DEFINITIONS

For the purpose of these Bylaws, the following terms shall have the following meanings:

ATTENDING PHYSICIAN: The member of the Medical Staff who is responsible for providing and assuring continuous medical care of the patient and who is responsible for the admission history and physical examination. Any member of the Medical Staff so designated by the attending physician to provide coverage in the absence of the attending physician, shall assume all of the responsibilities and obligations of the attending physician in the provision of patients' health care, as outlined in the medical staff rules and regulations.

CLINICAL PRIVILEGES: Authorization to provide delineated professional health care services, which includes access to hospital resources.

DEPARTMENT: One of the major clinical services of the Hospital organized as a clinical department as described in these Bylaws.

EXECUTIVE COMMITTEE (“MEC”): The Medical Executive Committee.

EX OFFICIO:	By virtue, or because of an office. Unless otherwise stated in these Bylaws, ex officio members of a committee shall not be entitled to vote.
GOVERNING BODY:	The Board of Trustees of the Anna Jaques Hospital.
HEALTH CARE FACILITY:	A hospital, clinic, institution for unwed mothers, nursing home, government hospital, entity operating more than one walk-in center or health maintenance organization.
HEALTH CARE PROVIDER:	Any doctor of medicine, osteopathy, podiatry or dental science, or any allied health professional.
HOSPITAL:	The Anna Jaques Hospital, Newburyport, Massachusetts.
INVESTIGATION:	A process specifically initiated by the Executive Committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual holding clinical privileges, and does not include (a) preliminary peer review, deliberations or inquiries of the Executive Committee to determine whether to initiate an investigation, or (b) activity of the medical staff Physician Health Committee.
PATIENT:	All persons admitted to or treated in any of the departments or divisions of the Hospital, whether inpatients, outpatients, emergency patients or otherwise as well as all other persons receiving health services provided by or on behalf of the Hospital.
PATIENT CARE:	Encompasses the entire field of medical, dental and other professional care, the evaluation and management of health and disease, and the utilization of supporting personnel, services and facilities for these purposes.
PRACTITIONER:	A member of or applicant to the Medical Staff, Associate Clinical Staff or Support Staff who is permitted by law and the Hospital to provide patient care services independently in the Hospital and is accorded specified practice privileges in the Hospital in accordance with these Bylaws.
PRESIDENT:	The President of the Medical Staff.
PROCTORSHIP:	A Department-specific, objective method of monitoring and evaluating a practitioner's clinical judgment and performance.
PROFESSIONAL EDUCATION:	Education of all of the disciplines, at all levels, and in all of the professional and technical fields that contribute to the effectiveness of health care. This is not limited to the education of physicians and dentists.
REGISTERED MAIL:	The term “registered mail” shall include certified mail as an alternative.
SPONSOR:	A member of the active staff who is responsible for the supervision and delineation of privileges of those practitioners whose medical staff membership and privileges are dependent upon such sponsorship.

ARTICLE I - NAME

Section 1 **Name**

The name of this organization shall be "The Medical Staff of the Anna Jaques Hospital."

ARTICLE II - MISSION

Section 1 **Mission**

1.1 The mission of the Medical Staff shall be:

a. To provide quality medical care, based on medical need, without discrimination to all patients treated in any of the Hospital’s facilities;

b. To promote a high level of professional performance from all practitioners privileged to practice in the Hospital, through appropriate delineation of clinical privileges, the continuous review and evaluation of the clinical activities of the Hospital, and through peer review;

c. To provide and maintain such medical education and educational standards to contribute to the continuing medical education of all individuals with clinical privileges;

d. To initiate and maintain Bylaws, Rules and Regulations for the government of the Medical Staff together with a means of accountability to the Governing Body;

e. To provide a means whereby issues concerning the Hospital may be discussed by the Medical Staff with the Governing Body and the President of the Hospital; and

f. To make recommendations to the Governing Body regarding appointment or reappointment to the Medical Staff, Associate Clinical Staff or Support Staff and the granting of initial or renewed clinical privileges.

g. To facilitate and demonstrate professional conduct, as evidenced by personal behaviors which demonstrate compliance with the policies and procedures of the medical staff and the Hospital, quality and safe patient care and treatment, ethical business practices and the recognized professional ethics of the clinical discipline.

ARTICLE III - QUALIFICATIONS FOR STAFF MEMBERSHIP

Section 1 **Medical Staff**

1.1 **Nature of Medical Staff Membership**

a. Membership on the Medical Staff of the Hospital is a privilege extended by written appointment of the Governing Body, in its best judgment and in the best interest of the Hospital and patient care, only to those professionally competent physicians, oral and/or maxillofacial surgeons, or podiatric surgeons who meet and continue to meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations

The Governing Body shall act on appointments, reappointments or revocation of appointments and delineation, restriction or revocation of clinical privileges only upon the recommendation of the Executive Committee and only as provided in these Bylaws.

1.2 **<u>Qualifications for Membership</u>**

Medical Staff membership shall be limited to those physicians, oral and/or maxillofacial surgeons, or podiatric surgeons whose background, experience, training and current qualifications demonstrate their competence to provide a high level of patient care and treatment, and who:

a. Are duly licensed to practice as physicians, oral and/or maxillofacial surgeons, or podiatric surgeons, as the case may be, in the Commonwealth of Massachusetts;

b. Have graduated from a medical school approved by the American Medical Association (AMA) or a School of Osteopathy approved by the American Osteopathic Association (AOA) as the case may be, and have completed an American College of Graduate Medical Education (ACGME) approved post graduate residency or fellowship training program in the specialty in which he/she is applying for privileges, and be in the process of board certification in that specialty (see Article III. 1.3 b. *Board Certification)*;

c. <u>or</u> have graduated from a foreign medical school and have Educational Commission for Foreign Medical Graduates (ECFMG) certification, or completed the requirements for medical education by an AMACME Fifth Pathway program, (prior to June 1, 2009) and have completed a post graduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) as the case may be; and be Board qualified;

d. <u>or</u> have graduated from a Dental School approved by the American Dental Association (ADA) and have completed a fellowship in oral surgery approved by the American Board of Oral and Maxillofacial Surgery (ABOMS);

e. <u>or</u> have graduated from a Podiatric Medical College approved by the American Podiatric Medical Association (APMA) and have completed the residency requirements of the American Board of Foot and Ankle Surgery (ABAFS) or the American Board of Podiatric Medicine (ABPM)

f. <u>or</u> have graduated from an accredited medical school and successfully completed and graduated from a Canadian post graduate residency or fellowship training program in the specialty in which he/she is applying for privileges, accredited by the Royal College of Physicians and Surgeons of Canada (RCPS), the College of Family Physicians of Canada (CFPC);

g. Maintain an office and be available when on call or on-duty in a location in sufficient proximity to the Hospital; and follow the hospital's medical staff on-call policy, to permit the proper exercise of clinical privileges and responsibilities;

h. Maintain professional liability insurance adequate for their specialty as determined from time to time by the Executive Committee with the approval of the Governing Body and in accordance with the regulations of the Board of Registration in Medicine of the Commonwealth of Massachusetts;

i. Shall strictly abide by the Principles of Medical Ethics adopted by the American Medical Association, or by the current Code of the American Osteopathic Association, American Dental Association or American Podiatric Medical Association, as the case may be;

j. Have agreed to abide and shall abide by all applicable standards and requirements set forth in these Bylaws, Rules and Regulations and in any policies duly adopted by the Hospital, including the Code of Conduct Policy, or the Medical Staff pursuant thereto;

k. Shall pay the appointment application fee as recommended by the Executive Committee and approved by the Governing Body;

l. Can document their background, experience, training, demonstrated competence, ability to work cooperatively with others, willingness to participate in Medical Staff affairs and physical and mental health status as required by the Executive Committee, to assure the Medical Staff and the Governing Body that

any given patient treated by them in the Hospital will receive care in conformity with the standards of the community as applicable to their respective professions;

m. Sign a statement agreeing to abide by the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures of the Medical Staff and the Delineation of their Clinical Privileges as granted by the Governing Body; and

n. Are determined on the basis of documented references to adhere strictly to the ethics of their respective professions, to work cooperatively with others as may affect patient care and to be willing to participate in the discharge of medical staff responsibilities and affairs.

1.3 **Board Certification**

a. With the exception of members on the Anna Jaques Hospital Medical Staff as of January 1, 2003, all members must be Board Certified in his/her specialty within 5 years of completing residency or fellowship training in the specialty in which the physician is requesting privileges. Board Certification must be recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Dental Association (ADA) or the Council on Podiatric Medical Education or by the Royal College of Physicians and Surgeons of Canada (RCPS), or the College of Family Physicians of Canada (CFPC).

b. Any member who has not become board certified at the end of the 5-year period referred to in 1.3 (a) will be ineligible for reappointment if on staff or will be ineligible for initial appointment if applying for initial appointment.

c. With the exception of members on the Anna Jaques Hospital Medical Staff as of January 1, 2003, all members shall maintain Board Certification recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Dental Association (ADA), or the Council on Podiatric Medical Education by participating in the specialty Maintenance of Certification Program in order to be eligible for reappointment.

d. Members who have not yet achieved initial board certification are required to provide written documentation as to the reasons for not becoming certified and provide documentation from their specialty board that they are in the active process for certifying. Members may be granted up to a two-year extension to achieve initial board certification with approval of the Department Chief, Medical Executive Committee and the Board of Trustees.

e. Members whose board certification has lapsed, are required to provide written documentation as to the reasons for the lapsed certification and provide documentation from their specialty board that they are in the active process for recertifying. Members may be expected to become re-certified by the next reappointment cycle with approval of the Department Chief, Medical Executive Committee and the Board of Trustees.

f. An exception to the Board Certification requirement can be made, on a case by case basis, with approval of the Department Chief, Medical Executive Committee and Board of Trustees only if privileging is needed to maintain an essential clinical service. The need to maintain the essential clinical service for which the exception was granted is limited to a maximum of a two-year period from the date of their appointment and cannot be renewed.

g. An exception to the Board Certification requirement can be made for telemedicine providers who are credentialed at a Joint Commission or Det Norske Veritas (DNV) accredited distant tertiary care hospital that has also waived the board certification requirement.

Section 2 **Associate Clinical Staff and Support Staff**

2.1 **Nature of Associate Clinical Staff and Support Staff Membership**

a. Membership on the Associate Clinical Staff or Support Staff of the Hospital is a privilege extended by written appointment of the Governing Body, in its best judgment and in the best interest of the Hospital and patient care, only to those professionally competent dentists, clinical psychologists, physician assistants, optometrists, certified nurse anesthetists, certified nurse midwives, certified nurse practitioners, psychiatric nurse mental health specialists, and allied health professionals who meet and continue to meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations.

Clinical privileges may be exercised only by those dentists, clinical psychologists and optometrists, who are permitted by law and who are also permitted by the Hospital to provide patient care services without direction or supervision, as outlined in the Delineation of Clinical Privileges, in accordance with these Bylaws. Physician Assistants, certified nurse anesthetists, certified nurse practitioners, certified nurse midwives, psychiatric nurse mental health specialists, and members of the Support Staff shall work under the supervision of a Sponsor, in which case continuation of Associate Clinical Staff or Support Staff membership and delineation of privileges shall be dependent upon that sponsorship.

2.2 **Qualifications for Associate Clinical Staff and Support Staff Membership**

Membership shall be limited to those practitioners whose background, experience, training and current qualifications demonstrate their competence to provide a high level of patient care and treatment and who:

a. Are duly licensed, if applicable, to practice their professions in the Commonwealth of Massachusetts and have graduated from a dental school approved by the American Dental Association; or have successfully completed a training program approved by their respective national associations and maintain certification based on the standards of their respective certifying agency in clinical psychology, nurse midwifery or nurse midwives, psychiatric nurse mental health specialists, physician assistants, optometrists, certified nurse practitioners or nurse anesthetists, as the case may be;

b. Maintain an office or home located in sufficient proximity to the Hospital to permit the proper exercise of clinical privileges and responsibilities;

c. Maintain professional liability insurance adequate for their specialty as determined from time to time by the Executive Committee with the approval of the Governing Body;

d. Shall strictly abide by the code of ethics established by their respective national associations, as the case may be;

e. Have agreed to abide and shall abide by all applicable standards and requirements set forth in the Bylaws of the Hospital, in these Bylaws, Rules and Regulations and in any policies duly adopted by the Medical Staff pursuant thereto;

f. Shall pay the appointment application fee as recommended by the Executive Committee with the approval of the Governing Body;

g. Can document their background, experience, training, demonstrated competence, ability to work cooperatively with others, willingness to participate in Medical Staff affairs, physical and mental health status upon the request of the Executive Committee, with sufficient adequacy to assure the Medical Staff and the Governing Body that any given patient treated by them in the Hospital will receive care in conformity with the standards of the community as applicable to their respective professions;

h. Sign a statement agreeing to abide by the Medical Staff Bylaws, Rules and Regulations Policies and Procedures of the Medical Staff and the Delineation of their Clinical Privileges as granted by the Governing Body; and

i. Are determined on the basis of documented references to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of medical staff responsibilities and affairs.

Section 3 **Patient History and Physical**

3.1 Members of the Medical Staff shall, in collaboration with the Hospital personnel, comply with the requirements for completing and documenting patient medical histories and physical examinations in accordance with the requirements for the federal Medicare/Medicaid Conditions of Participation and as further specified in the Medical Staff Rules and Regulations. Members of the Medical Staff shall, in collaboration with the Hospital personnel, comply with the requirements for completing and documenting patient medical histories and physical examinations in accordance with the requirements for the federal Medicare/Medicaid Conditions of Participation, and as further specified in the Medical Staff Rules and Regulations.

3.2 A medical history and physical examination shall be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, qualified podiatric surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

3.3 When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changing in the patient's condition must be completed and documented by a physician, an oromaxillofacial surgeon, qualified podiatric surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

3.4 The content of complete and focused history and physical examination is delineated in the hospital's policy on documentation of requirements for a History and Physical report.

Section 4 **Medical Record Suspension Threshold**

If a practitioner is suspended six (6) times within a reappointment cycle for failure to complete medical records, the Chief of the practitioner's Department will review and make a determination regarding whether the matter should be brought before the Medical Executive Committee for potential action, up to and including termination of the practitioner from the Medical Staff. Termination under this section is by operation of the Medical Staff Bylaws and does not constitute a disciplinary action or a professional review action.

ARTICLE IV – CATEGORIES OF STAFF MEMBERSHIP

Section 1 **Medical Staff**

1.1 The Medical Staff shall be divided into the following categories: Active Medical Staff, Courtesy Medical Staff, Affiliate Medical Staff, Senior Active Medical Staff, Honorary Medical Staff, Administrative Medical Staff, Retired Medical Staff and Telemedicine Medical Staff.

a. **Active Medical Staff**

The Active Medical Staff shall consist of physicians, eligible oral and/or maxillofacial surgeons, or podiatric surgeons who have been selected based on their qualifications to admit and/or care for patients in the Anna Jaques Hospital and who assume the functions and responsibilities of membership, as follows:

Eligibility and Responsibilities:

1. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing and risk and utilization management,

medical records completion, monitoring activities and the discharge of other staff functions as may be required;
2. Provide patient care in the inpatient and outpatient units of the hospital;
3. Meet their specific departmental volume performance criteria for proficiency, and maintain all credentialing certificates as deemed appropriate by the department;
4. Contribute to organizational and administrative affairs of the Medical Staff;
5. Accept appropriate referrals;
6. Fulfill any meeting attendance requirements as established by the MEC or by Departments;
7. Fulfill call coverage requirements, regardless of patients' insurance status or ability to pay for services rendered, as applicable in the Medical Staff policies and rules and regulations and hospital policies, at the discretion of the chief of the department or the Medical Executive Committee if there is a conflict;
8. Fulfill or comply with any applicable Medical Staff policies and procedures;
9. Pay their Medical Staff dues;
10. Serve on committees to support the Medical Staff, as requested.

Prerogatives:

1. Exercise such clinical privileges as granted by the Board;
2. Vote on all Medical Staff, Departmental and Committee business;
3. Hold Medical Staff office and be the Chief or Assistant Chief of their applicable Department or the Chairperson of any committee in accordance with any qualifying criteria set forth the Medical Staff Bylaws or Medical Staff Policies and Procedures;
4. Seek a Hearing and Appellate Review, according to Article IX of these bylaws.

b. **Courtesy Medical Staff**

The Courtesy Medical Staff shall consist of physicians, eligible oral and/or maxillofacial surgeons, or podiatric surgeons **whose primary association is at another accredited healthcare facility,** who have been selected based on their qualifications to admit or consult on patients, or who provide limited coverage as part of an organized program, to patients in the Anna Jaques Hospital and who assume the functions and responsibilities of membership, as follows:

Eligibility and Responsibilities:

1. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing and risk and utilization management, medical records completion, monitoring activities and the discharge of other staff functions as may be required;
2. Hold a current appointment at an accredited hospital, the criteria for which appointment are at least substantially equivalent to the criteria for Active Staff membership at this hospital
3. Accept appropriate referrals;
4. Fulfill call coverage requirements, regardless of patients' insurance status or ability to pay for services rendered, as applicable in the Medical Staff policies and rules and regulations and hospital policies, at the discretion of the chief of the department or the Executive Committee if there is a conflict.
5. Meet their specific departmental volume performance criteria for proficiency, and maintain all credentialing certificates as deemed appropriate by the department
6. Fulfill or comply with any applicable Medical Staff policies and procedures;
7. Pay their Medical Staff dues;
8. Serve on committees to support the Medical Staff, as requested

Prerogatives:

1. Exercise such clinical privileges as granted by the Board;
2. Vote on all Medical Staff, Departmental and Committee business;
3. Seek a Hearing and Appellate Review, according to Article IX of these bylaws.

c. **Affiliate Medical Staff – With Clinical Privileges**

The Affiliate Medical Staff shall consist of physicians, eligible oral and/or maxillofacial surgeons, or podiatric surgeons who have been selected based on their qualifications to be members of the Medical Staff. Affiliate Medical Staff members do not have admitting privileges to the hospital. Their patients shall be referred to active staff members for hospitalization and affiliate medical staff members may follow the patient's progress. Affiliate medical staff members will have privileges to communicate with attending physicians, obtain results and review the charts of their private patients, unless otherwise declined by the patient. Members of the affiliate medical staff may not admit patients or write orders or notes on the chart.

