

**BYLAWS**  
**of the**  
**YALE-NEW HAVEN HOSPITAL, INC.**  
**for the**  
**MEDICAL STAFF**

**JANUARY 27, 1982**

**(Revised to June 16, 2009)**

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**BYLAWS**  
**of the**  
**YALE-NEW HAVEN HOSPITAL, INC.**  
**for the**  
**MEDICAL STAFF**

**PREAMBLE**

The Yale-New Haven Hospital (hereinafter referred to as “the Hospital), is a unique blend of a major community hospital serving as the primary teaching hospital of the Yale University School of Medicine. Since the basic objectives of the Medical Staff of this Hospital are to provide the best possible care for patients, to support the education of doctors, nurses, and paramedical personnel, to contribute to the development of medical knowledge, and thereby to enhance the provision of service to the community, the physicians and dentists practicing in the Hospital are hereby organized as a single Medical Staff in conformity with the Bylaws hereinafter set forth.

In accordance with Hospital policy, all provisions of the Bylaws and of the accompanying Rules and Regulations shall be interpreted and applied so that no person, member of the Medical Staff, applicant for membership, patient or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activity of the Hospital. All patients are to be available for teaching undergraduate and graduate Medical School students at the discretion of the responsible physician and the patient.

For the purpose of these Bylaws:

“ASSOCIATE CHIEF” means an Associate Chief of Department selected in accordance with the provisions of ARTICLE X of these Bylaws.

“ASSOCIATE SECTION CHIEF” means an Associate Chief of a Section appointed in accordance with the provisions of ARTICLE VIII, SECTION B of these Bylaws.

“BOARD OF TRUSTEES” means the Board of Trustees of the Hospital.

“CHIEF” means a Chief of Department selected in accordance with the provisions of ARTICLE IX of these Bylaws.

“COMMUNITY PHYSICIAN” means a physician whose practice is based in the community and who is not a University Physician.

“DEAN” means the Dean of the Yale University School of Medicine.

“DENTIST” means any person who holds the degree of Doctor of Medical Dentistry or Doctor of Dental Surgery.

“DEPARTMENT” means one of the Departments of the Medical Staff of the Hospital.

“HOSPITAL”, whenever capitalized, means Yale-New Haven Hospital and includes all its locations and satellites.

“JOINT CONFERENCE COMMITTEE” means the Joint Conference Committee established by ARTICLE XVI of these Bylaws.

“PATIENT SAFETY & CLINICAL QUALITY COMMITTEE” means the Patient Safety & Clinical Quality Committee of the Board of Trustees of the Hospital.

“MEDICAL REVIEW COMMITTEE” as defined in these Bylaws and in Chapter 368 of the Connecticut General Statutes (as amended from time to time), shall include but not be limited to the following committees, whenever they are engaged in peer review as defined in Connecticut General Statute § 19a-17b (a)(2).:

- Institutional Practice Quality and Peer Review Committee
- The Medical Board, its Credentials Committee, the Patient Safety & Clinical Quality Committee, the Human Investigation Committee, Department and Section committees, clinical practice councils, and their respective subcommittees or liaison committees;
- Meetings of any Department or Section or any of their committees or subcommittees or liaison committees;
- Any other committee, subcommittee, liaison committee, or ad hoc committee referred to in or authorized by these Bylaws or those of the Hospital;
- The Board of Trustees and its committees, subcommittees and liaison committees; and
- Any individual gathering information or providing services for or acting on behalf of, and at the direction of, any such committee, including but not limited to the Chief of Staff and the Associate Chief of Staff, Department Chairs, Section Chiefs and Associate Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, and experts or consultants retained to perform peer review functions.
- The Joint Commission, while performing accreditation services for the Hospital, shall be acting as a Medical Review Committee engaged in peer review, as an agent of the Hospital

Wherever practicable, peer review documents prepared for or by all such committees or their delegates, or studies of morbidity and mortality undertaken by such committees or their delegates, should be clearly identified as peer review documents, and their use should be

restricted to peer review. Issues of significance identified in the course of peer review activities by any of the above committees shall be referred to the Institutional Practice Quality and Peer Review Committee.

All individuals, Committees and agents acting as a Medical Review Committee shall be bound to protect the confidentiality of information of the Committee engaged in peer review, pursuant to state law and a contract, if any between the Hospital and the agent.

“MEDICAL SCHOOL” means the Yale University School of Medicine.

“MEDICAL STAFF” means all physicians and dentists who are privileged to attend patients in the Hospital as provided in these Bylaws.

“PEER REVIEW” functions shall be peer review activities of the Medical Review Committees as defined in Connecticut General Statutes § 19a-17b(a)(2) and shall be kept in strict confidence.

“PHYSICIAN” means any person who holds the degree of Doctor of Medicine or its equivalent.

“PODIATRIST” means any person who has graduated from an accredited College of Podiatric Medicine.

“PRESIDENT” means the President (Chief Executive Officer) of the Hospital.

