ST. MARY'S HOSPITAL
MEDICAL STAFF BYLAWS,
POLICIES AND RULES AND REGULATIONS

MEDICAL STAFF BYLAWS

Approved by the Medical Staff
November 16, 2007

Approved by the Board of Directors
12/20/07
Horty, Springer & Mattern, P.C.
AMENDMENTS TO MEDICAL STAFF BYLAWS, RULES AND PROCEDURES

MEDICAL STAFF BYLAWS:

<table>
<thead>
<tr>
<th>ARTICLE</th>
<th>MEDICAL STAFF APPROVAL</th>
<th>BOARD APPROVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARTICLE 2.1 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j)</td>
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<td>04/16/14</td>
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<td>ARTICLE 2.AB</td>
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<td>ARTICLE 2.C</td>
<td>07/31/14</td>
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<td>ARTICLE 5.B.1 (a)</td>
<td>09/24/09</td>
<td>10/08/09</td>
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<tr>
<td>ARTICLE 5.B.1 (a)</td>
<td>05/23/11</td>
<td>06/06/11</td>
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<tr>
<td>ARTICLE 5.B.1 (c)</td>
<td>01/17/12</td>
<td>03/08/12</td>
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<tr>
<td>ARTICLE 5.B.1 (e)</td>
<td>09/24/09</td>
<td>10/08/09</td>
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<tr>
<td>ARTICLE 5.B.2 (g)</td>
<td>05/23/11</td>
<td>06/06/11</td>
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<tr>
<td>ARTICLE 5.C.1 (g)</td>
<td>09/24/09</td>
<td>10/08/09</td>
</tr>
<tr>
<td>ARTICLE 5.C.1 (h)</td>
<td>09/24/09</td>
<td>10/08/09</td>
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<tr>
<td>ARTICLE 5.C.3 (e)</td>
<td>09/24/09</td>
<td>10/08/09</td>
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<tr>
<td>ARTICLE 5.C.3 (f)</td>
<td>09/24/09</td>
<td>10/08/09</td>
</tr>
<tr>
<td>ARTICLE 8(c)</td>
<td>09/23/10</td>
<td>10/07/10</td>
</tr>
<tr>
<td>ADDENDUM (H&amp;P)</td>
<td>09/24/09</td>
<td>10/08/09</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>1. GENERAL</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A. DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>1.B. TIME LIMITS</td>
<td>2</td>
</tr>
<tr>
<td>1.C. DELEGATION OF FUNCTIONS</td>
<td>2</td>
</tr>
<tr>
<td>1.D. MEDICAL STAFF DUES</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. CATEGORIES OF THE MEDICAL STAFF</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A. ACTIVE STAFF</td>
<td>5</td>
</tr>
<tr>
<td>2.A.1. Qualifications</td>
<td>5</td>
</tr>
<tr>
<td>2.A.2. Prerogatives</td>
<td>6</td>
</tr>
<tr>
<td>2.A.3. Responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>2AA. SENIOR ACTIVE STAFF</td>
<td>7</td>
</tr>
<tr>
<td>2AA.1 Qualifications</td>
<td>7</td>
</tr>
<tr>
<td>2AA.2 Prerogatives</td>
<td>7</td>
</tr>
<tr>
<td>2AB. ACTIVE ADMINISTRATIVE STAFF</td>
<td>7</td>
</tr>
<tr>
<td>2.AB.1 Qualifications</td>
<td>8</td>
</tr>
<tr>
<td>2.AB.2 Prerogatives</td>
<td>8</td>
</tr>
<tr>
<td>2.AB.3 Responsibilities</td>
<td>8</td>
</tr>
<tr>
<td>2.B. ASSOCIATE STAFF</td>
<td>9</td>
</tr>
<tr>
<td>2.B.1. Qualifications</td>
<td>10</td>
</tr>
<tr>
<td>2.B.2. Prerogatives and Responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>2.B.3 Responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>2.C. COMMUNITY ACTIVE STAFF</td>
<td>10</td>
</tr>
<tr>
<td>2.C.1. Qualifications</td>
<td>10</td>
</tr>
<tr>
<td>2.C.2. Prerogatives</td>
<td>10</td>
</tr>
</tbody>
</table>
2.C.3. Responsibilities

2.D. CONSULTING STAFF

2.D.1. Qualifications
2.D.2. Prerogatives and Responsibilities

2.E. COURTESY STAFF

2.E.1. Qualifications
2.E.2. Prerogatives and Responsibilities

2.F. EMERITUS STAFF

2.F.1. Qualifications
2.F.2. Prerogatives and Responsibilities

3. OFFICERS

3.A. DESIGNATION

3.B. ELIGIBILITY CRITERIA

3.C. DUTIES

3.C.1. Chief of Staff
3.C.2. Associate Chief of Staff
3.C.3. Secretary-Treasurer
3.C.4. Immediate Past Chief of Staff

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Committee

3.E. VACANCIES AND REMOVAL

3.E.1. Vacancies in Office
3.E.2. Removal from Office

PAGE
4. CLINICAL DEPARTMENTS ........................................................................................................ 22

4.A. ORGANIZATION .................................................................................................................. 22

4.A.1. Organization of Departments ....................................................................................... 22
4.A.2. Assignment to Department .......................................................................................... 22
4.A.3. Functions of Departments .......................................................................................... 23

4.B. DEPARTMENT CHAIRPERSONS .................................................................................. 23

4.B.1. Qualifications of Department Chairpersons ................................................................ 23
4.B.2. Selection of Department Chairpersons ....................................................................... 23
4.B.3. Roles and Responsibilities of Department Chairpersons ........................................... 24
4.B.4. Removal of Department Chairpersons ....................................................................... 24

4.C. DEPARTMENTS/SECTIONS ......................................................................................... 25

4.C.1. Functions of Department/Section ................................................................................ 25
4.C.2. Qualifications and Appointment of Section Chief ....................................................... 26
4.C.3. Duties of Section Chief ............................................................................................... 26

5. MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS .......... 27

5.A. APPOINTMENT .............................................................................................................. 27

5.B. MEDICAL EXECUTIVE COMMITTEE .......................................................................... 27

5.B.1. Composition ................................................................................................................ 27
5.B.2. Duties .......................................................................................................................... 28
5.B.3. Meetings, Reports and Recommendations ................................................................. 30