Eligibility and Responsibilities:

1. Fulfill call coverage requirements and accept appropriate referrals for outpatient care of unassigned patients seen in the Emergency Department or hospital, regardless of patients' insurance status or ability to pay for services rendered, as determined by the call schedule. Affiliate staff has no emergency room or inpatient call requirements, at the discretion of the chief of the department or the Medical Executive Committee if there is a conflict;
2. Fulfill or comply with any applicable Medical Staff policies and procedures;
3. Pay their Medical Staff dues;
4. Affiliate Medical staff may apply for limited privileges to perform specific outpatient procedures. Providers must meet the specific departmental volume performance criteria for proficiency, and maintain all credentialing certificates as deemed appropriate by the department, to provide specific testing or procedures;
5. Affiliate medical staff may serve on committees and/or serve as Chairs or Vice Chairs of Committees to support the Medical Staff, as requested. Affiliate medical staff may vote on committee business.

Prerogatives:

1. Exercise limited outpatient clinical privileges as granted by the Board;
2. Affiliate medical staff have no voting rights at General Medical Staff meetings but may vote on Committee business;
3. Seek a Hearing and Appellate Review, according to Article XI of these bylaws.

d. Affiliate Medical Staff – With No Clinical Privileges

The Affiliate Medical Staff shall consist of physicians, eligible oral and/or maxillofacial surgeons, or podiatric surgeons who have been selected based on their qualifications to be members of the Medical Staff. Affiliate Medical Staff members do not have admitting privileges to the hospital. Their patients shall be referred to active staff members for hospitalization and affiliate medical staff members may follow the patient's progress. Affiliate medical staff members will have privileges to communicate with attending physicians, obtain results and review the charts of their private patients, unless otherwise declined by the patient. Members of the affiliate medical staff may not admit patients or write orders or notes on the chart.

Eligibility and Responsibilities:

1. Fulfill call coverage requirements and accept appropriate referrals for outpatient care of unassigned patients seen in the Emergency Department or hospital, regardless of patients' insurance status or ability to pay for services rendered, as determined by the call schedule. Affiliate staff has no emergency room or inpatient call requirements, at the discretion of the chief of the department or the Medical Executive Committee if there is a conflict;
2. Fulfill or comply with any applicable Medical Staff policies and procedures;
3. Pay their Medical Staff dues;
4. Affiliate Medical staff may apply for limited privileges to perform specific outpatient procedures. Providers must meet the specific departmental volume performance criteria for proficiency, and

maintain all credentialing certificates as deemed appropriate by the department, to provide specific testing or procedures;

5. Affiliate medical staff may serve on committees and/or serve as Chairs or Vice Chairs of Committees to support the Medical Staff, as requested. Affiliate medical staff may vote on committee business.

Prerogatives:

1. Affiliate medical staff have no voting rights at General Medical Staff meetings but may vote on Committee business;
2. Seek a Hearing and Appellate Review, according to Article XI of these bylaws.

d. **Telemedicine Medical Staff**

Telemedicine Medical Staff shall consist of physicians, oral and/or maxillofacial surgeons or podiatric surgeons, currently licensed to practice in the State, who meet the basic qualifications for Medical Staff membership, and whose primary activity involves the care and consultative services of patients from a distant site (via telemedicine). Members of the Telemedicine Medical Staff do not have privileges to admit patients to the Hospital. They shall be assigned to specific Departments and are not required to attend Department and Medical Staff meetings and shall not have voting privileges. Members of the Telemedicine Medical Staff shall not be required to serve on Medical Staff Committees but may elect to do so if appointed. Each member of the Telemedicine Medical Staff shall pay dues as assessed. Members of the Telemedicine Medical Staff may be required to participate in on-call Departmental rotation.

e. **Senior Medical Staff**

All Medical Staff members (with the exception of Telemedicine & Administrative Medical Staff) shall be eligible for appointment as Senior Medical Staff members upon either of the following conditions: (A) At least sixty (60) years old and having served on the Medical Staff of the Anna Jaques Hospital for at least twenty-five (25) years or (B) At least sixty-five (65) years old and having served on the Medical Staff of the Anna Jaques Hospital for at least fifteen (15) years.

An eligible member may request such appointment by written notice to the Chief of his/her Department. Such appointment shall require a recommendation of the Department and approval of the Medical Executive Committee and approval by the Governing Body, which shall only be withheld due to issues regarding the member's professional qualifications.

Senior Medical Staff will maintain all of the rights, privileges and responsibilities of their current staff category: Active, Courtesy or Affiliate Medical Staff. He/she shall be excused from committee and on-call responsibilities for unassigned emergency department patients and inpatients. He/she is still responsible for providing 24/7 coverage for his/her own patients.
Departments will be responsible for defining call coverage requirements for their individual departments.

Transfer to the Senior Medical Staff shall not per se result in any change in admitting or clinical privileges. Although their attendance at the regularly scheduled Departmental and Medical Staff meetings is not obligatory, it is encouraged. Senior Medical Staff Physicians shall pay Medical Staff dues as assessed.

f. **Honorary Medical Staff**

Appointments to the Honorary Medical Staff shall be acknowledgments of honor and respect which the governing Body may accord to former members of the Active Medical Staff or physicians of outstanding reputation not necessarily residing in the community. Honorary Medical Staff members are not eligible to vote, hold office or admit patients. Honorary Medical Staff members are not required to attend Staff meetings or pay Staff dues. Recommendation for appointment to the Honorary Medical Staff will originate in the appropriate Department, or from a recommendation from the President or Vice President of the

Medical Staff and should then be submitted to the Executive Committee for their recommendation and then submitted to the Governing Body for approval.

g. **Administrative Medical Staff**

Administrative Staff category consists of any Chief Medical Officer or any physician, oromaxillofacial surgeon or podiatric surgeon who is retained by the hospital exclusively to perform administrative functions, who are not members of other medical staff categories. Administrative staff members shall maintain the medical staff membership qualifications set forth in these bylaws. Administrative staff members shall not have clinical privileges but shall meet the requirements of their positions; failure to do so may result in an action against membership consistent with these Bylaws. Each member of the Administrative Medical Staff shall not have voting rights on Medical Staff Committees except where specifically included in these Medical Staff Bylaws. Each member of the Administrative Medical Staff shall pay Medical Staff dues as assessed.

h. Retired Medical Staff

Appointments to the Retired Medical Staff shall be acknowledgements of honor and respect which the governing body may accord to former members of the medical staff. Medical staff members may request from the Medical Staff President a change in staff status to Retired Medical Staff after having been a member of the Anna Jaques Hospital medical Staff for over 10 years and who no longer maintain privileges at Anna Jaques Hospital or any other healthcare facility. Retired Medical Staff members are not eligible to vote, hold office or admit patients. Retired Medical Staff members may not attend staff meetings and do not pay dues, but are welcome to attend Continuing Medical Education programs and have access to the physician lounge.

Section 2 Associate Clinical Staff

2.1 The Associate Clinical Staff are those members of the Allied Health Professions who are licensed or registered by the Commonwealth of Massachusetts as required including, but not limited to, dentists not eligible for Medical Staff membership and clinical psychologists and optometrists, who are permitted by law to provide patient care services without direction or supervision; and Certified Nurse Anesthetists, Certified Nurse Practitioners, Certified Nurse Midwives, Psychiatric Nurse Mental Health Specialists and Physician Assistants who shall work under the supervision of a member of the Active Medical Staff (Sponsor/supervising physician), in which case continuation of Staff membership and delineation of privileges shall be dependent upon that sponsorship.

2.2 Clinical oversight of the activities of these professionals and review thereof shall either be the responsibility of the Medical Staff member by whom they are employed or the Chief of the relevant Department to which they are assigned. All members of the Associate Clinical Staff shall be subject to these Bylaws, Rules and Regulations and shall be responsible to the Governing Body. Although their attendance at the regularly scheduled Medical Staff meetings is not obligatory, it is encouraged. They may be requested to serve on Medical Staff or Departmental Committees. They shall not be entitled to vote or hold office. They shall pay Medical Staff dues as assessed. Appointment and reappointment procedures and delineation of clinical privileges shall be in accordance with these Bylaws.

Section 3 Support Staff

Allied Health Professionals including, but not limited to: acupuncturists, licensed massage therapists, speech pathologists, licensed social workers, occupational therapists, and others who are permitted by law and who may be permitted by the Hospital to provide patient care services in the Hospital, who are licensed or registered by the Commonwealth of Massachusetts as required and who meet the basic qualification for privileges may be accorded specified practice privileges in the Hospital limited to their areas of competence. These professionals shall work under the supervision of a member of the Active Medical Staff (Sponsor/supervising physician), in which case continuation of Staff membership and delineation of privileges shall be dependent upon that sponsorship. These professionals shall not be eligible for

membership on the Medical Staff or Associate Clinical Staff. They shall pay Medical Staff dues as assessed. Activities of these professionals and review thereof shall either be the sole responsibility of the Medical Staff member by whom they are employed or the Chief of the relevant Department to which they are assigned. They shall be subject to the Medical Staff Bylaws, Rules and Regulations and shall be responsible to the Governing Body. Appointment and reappointment procedures and delineation of clinical privileges shall be in accordance with these Bylaws.

Section 4 Residents and Fellows

Residents or fellows in training in the Hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges, unless outside of the scope of their residency or fellowship the resident or fellow meets applicable eligibility criteria for membership and privileges pursuant to Article III, Section 1.2 and 1.3: Article IV, Section 1; and Article VI of the Medical Staff Bylaws. Rather, residents and fellows in training shall be permitted to function clinically in the hospital only in accordance with the written training protocols developed by the sponsor institution and approved by the department and Medical Executive Committee. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independent in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The sponsor institution of the training program must communicate periodically with the Medical Executive Committee and the Board of Trustees about the performance of its residents, patient safety issues, and quality of patient care and must work with the Medical Executive Committee to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

The hearing and appeals procedures under Article IX of these Bylaws shall not apply to post-doctoral trainees.

ARTICLE V - PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1 **Application for Appointment**

1.1 The Application

a. All applications for appointment to the Medical Staff, Associate Clinical Staff or Support Staff shall be in writing on the form prescribed by the Governing Body after recommendation by the Executive Committee and shall be signed by the applicant.

b. The medical staff will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, sexual orientation, religion, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

c. The applicant is responsible for completion of the application in its entirety.

d. A check or money order covering the non-refundable application fee must accompany this application.

e. Appointment of Certified Nurse Anesthetists, Certified Nurse Midwives, Certified Nurse Practitioners, Psychiatric Nurse Mental Health Specialists Physician Assistants and Support Staff applicants is dependent upon sponsorship by a member of the Active Medical Staff.

1.2 Criteria for Appointment

Initial appointment to the Medical Staff shall be contingent upon the Hospital's ability to provide adequate facilities and supportive services for the applicant and his/her patients, the patient care needs for additional staff members with the applicant's skill and training, the applicant's ability to demonstrate skills in areas of identified need, and to satisfy such additional criteria based on prior specialized training, experience or professional competence as may be recommended by the Executive Committee and approved by the Governing Body with respect to the Medical Staff Department to which the applicant seeks appointment.

1.3 Processing the Application

a. The application will be processed in accordance with these Bylaws and relevant policies and procedures of the Medical Staff.

b. When the application is returned, completeness of the application and supporting documentation is confirmed by the Medical Staff Services Department. It is the applicant's responsibility to obtain all requested information.

c. Written and/or verbal primary source verification of the application information and supporting material review will be performed where required by regulatory authorities, and shall be obtained and documented in the applicant's file by the Medical Staff Services Department pursuant to these Bylaws and Medical Staff policy, unless waived by the Governing Body upon recommendation of the Executive Committee.

d. Information may be obtained from on-line sources via the Internet and must be obtained from the National Practitioner Data Bank and the Office of Inspector General.

e. The processes for credentialing and privileging incorporate the requirements of the Joint Commission for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation, and reflect the six areas of General Competencies which inform those requirements: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice.

f. The completed application for Medical Staff appointment and/or clinical privileges will be acted on through the medical staff processes within 90 days of completion of the application. An application is considered complete when:

- All elements required in the bylaws, rules and regulations, and requirements for credentialing and privileging procedures are completed and received
- Adequate clinical performance information is received in order to make an informed decision
- Medical Staff Services Department receives and verifies any additional information requested by the Medical staff

g. The completed application shall be reviewed by the Chief of the appropriate Departments considering the needs of the Departments, the effects upon the Hospital, and the qualifications of the applicant, in accordance with the Bylaws of the Medical Staff.

The Chief of the Department/designee reviews the complete application and gives a recommendation to the Credentials Committee.

h. The Credentials Committee shall review the application and the recommendation of the Department Chief at the next scheduled meeting. The Committee's recommendation shall be forwarded to the Medical

Executive Committee.

i. The Medical Executive Committee, at its next regularly scheduled meeting, after receiving the recommendation from the Credentials Committee shall act on the application, in accordance with the Bylaws of the Medical Staff. The recommendation for acceptance or rejection of the application shall be forwarded promptly to the Governing Body.

j. The Governing Body, at its next regularly scheduled meeting, shall make a decision to either accept or reject the application in accordance with the Bylaws of the Medical Staff. In the event the decision is contrary to the decision of the Medical Executive Committee, the matter shall be referred to the Joint Conference Committee for further review and recommendation prior to a final decision being made by the Governing Body.

k. An interview of all Medical Staff applicants may be required by the Chief Medical Officer or designee.

l. The applicant will be notified of the Governing Body's decision of appointment and/or to grant, deny, revise or revoke any or all clinical privileges within three weeks of its decision.

m. Interim appointment and/or privileges may be granted pursuant to Article VI, Section 8 of these Bylaws and in accordance with the relevant policies and procedures of the Medical Staff, consistent with the hearing and appellate review processes set forth in Article VIII of these Bylaws.

1.4 Initial Appointment

a. All initial appointments to the Medical Staff, Associate Clinical Staff or Support Staff shall be made by the Governing Body after consideration of the Executive Committee's recommendation.

b. Professional Practice Evaluation of Medical Staff Members

In order to provide a means for the hospital to carefully monitor and evaluate each medical staff member's professional practice, while giving the practitioner an adequate opportunity to demonstrate his/her competence, appropriate policies, procedures and/or protocols will be developed subject to review and approval by the Executive Committee and the Governing Body, to establish the method by which the professional activities of the appointee shall be monitored and evaluated.

A period of focused professional practice monitoring will be instituted for all requests for initial privileges for at least the first three months of appointment. Once the focused monitoring period is completed, ongoing monitoring will occur for all medical staff members based on privileges requested and the specialty of the provider. Upon reaching the age of 75, the OPPE process will include a chart review as determined by the Chief or Assistant Chief and ongoing chart reviews will continue at least once every two years.

1.5 Denial of Appointment

Whenever the Governing Body shall reject an applicant, the applicant shall be entitled, if so requested, to receive an explanation of the basis for such action and to appeal such action in accordance with these Bylaws. The applicant shall be notified of this by the President of the Hospital.

Section 2 **Application for Reappointment**

2.1 Term of Reappointment

Members of the Medical Staff, Associate Clinical Staff and Support Staff shall be subject to reappointment every two years. In order to facilitate processing, renewal of appointment and clinical privileges will occur on a birthday month cycle.

New appointees may be subject to reappointment and renewal of clinical privileges prior to the two-year period depending on when their first birthday falls after initial appointment.

Members of the Medical Staff shall be subject to reappointment as outlined above.