“SECTION CHIEF” means a Section Chief appointed in accordance with the provisions of ARTICLE VIII, SECTION B of these Bylaws.

“UNIVERSITY PHYSICIAN” means a physician who is a member of the full-time faculty of the Yale University School of Medicine.

“YALE” means Yale University.

## **CONFIDENTIALITY**

All medical records and patient-specific information, records of peer review and other committee proceedings, quality assurance and risk management materials including incident reports, Medical Staff credentialing records and files, minutes of Medical Staff and Hospital meetings, business plans of the Hospital and Medical Staff, and other confidential Hospital and Medical Staff records, data, and information, may not be used for purposes other than patient care, peer review, risk management, and other proper Hospital and Medical Staff functions. Such confidential materials (whether maintained in hard copy, in computer memory or diskette, on microfilm or microfiche, or in any other format), may not be removed from the Hospital, duplicated, transmitted, or otherwise disclosed to parties outside of the Hospital without proper authorization in accordance with Hospital and Medical Staff policies. Compliance with this Confidentiality Policy shall constitute a condition of continuing Staff membership.

## **INTERPRETATION OF THE BYLAWS**

In construing these Bylaws and Rules and Regulations, and the policies of Departments, Sections, and Committees, the Medical Staff may take into account its usual and customary policies and practices, whether written or unwritten, and may also bring to bear the expert knowledge of members of the Staff, provided that such policies, practices, and expert knowledge is applied in the manner fully consistent with the specific provisions of the Bylaws, Rules and Regulations, and policies.

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

It is intended that the reasonable construction of these Bylaws and Rules and Regulations and policies shall be recognized and deferred to by a court or administrative agency or accreditation body, and that the Bylaws and Rules and Regulations and policies shall be so interpreted with consideration given to the fact that the Medical Staff requires reasonable flexibility in interpretation and application.

## **ARTICLE I. NAME**

The name of this organization shall be “Medical Staff” of the “Yale-New Haven Hospital”.

## **ARTICLE II. PURPOSE**

The purpose of the organization shall be:

1. To insure that all patients admitted to the Hospital, cared for in the emergency service, or treated in the ambulatory service and/or other Hospital locations receive appropriate care;
2. To insure that all members of the Medical and Affiliated Staffs have appropriate education, training and experience and are credentialed, and to insure that appropriate health care is provided only by credentialed staff.
3. To provide health care to patients referred by members of the Medical Staff for further diagnosis or treatment;
4. To provide exemplary education programs in which students and practitioners in the health professions may develop their understanding and skills;
5. To foster the development of facilities and programs for clinical research;
6. To provide mechanisms through which the Medical Staff, the Board of Trustees and the Administration of the Hospital may discuss matters of mutual concern.

## **ARTICLE III. THE MEDICAL STAFF**

### **SECTION A. Staff Categories**

1. The Medical Staff shall be divided into the following categories:
  - a. The Active Staff
  - b. The Courtesy Staff
  - c. The Visiting Staff
  - d. The Honorary Staff
  - e. The House and Clinical Fellows Staff
2. Members of each staff category shall be limited in their practice to the particular Department(s) to which they are appointed, unless voted otherwise by the Medical Board. They shall limit the scope of their clinical activities to those specified in the signed statement delineating clinical privileges, a copy of which accompanies their official notices of appointment to the Medical Staff.
3. When access to operating rooms and beds become restricted because of patient demand, members of the Staff in the Active category shall enjoy a higher priority of access for their elective admissions. Each Department shall prepare a protocol that addresses such priority of access. Such protocol shall be reviewed by the Medical Board, which shall submit its recommendations to the Board of Trustees, through its Patient Safety & Clinical Quality Committee, for ultimate approval, rejection or amendment. Emergency admissions shall be accepted irrespective of Staff Category.
4. All Medical Staff members are required to comply with their obligations under the Emergency Medical Treatment and Labor Act and its corresponding regulations. The purpose of this requirement is to assure that all patients are screened and stabilized within the capability of this Hospital, as required by law. All physician and dentist members of the Medical Staff are authorized to conduct appropriate medical screening examinations. Other members of the Medical Staff and members of the Affiliated Staff are authorized to conduct medical screening examinations if appropriately delineated to do so.