5.C. PERFORMANCE IMPROVEMENT AND MEASUREMENT FUNCTIONS ......................... 30

5.D. CREATION OF STANDING COMMITTEES AND TASK FORCES ....................... 32
6. **MEETINGS** ..................................................................................................................................33
   6.A. **GENERAL** ................................................................................................................................33
       6.A.1. Medical Staff Year ................................................................................................................33
       6.A.2. Meetings ..................................................................................................................................33
       6.A.3. Regular Meetings ..................................................................................................................34
       6.A.4. Special Meetings ....................................................................................................................34
       6.A.5. Notice ......................................................................................................................................34
       6.A.6. Quorum ....................................................................................................................................34
       6.A.8. Agenda ......................................................................................................................................35
       6.A.10. Minutes ...................................................................................................................................36
       6.A.11. Attendance Requirements ......................................................................................................37
   6.B. **CONFIDENTIALITY** ..................................................................................................................37

7. **MISCELLANEOUS** ..........................................................................................................................38
   7.A. **CONFLICT OF INTEREST** ..........................................................................................................38
   7.B. **INDEMNIFICATION** ....................................................................................................................39
   7.C. **RULES AND REGULATIONS OF THE MEDICAL STAFF** ..........................................................39
   7.D. **OTHER MEDICAL STAFF DOCUMENTS** ..................................................................................40

8. **AMENDMENTS** ..............................................................................................................................41

9. **ADOPTION** .....................................................................................................................................43

**ADDENDUM A: HISTORY AND PHYSICAL EXAMINATION** ..........................................................44
ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in these Bylaws and related policies and manuals:

(1) "ALLIED HEALTH PRACTITIONER" means individuals other than members of the Medical Staff who are authorized by law to provide patient care services and whose scope of practice is defined in the Allied Health Practitioners Policy.

(2) "BOARD" means the Board of Directors of the Hospital which has the overall responsibility for the Hospital and approves and complies with the medical staff bylaws.

(3) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(5) "CREDENTIALING POLICY" means the Hospital's Medical Staff Credentialing Policy.

(6) "DAYS" means calendar days.

(7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(8) "HOSPITAL" means St. Mary's Hospital in Waterbury, Connecticut.

(9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
(10) "MEDICAL STAFF" means all physicians, dentists, oral surgeons and podiatrists, and allied health professionals who have been appointed to the Medical Staff and granted clinical privileges.

(11) “ORGANIZED MEDICAL STAFF” means a group of licensed independent practitioners responsible for oversight of care, treatment, and services provided by the practitioners with privileges, provides for a uniform quality of patient care, treatment, and services and for approval and amendment, enforcement and adherence to the Medical Staff Bylaws, and reports to and is accountable to the Board.

(12) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

(13) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(14) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.

(15) "PODIATRIST" means a doctor of podiatric medicine.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS
When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the Medical Executive Committee and may vary by category.

(2) Dues shall be payable annually. Failure to pay dues shall result in ineligibility to apply for reappointment to the Medical Staff.

(3) Signatories to the Hospital's Medical Staff account shall be the Chief of Staff or Secretary-Treasurer.
ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

(1) Qualifications and conditions for appointment to the Medical Staff as listed below are outlined in detail in the Credentialing Policy.

(a) The process for credentialing and re-credentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing other practitioners.

(b) The process for appointment and reappointment to membership on the medical staff.

(c) The indications for automatic suspension of practitioner’s medical staff membership or clinical privileges.

(d) The indications for summary suspension of a practitioner’s medical staff membership or clinical privileges.

(e) The indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.

(f) The process for automatic suspension of a practitioner’s medical staff membership or clinical privileges.

(g) The process for summary suspension of a practitioner’s medical staff membership or clinical privileges.

(h) The process for recommending termination or suspension of medical staff membership and/or termination, suspension or reduction of clinical privileges.

(i) The fair hearing and appeal process which at a minimum shall include:
   · The process for scheduling hearings and appeals
The process for conducting hearings and appeals

(j) The composition of the fair hearing committee.

The qualifications for appointment to the specific categories of the Medical Staff are outlined below.

(2) All appointments to the Medical Staff shall be made by the Board to one of the following staff categories: Active, Senior Active, Associate, Community Active, Consulting, Courtesy, and Emeritus. Only those individuals who satisfy the qualifications and conditions contained in the Credentialing Policy are eligible to apply for appointment to the Medical Staff.

(3) The qualifications, prerogatives and responsibilities set forth below are general in nature and may be subject to revision or modification by the Board upon recommendation by the Medical Executive Committee.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of members who:

(a) satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentialing Policy; and

(b) are involved in at least 20 patient contacts per appointment term.
2.A.2. Prerogatives:

Active Staff members:

(a) may vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings;

(b) may hold office, serve as a chairperson of a department or committee or as chief of a service;

(c) may attend meetings of the Medical Executive Committee, without vote, so long as two weeks' notice is given to the Chief of Staff. Participation in such meetings may be limited by the Chief of Staff and shall not include attendance at any portion of the meeting dealing with confidential peer review issues.

2.A.3. Responsibilities:

(a) Active Staff members must:

(1) assume all the responsibilities of membership on the Medical Staff, as assigned, including committee service, emergency call, care of unassigned patients and evaluation of members during the provisional period.

(2) actively participate in the peer review and performance improvement process;

(3) accept consultations where applicable;

(4) attend staff and applicable department and committee meetings; a

(5) pay application fees and dues.

(b) Members of the Active Staff who are at least 62 years of age or who have served on the Active Staff for at least 25 years may request removal from emergency call and other rotational obligations.
(c) A change in status requested during the calendar year requires the endorsement of the Section Chief and/or Department Chair. The requesting member is obligated to complete his emergency call and other rotational duties through the current calendar year.

2.AA  SENIOR ACTIVE STAFF

2AA.1 Qualifications:

The Senior Active Staff shall consist of members who:

(a) satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentialing policy; and

(b) are at least 62 years of age or have served on the Active Staff for at least 25 years.