2.2 The Application

a. All members of the Medical Staff, Associate Clinical Staff and Support Staff scheduled for reappointment and redelineation of privileges, shall receive an application form for reappointment, and a request for an updated CV, Primary Source Verification (PSV) of current Massachusetts licensure, most recent Massachusetts medical license application (physicians only), drug enforcement registrations, professional liability insurance front sheet, and a description of all malpractice claims brought against him/her that have been settled out of court, have resulted in a judgment against the applicant, or are pending at least one hundred twenty (120) days prior to the termination of his/her appointment/privileges.

b. The application will be processed as provided for in these Medical Staff Bylaws and in accordance with the relevant policies and procedures of the Medical Staff, consistent with the hearing and appellate review processes set forth in Article VIII of these Bylaws.

c. The completed application shall be reviewed and acted on through the medical staff processes within 90 days of completion of the application. The applicant will be notified of the Governing Body's decision within three (3) weeks of its decision.

d. Reappointment of Certified Nurse Anesthetists, Certified Nurse Midwives, Certified Nurse Practitioners, Psychiatric Nurse Mental Health Specialists, Physician Assistants and members of the Support Staff is dependent upon sponsorship by a member of the Active Medical Staff. A statement of responsibility by the sponsor must accompany this application. A common redelineation of privileges application form shall be sent to all applicants regardless of type of appointment sought, in accordance with Article VI of these Bylaws; however, when applicable, a detailed job description can be used in lieu of this form by Support Staff applicants.

2.3 Processing the Application

a. The Application for Reappointment will be processed in accordance with these Bylaws and relevant policies and procedures of the Medical Staff.

b. When the application is returned, completeness of the application and supporting documentation is confirmed by the Medical Staff Services Department. It is the applicant's responsibility to obtain all requested information.

c. Written and/or verbal primary source verification of the application information and supporting material review will be performed where required by regulatory authorities and shall be obtained and documented in the applicant's file by the Medical Staff Services Department pursuant to these Bylaws and Medical Staff policy, unless waived by the Governing Body upon recommendation of the Executive Committee.

d. Information may be obtained from on-line sources via the Internet and must be obtained from the National Practitioner Data Bank and the Office of Inspector General.

e. The Hospital shall make reasonable inquiry of every healthcare facility in which the applicant has had employment, practice, association for the purpose of providing patient care, or privileges during the previous three (3) years in accordance with the regulations of the Board of Registration in Medicine of the Commonwealth of Massachusetts.

f. The completed application for reappointment and copy of the Physician Activity Profile shall be reviewed by the Chief of the practitioner's Department prior to Credentials Committee review.

g. In making recommendations, the Chief shall consider and evaluate each practitioner's:

1. Medical/Clinical knowledge, professional and clinical competence, clinical skills and judgment; patient care, practice-based learning and improvement, and communication and interpersonal skills;
2. Physical and mental health status;
3. Discharge of Medical Staff obligations;
4. Participation and cooperation with the Administration in the affairs of the Hospital;
5. Results of quality management/risk management activities;
6. Continuing medical education;
7. Peer and/or Department recommendations;
8. Other reasonable indicators.
9. Surgical case review;

The following may be considered and evaluated by the Chief:

1. Utilization procedures;
2. Drug usage review;
3. Transfusion review

h. Peer protected reports will be kept in a separate folder in the Medical Staff Services Department. At the time of reappointment, this information, within a separate folder, will be included in the physician's credentials file for the Chief of the Department and the Credentials Committee to review. The peer-protected reports include, but are not limited to, the following:

1. Chart reviews
2. Disruptive conduct reports

i. If the applicant has had a low number of encounters at Anna Jaques Hospital (as determined by the Credentials Committee), a Low Volume Practitioner Evaluation Form will be sent to the applicant to obtain information from the applicant's primary hospital affiliation on the applicant's clinical competence, personal responsibility and conduct, administrative responsibility, health status and recommendations.

j. The completed reappointment application shall be reviewed by all other Department Chief(s) where subspecialty privilege additions or extensions are requested.

k. The reappointment application of the Chief will be evaluated by the Assistant Chief and will be processed in a similar manner.

l. The completed reappointment application together with the practitioner's credentials file shall be forwarded to the Credentials Committee at least sixty (60) days prior to the termination of the current appointment and/or privileges.

m. The Credentials Committee shall act on the application at its next regularly scheduled meeting and shall forward its recommendation for continuation, promotion, termination, expansion or reduction in Medical Staff category or privileges with reasons therefore, to the Executive Committee.

n. The Executive Committee, at its next regularly scheduled meeting, after receiving the recommendation from the Credentials Committee shall act on the reappointment application.

o. In the event that the decision of the Executive Committee is for deferment, it shall act on the application again at its next regularly scheduled meeting.

p. The Executive Committee's recommendation for continuation, promotion, termination, expansion or reduction in Medical Staff category or privileges with reasons therefore, shall be forwarded promptly to the Governing Body.

q. The Governing Body, at its next regularly scheduled meeting, shall act upon all recommendations. In the event the decision is contrary to that of the Executive Committee, the matter shall be referred to the Joint Conference Committee for further review and recommendations, prior to a final decision being made by the Governing Body.

r. The President of the Hospital shall notify the practitioner of the decision of the Governing Body within three (3) weeks of its decision.

s. All reappointments to the Medical Staff, Associate Clinical Staff or Support Staff or redelineation of privileges shall be made by the Governing Body after consideration of the Executive Committee recommendations and shall be for a maximum of two years. Every such reappointment or redelineation of privileges shall confer on the practitioner only such privileges as shall be specified on the approved application for reappointment and approved redelineation of privileges forms or approved Job Descriptions.

t. Practitioners in administrative positions who are seeking reappointment to the Medical Staff, Associate Clinical Staff or Support Staff are reappointed through the same procedure used for all other practitioners.

u. Practitioners reapplying for administratively responsible Hospital positions on a contractual basis are reappointed through the same procedures used for all other practitioners. All contracted practitioners in the Departments of Radiology, Pathology, Anesthesiology or Emergency Medicine shall be notified by the President of the Hospital or his or her designee that eligibility for continued reappointment is contingent upon continuance of the contractual agreement. Reappointment to other departments shall not be contingent upon a contractual agreement.

Interim reappointment and/or privileges may be granted pursuant to Article VI, Section 8 of these Bylaws and in accordance with the relevant policies and procedures of the Medical Staff, consistent with the hearing and appellate review processes set forth in Article VIII of these Bylaws.

2.4 Denial of Reappointment and/or Denial or Reduction of Privileges

Whenever the decision of the Governing Body is for reduction of Medical Staff category or privileges or for the termination of appointment, the practitioner shall be entitled, if so requested, to receive an explanation of the basis for such action and to appeal such action in accordance with these Bylaws. The practitioner shall be notified of this by the President of the Hospital.

Notification of the Board of Registration in Medicine of such denial(s) shall be in accordance with these Bylaws and the laws and regulations applicable to the Board.

Section 3 **Leave of Absence**

3.1 Members of the Medical Staff, Associate Clinical Staff or Support Staff requesting a leave of absence in excess of ninety (90) days, shall obtain the prior approval of the Chief of the appropriate Department, President of the Hospital, Executive Committee and the Governing Body. In instances where the Leave of Absence was granted for a health issue, the practitioner must provide appropriate documentation prior to returning from the Leave that such health issue does not and will not interfere with his/her ability to provide patient care and participate in requisite activities of staff membership. Every member of the Medical Staff, Associate Clinical Staff or Support Staff, upon returning from a leave of absence of less than ninety (90) days, to serve the unexpired portion of the term of appointment, shall be entitled to resume clinical privileges for the unexpired portion of the term. If the leave of absence was

in excess of ninety (90) days, the practitioner must obtain the approval of the Executive Committee and the Governing Body prior to resuming clinical privileges for the unexpired portion of the term. The practitioner is entitled to the rights afforded in these Bylaws.

3.2 If a practitioner's privileges would lapse during a Leave of Absence, there are three (3) mechanisms the Medical Staff can use to address this situation. These should be implemented only to handle a planned leave of absence and not as an alternative method to handle situations where a reappointment within two-years does not occur because an applicant fails to submit an application in time or there is a delay approving the application.

3.2.1 The Medical Staff can reappoint a practitioner prior to the start of the leave of absence, at the request of the practitioner, even if the two (2) year reappointment date is months away (therefore preventing a lapse from occurring).

3.2.2 The Medical Staff can allow the appointment or privileges to lapse. Upon the practitioner's return, the Medical Staff can implement the process to grant temporary privileges for up to 120 days. Temporary privileges can be granted based on the verified credentials information in the practitioner's existing file, along with an updated query of the National Practitioner Data Bank and verification of current licensure with the ability to perform the granted privileges. Before those temporary privileges expire, the Medical Staff should fully re-credential and reappoint the practitioner with the expectation that all the information from the previous two years of activity be the basis of the decisions.

3.2.3 Based on appropriate circumstances determined by the Medical Staff, a practitioner can be reappointed during a leave of absence based on information gathered to date, on the condition that the practitioner submits evidence of his ability to perform the privileges granted upon his or her return.

3.3 Under all circumstances, the practitioner's current competence and ability to perform the requested privileges must be verified. Additionally, the practitioner should provide a summary of professional activities undertaken during the leave of absence and any additional information requested by the hospital. Verification of this information should be consistent with the Medical Staff's credentialing and privileging policies and procedures.

Section 4 **Resignation**

4.1 Any member of the Medical Staff, Associate Clinical Staff or Support Staff may at any time resign from the Medical Staff, Associate Clinical Staff or Support Staff or relinquish the clinical privileges by submitting a written resignation or request to the Chief of the applicable Department. This shall then be forwarded by the Chief to the Chief Medical Officer for presentation to the Credentials Committee, Executive Committee and the Governing Body.

Section 5 **Verification**

5.1 The credentials of the Medical Staff will be verified according to regulatory authority standards, and shall include a query of other facilities, and appropriate licensing and disciplinary authorities, including review of any adverse actions taken against the individual that might impair his/her or her performance of duties or other responsibilities on behalf of Anna Jaques Hospital. The verification process shall also include a reasonable effort to check against the List of Excluded Individuals/Entities of the Office of the Inspector General of the United States Department of

Health and Human Services, and the National Practitioner Data Bank.

ARTICLE VI - PROCEDURE FOR OBTAINING CLINICAL PRIVILEGES

Section 1 **Clinical Privileges**

Clinical privileges are granted exclusively on the basis of the clinician's qualifications and experience in the areas requested and shall be contingent upon the Hospital's ability to provide adequate facilities and supportive services. Every practitioner practicing at the Hospital by virtue of his/her Medical Staff, Associate Clinical Staff or Support Staff membership shall be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body. These privileges must be within the scope of the license, certificate or other legal credential authorizing the practitioner to practice in the Commonwealth of Massachusetts and consistent with any other restrictions thereon.

Section 2 **Granting of Privileges**

2.1 Application for Delineation of Privileges

Every applicant for appointment or reappointment to the Medical Staff, Associate Clinical Staff or Support Staff must complete the appropriate application for clinical privileges or submit an appropriate job description as described in these Bylaws.

2.2 Processing the Application for Privileges

a. The evaluation of such requests shall be based upon the applicant's education, training experience, demonstrated competence and judgment, professional recommendations and written credentials and other relevant information, including but not limited to information provided by the National Practitioner Data Bank.

   The application will be processed as provided for in these Medical Staff Bylaws and in accordance with the relevant Policies and Procedures of the Medical Staff, consistent with the hearing and appellate review processes set forth in Article VII of these Bylaws.

b. The completed application shall be reviewed and acted on through the medical staff processes within 90 days of completion of the application.

c. The completed application shall be reviewed by the Chief of the appropriate Departments considering the needs of the Departments, the effects upon the Hospital, and the qualifications of the applicant, in accordance with the Bylaws of the Medical Staff.

   The Chief of the Department/designee reviews the complete application and gives a recommendation to Credentials Committee.

d. The Credentials Committee shall review the application and the recommendation of the Department Chief at the next regularly scheduled meeting. The Committee's recommendation shall be forwarded to the Medical Executive Committee.

e. The Medical Executive Committee, at its next regularly scheduled meeting, after receiving the recommendation from the Credentials Committee shall act on the application, in accordance with the Bylaws of the Medical Staff. The recommendation for acceptance or rejection of the application shall be forwarded promptly to the Governing Body.

f. The Governing Body, at its next regularly scheduled meeting, shall make a decision to either accept or reject the application in accordance with the Bylaws of the Medical Staff. In the event the decision is contrary to the decision of the Medical Executive Committee, the matter shall be referred to the Joint Conference Committee for further review and recommendation prior to a final decision being made by the Governing Body.

g. All individuals in the Departments of Radiology, Pathology, Anesthesiology or Emergency Medicine shall be notified by the President of the Hospital or his or her designee that those privileges are contingent upon the continuance of the contractual agreement.

h. The clinical privileges of certified nurse anesthetists, certified nurse practitioners, certified nurse midwives, psychiatric nurse mental health specialists, physician assistants and members of the Support Staff are dependent upon sponsorship by a member of the Active Medical Staff.

i. The applicant shall in all instances have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

j. The applicant will be notified of the Governing Body's decision of appointment and/or to grant, deny, revise or revoke any or all clinical privileges within three weeks of its decision.

2.3 Additional Clinical Privileges

Additional clinical privileges will be recommended by the Executive Committee based on the demonstrated ability of the practitioner and the recommendations of the Chief of his/her Department. The evaluation by the Chief of the Department shall among other things include the direct observation of patient care provided and review of the medical records of patients treated. Every practitioner practicing in the Hospital shall exercise only those clinical privileges specifically granted to him by the Governing Body upon recommendation of the Credentials Committee, the Executive Committee and the Hospital's ability to provide the practitioner with adequate facilities and support services in connection with the exercise of clinical privileges.

Section 3 **Temporary Privileges**

3.1 Temporary privileges may be granted to an applicant who has completed the appropriate application and who meets the eligibility criteria only in two (2) circumstances: 1) when there is an important patient care need that mandates immediate authorization to provide care for a limited period of time, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Trustees

3.2 When there is an important patient care need that mandates immediate authorization to provide care for a limited period of time, temporary privileges may be granted up to 60 days by the CEO or his or her designee, upon recommendation of the president of the medical staff, or his or her designee. Current licensure and current competence must be verified prior to the granting of temporary privileges and the hospital always queries the National Practitioner Data Bank about the applicant prior to granting such temporary privileges.

3.3 When an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Trustees, temporary privileges may be granted by the President/CEO of the hospital or authorized designee only after there has been a favorable recommendation for the clinical privileges from the Chief of the applicable department or authorized designee, the Chair of Credentials Committee or authorized designee, if available, and the President of the Medical Staff or authorized designee. In order for an initial applicant to be eligible for Temporary Privileges the applicant must have

1. Primary source verification of current licensure; education training and experience, current competence; current DEA (if applicable); current professional liability insurance in the amount required;
2. No current or previously successful challenges to licensure or registration.

3. No involuntary termination of Medical Staff membership at another organization.
4. No involuntary limitation, reduction, denial or loss of clinical privileges
5. No pending or past restrictions, investigations, or disciplinary actions from any hospital or licensing agency;
6. No unusual pattern of, or excessive number of, professional liability actions resulting in a final judgment against the applicant;
7. No member of the hospital Medical Staff has raised a concern about the applicant's qualifications.
8. No health concerns regarding the privileges requested.
9. A query and evaluation of the National Practitioner Data Bank (NPDB) information
10. Already provided sufficient information to the hospital as part of the initial application for staff membership so that the hospital may maintain a file with written and timely evidence of valid Massachusetts license, malpractice insurance, a current DEA certificate of registration and appropriate references.
11. Verification of current competence and ability to perform the privileges requested.

3.3 Requests for temporary privileges will be granted in accordance with the processes outlined in the Medical Staff Temporary Privileges Policy and these Bylaws.

3.4 Prior to being granted temporary privileges, the applicant must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the hospital.

3.5 Temporary privileges shall not exceed 60 days in any one-year period, as determined by the Chief of the applicable Department, or authorized designee, President of the Medical Staff, or authorized designee and/or the President/CEO of the hospital or authorized designee.

3.6 During the period an initial applicant for Medical Staff membership is granted temporary privileges the Medical Staff and the hospital shall pursue in good faith the completion of the credentialing process for the applicant holding such temporary privileges.

Section 4 **Limited Privileges**

On occasion, physicians who demonstrate recognized professional ability may be asked to give assistance or consultation in matters concerning patient care on a one-case or one-day basis not to exceed thirty (30) days in any one-year period.

The procedural rights afforded in these Bylaws shall not be applicable to the denial of limited privileges or the termination or suspension of all or any portion of such privileges.

The application will be processed in accordance with the relevant Policies and Procedures of the Medical Staff.

Section 5 **Emergency Privileges**

In the case of an emergency, any member of the Medical Staff who has been granted delineated clinical privileges, regardless of the nature of those clinical privileges, shall be permitted to do everything possible within the limitations of his/her license to save the life of an individual, using every facility of the Hospital necessary for that intent. Any member of the Associate Clinical Staff or Support Staff who desires such privileges should specifically request such privileges in accordance with these Bylaws. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm would result to an individual or in which the life of an individual is in immediate danger and any delay in administering treatment would add to that danger.

Section 6 **Educational Privileges**

6.1 The President of the Hospital, after conferring with the President of the Medical Staff and the Chief of the applicable Department, may grant specified Educational Privileges to any physician or other professional

requesting or providing specialized training. In exercising such privileges, the practitioner shall be under the direct supervision of the Chief of the applicable Department or the member of the Active Medical Staff responsible for the educational program.

6.2 The application for Educational Privileges will be processed in accordance with the relevant Policies and Procedures of the Medical Staff.

Section 7 **Disaster Emergency Privileges**

Disaster privileges may be granted on a case-by-case basis to a volunteer practitioner by the hospital President/CEO or designee, the Chief Medical Officer or designee or the President of the Medical Staff or designee when the hospital's emergency management plan has been activated and the hospital is unable to handle immediate patient care needs.

Before granting disaster privileges, the volunteer practitioner must present a valid government-issued photo identification issued by a state or federal agency and one of the following forms of identification:

1. Current picture hospital ID card that clearly identifies professional designation, or;
2. Primary Source Verification (PSV) of medical /professional license by the Medical Staff Office, or;
3. Identification indicating that the volunteer practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances or is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group, or;

In the absence of one of the three forms of identification noted above, a current hospital employee or Medical Staff member with personal knowledge of the practitioner may attest to the identity of the volunteer practitioner.

The Medical Staff Services Department will attempt to verify medical/professional licensure upon request for disaster privileges. Should this not be possible, verification will occur as soon as possible after the immediate situation is under control and except in extraordinary circumstances, will be completed within 72 hours from the time when the volunteer practitioner presents to the organization.

If possible, the Medical Staff Services Department shall continue to verify the following as the volunteer practitioner attends to the disaster situation:

1. Volunteer practitioner's malpractice coverage
2. Current hospital affiliations
3. National Practitioner Data Bank (NPDB) disclosure report
4. Office of Inspector General (OIG) sanctions list
5. UPIN number status
6. State and Federal DEA numbers
7. Board Certification status

The patient care, treatment, and services provided by volunteer practitioner will be monitored and overseen by the Chief Medical Officer and/or the Chief of the Department in which he/she serves.

If after the granting of privileges, the volunteer practitioner does not have a recognized state or federal disaster organization identification badge a temporary hospital identification badge will be issued to the practitioner.

The time the privileges were granted will be documented, and the hospital President/CEO or designee will make a decision within 72 hours regarding whether to continue the privileges. This decision will be based upon information regarding the volunteer practitioner's professional practice.

Disaster privileges shall automatically terminate once the state of emergency no longer exists or when the volunteer practitioner's services are no longer required, as determined by the hospital President/CEO or designee. Disaster privileges may be revoked at any time. The termination of disaster privileges shall be final, and the medical staff's hearing and appellate review procedures shall not apply.

Section 8 **Denial or Reduction of Privileges**

Whenever the decision of the Governing Body is for denial or reduction of privileges, the practitioner shall be entitled, if so requested, to appeal such action in accordance with these Bylaws. The practitioner shall be notified of this by the President of the Hospital.

ARTICLE VII - PRACTITIONER RIGHTS

Section 1

1.1 Each physician on the Medical Staff has the right to a meeting with the Executive Committee.

1.2 In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair that physician may, upon presentation of written request, be granted a meeting with the Executive Committee.

1.3 Any Medical Staff member may raise a challenge to any rule or policy established by the Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition signed by three (3) of the members of the Active Staff. When such a petition has been received by the Executive Committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

1.4 Any practitioner may call for a general staff meeting. Upon presentation of a petition signed by five (5) of the members of the Active Staff, the Executive Committee will schedule a meeting within thirty (30) days for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

1.5 Any practitioner has the right to initiate a recall election of a Medical Staff Officer and/or department chief. A petition for the recall of a medical staff officer must be presented, signed by at least five (5) members of the active medical staff. A petition for the recall of a Department Chief must be presented, signed by at least five (5) members of that department on the active medical staff.

Upon presentation of such a petition, the Medical Executive Committee will schedule a special medical staff meeting within thirty (30) days.

1.6 Any member of the Department may request a department meeting within thirty (30) days upon petition of five (5) members of the Department or a majority.

1.7 Any practitioner has the right to a hearing/appeal in accordance with the Bylaws of the Medical Staff.

1.8 The Medical Staff shall have the right to hire independent legal counsel.

ARTICLE VIII - CORRECTIVE ACTION

Section 1 **Disciplinary Action**

1.1 Disciplinary action includes any of the following with respect to an individual licensed to practice medicine by the Board, whether formal or informal, oral or written (but excluding an oral reprimand), voluntary or involuntary: revocation, suspension, restriction, non-renewal or denial of a right or privilege; censure;

written reprimand or admonition; fine; required performance of public service; a course of education, training, counseling, or monitoring, but only if such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee's competence to practice medicine; resignation; leave of absence; withdrawal of an application; and termination or non-renewal of a contract with a licensee provided that in the case of such restriction, non-renewal or denial of a right or privilege, resignation, leave of absence, withdrawal of an application, or termination or non-renewal of a contract, the action relates directly or indirectly to the licensee's competence to practice medicine, or a complaint or allegation regarding any violation of law or regulation or of the Bylaws of the Hospital, or these Bylaws, whether or not the complaint or allegation specifically cites violation of a specific law, regulation, or bylaw.

1.2 Notification of the Board of Registration in Medicine

The Hospital shall report to the Board any disciplinary action by the Hospital against a member of the Medical Staff as required by law, including, when required under Massachusetts law, the following actions specifically required by the National Practitioner Data Bank:

a. Any Professional Review Action, as defined in the federal Health Care Quality Improvement Act of 1986 as amended, that adversely affects the clinical privileges of a physician or dentist for a period longer than thirty (30) days;

b. The voluntary surrender of medical staff membership or clinical privileges of a physician or dentist to the Board (of Medicine or Dentistry), if the physician or dentist is under investigation for possible incompetence or improper professional conduct or where surrender is in lieu of an investigation;

c. Revisions of previous Professional Review Actions.

Section 2 **Corrective Action**

2.1 Initiation of Corrective Action

Whenever the activities or professional conduct of any member of the Medical Staff, Associate Clinical Staff or Support Staff, with or without clinical privileges, are considered to be contrary to professional standards, to be lower than Hospital standards, to be in violation of the Medical Staff and/or Corporate Bylaws or the Medical Staff and/or Rules and Regulations, to be detrimental to the delivery of quality patient care, to be detrimental to patient safety, or to be disruptive to the operations of the Hospital, corrective action against such practitioner may be requested by any Officer of the Medical Staff, by the Chief of any Department, by the Chairperson of any committee of the Medical Staff performing medical peer review activities, by the President of the Hospital, or by the Governing Body. The term “disruptive” to the operations of the Hospital shall not include competition for business, or criticism offered in good faith with the aim of improving patient care, provided that such criticism is not communicated in a disrespectful or otherwise inappropriate manner and that such criticism is not used as a vehicle for conduct that would otherwise constitute disruptive conduct.

2.2 Nature of Request or Notice

All requests for corrective action shall be in writing and submitted to the Executive Committee and the President of the Hospital. Such a recommendation shall contain a brief statement of the reasons for the action. The Chief of any Department may at any time recommend in writing to the Executive Committee termination of any appointment or reduction or restriction in the privileges of any staff member within his/her Department. Upon receipt of a request for corrective action, the President of the Hospital shall promptly notify the affected practitioner by registered mail, return receipt requested, of the request for corrective action and the general basis therefore; his/her right to ask for a hearing on the request for corrective action in accordance with these Bylaws and any time restrictions on making such a request; and

a summary of his/her rights at such hearing (refer to Article IX, Section 2.1). The Governing Body must also be immediately notified of this request.

2.3 Executive Committee Action

a. Investigation

Upon receipt of a request for corrective action, the Executive Committee, in its sole discretion, shall initiate an investigation of the matter, unless it has determined that an investigation is not warranted. The Executive Committee, in its sole discretion, may invite the affected practitioner to meet with the Executive Committee in an informal meeting, which shall in no event constitute a hearing, shall involve none of the procedural rules provided in these Bylaws and shall be conducted in such manner as the President, in his/her sole discretion, shall decide.

b. Recommendation

Within thirty (30) days of receiving a request for corrective action, the Executive Committee shall, unless it has determined that an investigation is not warranted, forward a report of its recommendation to the President of the Hospital and the Governing Body for action by the Governing Body when indicated. The recommendation may be based on any matter relevant to the issue(s) which came to the attention of the Executive Committee. If the affected practitioner is a member of the Executive Committee, he/she shall not participate in any deliberation or recommendation of the Executive Committee.

2.4 Hearing and Appellate Review Rights

A decision by the Governing Body for reduction, restriction, suspension or termination of clinical privileges with or without staff membership or for suspension or termination of Medical Staff, Associate Clinical Staff or Support Staff membership shall entitle the affected practitioner to the rights provided in these Bylaws (Article IX). Members of the Support Staff and physician assistants, certified nurse anesthetist, certified nurse practitioner, psychiatric nurse, mental health specialist, or certified nurse midwife members of the Associate Clinical Staff shall not be entitled to these rights in the event the corrective action is related to termination of sponsorship by a member of the Active Medical Staff.

Section 3 **Summary Suspension**

The President of the Medical Staff and the President of the Hospital or their designated representatives, acting jointly, shall have the authority, whenever action must be taken immediately for the welfare and safety of patients or in order to prevent an imminent danger to the health of any individual to suspend summarily all or any portion of the clinical privileges of a practitioner. Such summary suspension shall become effective immediately upon imposition. Violation of any Bylaw, Rule or Regulation of the Hospital required as part of the Qualified Patient Care Assessment Program may be grounds for summary suspension.

3.1 Notice

The President of the Hospital shall promptly notify the affected practitioner by registered mail, return receipt requested, of the summary suspension and the general basis therefore; his/her right to request a hearing, when applicable, on the action in accordance with these Bylaws; any time restrictions on making such a request; and a summary of his/her rights at such hearing. The President of the Hospital shall also make a reasonable attempt to verbally notify the practitioner of this action. The Governing Body must also be notified of this request.

3.2 Executive Committee Action

The Executive Committee in its sole discretion shall initiate an investigation of the matter. The Executive Committee may also request the presence of the affected practitioner, which shall in no event constitute a hearing, shall involve none of the procedural rules provided in these Bylaws, and shall be conducted in such manner as the President shall decide.

3.3 Recommendation

As soon as practical after receiving notice of a summary suspension but in no instance more than seven (7) days, the Executive Committee shall forward a report of its recommendation to the President of the Hospital and the Governing Body for action by the Governing Body when indicated. The affected practitioner shall be entitled to receive a copy of this report. The recommendation may be based on any matter relevant to the issue(s) which came to the attention of the Executive Committee. Such recommendation by the Executive Committee shall include but not be limited to acceptance, rejection, or modification of the original summary suspension; issuance of a warning; issuance of a letter of admonition; issuance of a letter of reprimand; imposition of terms of probation or a requirement for consultation; reduction, restriction, suspension or termination of clinical privileges, with or without staff membership; and/or suspension or termination of Medical Staff, Associate Clinical Staff or Support Staff membership. If the affected practitioner is a member of the Executive Committee, he/she shall not participate in any deliberation, nor any recommendation of the Executive Committee. The summary suspension shall remain in effect pending a final decision by the Governing Body, as soon as practical after receiving notice of the recommendation of the Executive Committee, but in no instance more than seven (7) days.

3.4 Hearing and Appellate Review Rights

In cases of this Section 3 of this Article VIII only a recommendation by the Executive Committee for reduction, restriction, suspension or termination of clinical privileges with or without staff membership or for suspension or termination of Medical Staff, Associate Clinical Staff or Support Staff membership may entitle the affected practitioner to the rights for a hearing and appellate review provided in these Bylaws.

3.5 Alternate Medical Coverage

Immediately upon the imposition of a summary suspension, the President of the Medical Staff or the President of the Hospital shall provide for alternate medical coverage for the patients of the suspended practitioner in the Hospital at the time of the suspension. The wishes of the patient shall be considered in the selection of such an alternate practitioner.

Section 4 **Automatic Suspension**

4.1 Initiation of Automatic Suspension

a. Whenever the Massachusetts license, certificate or other legal credential authorizing the member of the Medical Staff, Associate Clinical Staff or Support Staff to practice in the Commonwealth is revoked or suspended, the practitioner's clinical privileges shall be immediately and automatically revoked or suspended accordingly

b. Whenever the Federal Drug Enforcement Agency (DEA) Registration of a member of the Medical Staff or Associate Clinical Staff is revoked or suspended, the practitioner's clinical privileges shall be immediately and automatically suspended.

c. Failure to provide the Medical Staff Office with current documentation of medical licensure, professional liability insurance, Federal DEA certificate or Massachusetts Controlled Substance Certificate as required for credentialing and privileging shall result in an immediate and automatic administrative suspension. Suspension will be lifted immediately upon receipt of required documents in the Medical Staff Office.

4.2 Duty to Notify

Whenever any action is initiated which could result in the revocation, restriction, suspension or probation of a practitioner's license to practice or DEA Registration, the practitioner shall immediately notify the Executive Committee and the President of the Hospital of this event.

4.3 Hearing and Appellate Review Rights

The practitioner shall not be entitled to any rights provided in these Bylaws with respect to automatic suspension.

4.4 Alternate Medical Coverage

Immediately upon the imposition of an automatic suspension, the President of the Medical Staff or the President of the Hospital shall provide for alternate medical coverage for the patients of the suspended practitioner in the hospital at the time of the suspension. The wishes of the patient shall be considered in the selection of such an alternate practitioner.

Section 5 **Loss of a Medical-Administrative Position**

The loss of a Medical-Administrative Position including but not limited to Chief of a Department, Officer of the Medical Staff or membership on any Committee of the Medical Staff, does not entitle the affected practitioner to any rights provided in these Bylaws.

Section 6 **Loss of Sponsorship**

Corrective action related to the termination of sponsorship of a member of the Support Staff and a physician assistant, certified nurse anesthetist, psychiatric nurse, mental health specialist, certified nurse practitioner or a certified nurse midwife member of the Associate Clinical Staff, by a member of the Active Medical Staff, does not entitle the affected practitioner to any rights provided in these Bylaws.

Section 7 **Reporting of Conduct of Health Care Providers**

Any conduct by a health care provider in the course of providing patient care in the Hospital that indicates incompetency in his/her specialty or that might be inconsistent with or harmful to good patient care or safety, shall be reported to the Executive Committee. Reports pertaining to members of the Medical Staff, Associate Clinical Staff and Support Staff shall be investigated by the Chief of the affected practitioner's Department and resolved in accordance with the procedures for action upon requests for corrective action set forth in these Bylaws. Reports pertaining to agents or employees of the Hospital who are not members of the Staff shall be investigated, reviewed and resolved in accordance with such policies and procedures as may be recommended by the Executive Committee and adopted by the Governing Body as part of the Hospital's Qualified Patient Care Assessment Program.

ARTICLE IX - HEARING AND APPELLATE REVIEW PROCEDURE

Section 1 **Right to Hearing and Appellate Review**

1.1 When a practitioner receives notice of a recommendation that constitutes grounds for a hearing as herein set forth and the general basis therefore, he/she shall be entitled to a hearing before an Ad Hoc Hearing Committee.

a. If the recommendation of the Ad Hoc Hearing Committee after such a hearing is still adverse, he/she shall be entitled to an appellate review by an Ad Hoc Appellate Review Committee, as provided herein for

members of the Medical Staff and for dentists, optometrists and clinical psychologists who are members of the associate clinical staff.

b. Any member of the Medical Staff and a dentist, optometrist, or a clinical psychologist who is a member of the Associate Clinical Staff engaged by the Hospital in an administrative capacity whose engagement requires membership on the Medical Staff or Associate Clinical Staff shall not have his/her Medical Staff or Associate Clinical Staff privileges terminated without the same due process provisions as must be provided any other member of the Medical Staff or Associate Clinical Staff unless otherwise provided in the contract with the Hospital.

1.2 One or more of the following recommendations shall constitute grounds for a hearing and, in the case of members of the Medical Staff and dentist, optometrist or clinical psychologist members of the Associate Clinical Staff, appellate review:

a. Denial of Medical Staff or Associate Clinical Staff appointment;

b. Denial of Medical Staff or Associate Clinical Staff reappointment;

c. Suspension of Medical Staff or Associate Clinical Staff membership;

d. Reduction, restriction, denial, or termination of clinical privileges;

e. Termination of Medical Staff or Associate Clinical Staff membership;

f. Demotion to a lower Medical Staff or Associate Clinical Staff category;

h. Suspension of clinical privileges other than automatic suspension.

i. Any other recommendation which could result in a disciplinary action subject to reporting to the Massachusetts Board of Registration in Medicine.

j. Any other recommendation which constitutes a Professional Review Action subject to reporting to the National Practitioner Data Bank under the federal Health Care Quality Improvement Act of 1986, as amended.

1.3 The following recommendations among others shall not constitute grounds for, nor create a right to a hearing or appellate review:

a. Issuance of a warning.

b. Imposition of terms of probation including mandatory consultation or concurrent monitoring, unless such is reportable to the Massachusetts Board of Registration in Medicine, or to the National Practitioner Data Bank under the federal Health Care Quality Improvement Act, as amended.

c. Termination or denial of temporary privileges;

d. Termination or denial of limited privileges;

e. Automatic suspension;

f. Denial of a request for change in Medical Staff category;

g. Termination of appointment and clinical privileges as a result of termination or expiration of a contract with the Hospital or cessation of membership in a group which has a contract with the Hospital unless otherwise provided by the contract with the Hospital;

h. Termination of Associate Clinical Staff membership and privileges of physician assistants, certified nurse anesthetists, certified nurse practitioners, psychiatric nurse mental health specialists, and certified nurse midwives as a result of discontinuation of sponsorship by a member of the Active Medical Staff; and

i. Termination of Support Staff membership and privileges as a result of a discontinuation of sponsorship by a member of the Active Medical Staff.