(c) A change in status requesting during the calendar year requires the endorsement of the Section Chief and/or Department Chair. The requesting member is obligated to complete his emergency call and other rotational duties through the current calendar year.

2AA.2 Prerogatives:

Same as Active Staff members with addition:

May request removal from Emergency call and other rotational obligations.

2.AB.ACTIVE ADMINISTRATIVE STAFF:
It is recognized that physicians and dentists requesting appointment to this category are essential to the community and are clinically active. They are usually treating large numbers of patients within the community and actively participating in assisting the hospital in fulfilling its mission.

2.AB.1 Qualifications:
The Active Administrative Staff shall consist of members who:

(a) Have, or have had, a Board certification recognized by the American Board of Medical Specialties.

(b) Acts in a Senior Administrative capacity within the hospital.

2.AB.2 Prerogatives:
The Active Administrative Staff members:

(a) Do not participate in Emergency call and other rotational obligations

(b) Do not have clinical privileges and, therefore, are not permitted to admit, consult, or attend patients.

(c) May not hold office or serve as Chairperson of any Department or committee or Chief of any service;

2.AB.3 Responsibilities:

(a) Active Administrative Staff members must:

(1) Assume all applicable responsibilities of membership on the Medical Staff:

(2) actively participate in peer review and performance improvement process;

(3) attend staff and applicable department and committee meetings/ and may function as may be required.
(4) Are required to pay dues.

(b) A change in status requested during the calendar year requires the endorsement of the CEO, Medical Executive Committee, and Board of Directors.

2.B. ASSOCIATE STAFF

2.B.1. Qualifications:

(a) The Associate Staff shall consist of members who are in the process of becoming eligible for appointment to the Active Staff and who meet all other qualifications of Active Staff appointment during their one-year appointment to this staff category.

(b) Upon completing one year on the Associate Staff, individuals who meet the qualifications for appointment to the Active Staff may request to be advanced to this staff category.

2.B.2. Prerogatives:

Associate Staff members:

(a) may attend Medical Staff meetings (without vote) and applicable department, service, and committee meetings (with vote); and

(b) may not hold office or serve as chairperson of any department or committee or as chief of any service.

2.B.3. Responsibilities:

Associate Staff members must:

(a) assume all the functions and responsibilities of membership on the Medical Staff;
(b) actively participate in the peer review and performance improvement process;
(c) attend Medical Staff and applicable department and committee meetings; and may be requested to respond to reasonable requests to perform Medical Staff functions, as may be required;
(d) pay application fees and dues.

2.C. COMMUNITY ACTIVE STAFF:
It is recognized that physicians and dentists requesting appointment to this category are essential to the community and are clinically active. They are usually treating large numbers of patients, within the community and actively participating in assisting the hospital in fulfilling its mission.

2.C.1 Qualifications:
The Community Based Staff shall consist of physician and dentists, each of whom:
(a) satisfies the basic qualifications and conditions for appointment to the Medical Staff contained in the Credentialing Policy; and
(b) is involved in the clinical affairs of the hospital and is clinically active within the hospital’s service area.

2.C.2 Prerogatives:
A Community Active Staff member:
(a) may attend meetings of the staff, serve on hospital committees, attend hospital education programs.
(b) may vote on all matters presented at general and special meetings of the medical staff and hospital committees of which he/she is a member.

2.C.3 Responsibilities:
If a physician is on the Medical Staff with Community Active Staff status and requests to be moved to the Active Medical Staff one of two different algorithms should be applied.

(a) If the physician previously had full Active Privileges and then moved to Community Staff status for a period of less than two years, their Active privileges would be automatically reinstated upon a written request by that physician sent to the Chief of the Medical Staff.

(b) If the physician has had Community Staff Status for greater than two years and then requests reactivitation to Full Active Staff membership, the physician must undergo a period of provisional privileges for a period of not less than three months and not greater than twelve months. During that period, the physician must undergo a full FPPE, the content of which would be determined by the Department Chair dependent on the specific situation of that physician and approved by the Credentials Committee and the Medical Executive Committee.

i. For example, if the physician had full Active privileges for ten years, then moved to Community Status for twenty-six months, their FPPE might be as simple as an intensive monthly review of that physician’s by chart review only.

ii. In another example in the more extreme case, if a physician had Active privileges for ten years then was on Community status for ten years, there might be a more prolonged FPPE involving the requirement for precepting, attending educational
conferences, etc. prior to that physician’s being elevated from provisional status.

2. If a physician on the Medical Staff never had prior Active Staff privileges, not only Community status, that physician requesting Active privileges would be required to have provisional status and undergo FPPE process similar to case “b” above.

2.D. CONSULTING STAFF

2.D.1. Qualifications:

(a) The Consulting Staff shall consist of practitioners who are faculty members of a medical school who are recommended by that medical school to assist in teaching at the Hospital or are of recognized professional ability and expertise who provide a service no otherwise available on the Medical Staff.

(b) provide services at the Hospital only at the request of other members of the Medical Staff;

(c) are members in good standing of the Active Staff at another hospital where they are currently practicing unless an exception is made by the Medical Executive Committee for physicians practicing in a specialty that has a limited hospital practice; and

(d) at each reappointment time, provide evidence of clinical performance in such form as may be required by the Credentials Committee, Medical Executive Committee or Board, in order to allow for an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges.

2.D.2. Prerogatives and Responsibilities:
Consulting Staff members:
(a) may treat (but not admit) patients in conjunction with another physician on the Active Staff;
(b) may attend meetings of the Medical Staff (without vote) and applicable department, service and committee meetings (with vote);
(c) may not hold office or serve as a chairperson of a department or committee or chief of a service;
(d) must pay application fees but not dues.