1.4 Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled to more than one hearing and one appellate review with respect to a recommendation that constitutes grounds for a hearing as set forth in Section 1.2 of this Article IX.

1.5 All notices required in these Bylaws shall be given by the President of the Hospital, in writing, by certified mail, return receipt requested.

Section 2 **Request for a Hearing**

2.1 The President of the Hospital shall give prompt notice of any action which constitutes grounds for a hearing to any affected practitioner who is entitled to a hearing, including the reasons for the action. The practitioner shall have thirty (30) days after receipt of the notice to file with the President of the Hospital a written request for a hearing.

2.2 A practitioner who fails to request a hearing in compliance with these Bylaws, waives his/her rights to such a hearing and to any appellate review.

2.3 Upon receipt of a request for a hearing in compliance with these Bylaws, from a practitioner entitled to a hearing according to these Bylaws, the President of the Hospital shall schedule and arrange for a hearing and shall notify the practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing shall be not less than thirty (30) days nor later than sixty (60) days from receipt of the request for a hearing. The notice of hearing shall include a summary of the reasons that were considered in making the adverse decision, a copy of the rights of the hearing process included in these Bylaws and a list of witnesses expected to testify at the hearing.

Section 3 **Composition of the Committee**

3.1 If the practitioner is a member of the Medical Staff, the hearing shall be conducted by an Ad Hoc Medical Staff Hearing Committee appointed by the President in consultation with the Executive Committee. This Committee shall consist of five (5) members of the Medical Staff, one of whom shall be a member of the same staff category as the practitioner and none of whom shall have actively been involved in formulating the recommendation upon which the Governing Body acted nor be in direct economic competition with the practitioner. The President in consultation with the Executive Committee, shall appoint one of the members to preside over the hearing as Chairperson of this Committee.

3.2 If the practitioner is a member of the Associate Clinical Staff, the hearing shall be conducted by an Ad Hoc Associate Clinical Staff Hearing Committee appointed by the President of the Hospital. This Committee shall be composed of five (5) persons not previously involved in the consideration of the matter nor in direct economic competition with the practitioner and shall include at least one physician. One of the members of this Committee, if possible, shall be a practitioner with a similar professional background as the affected practitioner. One of the members so appointed shall be designated as Chairperson of this Committee by the President of the Hospital.

3.3 If the practitioner is a member of the Support Staff, the hearing shall be conducted by an Ad Hoc Support Staff Hearing Committee appointed by the President of the Hospital. This Committee shall be composed of five (5) persons not previously involved in the consideration of the matter nor in direct economic competition with the practitioner and shall include at least one physician. One of the members of this

Committee, if possible, shall be a practitioner with a similar professional background as the affected practitioner. One of the members so appointed shall be designated as Chairperson of this Committee by the President of the Hospital.

3.4 Any Ad Hoc Hearing Committee appointed pursuant to paragraphs 3.1, 3.2 or 3.3 of this Section 3 of this Article IX shall be deemed to be a medical peer review committee within the meaning of the Massachusetts law and, to the extent applicable, a professional review body under the federal Health Care Quality Improvement Act of 1986, as amended.

Section 4 **Request for Postponement of a Hearing**

A request for postponement of a hearing shall be granted by the Ad Hoc Hearing Committee in its sole discretion and only if the request therefore is made as soon as is reasonably practical. The Chairperson of this Committee may recess the hearing and reconvene it for convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

Section 5 **Conduct of the Hearing**

5.1 The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails, without good cause, to appear at the hearing shall be deemed to have waived his/her rights to a hearing and to any appellate review. The hearing is for the purpose of resolution of matters bearing on professional competency and conduct. The affected practitioner shall have the right to be represented by an attorney or other person of his/her choice at any proceeding or hearing in accordance with these Bylaws. The Executive Committee, the Ad Hoc Hearing Committee and the Governing Body shall also have the right to be represented by legal counsel in connection with all aspects of the proceedings included in these Bylaws.

5.2 The Chairperson of the Ad Hoc Hearing Committee shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence relevant to the issue(s) and that decorum is maintained. He/she shall determine the order of procedure and admissibility of evidence at the hearing.

5.3 The practitioner and the Executive Committee shall have the right to request that an accurate record of the hearing be maintained. The mechanism for this shall be determined by the Chairperson of this Ad Hoc Hearing Committee. He/She may order that a stenographer be retained to make a transcript of the hearing. The practitioner may receive a copy of this transcript at his/her own expense. The Executive Committee may also receive a copy of this transcript.

5.4 Oral evidence relevant to the issue(s) may, in the discretion of the Chairperson of the Ad Hoc Hearing Committee be taken only on oath or affirmation administered by a person who is authorized by law to administer oaths, as designated by the Chairperson of the Ad Hoc Hearing Committee.

5.5 The practitioner and the Executive Committee shall each have the right to call and examine witnesses, introduce exhibits, present evidence, cross-examine any witness on any matter relevant to the issue(s), impeach any witness, rebut any evidence, and submit a written statement at the close of the hearing. In the event the practitioner does not testify in his/her own behalf, he/she may be called and examined by the Executive Committee.

5.6 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any matter relevant to the issue(s) upon which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions, as determined by the Chairperson of the Ad Hoc Hearing Committee, shall be considered. The practitioner and the Executive Committee shall be entitled to submit memoranda concerning any issue of law or fact, prior to or during the hearing, and such memoranda shall become a part of the hearing record. At any hearing involving denial of initial Medical Staff membership, or requested advancement in

Medical Staff category, or denial for initial or additional clinical privileges, it shall be incumbent on the practitioner who requested the hearing initially to come forward with evidence in support of his/her position. In all other cases it shall be incumbent on the Executive Committee to come forward with evidence in support of its recommendation, and thereafter, the burden shall shift to the practitioner who requested the hearing to come forward with evidence in his/her support.

5.7 The Ad Hoc Hearing Committee may take notice of any generally accepted technical or scientific matter relevant to the issue(s) considered at the hearing. The participants at the hearing shall be informed of all matters of which notice shall be taken and these matters shall be noted on the hearing record. Any party to the hearing shall be given reasonable opportunity on request to refute the noticed matters by evidence and testimony. The Ad Hoc Hearing Committee shall be entitled to examine the practitioner's credentials file at the hospital, his/her application, and accompanying documents, and any and all records relevant to the appeal. Upon conclusion of the presentation, the hearing shall be closed. The Ad Hoc Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside of the presence of the affected practitioner. The Ad Hoc Hearing Committee shall affirm the Executive Committee's recommendation only if it finds that the recommendation is supported by a preponderance of the evidence, except in cases involving the denial of initial Medical Staff appointment, in which event the practitioner must have supported his/her position by a preponderance of the evidence in order to prevail. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

5.8 After final adjournment of the hearing, the Ad Hoc Hearing Committee, by at least a majority of the Committee Members, shall make a written recommendation, which includes a statement for the basis for the recommendation, to the Governing Body within thirty (30) days. The recommendation shall be forwarded to the President of the Hospital. The recommendation may be based on any matter relevant to the issue(s) which came to the attention of the Ad Hoc Hearing Committee during any stage of the proceedings contemplated under these Bylaws. The President of the Hospital shall promptly send a copy of the recommendation to the affected practitioner by registered mail, return receipt requested, and to the Executive Committee and the Governing Body.

5.9 The Governing Body shall take final action with respect to the report and recommendation unless the affected practitioner or the Executive Committee should request an appellate review of the report and recommendations within ten (10) days after receipt thereof. Such a request by the affected practitioner or the Executive Committee should be made in writing to the President of the Hospital by certified mail. Only members of the Medical Staff and a dentist, an optometrist or a clinical psychologist who are members of the Associate Clinical Staff shall be eligible for appellate review.

5.10 If either party fails to request an appellate review in the manner herein provided, it waives its rights to such review. In that event, the Governing Body may take final action in the matter.

Section 6 **Appellate Review Procedure**

6.1 Notice

a. Upon receipt of a request for an appellate review which complies with these Bylaws, the President of the Hospital shall notify the affected practitioner and the Executive Committee of the time, place and date so scheduled. The appellate review date shall be not later than thirty (30) days from receipt of the request for an appellate review. Members of the Support Staff and physician assistant, psychiatric nurse mental health specialist, certified nurse anesthetist, certified nurse practitioner or certified nurse midwife members of the Associate Clinical Staff shall not be entitled to appellate review.

b. An appellate review shall be conducted by an Ad Hoc Governing Body Appellate Review Committee of three members of the Governing Body appointed by the Chairperson of the Governing Body, one of whom shall be designated as Chairperson of this Committee.

d. Any Ad Hoc Governing Body Appellate Review Committee appointed pursuant to paragraph (b) of this Section 6.1 Article IX shall be deemed to be a medical peer review committee within the meaning of

Massachusetts law and, to the extent applicable, a professional review body under the federal Health Care Quality Improvement Act of 1986 as amended.

6.2 Conduct of the Appellate Review

a. The proceedings of the Ad Hoc Governing Body Appellate Review Committee shall be in the nature of an appellate hearing based upon the record of the hearing before the Ad Hoc Hearing Committee. The Ad Hoc Governing Body Appellate Review Committee shall also consider written statements relevant to the issue(s) submitted in accordance with these Bylaws.

b. The practitioner requesting the appellate review shall not be entitled to appear personally before the Ad Hoc Governing Body Appellate Review Committee, unless this Committee in its discretion is willing to accept additional oral evidence relevant to the issue(s), but may submit one written statement on his/her behalf setting forth those factual and procedural matters with which he/she disagrees and the reasons for such disagreement. This written statement may cover any matters relevant to the issue(s) raised at any step in the procedure to which the appeal is related and legal counsel may assist in its preparation. Such written statements shall be submitted to the Ad Hoc Governing Body Appellate Review Committee and to the opposing party through the President of the Hospital by registered mail, return receipt requested, at least fourteen (14) days prior to the scheduled date for the appellate review. A written statement or reply may be submitted by the opposing party at least seven (7) days prior to the scheduled date for the appellate review, and if submitted, the President of the Hospital shall provide a copy of it to the appealing party prior to the scheduled date of the appellate review.

c. The Ad Hoc Governing Body Appellate Review Committee shall make a recommendation to the Governing Body and shall forward it to the President of the Hospital within fifteen (15) days after the conclusion of the proceedings. The recommendation may be based on any matter relevant to the issue(s) which came to the attention of the Committee during any stage of the proceedings contemplated under these Bylaws. The President of the Hospital shall promptly send a copy of the recommendation to the affected practitioner by registered mail, return receipt requested, and to the Executive Committee.

e. Within fifteen (15) days after receiving the recommendation of the Ad Hoc Governing Body Appellate Review Committee, the Governing Body shall render a final decision in writing, including a statement of the basis for the decision to the affected practitioner and to the Executive Committee. Any member of the Governing Body who participated on the Ad Hoc Governing Body Appellate Review Committee in regard to the action against the affected practitioner shall not vote in the Governing Body's final decision on the matter. The final decision of the Governing Body shall be effective immediately and shall not be subject to further appeal. Any final decision by the Governing Body rendered in substantial conformity with the provisions of these Bylaws shall be binding on all parties to such decision.

ARTICLE X – OFFICERS

Section 1 **Officers**

The Officers of the Medical Staff shall be:

1.1 President,

1.2 Vice-President,

1.3 Secretary/Treasurer.

Section 2 **Election of Officers**

The President and the Vice-President of the Medical Staff shall be elected every two years at the Annual Meeting of the Medical Staff from a slate of persons nominated by the Nominating Committee as herein

provided and listed in the notice of such meeting, and all persons, if any, nominated from the floor at the time of the Annual Meeting upon proper motion and seconding by a member of the Active Medical Staff. In each contested election, the nominee receiving a plurality of votes cast shall be elected. In the event that more than two people are nominated, with no nominee getting a majority of votes cast, a run-off vote shall be held between the two nominees with the most votes. Election of Medical Staff Officers shall be reported to the Governing Body.

The Secretary/Treasurer of the Medical Staff shall be elected by the Executive Committee from among its membership.

Section 3 **Qualification of Officers**

All officers must, at the time of their election and throughout the term of their office, be members of the Active Medical Staff.

Section 4 **Nominating Committee**

The Nominating Committee shall consist of three (3) members of the Active Medical Staff elected by a plurality of votes cast from nominations from the floor at the Annual Meeting. In the event that more than two people are nominated, with no nominee getting a majority of votes cast, a run-off vote shall be held between the two nominees with the most votes. One member will be elected each year to serve for three (3) consecutive years. The Chairperson of the Nominating Committee shall be the member serving his/her third year on this Committee. The Nominating Committee shall convene at least thirty (30) days prior to the Annual Meeting and propose a slate of candidates for election. This slate of candidates shall be transmitted to the Medical Staff with the notice of the Annual Meeting at least fifteen (15) days prior to that meeting.

Section 5 **Term of Office**

Each officer of the Medical Staff shall serve a term of two years commencing on January 1st. Each officer shall hold office until his/her successor is elected and qualified, unless he/she dies, resigns, or is removed before such time. No officer shall serve for more than three consecutive terms. A vacancy in the Presidency shall be filled by the Vice-President who shall serve out the President's term of office. A vacancy in the Vice-Presidency shall be filled by appointment of the Executive Committee, ratified by vote of the Active Staff at the next regularly scheduled meeting of the Medical Staff. A vacancy by the Secretary/Treasurer of the Medical Staff shall be filled by the Executive Committee from among its membership.

Section 6 **Duties of Officers**

6.1 President

The President shall serve as the Chief of Staff and shall:

a. Preside and be responsible for the agenda of all regularly scheduled meetings and special meetings of the Medical Staff;

b. Serve on and act as Chairperson of the Executive Committee;

c. Serve on and act as Chairperson of the Performance Improvement Committee;

d. Serve on and act as Chairperson of the Patient Care Assessment Committee;

e. Serve as an ex-officio member, on all standing and special committees of the Medical Staff (excluding committees on which he/she is presently designated as a voting committee member);

f. Work cooperatively with the President of the Hospital in all matters of mutual concern involving Medical Staff/Hospital affairs;

g. Appoint members to all standing, special and ad hoc committees of the Medical Staff in consultation with the Executive Committee, in accordance with these Bylaws;

h. In consultation with the Executive Committee, appoint the Chairmen of all standing and special ad hoc committees/task forces of the Executive Committee except as otherwise provided in these Bylaws;

i. In consultation with the Executive Committee, appoint the Delegate and Alternate Delegate to the American Medical Association Organized Medical Staff Section and the Massachusetts Medical Society Organized Medical Staff Section;

j. Represent the Medical Staff in its relationship with the Governing Body and the community at-large;

l. Authorize expenditures from the Medical Staff treasury, not to exceed $300.00, and report such transactions at the next meeting of the Executive Committee;

m. Receive and forward reports of the Governing Body to the Medical Staff and report to the Governing Body on the performance and quality of the Medical Staff's responsibility to monitor the quality of patient care activities of all practitioners; and

n. Participate with the President of the Hospital in the granting of temporary privileges and in the provision for alternate medical coverage for patients of suspended practitioners.

o. Review and sign-off on Credentials files in the absence of the Chief and Assistant chief of any given department.

6.2 Vice-President

The Vice-President shall, in the absence of the President assume all of his/her duties and have all of his/her authority and shall be expected to perform such duties of an administrative nature as may be assigned to him by the President. He/she shall automatically succeed the President in the event the latter fails to serve for any reason.

a. He/she shall be a member of the Executive Committee.

b. He/she shall serve on the Credentials Committee.

c. He/she shall serve on and act as Chairperson of the Medical Staff Bylaws Committee.

d. The Vice President of the Medical Staff will serve as an ex-officio member, on all standing and special committees of the Medical Staff (excluding committees on which he/she is presently designated as a voting committee member).

6.3 Secretary/Treasurer

The Secretary/Treasurer of the Medical Staff shall exercise the power and discharge the duties customary to the office. He/she shall attend to all correspondence of the Medical Staff; and keep an accurate account of the financial status and financial transactions of the Medical Staff. He/she shall be a member of and be elected by the Executive Committee.

Section 7 **Removal of an Elected Officer**

7.1 Criteria for Removal

a. Failure of the elected officer to fulfill his/her duties as defined in these Bylaws;

b. Conduct by the officer detrimental to the interests of the Medical Staff/Hospital;

c. Loss of Active Medical Staff status (as applicable);

d. Physical or mental impairment that interferes with his/her ability to fulfill the duties of the office as defined in these Bylaws.

7.2 Motion for Removal

a. Any Medical Staff member has the right to initiate a recall election of a Medical Staff Officer. A petition for such recall must be presented, signed by at least five (5) of the members of the Active Staff.

Upon presentation of such a petition, the Executive Committee will schedule a special medical staff meeting within 30 days.

b. A motion for removal of an officer of the Medical Staff may be made at any valid meeting of the Medical Staff as defined in these Bylaws.

7.3 Vote for Removal

A successful motion for the removal of an officer of the Medical Staff shall require that a vote for removal be taken at the next regularly scheduled valid meeting of the Medical Staff as defined in these Bylaws, the notice of which shall contain announcement of such intention, and shall be distributed at least thirty (30) days in advance of such meeting. An affirmative vote of at least two-thirds of the Active Staff present or represented by proxy shall be necessary for such action. A vote to remove an officer of the Medical Staff shall be reported to the Governing Body.

ARTICLE XI - CHIEF MEDICAL OFFICER

Section 1 **Chief Medical Officer**

a. The Chief Medical Officer (CMO) shall be an administrative member of the Anna Jaques Hospital Medical Staff. The CMO shall be licensed to practice medicine in the Commonwealth of Massachusetts. The President of Anna Jaques Hospital and the Governing Body shall appoint the CMO.

b. The President of the Medical Staff, with advice and consent from the Executive Committee, will select three members of the Medical Staff at large, and those 4 members of the Medical Staff shall participate in the selection process of the CMO as members of the Search Committee, which serves in an advisory capacity.

c. The CMO shall work closely with both Administration and members of the Medical Staff to facilitate and maintain the high quality of the Medical Staff and the high quality of patient care. The CMO shall provide oversight to ensure departments of the Medical Staff comply with State and Federal regulations and other regulatory bodies as required.

d. The CMO shall report directly to the President of the Hospital, and shall have such responsibilities as are determined from time to time by the President of the Hospital and the Governing Body. For issues related to quality improvement and risk management the CMO will fulfill assigned functions for the Performance Improvement Committee and the Medical Executive Committee and the Patient Care Assessment Committee. The CMO shall act as a liaison between the President of the Hospital, President of the Medical Staff and Chiefs of all the Medical Staff Departments and Committees. The CMO shall be an ex officio member of all Medical Staff and combined Hospital Medical Staff Committees.

ARTICLE XII - DEPARTMENTAL ORGANIZATION

Section 1 **Organization of Departments**

1.1 Departments

The Medical Staff shall be organized into the Departments of Medicine, Pediatrics, OB/GYN, Surgery, Anesthesia, Radiology, Psychiatry, Pathology and Emergency Medicine.–The Departments shall deal primarily with administrative, peer review and quality aspects of the Medical Staff.

1.2 Future Departments

From to time, it may be advisable to modify the organization of departments by amendment of these Bylaws.

1.3 Policies and Procedures

All individuals with delineated clinical privileges, with or without Medical Staff membership, must be assigned to one Department and may be granted clinical privileges in additional Departments. Such privileges within any Department are subject to the Policies and Procedures of the Medical Staff. Each Department shall be so organized as to assure the provision of the same level of quality of patient care by all individuals with delineated clinical privileges within Medical Staff Departments, across Departments, and between members and nonmembers of the Medical Staff who have delineated clinical privileges. The Department may be subdivided into sections to assure the provision of the same level of quality of patient care within a specialty.

1.4 Chief and Assistant Chief

Each Department, in accordance with these Medical Staff Bylaws, by the November meeting every two (2) years, shall elect a Chief and Assistant Chief of that Department, for a two-year term. This election shall be submitted to the Executive Committee at the Committee's December meeting for approval. Each Chief and Assistant Chief so approved shall take office on January 1 of the year following appointment by the Governing Body.

In the absence of an elected Chief, the Assistant Chief will act as the Interim Department Chief for the remainder of the Chief's term and a new assistant chief will be elected. Should the Assistant Chief be unable to assume the role, the Department will elect a new Chief for the remainder of the term. In the absence of an elected Chief and Assistant Chief, the Medical Executive Committee shall appoint an interim Chief and/or Assistant Chief. The election shall be submitted to the Executive Committee for approval and the Governing Body for appointment.

a. The Chief and Assistant Chief may be reelected for a maximum of three (3) consecutive terms.

Section 2 **Function of Chief of Department**

2.1 The Chief shall be a board certified, member of the Active Staff who has been on the Medical Staff for at least one year;

a. Shall make recommendations to the Executive Committee on all matters of concern to his/her Department;

b. Shall be responsible for the best-achievable quality and appropriateness of care being rendered all patients within his/her Department;

c. Shall be responsible for implementation of programs and policies of the Executive Committee referable to his/her Department;

d. Shall be a voting member of the Executive Committee giving guidance on the overall medical policies of the Hospital in relation to the services of his/her Department. The Chief of Medicine, Surgery, OB/GYN and Emergency Medicine (designated as high-volume departments) will be a member of the Performance Improvement Committee. The Chief of a department involved in a special issue shall, upon invitation by the Performance Improvement Committee, attend the appropriate meeting to give guidance to the Committee.

e. Shall be responsible for enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations within his/her Department;

f. Shall make recommendations to the President of the Hospital with respect to planning of Hospital facilities, equipment, routine procedures and other matters concerning patient care within his/her Department;

g. Shall be responsible to the Executive Committee and the Governing Body for reviewing the quality of care rendered by all practitioners assigned to his/her Department and specifically:

  (i) Shall periodically review the delineated privileges of all practitioners assigned to his/her Department;

  (ii) Shall cooperate with the Performance Improvement Committee and other medical staff committees/task forces officially designated to improve patient care and perform peer review;

  (iii) Shall perform Departmental reviews for the purpose of establishing, updating and ascertaining compliance with criteria for adequate levels of patient care; and

  (iv) Shall investigate claims of incompetency that might be result in harm to patient care or safety by members of his/her Department.

h. Shall be responsible for documentation in Department minutes of such reviews and actions performed in compliance with regulations and procedures, including but not limited to, utilization review, quality assurance, risk management, drug usage, medical records and tissue and transfusion review;

i. Shall act as presiding officer at Department meetings;

j. Shall review and evaluate applications for appointment and/or delineation of clinical privileges and forward recommendations concerning the appointment and/or delineation of clinical privileges to the Credentials Committee in accordance with these Bylaws;

k. Shall review the application for reappointment and redelineation of clinical privileges, make recommendations concerning this and forward the completed application to the Credentials Committee in accordance with these Bylaws;

l. Shall evaluate information referable to physical and mental health status;

m. Shall recommend to the Executive Committee the criteria for clinical privileges within the Department;

n. Shall be responsible for the conduct of all programs of continuing education within his/her Department;

o. Shall have the authority to ask the Physician Health Committee to request information as to the health of the members of the Department, as it pertains to their ability to provide patient care and participate in requisite activities of Staff membership and also the authority to request information concerning present and prior professional liability activity from the practitioner's insurance carrier(s). Furthermore, he/she shall have the authority to require the practitioner to sign appropriate release of information in order to obtain this information;

p. Shall be responsible for developing, implementing and monitoring an evaluation program, pursuant to these Medical Staff Bylaws and the Policies and Procedures of the Medical Staff with the approval of the Executive Committee and the Governing Body;

    (i) for each new appointee to his/her Department, conduct a period of focused evaluation and monitoring;

    (ii) for any member of the Department whenever necessary for performance enhancement with the approval of the Executive Committee; and

q. Shall be responsible for the rotational on-call schedule of members of the Department who shall serve as consultants to the Department of Emergency Medicine and who shall admit to the Hospital those patients who require admission and who do not have an available attending physician;

r. Shall work closely with the Medical Staff Officers and Chief Medical Officer;

s. Shall have all requisite authority to carry out the duties and functions of his/her office as herein defined including without limitation the authority to develop and enforce, with the concurrence of the President, measures designed to correct demonstrated deficiencies in the delivery of patient care within his/her department.

Section 3 **Function of Assistant Chief of the Department**

The Assistant Chief shall be a member of the Active Staff. The Assistant Chief shall have all of the authority and responsibility of the Chief of the Department in his/her absence. A vacancy in the office of Chief shall be filled by the Assistant Chief who shall serve out the remaining term of office. This shall include, but not be limited to, approval of temporary appointments and functioning in the areas of discipline. The Assistant Chief shall also be responsible for evaluating the clinical performance and activities of the Chief of the Department for purposes of reappointment, shall make recommendations concerning this and shall forward the application to the Credentials Committee in accordance with these Bylaws. The Assistant Chief shall also function as Secretary of the Department. The Assistant Chief shall perform those duties delegated to him/her by the Department Chief, and the Executive Committee.

Section 4 **Acting Chief or Acting Assistant Chief of Department**

Each Department, in accordance with these Medical Staff Bylaws, may elect an Acting Chief and/or Acting Assistant Chief in lieu of a Chief and/or Assistant Chief. Each acting officer so elected can be a Member of the Active Staff. Each Acting Chief shall have the authority and responsibility of the Chief of the Department as outlined in these Bylaws and shall be a voting member of the Executive Committee. Each Acting Assistant Chief shall have the authority and responsibility of the Assistant Chief of the Department as outlined in these Bylaws and shall be a voting member of the Executive Committee.

Section 5 **Meetings of Departments**

Each Department shall meet no less than-quarterly to consider the administrative and business matters of the Department, selected quality of care issues, recommendations to the Executive Committee, matters referred from Committees and other pertinent departmental issues. Agendas for departmental meetings

shall be distributed and posted no later than ten (10) days prior to the meeting. The quorum requirement for a departmental meeting shall be those members present and voting. One designated meeting of the department each year shall be considered its annual meeting. The minutes of the departmental meetings shall be forwarded to the Executive Committee for approval and shall be filed with the records of the Department.

Section 6 **Removal of Department Chiefs, Assistant Chiefs, Acting Chiefs and Assistant Acting Chiefs, and Section Leaders**

6.1 Criteria for Removal

a. Failure of the Elected Chiefs, Assistant Chiefs, Acting Chiefs, Acting Assistant Chiefs and Section Leaders to fulfill their duties as defined in these Bylaws:

b. Conduct detrimental to the interests of the Medical Staff/Hospital, Department/Section;

c. Loss of Active Medical Staff status (as applicable);

d. Physical or mental impairment that interferes with his/her ability to fulfill the duties of the office as defined in these Bylaws.

6.2 Motion for Removal

a. Any practitioner has the right to initiate a recall election of Department Officers. A petition for such recall must be presented, signed by at least five (5) of the members of the Active Staff in that Department.

Upon presentation of such a petition, the Executive Committee will schedule a special Department meeting within 30 days.

b. A motion for removal of an officer of the Department may be made at any valid meeting of the Department.

6.3 Vote for Removal

A successful motion for the removal of an officer of the Department shall require that a vote for removal be taken at the next valid meeting of the Department as defined in these Bylaws, the notice of which shall contain announcement of such intention, and shall be distributed at least fifteen (15) days in advance of such meeting. An affirmative vote of at least two-thirds of the Active Staff present or represented by proxy shall be necessary for such action.

ARTICLE XIII - COMMITTEES

Section 1 **Medical Executive Committee**

1.1. Membership

a. The Medical Executive Committee shall consist of a number of regular members which may vary depending on the number of Departments [see Section 1.2 of Article XII of these Bylaws) and five ex officio members. The regular members are the President of the Medical Staff, the Vice President of the Medical Staff, and the Chief of each Department and a representative from the Hospitalist service elected by the Department of Medicine who shall be a non-voting member of the Medical Executive Committee. All members of the Medical Staff are eligible for membership on the Medical Executive Committee, but a majority of the Medical Executive Committee members must be fully licensed doctors of medicine or osteopathy members of the Medical Staff actively practicing in the Hospital.

b. Ex officio members of the Medical Executive Committee shall include the Chairperson of the Governing Body or another member of the Governing Body designated by the Chairperson, the President of the Hospital, the Chief Medical Officer, the Chief Nursing Officer, and the Director of Quality.

1.2. Meetings

a. The President of the Medical Staff shall be the Chairperson of the Medical Executive Committee. The Medical Executive Committee shall meet monthly. Meetings of the Medical Executive Committee are open to all members of the Medical Staff. Agendas for each meeting of the Medical Executive Committee shall be set by the President of the Medical Staff and shall be distributed and posted no less than seven (7) days before the scheduled meeting. Any member of the Medical Staff may address any agenda item. Other issues as described in the Practitioner Rights may be addressed. The quorum requirement for the Medical Executive Committee is fifty percent of the voting members of the Committee.

1.3. Functions

a. The duties of the Medical Executive Committee shall include, without limitation:

(i) Oversee all of the principal functions for which the Medical Staff is responsible.

(ii) Represent and act on behalf of the Medical Staff and Associate Clinical Staff and Support Staff subject to such limitations as may be imposed by these Bylaws. The Medical Executive Committee shall carry out its work within the context of the organization functions of governance, leadership and performance improvement. The Medical Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by members of the Medical Staff, Associate Clinical Staff and Support Staff. Under these Bylaws, the Medical Executive Committee has been delegated the authority to act on behalf of the Medical Staff in all matters related to the mission of the Medical Staff as set forth in Article II hereof, in between meetings of the Medical Staff, except for approval of Bylaws amendments under Article XVII. The Medical Staff retains the right to remove all or any portion of such delegated authority by vote at any annual, regular or special meeting of the Medical Staff in accordance with Article XIV of these Bylaws, provided such removal may not affect any authority, charge or function which is assigned to the Medical Executive Committee under these Bylaws. This delegation of authority and the exercise of the retained right to remove any or all such authority are each subject to any limitations of applicable law or governmental regulation.

(iii) Make recommendations directly to the Governing Body on the structure of the Medical Staff, and the process used to review credentials and delineate privileges; and receive, review and make recommendations on all appointments, reappointments and delineation of clinical privileges; and request evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

(iv) Request information as to the health of members of the Medical Staff, Associate Clinical Staff and Support Staff including a possible mental or physical examination, as it pertains to his/her ability to provide patient care and participate in requisite activities of staff membership and request information concerning present and prior professional liability activity from the practitioner's insurance carrier/carriers; and furthermore require the practitioner to sign appropriate release of information in order to obtain this information.

(v) Receive, review and make recommendations on reductions, promotions, extensions, suspensions and terminations of privileges.

(vi) Receive, review and coordinate the activities of the Medical Staff and its departments, committees and task forces.

(vii) Receive communications from any staff member.

(viii) Recommend to the President of the Medical Staff the constitution and composition of such committees and task forces as may be necessary for the proper functioning of the Medical Staff.

(ix) Perform any activity authorized under these Bylaws necessary for the proper operation thereof.

(x) Receive and be responsible for the resolution of all complaints against any member of the Medical Staff, Associate Clinical Staff or Support Staff in conformity with these Bylaws when warranted.

(xi) Receive and act upon reports and recommendations from the departments, services, Medical Staff committees, task forces, officers of the Medical Staff, President of the Hospital and the Governing Body concerning patient care and other quality assurance activities. The Executive Committee is responsible for the organization of the quality assurance activities of the Medical Staff in conjunction with the Patient Care Assessment Committee, as well as the mechanism used to conduct, evaluate and revise such activities.

(xii) Develop the mechanism for fair hearing procedures in conformity with these Bylaws.

(xiii) Review periodically all information available regarding the performance and clinical competence of the Medical Staff, Associate Clinical Staff and Support Staff members and, as a result of such reviews, make recommendations to the Governing Body for reappointments, renewals, changes in clinical privileges and corrective action in conformity with these Bylaws.

(xiv) Act as a liaison between the Medical Staff, Associate Clinical Staff, and Support Staff, and the President of the Hospital and the Governing Body.

(xv) Initiate and implement Medical Staff policies; any such policies which relate to the Hospital's Qualified Patient Care Assessment Program shall be initiated and implemented in conjunction with the PCAC.

(xvi) Receive, review and approve Medical Staff departmental policies.

(xvii) Approve any expenditures from the Medical Staff treasury exceeding three hundred ($300.00) dollars.

(xviii) Act for the Medical Staff in the intervals between Medical Staff meetings.

1.4. Removal

a. Medical Staff members of the Medical Executive Committee may, and will automatically be, removed from membership on the Medical Executive Committee if he/she is removed from his/her position as an Officer of the Medical Staff under Section 7 of Article X of these Bylaws, or from his/her position as a Department Chief under Section 7 of Article XII of these Bylaws, as may be applicable.

b. An ex officio member of the Executive Committee shall no longer serve as such when he/she no longer holds the position from which that status derived.

c. The Hospitalist Representative will be removed from Medical Executive Committee when his/her two-year term expires or when employment with the Hospital is terminated.

Section 2 **Performance Improvement Committee**

2.1. Membership

a. The Performance Improvement Committee ("PIC") shall consist of the President of the Medical Staff, the Vice President of the Medical Staff, and the Department Chiefs of Surgery, Medicine, Emergency Medicine and OB/GYN, and the elected Hospitalist Representative (ex-officio member) to the Medical Executive Committee.

b. Ex officio members of the PIC are the Chief Medical Officer and Director of Quality.

c. The President of the Medical Staff shall serve as the Chairperson of the PIC and shall set the agenda of the PIC meetings.

2.2. Meetings

a. The PIC shall meet monthly and shall, in matters of the Hospital's Qualified Patient Care Assessment Program, report to the Patient Care Assessment Committee. Meetings of the PIC are limited to members of the committee only, and invited chief of a department involved in a specific case review. Health Care Providers of other departments or services, involved in a specific issue or case, will be invited to attend the appropriate PIC meeting when needed to provide detailed information regarding a specific individual case.

b. Quorum requirement for the PIC Committee is fifty percent of the voting members of the committee.