2.E. COURTESY STAFF
2.E.1. Qualifications:

The Courtesy Staff shall consist of members who:

(a) should have more than two but must have fewer than 20 patient contacts per appointment term (involvement in a greater number of patient contacts shall result an immediate and automatic transfer to the Active Staff);
(b) are members in good standing of the Active Staff at another hospital where they are currently practicing or have previously served as a member of the Active Staff of the Hospital for a period of at least three years; and
(c) at each reappointment time, provide evidence of clinical performance at their primary hospital in such form as may be requested. In addition, especially for those Courtesy Staff members who do not maintain a primary appointment at another hospital, they shall provide other information as may be required in order to perform an appropriate evaluation of qualifications.
2.E.2. Prerogatives and Responsibilities:

   Courtesy Staff members:

   (a) may attend Medical Staff and applicable department and service
       meetings (without vote);
   (b) may not hold office or serve as chairperson of a department or
       committee or as chief of a service;
   (c) may serve on committees (with vote);
   (d) shall cooperate in the peer review and performance improvement
       process; may be requested to respond to requests to perform Medical
       Staff functions, as may be required;
   (e) must pay application fees and dues.
   (f) A change in status requesting during the calendar year, after having
       served as a member of the Active Staff of the Hospital for a period of at
       least three years, requires the endorsement of the Section Chief and/or
       Department Chair.

2.F. EMERITUS STAFF

2.F.1. Qualifications:

   The Emeritus Staff shall consist of practitioners who are recognized for
   outstanding or noteworthy contributions to the medical sciences or have a
   record of previous long-standing service to the Hospital and have retired from
   the active practice of medicine.

2.F.2. Prerogatives and Responsibilities:

   Emeritus Staff members:

   (a) do not have clinical privileges and therefore are not permitted to admit,
       consult, or attend to patients;
(b) may attend meetings of the Medical Staff and applicable department and service meetings (without vote);

(c) may be appointed to committees (with vote);

(d) may not hold office or serve as chairperson of any department or committee or as chief of any service; and

(e) are not required to pay application fee or dues.
ARTICLE 3
OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be:

- Chief of Staff
- Associate Chief of Staff
- Secretary-Treasurer
- Immediate Past Chief of Staff

3.B. ELIGIBILITY CRITERIA

Only those members of the Organized Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

1. be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years;
2. have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
3. not presently be serving as a Medical Staff officer, Board member or department chairperson at any other hospital and shall not so serve during their term of office;
4. be willing to faithfully discharge the duties and responsibilities of the position;
5. have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
6. attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;
(7) have demonstrated an ability to work well with others; and
(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with any other state licensed institution that competes with the Hospital or any affiliate.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the Chief Executive Officer and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;

(d) appoint all committee chairpersons and committee members, in consultation with the Medical Executive Committee, and input from the Nominating Committee, subject to review by the Board;

(e) serve as chairperson of the Medical Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, ex officio, without vote;

(f) promote adherence to the bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital;

(g) recommend Medical Staff representatives to Hospital committees; and

(h) perform all functions authorized in all applicable policies.
3.C.2. Associate Chief of Staff:
The Associate Chief of Staff shall:
(a) assume all duties of the Chief of Staff and act with full authority as Chief
of Staff in his or her absence;
(b) serve on the Medical Executive Committee; and
(c) assume all such additional duties as are assigned to him or her by the
Chief of Staff or the Medical Executive Committee.

3.C.3. Secretary-Treasurer:
The Secretary-Treasurer shall:
(a) be responsible for providing notices as specified in these Bylaws;
(b) serve on the Medical Executive Committee;
(c) cause to be kept accurate and complete minutes of all Medical Staff
meetings;
(d) be responsible for the collection of, accounting for, and disbursements of
any funds collected, donated, or otherwise assessed and present in the
Medical Staff Fund and report to the Medical Staff; and
(e) attend to such other duties as ordinarily pertain to this office.

3.C.4. Immediate Past Chief of Staff:
The Immediate Past Chief of Staff shall:
(a) serve on the Medical Executive Committee;
(b) serve as an advisor to other medical staff leaders;
(c) serve as chairperson of the Nominating Committee
(d) assume all duties assigned by the Chief of Staff or the Medical Executive
Committee.
3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Committee:

(a) The Nominating Committee shall be comprised of the Chief of Staff, the Immediate Past Chief of Staff, and three Department Chairpersons selected by the Medical Executive Committee. The Immediate Past Chief of Staff shall serve as chairperson of the Nominating Committee.


(a) Ten weeks prior to the annual meeting of the Medical Staff, the Nominating Committee shall send notice to all eligible staff members asking them to notify their Department Chairperson and/or the Nominating Committee of any interest in being nominated for an officer position or to serve as an at-large member of the Medical Executive Committee.

(b) The Nominating Committee shall meet eight weeks prior to the annual meeting to consider nominees for each office and for the at-large members of the Medical Executive Committee.

(c) The Nominating Committee shall contact all potential nominees, advise them of the obligations of the office or position for which they are being considered, and inquire about their willingness to serve. The Nominating Committee shall also consider whether potential nominees satisfy the qualifications set forth in Section 3.B of these Bylaws. Only individuals who satisfy these qualifications shall be included on the slate of nominees.

(d) At least four weeks prior to the election, the Medical Staff shall be provided with a list of the nominees and the offices or positions for which they have been nominated.
(e) No later than two weeks prior to the election, a petition signed by at least 10% of the members of the Organized Medical Staff may be submitted to the Chief of Staff naming a qualified member of the Medical Staff for inclusion on the ballot. The Chief of Staff shall deliver a copy of the petition to the Nominating Committee.

(f) The Nominating Committee shall contact any individual identified on the petition to discuss the obligations of the office and ascertain his or her willingness to serve. The Nominating Committee will also determine whether such individual satisfies the qualifications as set forth in Section 3.B of these Bylaws.

(g) At least one week prior to the election, the Nominating Committee shall prepare a final ballot, a copy of which will be provided to all voting members of the Medical Staff. Nominations from the floor shall not be accepted.

3.D.3. Election:

(a) The election shall be by ballot. Candidates receiving a majority of the votes cast shall be elected, subject to Board confirmation.

(b) If no candidate receives a simple majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

3.D.4. Term of Office:

(a) The officers of the Medical Staff shall take office on the first day of the medical staff year and shall serve a two-year term, and no more than two terms.
(b) At-large members of the Medical Executive Committee shall serve a four-year term which may be renewed.

3.E. VACANCIES AND REMOVAL

3.E.1. Vacancies in Office:

(a) A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff, who shall serve until the end of the Chief's unexpired term. In the event there is a vacancy in another office, the Medical Executive Committee, at its discretion, shall appoint an individual to fill the office for the remainder of the term or until a special election can be held.