2.3. Functions

a. The PIC shall receive, review and coordinate all activities of the Medical Staff relating to medical peer review. Issues related to Medical Staff performance, complaints, evaluation, grievances, and similar such matters will be evaluated through the PIC. Only the physician members of the PIC shall vote on matters involving or related to medical peer review.

b. The PIC is a medical peer review committee under Massachusetts law (Mass. G.L. Ch. 111, §1) and the proceedings, reports, records, findings, recommendations, evaluations, opinions, deliberations and other actions of the PIC in its discharge of the medical peer review functions, and by any other medical peer review committee of the Medical Staff or of the Hospital, and the identity of any information provided to such medical peer review committees by witnesses or any other individuals are confidential, are not subject to subpoena or discovery, and may not be introduced into evidence in any judicial or administrative proceedings except with respect to proceedings held by the Board of Registration in Medicine to the extent permitted under Mass. G.L., Ch. 111, §204(a), or, to the extent permitted by law, with respect to proceedings against a member of, or witness to, a medical peer review Committee under Massachusetts General Laws Chapter 231, Section 85N, but in actions brought under Chapter 231, Section 85N the identity of any person furnishing information or opinions to a medical peer review committee may not be disclosed without permission of such person.

c. All individuals participating in the Medical Staff's or Hospital's peer review activities in good faith and without malice, including without limitation those persons who serve on medical peer review committees of the Medical Staff or of the Hospital or who provide information or services to such committees in any way, shall be immune from liability in accordance with the provisions of the Federal Health Care Quality Improvement Act and with applicable provisions of Massachusetts law, including without limitation Mass. G.L. Ch. 111, §203 and Mass. G.L. Ch. 231, §85N.

Medical peer review is the process by which the quality and appropriateness of patient care in the Hospital are monitored and evaluated, including the evaluation or improvement of the quality of health care rendered by practitioners who have been granted clinical privileges in accordance with these Bylaws; the determination whether health care services were performed in compliance with the applicable standards of care; the determination whether the actions of a practitioner or Advanced Care Practitioner call into question his/her fitness to provide health care services; or the evaluation and assistance of practitioners

impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental disability or mental instability or otherwise.

All medical peer review conducted by a medical peer review committee of the Medical Staff or of the Hospital shall be conducted in a consistent, timely, balanced and fair manner, using evidenced-based standards of care and practice whenever available and appropriate, and in accordance with any and all procedural rights that are applicable to a particular setting under these Bylaws or under any Medical Staff policy, rule or regulation. The Massachusetts Medical Society, *Principles for Incident Based Peer Review for Health Care Facilities* (June 2005) shall serve as authoritative but non-directive guidance for the conduct of such medical peer review.

d. Pursuant to Mass. G.L. Ch. 111, §203(b), as part of the Anna Jaques Hospital Qualified Patient Care Assessment Program, whenever following review by a medical peer review committee, a determination is reached that a health care provider should be subject to a disciplinary action, such committee shall immediately forward the recommendation to the Medical Executive Committee and the Governing Body for action. (This provision is required by the BRM PCA regulations at 243 CMR 3.07(2)

e. As part of the Anna Jaques Hospital Qualified Patient Care Assessment Program, a procedure shall be established for ongoing review and counseling of health care providers impaired by drugs or alcohol, or for the arrangement and monitoring of participation by such providers in other established review and counseling programs. A procedure shall also be established to ensure compliance with Mass. G.L., Ch. 112, §5F, with specific regard to reporting impaired licensees to the Board of Registration in Medicine. (This provision also is required by BRM PCA regulations at 243 CMR 3.09(1))

Section 3 **Patient Care Assessment Committee (PCAC)**

3.1. Introduction

Under the Board of Registration and Medicine regulations the Patient Care Assessment Committee (PCAC) is a board level committee and must include no fewer than one trustee and other senior personnel essential to the quality of patient care. 243 CMR 3.02 and 3.06(1). The programs associated with patient care assessment (PCA) (credentialing, quality assurance, utilization review, risk management and peer review) are to be overseen by Anna Jaques Hospital's corporate and physician leadership but it is the Board of Trustees which has the responsibility for the Qualified Patient Care Assessment Program (QPCAP), including the PCA committee. Thus, while Anna Jaques Hospital physician leadership (which institutionally acts through its Medical Staff) is an integral participant in the PCA matters, the Board of Registration in Medicine regulations established the Board of Trustees as the body with the ultimate institutional authority and responsibility for Anna Jaques Hospital's QPCAP structure, including the designation of the Patient Care Assessment Coordinator and the formation and composition of the Patient Care Assessment Committee. 243-CMR 3.01 and 3.03.

The Board of Registration in Medicine regulations vests the choice of the PCA Coordinator in the Anna Jaques Hospital Board of Trustees (also referred to as the Governing Body). The PCA Coordinator may be a qualified physician or a qualified non-physician. To be qualified the PCA Coordinator must evidence by education, training or experience, the ability to carry out the functions and activities of the Anna Jaques Hospital's Qualified Patient Care Assessment Program (QPCAP). The PCA Coordinator is responsible to the PCA Committee 243 CMR 3.06(2).

3.2. Membership

a. The Patient Care Assessment Committee shall consist of the President of the Hospital, the Chief Medical Officer, the Chairperson of the Board of Trustees and another member of the Board of Trustees (to be appointed by the Governing Body), Director of Quality, President of the Medical Staff, Vice President of the Medical Staff, Chiefs of the Departments of Medicine, Surgery, Emergency Medicine, and Obstetrics and Gynecology. Each member shall have one vote.

b. The President of the Medical Staff shall be the Chairperson of the Patient Care Assessment Committee.

c. The PCA Coordinator, a function required by the BORM regulations, shall be the CMO, as designated by the Governing Body of Anna Jaques Hospital and, in regards to the Anna Jaques Hospital Qualified Patient Care Assessment Program, shall be responsible to the Patient Care Assessment Committee.

3.3. Meetings

a. The Chairperson of the Patient Care Assessment Committee in consultation with the PCA Coordinator shall set the agenda for the Patient Care Assessment Committee meetings. The Patient Care Assessment Committee shall meet quarterly. Meetings of the Patient Care Assessment Committee are open only to members of the Patient Care Assessment Committee. The quorum required for the Patient Care Assessment Committee is fifty percent of the voting members of the Committee.

3.4. Functions (Sections 3.3a through 3.3j informational only)

a. The Governing Body shall establish a Qualified Patient Care Assessment Program as defined by the Board of Registration in Medicine, in these Bylaws, and in the Patient Care Assessment Plan.

b. The Patient Care Assessment Plan shall be reviewed no less than annually by the Governing Body and the Performance Improvement Committee.

c. The Patient Care Assessment Committee shall fulfill the functions of the Patient Care Assessment Committee in accordance with these Bylaws and the Qualified Patient Care Assessment Program, which includes policies, standards and procedures adopted by the Governing Body upon the recommendation of the Medical Staff to establish effective programs of quality management, risk prevention and management and medical peer review, and patient care assessment in accordance with the Qualified Patient Care Assessment Program regulations of the Board of Registration in Medicine, 243 CMR 3.00.

d. The Patient Care Assessment Committee shall review and coordinate proceedings, reports and records relating to peer review functions relative to members of the Medical Staff, Associate Clinical Staff and Support Staff. These include but shall not be limited to peer review functions of the various Clinical Departments, Quality Management Committee, Performance Improvement Committee, Credentials Committee and various Medical Staff Task Forces.

e. The Patient Care Assessment Committee shall ensure the participation of all members of the Medical Staff in the Qualified Patient Care Assessment Program.

f. All incident reports, summary reports and written recommendations to and from the Patient Care Assessment Committee shall be maintained for no less than three (3) years.

g. The Patient Care Assessment Committee shall be responsible for Medical Staff compliance with accreditation standards.

h. The Patient Care Assessment Committee shall implement Morbidity and Mortality Conferences as appropriate.

i. The Patient Care Assessment Committee is a medical peer review committee under Massachusetts law (Mass. G.L. Ch. 111, §1) and the proceedings, reports, records, findings, recommendations, evaluations, opinions, deliberations and other actions of the Patient Care Assessment Committee and by any other medical peer review committee of the Medical Staff or of the Hospital in its discharge of the medical peer review functions and the identity of any information provided to such medical peer review committees by witnesses or any other individuals are confidential, are not subject to subpoena or discovery, and may not be introduced into evidence into any judicial or administrative proceedings except with respect to proceedings held by the Board of Registration in Medicine to the extent permitted under Mass. G.L., Ch. 111, §204(a), or, to the extent permitted by law, with respect to proceedings against a member of, or witness to, a medical peer review committee under Massachusetts General Laws Chapter 231, Section 85N,

but in actions brought under Chapter 231, Section 85N the identity of any person furnishing information or opinions to a Medical Peer Review Committee may not be disclosed without permission of such person.

j. All individuals participating in the Hospital's Patient Care Assessment Committee peer review activities, in good faith and without malice, shall be immune from liability in accordance with the provisions of the Federal Health Care Quality Improvement Act and with applicable provisions of Massachusetts law, including without limitation Mass. G.L. Ch. 111, §203 and Mass. G.L. Ch. 231, §85N.

k. The Governing Body shall establish a Qualified Patient Care Assessment Program as defined by the Board of Registration in Medicine, in these Bylaws, and in the Patient Care Assessment Plan.

3.5. Patient Care Assessment Coordinator (section 3 for informational purposes)

a. The Chief Medical Officer shall be the Patient Care Assessment Coordinator, pursuant to the Board of Registration in Medicine Patient Care Assessment regulations at 243 CMR 3.00, and, in regard to the Anna Jaques Hospital Qualified Patient Care Assessment Program, shall be responsible to the Patient Care Assessment Committee.

b. The PCA Coordinator functions are as specified in these Bylaws, the Patient Care Assessment Plan, and the Board of Registration in Medicine Patient Care Assessment regulations at BRM 243CMR 3.00.

c. To protect the confidentiality of information and records both generated pursuant to the Board of Registration in Medicine Patient Care Assessment regulations at 243 CMR 3.00 and which also relate to the functions of a medical peer review committee and to assure that this information and these records are not subject to subpoena, discovery or introduction into evidence, the Patient Care Assessment Coordinator may designate such information and records as "proceedings, reports and records of a medical peer review committee" within the meaning of Mass. G.L. Ch. 111, §204(a).

Section 4 **Medical Staff Committees and Task Forces**

All Medical Staff committees are subcommittees of the Executive Committee. All Medical Staff task forces are task forces of the Executive Committee. Only the physician members shall vote on matters involving or related to medical peer review

4.1 **Credentials Committee**

a. Membership - The Credentials Committee shall consist of the Chair (Immediate Past-President) and current Vice-President of the Medical Staff and five (5) senior members of the Medical Staff (a member of the active medical staff for at least five (5) years, representing various departments of the Medical Staff, at least two (2) of whom shall be a past President of the Medical Staff appointed biannually by the President for a term of two years. One member representing the Governing Body shall also be on the Committee, appointed by the Chairperson of the Governing Body, for a two (2) year term; the Chief Medical Officer and the Director, Medical Staff Office shall be ex-officio of the Committee.

b. Meetings - The Credentials Committee shall meet monthly and shall report its recommendations to the Patient Care Assessment Committee. The Immediate Past President of the Medical Staff shall serve as Chairperson. Quorum shall be 50 percent of the voting members of the Credentials Committee.

c. Function - The Credentials Committee shall:

(i) Review the credentials of all applicants and the recommendations of each Department concerning such applicants, and make recommendations for membership and delineation of clinical privileges in accordance with these Bylaws and in compliance with the Regulations of the Board of Registration in Medicine of the Commonwealth of Massachusetts;

(ii) Review the credentials of all applicants for reappointment and redelineation of clinical privileges and the recommendations of each Department concerning such applicants, and to make recommendations for reappointment and redelineation of clinical privileges in accordance with these Bylaws and in compliance with the Regulations of the Board of Registration in Medicine of the Commonwealth of Massachusetts;

(iii) Report to the Executive Committee on each applicant for Medical Staff appointment or reappointment, Associate Clinical Staff appointment or reappointment, Support Staff appointment or reappointment, and delineated or redelineated clinical privileges;

(iv) Carry out such other duties as may be delegated to it by the President, the Executive Committee or the President of the Hospital; and

(v) Interview applicants, as necessary.

4.2 Physicians' Committee on Medical Education

a. Membership - The Physicians' Committee on Medical Education shall consist of at least five (5) members of the Medical Staff appointed by the President for a term of two (2) years. The President of the Medical Staff shall designate the Chairperson of this Committee from one of its physician members. The President of the Hospital may appoint additional non-physician members.

b. Meetings - The Physicians' Committee on Medical Education shall meet quarterly and shall report to the Executive Committee.

c. Function - The Physicians' Committee on Medical Education shall be responsible for:

(i) Helping coordinate the physicians' continuing medical education program by selecting priority topics and identifying practice gaps within a multi-disciplinary medical staff community;

(ii) Helping maintain the standards of medical education offered;

(iii) Advising Administration of adherence to accreditation guidelines set forth by the Massachusetts Medical Society and American College Continuing Medical Education (ACCME);

(vii) Integrating quality assurance and risk management and required credits of the Massachusetts Board of Registration in Medicine into the selection of continuing medical education programs.

4.3 Bylaws Committee

a. Membership **–** The Bylaws Committee shall consist of the Chair (Vice President) and at least five (5) members of the Medical Staff, either active or affiliate. These members shall be appointed by the President of the Medical Staff annually for a term of two (2) years. The Chief Medical Officer shall be an ex-officio member of the Bylaws Committee. The Director of the Medical Staff Office shall be ex-officio member of the Bylaws Committee.

b. Meetings – The Bylaws Committee shall meet at least quarterly and shall report recommendations to the Medical Executive Committee. If necessary, meetings may be held as often as monthly. A quorum shall be at least three (3) voting members of the Bylaws Committee.

c. Function

(i) The Bylaws Committee shall conduct an annual review of the medical staff bylaws, as well as the Rules and Regulations of the Medical Staff.

(ii) The Bylaws Committee will submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current requirements of The Joint commission, the Board of Registration of Medicine and the MMS. Changes may also reflect changes in current medical staff practices.

(iii) The Bylaws Committee will receive and evaluate recommendations for bylaws changes and Rules and Regulation changes as proposed by medical staff members and/or Med Exec committee

(iv) Any Active Medical Staff Member may initiate a proposal to supplement, amend or repeal any or all of these Bylaws by submitting such a proposal in writing to the Executive Committee who will refer it to the Medical Staff Bylaws Committee with or without recommendation.

4.4 **Physician Health Committee**

a. Membership – The Physician Health Committee shall consist of the Physician Chairperson, designated by the President of the Medical Staff, five (5) to seven (7) on staff physicians, including the hospital's Chief Medical Officer, representing a cross-section of age, sex and specialty. At least one member shall have an interest in, or expertise in, chemical dependency, mental illness and aging/cognitive problems. To the fullest extent possible, members should avoid membership on other committees that may conflict with their responsibilities on the Physician Health Committee. One member shall be designated as a liaison with the Massachusetts Medical Society and Physician Health Services, Inc.

b. Meetings – The Physician Health Committee shall meet on an ad hoc basis.

c. Function – Anna Jaques Hospital promotes appropriate physician health in order to insure the delivery of safe and effective care to patients. To accomplish this, the Physician Health Committee shall aid in the prevention of physician impairment and identify physicians in need of assistance in accordance with these Medical Staff Bylaws and Hospital Policy.

4.5 The Cancer Committee

a. Membership - The Cancer Committee shall consist of the Chair, appointed by the Medical Staff President and at least five (5) physician members of the Medical Staff, including a diagnostic radiologist, a pathologist, a general surgeon or surgical specialist involved in cancer care, a radiation oncologist and a medical oncologist. The Cancer Committee shall also consist of at least four (4) non-physician members.

b. Meetings - The Cancer Committee shall meet at least quarterly. A written record shall be kept of each meeting and shall be forwarded to the Medical Executive Committee.

c. Function - The Cancer Committee is responsible and accountable for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related program activities at Anna Jaques Hospital. The Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care.

Section 5 **Conferences**

Medical Staff Conferences shall include the Joint Conference, and the Tumor Conference.

5.1 **Joint Conference Committee**

a. Membership – The Joint Conference Committee shall consist of the Executive Committee of the Governing Body, the Executive Committee of the Medical Staff and appointed representatives of Hospital Administration. The Chairpersonship shall alternate between the Governing Body and Medical Staff every

other meeting.

b. Meetings – The Joint Conference Committee shall meet as needed. Meeting requests shall be submitted in writing to the chair of the governing body.

c. Function – This Committee shall:

(i) Be a liaison group to discuss medical-administrative matters and be the official point of contact among the Governing Body, the organized Medical Staff and the President of the Hospital.

(ii.) Undertake such duties as are assigned to it by the Governing Body or by the Medical Executive Committee.

(iii.) Serve as a forum and resource for managing conflicts among the Board of Trustees, the Medical Staff, and its leadership and Administration utilizing, when needed, appropriate personnel skilled in conflict management to meet with the involved parties as early as possible to identify the conflict, gather relevant information, and work with the parties to manage and, when possible, resolve the conflict all while protecting the safety and quality of care.