(b) The prior Nominating Committee shall nominate candidates and the nomination and election process set forth above will then be followed.

3.E.2. Removal from Office:

(a) Removal of an elected officer or an at-large member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Staff, the Medical Executive Committee, or the Board for:

(1) failure to comply with applicable policies, bylaws, or rules and regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Hospital and/or the Medical Staff;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continuously satisfy the criteria set forth in Section 3.B of these Bylaws.
(b) At least ten days prior to the initiation of any removal action, the individual shall be given special notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Staff, the Medical Executive Committee, or the Board prior to a vote on removal.

(c) Removal proceedings undertaken by the Medical Staff or the Medical Executive Committee shall be effective when approved by a majority of the Board.
ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1. Organization of Departments:

(a) The Medical Staff shall be organized into the current departments as follows:
   - Anesthesiology
   - Dentistry
   - Emergency Services
   - Medicine
   - Obstetrics & Gynecology
   - Pathology
   - Pediatrics
   - Psychiatry
   - Radiology
   - Surgery

(b) The Medical Executive Committee may create new departments, eliminate departments, create services within departments, or otherwise reorganize the department structure subject only to the approval of the Board. A complete list of all departments and services shall be set forth in the Organization and Functions Manual.

4.A.2. Assignment to Department:

(a) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department
does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(b) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.A.3. Functions of Departments:

(a) The departments shall be organized for the purpose of implementing processes to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, and to monitor the practice of all those with clinical privileges in a given department.

(b) Each department shall assure emergency call coverage for all patients.

4.B. DEPARTMENT CHAIRPERSONS

4.B.1. Qualifications of Department Chairpersons:

Each department chairperson shall:

(a) be an Active Staff member;
(b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
(c) satisfy the eligibility criteria in Section 3.B of these Bylaws.

4.B.2. Selection of Department Chairpersons:

(a) Except as otherwise provided by contract, department chairpersons shall be elected by the department, subject to confirmation by the Board.
4.B.3. Role and Responsibilities of Department Chairpersons:

Each department chairperson is accountable for the following:

(a) all clinically and administratively related activities of the department; unless otherwise provided for by the Hospital;

(b) recommending clinical privileges for each member of the Department as well as providing continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(c) recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department and provide continuous assessment and improvement of the quality of care, treatment and service and quality control procedures as appropriate.

(d) Develop and implement policies and procedures that guide and support provision of care, treatment and services; insure that a sufficient number of qualified, competent persons are available to provide the patient care, treatment and services.

(e) oversee the orientation and continuing education of all persons in the department.

(f) Assess and coordinate the integration of the department into the primary functions of the Hospital including inter- and intradepartmental services.

(g) requests space and other resources needed including relevant off site resources and determination of qualification of non LIP’s to insure sufficient support to provide care, treatment, and services.

B.4. Removal of Department Chair:
(a) A request to remove a department chairperson requires a two-thirds vote of the department members, subject to recommendation by Medical Executive Committee and ratification by the Board of Directors. Grounds for removal shall be:

(1) failure to comply with applicable policies, bylaws, or rules and regulations;
(2) failure to perform the duties of the position;
(3) conduct detrimental to the interests of the Medical Staff or the Hospital; or
(4) an infirmity that renders the individual incapable of fulfilling the duties of the position.

(b) At least ten days prior to the initiation of any removal action, the individual shall be given special notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the department prior to a vote on removal.

4.C. DEPARTMENT/SECTION:
4.C.1. Functions of Department/Section:

(a) A service may perform any of the following activities:

(1) continuing education;
(2) discussion of policy;
(3) discussion of equipment needs;
(4) development of recommendations to the department chairperson or the Medical Executive Committee;
(5) participation in the development of criteria for clinical privileges (when requested by the department chairperson); and
(6) discussion of a specific issue at the special request of a department chairperson or the Medical Executive Committee.

(b) No minutes or reports will be required reflecting the activities of service, except when a service is making a formal recommendation to a department, department chairperson, Credentials Committee, or Medical Executive Committee.

(c) Service shall not be required to hold any number of regularly scheduled meetings.

4.C.2. Qualifications and Appointment of Section Chief:

Service chairpersons shall meet the same qualifications, and shall be subject to the same appointment and removal provisions as department chairpersons.

4.C.3. Duties of Section Chief:

The service chairperson shall carry out the duties requested by the department chairperson. These duties may include:

(a) review and reporting on applications for initial appointment and clinical privileges, including interviewing applicants;

(b) review and reporting on applications for reappointment and renewal of clinical privileges;

(c) evaluation of individuals during the provisional period;

(d) participation in the development of criteria for clinical privileges; and

(e) review and reporting on the professional performance of individuals practicing within the service.
ARTICLE 5
MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. APPOINTMENT

(1) All standing committee chairpersons and committee members shall be appointed by the Chief of Staff, in consultation with the Medical Executive Committee, and subject to final confirmation by the Board. Committee chairpersons shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Except as otherwise provided, chairpersons and members of standing committees shall be appointed for an initial term of one year, but may be reappointed for additional terms.

(3) The Chief of Staff, the Chief Medical Officer, and the Chief Executive Officer or designee shall be members, ex officio, without vote, on all committees.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1. Composition:

(a) The Medical Executive Committee shall include the officers of the Medical Staff, the Chief Medical Officer, the department chairpersons, and four other Active Staff members elected at large. The Medical Executive Committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff. The Chairperson of the Credentials Committee, the Chairman of the Quality-Coordinating Council and the Chairperson of
the Peer Review Oversight Committee may also be members of the
Medical Executive Committee.

(b) The Chief of Staff will serve as Chairperson of the Medical Executive
Committee.

(c) The Vice President for Patient Care Services, the President of Trinity
Medical Group, and a representative from the Board shall be *ex officio*
members, without vote.

(d) The majority of the members of the Medical Executive Committee shall
not be full-time Hospital employees.

(e) The Chief medical Officer will remain a voting member of the Medical
Executive Committee as long as that individual maintains Active
(including Senior Active) status on the medical staff; otherwise the
position will change to *ex officio*.