5.2 **Tumor Conference Committee**

The Tumor Conference Committee shall consist of one oncologist, one radiologist, one radiotherapist, one pathologist appointed by the President; and a Medical Record Representative. The Chairperson shall be appointed by the President. It shall meet monthly and shall report to the Executive Committee. The Tumor Conference shall be open to the entire Medical Staff and allow for case discussion by physicians from all disciplines on the management and treatment of the tumor. One Category One CME credit hour shall be granted for each Tumor Conference attended.

Section 6 **Task Forces**

Task Forces shall facilitate certain specific functions of the Executive Committee and Patient Care Assessment Committees. These shall include but not be limited to Nominating, Perinatal, Trauma and O.R, ICU/Code 99, Infection Control, Pharmacy & Therapeutics, Medical Records, Endoscopy, Cardiology and Breast Care.

These task forces shall develop their own working plan which must be approved by the Executive Committee and shall report to the Executive Committee on a regular basis but not less than annually.

All Medical Staff peer review issues discussed at task force meetings will be reported directly to the Performance Improvement Committee.

All Medical Staff non-peer review issues discussed at task force meetings will be reported directly to the Executive Committee.

Section 7 **Future Committees, Task Forces and Conferences**

From time to time it may be desirable to add, delete or consolidate committees, task forces and conferences of the Medical Staff or from Special Committees. Recommendations in this regard shall be made by the Executive Committee to the Governing Body.

ARTICLE XIV - MEETINGS OF THE MEDICAL STAFF

Section 1 **Annual Meetings**

The Annual Meeting of the Medical Staff shall take place prior to the conclusion of the Staff year. The Medical Staff year shall commence on January 1 and shall conclude on December 31.

Section 2 **Regular Meetings**

Regular meetings of the Medical Staff shall be held four times a year.

Section 3 **Special Meetings**

Special meetings of the Medical Staff shall take place upon proper notice to the Medical Staff within seven (7) days of receipt of such notice and agenda. Such meetings may be called by the President of the Hospital, the President of the Medical Staff upon the vote of the Executive Committee, and as described in these Bylaws.

Section 4 **Notice of Meetings**

At least seven (7) days prior to the date of each annual or regular meeting of the Medical Staff, written notice and agenda thereof shall be given to each member of the Medical Staff at his/her most recent address in the Hospital records. Every such notice shall state the place, date, hour and purpose of the meeting.

Section 5 **Quorum**

The quorum requirement for a Medical Staff meeting shall be twenty (20) **voting** members of the Medical Staff present. If any meeting shall be a valid meeting, the affirmative vote of at least a majority of the Medical Staff members present and eligible to vote, in person, or represented by written proxy, shall be sufficient for the transaction of ordinary business. Members may participate in a meeting by means of a conference telephone call or other communications equipment that allows all members participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

Section 6 **Voting Rights**

Medical Staff members eligible to vote shall be limited to those who are members of the Active Medical Staff or Courtesy Medical Staff. Votes may be cast by written proxies unless otherwise prohibited in these Bylaws.

ARTICLE XV - IMMUNITY FROM LIABILITY AND INDEMNIFICATION

Section 1 **Immunity from Liability**

The following shall be expressed conditions to any practitioner's application for or exercise of clinical privileges at this Hospital:

1.1 That any act, communication, report, recommendation or disclosure with respect to any such practitioner, performed or made in good faith and without malice at the request of an authorized representative of this or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be deemed a privileged communication to the fullest extent permitted by law, including, but not limited to, any act, communication, report, recommendation or disclosure performed, or made in connection with this or any other health care facilities' activities related to applications for appointment or clinical privileges, periodic reappraisals for reappointment or clinical privileges, corrective action including summary suspension, hearings and appellate review, medical peer review, medical care review, utilization review and other Hospital, Medical Staff Department or Committee activities related to quality patient care and professional conduct.

1.2 That the provisions in Section 1 of this Article XV shall extend to the acts, communications, reports, recommendations or disclosures of members of the Medical Staff and Governing Body and the employees and agents of the Hospital, and to third parties who supply information to any of the foregoing. (For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested).

1.3 That there shall to the fullest extent permitted by law be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed confidential.

1.4 That in furtherance of the foregoing, each practitioner shall upon request of the Hospital execute a release in accordance with the tenor and import of this Article.

Section 2

The Hospital agrees to indemnify and otherwise cover the costs of defense and of any settlements, judgments and damages incurred by any Medical Staff officer, department chief, assistant department chief, committee member, or member acting in good faith, as a result of carrying out duties under the Medical Staff Bylaws, Rules and Regulations, and Policies.

XVI - PARLIAMENTARY AUTHORITY

Section 1

All meetings of the Medical Staff, its sections, departments, committees, Executive Committee and Patient Care Assessment Committee shall be governed by the parliamentary rules and usage contained in the current edition of Sturgis Standard Code of Parliamentary Procedure when not in conflict with these bylaws.

XVII - AMENDMENTS TO BYLAWS, RULES AND REGULATIONS AND POLICIES

Section 1 Proposal to Amend the Bylaws

Any voting Medical Staff member may initiate a proposal to supplement, amend or repeal any or all of these Bylaws by submitting such a proposal in writing to the Executive Committee.

The Executive Committee shall refer it to the Medical Staff Bylaws Committee with or without recommendations. The Medical Staff Bylaws Committee must meet and consider the proposal within ninety (90) days. The recommendation of the Medical Staff Bylaws Committee shall then be reported to the Executive Committee for consideration.

The Medical Staff President shall submit the recommendations of the Medical Staff Bylaws Committee and of the Executive Committee to either a regular or special meeting of the Medical Staff.

The notice for the regular or special meeting of the Medical Staff shall contain the original proposal and such recommendations regarding it, and shall be distributed at least fifteen (15) days in advance of such meeting.

Section 2 Approval of Amendment to Bylaws

If such meeting conforms to the requirements of a valid meeting as stated in these Bylaws, the affirmative vote of at least two-thirds of the voting medical staff present at that meeting shall determine the Medical Staff's action on the proposal.

If such action shall result in any proposal to supplement, amend or repeal these Bylaws, the President of the Hospital shall submit such a proposal to the Governing Body.

Amendments to these Bylaws shall become effective on the first day of the following month following approval by the Governing Body, unless otherwise stated in the amendment.

Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws.

Should any voting medical staff member disagree with proposals to supplement, amend or repeal any Bylaw, adopted by the organized medical staff, the medical staff member may make a written request to the Chair of the Governing Body to convene a Joint Conference Committee meeting, pursuant to Article XIII of these bylaws.

Section 3 Adoption and Amendment of Rules and Regulations and Policies

The Medical Staff, by vote of the Medical Executive Committee, shall adopt, and may from time to time amend, such Rules and Regulations and Policies as are necessary or appropriate to implement the Medical Staff Bylaws, to define the general principles contained therein, or for patient care or the proper conduct and responsibilities of each practitioner in the Hospital.

The Governing Body, the Medical Executive Committee, or any voting member of the Medical Staff may propose an amendment to the Medical Staff Rules and Regulations and Policies.

Any Proposal to adopt a rule or regulation or policy, or an amendment thereto, is communicated to the medical staff. Any amendment to the Medical Staff Rules & Regulations and Policies requires the approval of the Governing Body. Neither the Medical Staff nor the Governing Body may unilaterally amend the Rules and Regulations or Policies of the medical staff.

Whenever changes are made to the Rules and Regulations or Policies of the Medical Staff, members shall be provided with revised texts of such changes. In cases of a documented need for an urgent amendment to the rules and regulations or policies necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the governing body may provisionally approve an urgent amendment. In such cases, the medical staff will be notified by the Medical Executive Committee and will have an opportunity to retrospectively review and comment on the provisional amendment.

Should any voting medical staff member disagree with proposals to adopt, supplement, amend or repeal any rule, regulation or policy, adopted by the Medical Executive Committee or organized medical staff, the medical staff member may make a written request to the Chair of the Governing Body to convene a Joint Conference Committee meeting, pursuant to Article XIII of these bylaws.

Section 4 Distribution

A copy of the Medical Staff Bylaws, Rules and Regulations and Policies are maintained online and are made available with each appointment and reappointment package. Hard copies are available upon request and shall be disseminated as may be determined by the Medical Staff President or the Medical Executive Committee, and shall be made available to Medical Staff members and other practitioners in the Hospital upon request.

Section 5 **Annual Review**

The Medical Staff Bylaws, and Rules and Regulations shall be reviewed bi-annually by August in even numbered years by the Bylaws Committee of the Medical Staff. The results of that review shall be reported to the Medical Executive Committee at its next regularly scheduled meeting following such review. Any issues that require a vote of the General Medical Staff, pursuant to the annual bylaws review, will be voted on at the November General Medical Staff meeting.

XVIII – ADOPTION OF BYLAWS

These Bylaws, Rules and Regulations of the Medical Staff shall supersede all prior Bylaws, Rules and Regulations of the Medical Staff and similar or related documents.

These Bylaws shall be adopted following review, constructive comment and approval by the members of the Medical Staff and approval by the Governing Body. Notice of the meeting shall be made in conformity with these Bylaws and shall contain an express reference to the review of these proposed Bylaws. Approval by the Medical Staff shall be performed in conformity with these Bylaws.

A copy of these Bylaws shall be readily available to any member of the Medical Staff so requesting.

Written 11/17
Approved MSEC 11/16/79
Approved BOT 12/19/79

Revision 7/87
Approved MSEC 7/31/87
Approved BOT 8/26/87

Revision 2/88
Approved MSEC 3/7/88
Approved BOT 3/88

Revision 7/88
Approved MSEC 7/11/88
Approved BOT 9/28/88

Revision 11/88
Approved MSEC 11/7/88, 11/18/88
Approved BOT 11/23/88

Revision 1/89
Approved MSEC 1/9/89
Approved BOT 1/25/89

Revision 3/89
Approved MSEC 3/13/89
Approved BOT 3/22/89

Revision 4/89
Approved MSEC 5/1/89
Approved BOT 5/24/89

Revision 5/89
Approved MSEC 6/89
Approved BOT 6/28/89

Revision 8/89
Approved MSEC 9/11/89
Approved BOT 9/27/89

Revision 1/90
Approved MSEC 12/28/89, 1/22/90
Approved BOT 1/24/90

Revision 1/91
Approved MSEC 10/1/90
Approved BOT 11/28/90

Revision: 09/04
Approved: 11/22/04
Approved BoT: 12/18/04

Revision: 08/05
Approved: 09/05
Approved BoT: 10/19/05

Revision 1/92
Approved MSEC 10/7/91
Approved BOT 3/19/92

Revision 1/1/93
Approved MSEC 9/14/92
Approved BOT 12/23/92

Revision 1/1/94
Approved MSEC 10/04/93
Approved BOT 11/24/93

Revision 1/1/95
Approved MSEC 1/13/95
Approved BOT 2/22/95

Revision 1/1/96
Approved MSEC 11/3/95
Approved BOT 11/29/95

Revision 12/11/96
Approved MSEC 12/13/96
Approved BOT 1/27/97

Revision 12/17/97
Approved MSEC 1/9/98
Approved BOT 2/25/98

Revision: 11/13/98
Approved MSEC 11/13/98
Approved BOT 2/24/99

Revision: 10/17/01
Approved MS: 11/16/01
Approved MSEC 02/08/02
Approved BOT: 02/27/02

Revision: 12/20/01
Approved MS: 03/15/02
Approved BOT: 03/27/02

Revision: 10/02/02
Approved MS: 11/15/02
Approved BOT: 12/18/02
Revision: 10/15/03
Approved MS: 11/21/03
Approved BOT: 12/17/03

Revision: 05/05
Approved:09/05
Approved BoT: 10/19/05

Revision: 04/07
Approved by MSEC: 04/04/07
Approved by MS: 05/18/07
Approved by BoT: 06/20/07

Revision:
Approved by MSEC:
Approved by MS: 11/16/07
Approved by BOT: 03/19/08

Revision: 12/05/07
Approved by MSEC: 02/08/08
Approved by MS: 05/16/08
Approved by BOT: 06/18/08

Revision: 07/02/08
Approved by MSEC 08/08/08
Approved by MS: 11/21/08
Approved by BOT: 12/17/08

Revision: 10/01/08
Approved by MSEC 0912/08
Approved by MS: 11/21/08
Approved by BOT: 12/17/08

Revision: 04/01/09
Approved by MSEC 04/10/09
Approved by MS: 05/16/09
Approved by BOT: 05/20/09

Revision:
Approved by MSEC 09/11/09
Approved by MS: 11/20/09
Approved by BOT: 12/16/2009

Approved by MSEC: 6.11.10; 5.14.10
Approved by MS: 8.20.10
Approved by BOT: 9.15.10

Approved by MSEC: 1/2011
Approved by BoT: 2/2011
Approved by BoT: 3/2011
Effective: 4/1/2011

Revision: 6.1.11
Approved MSEC: 7/2011
Approved MS: 8/2011
Approved BoT: 9/2011
Effective: 10.1.11

Revision 10/2011
Approved MSEC: 10/2011
Approved by MS: 11/2011
Approved by BoT: 12/2011

Revision 12.7.11
Approved MSEC: 1.13.12
Approved Med Staff: 2.17.12
Approved BoT: 2.29.12
Effective: 3.1.12

Revisions: Article III. b., c., g; Article IV; article VI 3.4
Approved by MSEC 8.2012
Approved by MS: 8.2012
Approved by BOT: 11.2012

Revision Article III. New Section 4
Approved MSEC: 10.2012
Approved by MS: 2.2013
Approved by BoT: 3.28.13
Effective: April 1, 2013

Revision III: Section 4.2; Article V, section 1.3; Article XIV section 1
Approved MSEC: 5/2013
Approved by MS: 5/2013
Approved by BoT: 5/2013
Effective: June 1, 2013

Annual Review of all sections 6/2014
Approved MSEC: 10.10.14
Approved MS: 02.13.15
Approved BoT: 02.26.15
Effective: 02.26.15

Revision Article IV, Honorary Medical Staff, Article IV, Senior Medical Staff; Article XIV, Quorum
Approved MSEC: 3.13.15
Approved MS: 03.23.15
Approved BoT: 03.26.15
Effective: 03.26.15

Revision Article XIII, Committees, Section 6, Task Forces; Article XVII, Amendments to Bylaws, Rules and Regulations and Policies, Section 5, Annual Review; Article V, Procedure for Appointment & Reappointment, Section 2, Application for Reappointment, 2.2a; Article V, Procedure for Obtaining Clinical Privileges, Section 7, Disaster Emergency Privileges, 1.
Approved MEC: 06.12.15
Approved MS: 06.22.15
Approved BoT: 06.25.15
Effective: 06.25.15

Revision Article V, Section 3, Leave of Absence
Approved MEC: 8.14.15
Approved MS: 9.24.15
Approved BoT: 12.17.2015
Effective: 12.17.15

Revision Article III, Section 1.3 Board Certification
Article IV Categories of the Staff Membership
Article V Appointment and Reappointment Section 1.3 Processing Application; Section 2 Application for reappointment 2.3 Processing the Application
Article VI Procedure for Obtaining Clinical privileges Section 2 Granting Privileges 2.2 Processing the Application for Privileges
Article VIII Corrective Action Section 4 Automatic Suspension
Article XII Committees Section 4 medical Staff Committees and Task Forces 4.1 Credentials Committee
Approved MEC: 03.11.15
Approved MS: 03.14.15
Approved BoT: 03.31.15
Effective 03.31.15

Revision Article VI Section 3. Temporary Privileges – Allowing Administrative Temp Privileges
Article III, Section 1.3 Board Certification – Podiatry Certifying Board
Article XII Committee Section. Section 4 Addition of The Cancer Committee
Approved by MEC: 06.10.16
Approved by MS: 06.14.16
Approved by BoT: 06.30.16
Effective: 06.30.16

Revision Article III Qualifications for Staff Membership re board certification wording for associate clinical staff
Revision Article IV Categories of Staff Membership – Addition of Retired Staff Status
Approved by MEC: 3/9/2018
Approved by MS: 6/19/2018
Approved by BoT: 6/28/18
Effective: 6/28/2018

Revision Article V Procedure for Appointment and Reappointment Section 11.4 Initial Appointment: RE: FPPE upon reaching the age of 75.
Revision Article XIII – Committees. RE: Change committee appointment to every two years.
Approved by MEC: 6/8/2018
Approved by MS: 9/25/2018
Approved by BoT: 9/27/2018
Effective 9/27/2018

Revision Article IV Categories of Staff Membership; Senior Medical Staff. Removed requirement of President of medical Staff to approve.
Revision Article III Qualifications for Staff Membership. Section 4 Medical Record Suspension Threshold.
Approved by MEC: 6/7/19
Approved by MS: 9/17/19

Approved by BoT: 9/26/19
Effective: 9/26/19

Revision Article IV Categories of Staff Membership. Section 4 Residents and Fellows
Approved MEC: 12/13/2019
Approved MS: 1/28/2020
Approved BOT: 7/30/2020
Effective 7/30/2020

Revision after biennial review. Updating proper names of the podiatric qualifying boards, inclusion of gender and sexual orientation in the application for appointment section
Approved MEC: 12/13/2019
Approved MS: 9/15/20
Approved BOT: 9/24/20
Effecitve 9/24/20