5.B.2. Duties:

The organized medical staff delegates authority in accordance with law and
regulation to the medical executive committee to carry out medical staff
responsibilities. The Medical Executive Committee carries 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 licensed
independent practitioners and other practitioners privileged through the medical
staff process. The Medical Executive Committee is responsible for the
following:

(a) acting on behalf of the Medical Staff in the intervals between Medical
Staff meetings;
(b) recommending directly to and accountable to the Board of Directors on at least the following:

(1) the Medical Staff's structure;
(2) the mechanism used to review credentials and to delineate individual clinical privileges;
(3) recommendations of individuals for Medical Staff appointment;
(4) recommendations for delineated clinical privileges for each eligible individual;
(5) participation of the Medical Staff in performance improvement activities;
(6) the mechanism by which Medical Staff appointment may be terminated; and
(7) hearing procedures.

(c) consulting with Administration on quality-related aspects of contracts for patient care services with entities outside the Hospital;

(d) receiving and acting on reports and recommendations from committees, departments, and other groups as appropriate;

(e) assisting in the identification of community health needs in keeping with the strategic plan of the Hospital, and implementing programs to meet those goals; and

(f) performing such other functions as are assigned to it by these Bylaws, the Credentialing Policy or other applicable policies.

(g) The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the forgoing is intended to prevent medical staff members from
communicating with the Board of Directors on a rule regulation or policy adopted by the organized medical staff or the medical executive committee. The Board of Directors determines the method of communication.

5.B.3. Meetings, Reports and Recommendations:

(a) The Medical Executive Committee shall meet at least ten times a year to fulfill its responsibilities.

(b) The Medical Executive Committee shall maintain a permanent record of its proceedings and actions. Copies of all minutes shall be transmitted to the Chief Executive Officer routinely as prepared. Recommendations of the Medical Executive Committee shall be transmitted to the Board.

5.C. PERFORMANCE IMPROVEMENT AND MEASUREMENT FUNCTIONS

(1) The Organized Medical Staff shall engage in peer review and performance improvement functions for the purpose of improving the care provided in the Hospital. These functions shall be performed by such committees, departments and individuals as may be designated by the Medical Executive Committee in consultation with the Chief Medical Officer. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:

(a) medical assessment and treatment of patients;

(b) assessment and management of pain;

(c) use of medications;

(d) use of blood and blood components;
(e) use of operative and other procedures;
(f) efficiency of clinical practice patterns; and
(g) significant departures from established patterns of clinical practice.
(h) sentinel events/adverse events

(2) A description of the committees that carry out systematic monitoring and peer review and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Organization and Functions Manual.

(3) The Organized Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, though are not limited to:
(a) education of patients and families;
(b) providing oversight in the process of analyzing and improving patient satisfaction.
(c) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and
(d) accurate, timely, and legible completion of patients' medical records.
(e) patient safety data.
(f) using QCC data to prioritize CME activities in conjunction with the CME committee.

5.D. CREATION OF STANDING COMMITTEES AND TASK FORCES
(1) The Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions, including peer review activities. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the Medical Executive Committee.

(2) Special task forces shall be created and their members and chairpersons shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.
ARTICLE 6
MEETINGS

6.A. GENERAL

6.A.1. Medical Staff Year:

For the purpose of these Bylaws, the medical staff year commences on the first
day of January and ends the 31st day of December.

6.A.2. Meetings:

(a) The Medical Staff shall meet at least twice a year. The annual meeting
shall be in November. Officers and at-large members of the Medical
Executive Committee shall be elected, as necessary. Reports from
officers and standing committees shall be presented at medical staff
meetings.

(b) Departments shall meet as often as necessary but at least quarterly. Each
department shall maintain a permanent record of its findings,
proceedings and actions and submit the same to the Medical Executive
Committee.

(c) Standing committees shall meet as set forth in these Bylaws or in the
Organization and Functions Manual. Each standing committee shall
maintain a permanent record of its findings, proceedings and actions and
submit the same to the Medical Executive Committee.

(d) Meetings may be conducted by telephone conference.
6.A.3. Regular Meetings:

(a) At the beginning of each medical staff year, the Chief of Staff shall schedule the regular meetings of the Medical Staff. Notice shall be provided to all members of the Medical Staff and shall state the date, time, and place of the meetings.

6.A.4. Special Meetings:

(a) Special meetings of the Medical Staff may be called at the request of the Chief of Staff, the Medical Executive Committee, or the Chairperson of the Board or by a petition signed by at least 20% of the voting members of the Medical Staff.

(b) A special meeting of any department or committee may be called by or at the request of the relevant chairperson or the Chief of Staff or by a petition signed by at least 20% of the voting members of the department or committee.

(c) No business shall be transacted at any special meeting except that stated in the meeting notice.

6.A.5. Notice:

(a) The notice of regular and special meetings shall state the date, time, and place of the meeting.

(b) Notice shall be by mail, telefax, e-mail or similar method at least one week in advance of such meeting.

6.A.6. Quorum:
(a) Except as otherwise provided in these Bylaws, for any regular or special meeting of the Medical Staff, department or committee, the presence of 20% of the voting members shall constitute a quorum.

(b) For meetings of the Medical Executive Committee and the Credentials Committee, the presence of at least 50% of the committee members shall constitute a quorum.

(c) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

6.A.7. Voting:

(a) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

(b) Recommendations and actions of the Medical Staff, departments and committees shall be by consensus. Except as otherwise provided in these Bylaws, in the event it is necessary to vote on an issue, the issue will be determined by a majority vote of those individuals present and eligible to vote.

(c) Voting for officers of the Medical Staff, at-large members of the Medical Executive Committee, department chairpersons and amendment to these Bylaws shall take place on a date and in a place specified by notice provided to all voting members of the Medical Staff. The notice shall be sent at least two weeks in advance of the vote. Mail, e-mail and FAX votes will be accepted if received one week prior to the meeting.

6.A.8. Agenda:

(a) The Chief of Staff shall set the agenda for regular and special meetings of the Medical Staff.
(b) The chairperson of each department and committee shall set the agenda for all general and special meetings of the respective department and committee.


The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department or committee custom shall prevail at all meetings, and the Chief of Staff, department chairperson or committee chairperson shall have the authority to rule definitively on all matters of procedure.

6.A.10. Minutes:

(a) Minutes of all medical staff, department and standing committee meetings shall be prepared and shall include a record of the attendance of members and the recommendations made. The minutes shall be authenticated by the presiding officer.

(b) Minutes of department, standing committee, and, where applicable, service meetings shall be forwarded to the Medical Executive Committee.

(c) The Chief Executive Officer shall receive a copy of all minutes and reports of the Medical Staff, departments, committees and, where applicable, services. The Board shall be kept apprised of the recommendations of the Medical Staff.

(d) A permanent file of the minutes of all meetings shall be maintained by the Hospital.
6.A.11. Attendance Requirements:

(a) Each Active and Associate Staff member is required to attend regular and special meetings of the Medical Staff and applicable department and committee meetings. Additionally, each Active and Associate Staff member is required to attend the annual meeting of the Medical Staff.

(b) Members of the Medical Staff must attend a minimum of ten of the following meetings: department, committee, staff, educational conferences. Meeting attendance will be considered at reappointment.

(c) Excused absences for regular or special meetings of the Medical Staff may be granted by the Chief of Staff. Excused absences for regular or special meetings of departments and committees may be granted by the relevant chairperson.

6.B. CONFIDENTIALITY

Members of the Medical Staff who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. A breach of confidentiality may result in the imposition of disciplinary action.
ARTICLE 7
MISCELLANEOUS

7.A. CONFLICT OF INTEREST

(1) When performing a function outlined in these Bylaws, the Credentialing Policy or Organization and Functions Manual, if any member of the Medical Staff has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another individual, the individual with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

(2) The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the Chief of Staff or applicable committee chairperson or department chairperson by any other member with knowledge of it.

(3) The fact that a department chairperson or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

(4) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

7.B. INDEMNIFICATION
All officers of the Medical Staff, department chairpersons, committee chairpersons, committee members, and authorized representatives shall be indemnified when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.

7.C. RULES AND REGULATIONS OF THE MEDICAL STAFF

(1) Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with this Article. Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as these Bylaws.

(2) Rules and regulations may be adopted, amended, repealed, or added by the Medical Executive Committee, provided that the notice provisions provided in these Bylaws are followed.

(3) Rules and regulations may also be adopted, amended, repealed, or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed.

(4) Adoption of and changes to the rules and regulations shall become effective only when approved by the Board.

(5) The present rules and regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the
terms of these Bylaws. To the extent they are inconsistent, they are of no force and effect.

7.D. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All medical staff policies, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws. The Bylaws of the Medical Staff including Rules and Regulations and Policies are not in conflict with those of the Saint Mary’s Health System.

(2) Medical staff documents other than the medical staff bylaws may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

(3) At least 7 days prior to the Medical Executive Committee meeting, members of the Medical Staff shall be notified that copies of all proposed amendments are available in the Medical Staff Office.

(4) History and Physical Policy is attached to this document and will be considered part of the Bylaws.
ARTICLE 8

AMENDMENTS

(a) Customarily, all proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(b) The Medical Executive Committee may present proposed amendments to the voting staff by mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. In the alternative, voting for proposed amendments to the Bylaws may take place on a date and in a place specified by notice provided to all members of the voting staff. The notice shall be sent at least two weeks in advance of the vote. To be adopted, an amendment must receive a majority of the votes cast.

(c) The organized medical staff can propose an amendment to the bylaws, rules, regulations or policies directly to the Board of Directors, only after a Medical Staff Meeting with a majority vote for the amendment has been held.

(d) The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of
reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(d) All amendments shall be effective only after approval by the Board.

(e) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request for same submitted by the Chief of Staff.
ARTICLE 9

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on:

Date: November 1, 2005

______________________________________________
Chief of Staff

Approved by the Board:

Date: December 8, 2005

______________________________________________
Secretary, Board of Directors
ADDENDUM A:

Policy and Procedure for History and Physical Examination
PURPOSE

This policy establishes standards for the history and physical examination consistent with legal regulations and accreditation standards.

SCOPE

A. This policy includes documentation standards for the initial diagnostic evaluation of hospital inpatients, hospital based outpatient procedure patients, observation patients, and ambulatory minor surgery patients having monitored anesthesia care.

B. Pre-Sedation Assessment:
   Except for procedures listed in A above, completion of the Procedural Sedation Record constitutes the practitioner’s complete pre-assessment for operative and other invasive procedures that involve moderate or deep sedation. (Anesthesia’s pre-anesthetic assessment form may be completed in lieu of the Procedural Sedation Record when sedation is administered by providers from the Anesthesia Department)

C. Invasive Procedures Without Sedation:
   There is no requirement for minimum documentation to be on the chart prior to invasive procedures that do not involve moderate or deep sedation or general anesthesia or which do not involve high-risk diagnostic or therapeutic intervention.

(See Attachment A)

DEFINITIONS

A. History and Physical Exam (H&P): The initial assessment of the patient, which documents the current and relevant prior medical history, physical examination, diagnosis or differential diagnosis, and treatment plan. The assessment should be sufficiently comprehensive to provide the necessary information to plan for appropriate care of the patient.

B. Interval Note: A note written on admission or prior to surgery, describing changes in the patient’s history and examination which have occurred since the H&P was completed, if the H&P was completed greater than 24 hours before the admission or the surgery.
C. Procedure: An operation, treatment or test performed in the Operating Room (OR) suite, outpatient surgical center, or procedural sedation areas.

D. Complex operative or invasive procedures:
   1. Procedures performed in an operating room
   2. Procedures involving anesthesia or monitored anesthesia care

E. Major high-risk diagnostic or therapeutic intervention:
   1. Procedures involving general anesthesia to patients who are poor anesthesia risks (for example, ASA rating greater than 3).
   2. Procedures which carry a significant risk of adverse outcome, complications or other sequelae
   3. Procedures performed on patients with co-morbidity likely to adversely affect the prospects for a favorable outcome.

POLICY

A. It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination is performed on patients being admitted for inpatient care, and for operative and complex invasive procedures in an inpatient or outpatient setting.

B. A history and physical examination may be performed and documented by the following:
   1. A doctor of medicine or osteopathy and who, by virtue of education, training and demonstrated competence, is granted clinical privileges to perform specific diagnostic and therapeutic procedures and who is fully licensed to practice medicine in accordance with Connecticut State law.

   2. Oral and Maxillofacial Surgeons if they possess the clinical privileges to do so in order to assess the medical, surgical and/or anesthetic risks of the proposed operative and/or other procedure.

   3. Dentists and Podiatrists are responsible for that part of the patient’s history and physical examination that relate, respectively, to dentistry and podiatry. They may perform a complete history and physical examination if they possess clinical privileges to do so. A qualified physician must endorse the findings prior to any major high-risk diagnostic or therapeutic intervention.

   4. Allied Health Professionals may perform part or all of the history and physical examination if granted clinical privileges to do so, provided that the findings, conclusions, and assessment of risk are endorsed by a qualified physician.
PROCEDURE

A. Timing and Expiration of the History and Physical Exam

1. An H&P must be performed and documented in the medical record for all patients admitted to the hospital or undergoing outpatient surgery within 24 hours of admission or prior to undergoing any procedure. The H&P remains valid throughout the entire hospitalization or procedure. If complications occur requiring either an unanticipated hospitalization or a hospital stay longer than initially intended, a note must be included in the medical record detailing the reason for the extended hospitalization including a focused physical examination and a revised assessment and plan.

2. The H&P may be completed in advance, though no more that 30 days before the planned procedure or admission and does not need to be completed by a practitioner who is credentialed and privileged by the admitting hospital. However an H&P performed prior to admission must be reviewed and updated within twenty-four (24) hours of admission prior to surgery by a practitioner who has been granted privileges by the organization to do so. An update note can be brief as long as the update adequately addresses any changes in the patient’s medical condition.

   [Per CMS – the interval or update note would be adequate for the provider to make an entry in the patient’s medical record stating: “H&P was reviewed, patient examined and “no change” has occurred in the patient’s condition since the H&P was completed.”]

   If the H&P has been performed within 30 days before admission, a durable, legible copy of this report may be used in the medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission (an interval note).

3. Prior to an operative or invasive procedure, a licensed independent practitioner must complete an interval note within 24 hours of the procedure if the H & P is older than 24 hours. In all cases, a copy of the H&P as well as the interval note must physically be present in the medical record. (see # 2 above)

4. If a patient is readmitted for the same or a related condition and has pertinent H&P done within the preceding 30 days, the H&P requirement may be satisfied by documenting an interval note and including a photocopy of the prior H&P in the current hospitalization record. (see # 2 above)

B. Content of History and Physical Examination

1. The H&P must contain sufficient information to support the diagnosis or differential diagnosis, justify the treatment plan, and facilitate the care after discharge.
2. Patients requiring an H&P will receive a history and physical exam or an interval note as set forth in this policy.

3. A history and physical exam shall include the following minimal elements:
   a. History
      (1) Identifying data: name, age, sex
      (2) Chief complaint
      (3) History of present illness
      (4) Medications
      (5) Allergies
      (6) Habits: tobacco, alcohol, other, as appropriate
      (7) Past medical and surgical history, as appropriate
      (8) Relevant past social and family history, as appropriate
   b. Physical
      (1) Heart
      (2) Lungs
      (3) Area of body as appropriate to the chief complaint
   c. Laboratory and other results, as appropriate
   d. Other relevant elements: Advance directives, informed consent
   e. Diagnosis
   f. Plan

4. If the H&P is older than 24 hours but less than 30 days, an interval note will be entered into the medical record. An interval note is a statement entered into the medical record that an H&P has been reviewed and that:
   a. There are no significant changes to the findings contained in the H&P since the time such H&P was performed, or
   b. There are significant changes and such changes are subsequently documented in the medical record

5. An H&P that has been documented over 30 days prior to an admission does not meet the requirement for a current H&P and cannot be updated with an interval note. A new H&P is, therefore, required.

C. Documentation of the History and Physical Examination

1. The H&P may be dictated and transcribed, computer generated, or handwritten.

2. The H&P must be legible and documented in a manner so as to be durable and permanent.

3. Only approved abbreviations are to be entered into the medical record.
4. A hand-written or transcribed H&P must be in the patient’s medical record within 24 hours of admission. If transcribed, the H&P must be authenticated within 14 days or prior to any high-risk diagnostic or therapeutic intervention.

REFERENCES:
· (Joint Commission: MS.03.01.01, EP 6-8; PC.01.02.03, EP 4-5; RC.01.03.01, EP 1 & 3)
· Medical Staff Rules and Regulations,
**ATTACHMENT A: Summary of Documentation Requirements**

<table>
<thead>
<tr>
<th>PROCEDURE (Fill in Department/Area Specific Procedure)</th>
<th>PROCEDURE PUTS PATIENT AT RISK</th>
<th>DISCIPLINE SEDATING THE PATIENT</th>
<th>PRE-ANESTHESIA ASSESSMENT</th>
<th>POST-ANESTHESIA NOTE</th>
<th>H&amp;P *RELATED TO PROCEDURE</th>
<th>POST-OP/POST PROCEDURE NOTE **</th>
<th>PROGRESS NOTE ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td></td>
<td></td>
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<tr>
<td>Total Hip Replacement</td>
<td>✓</td>
<td>Anesthesia</td>
<td>Anesthesia form</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardioversion with Deep Sedation</td>
<td>✓</td>
<td>Cardiologist</td>
<td>Procedural Sedation form</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>MRI with Moderate Sedation</td>
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<td>Radiologist</td>
<td>Procedural Sedation form</td>
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<td></td>
<td>Imaging Report</td>
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<tr>
<td>Trigger Point Injection</td>
<td></td>
<td>Anesthesia</td>
<td>Anesthesia form</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Insertion of Swan Ganz Catheter</td>
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<td>None</td>
<td></td>
<td></td>
<td></td>
<td>Admitting H&amp;P</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Post op note is to be in the medical record before the patient leaves the setting**

*** Progress note does not have to be in the medical record before the patient leaves the setting

Note: Non invasive procedures that do not require the above documentation requirements include the following examples: conservative sharp wound debridement, nasopharyngeal tubes, oropharyngeal tubes, NT suction, tracheal suction, casting, GT/NG, ostomy irrigations, urinary catheters, IV insertion, lab draws, stage 3-4 wound care.