### **SECTION B. The Active Staff**

1. The Active Staff shall consist of selected physicians, dentists, and podiatrists who demonstrate substantial commitment to the welfare and programs of the Hospital and who specify such commitment as part of the appointment/reappointment process. This commitment shall include all of the following:

- a. utilization of Yale-New Haven Hospital as a principal site of hospital practice (a physician, dentist or podiatrist will be deemed to have utilized the Hospital as a principal site of practice during any period in which the practitioner has made a reasonable, good faith effort to utilize the Hospital as a principal site of practice but has been prevented from doing so because the facilities of the Hospital were not made reasonably available); or active participation in caring for patients at the Hospital;
  - b. a willingness to participate in teaching programs;
  - c. a willingness to serve on committees, boards, or in administrative positions;
  - d. a willingness to have their patients participate as part of teaching and research efforts, with research involvement requiring the attending's and patient's concurrence;
  - e. participation in Departmental and Sectional meetings; including quality review programs and teaching conferences; and
  - f. demonstration of a significant commitment to the Hospital's purposes, objectives and mission.
2. The Active Staff shall be divided into Attending Physicians, Dentists and Podiatrists and Associate Physicians, Dentists and Podiatrists as follows:
- a. Attending Physicians, Dentists and Podiatrists shall be diplomats of a U. S. specialty certifying board deemed appropriate by the Chief and the Chief of Staff or shall present equivalent qualifications. This requirement is not made retroactive for those serving as Attending Physicians or Dentists as of May 1, 1960.
  - b. Associate Physicians and Dentists shall be those who have completed all of the relevant U. S. Specialty Board certification training requirements. In addition, the applicant, at the time the application is considered complete pursuant to Article V, Section E, paragraph 4 below, must be considered by the designated Board as eligible to take the required examination(s) leading to Board Certification, or as eligible to do so after obtaining the Board-required practice experience. Membership in this category shall not exceed five years from the date of appointment to the Medical Staff by the Board of Trustees. If the physician has previously held US Board Certification that has lapsed, but the physician remains eligible for recertification, membership in this category shall not exceed three years from the date of appointment to the Medical Staff by the Board of Trustees. If a staff member does

not advance to the Attending category by virtue of Specialty Board Certification deemed appropriate by the Chief and the Chief of Staff within such period, the practitioner shall lose Staff privileges. Staff members whose Board Certificates bear an expiration date shall successfully complete recertification no later than three years following such date to maintain Staff appointment. This requirement is not made retroactive for physicians or dentists engaged in the general practice of Medicine or Dentistry who held an appointment as Associate prior to January 1, 1982, nor for members of the Courtesy Staff appointed prior to July 1, 1991, or other Associate Staff appointed prior to July 1, 1991, who, absent Specialty Board Certification, shall be assigned to the Courtesy Staff. Board Certified Attending Staff appointed prior to July 1, 1991, who do not achieve specialty board recertification where applicable, shall be assigned to the Courtesy Staff. Practitioners who, by virtue of specialty board certification, maintain Attending status in one department may, without additional Board Certification, be assigned to the Associate Staff without term in one or more other departments.

- c. At the discretion of the Chief and Chief of Staff, an exception to the Specialty Board Certification/Recertification requirement may be recommended through the appointment and reappointment process on the basis of equivalent qualification, special clinical expertise, or unique educational contribution. Such exception will generally apply only to full-time faculty who attained senior faculty rank in other countries and are appointed at the Associate or higher professorial level in the Yale School of Medicine.
3. Only Active Staff members may vote or hold office.
4. The resources of the Hospital shall be available to all Active Staff members without regard to whether they are Community practitioners or University practitioners, unless an exception has been made through the medical governance structure. Any exception shall be based on the principles set forth in paragraphs 1-5 on pages 80-83 of the Final Report of the Ad Hoc Trustees Committee on Medical Practice and Governance dated July 29, 1981.
5. Active Staff members may be eligible to participate in malpractice insurance programs offered by or under the auspices of the Hospital.

### **SECTION C. The Courtesy Staff**

1. The Courtesy Staff shall consist of selected physicians, dentists, and podiatrists who meet all of the basic qualifications for Medical Staff membership set forth in ARTICLE V, SECTIONS A and B, but who do not meet the qualifications

for appointment to the Active staff category as set forth in ARTICLE III, SECTION B., Paragraph 1.

2. Members of the Courtesy Staff are not eligible to vote, hold office, or participate in malpractice insurance programs sponsored by the Hospital.
3. Requirements for and exceptions to specialty board certification and recertification described in ARTICLE III, SECTION B, Paragraph 2b, shall apply to members of the Courtesy Staff appointed after July 1, 1991.

**SECTION D. The Visiting Staff**

1. The Visiting Staff shall consist of physicians, and dentists and podiatrists who are:
  - a. Specialists who require the unique resources of the Hospital for some of their patients and practice, but who do not meet the requirements for Active Staff; or
  - b. Distinguished specialists recommended for such appointment by the Medical Board; or
  - c. Physicians, dentists and podiatrists who shall have the privilege of caring for patients in the Ambulatory Clinics and Emergency Service, and may also participate, for the purpose of teaching students and house staff, in selected inpatient care functions when so directed by a Chief or Associate Chief of Department, or one of the Section Chiefs, provided that such functions are specified in their delineations of clinical privileges.
2. Members of this Staff category are not subject to the geographic qualifications for appointment specified in Article V, Section B(5).
3. Member of this Staff generally may not admit or serve as the responsible attending but may render consultation to inpatients as provided in their delineation of clinical privileges. This provision is not retroactive for those serving as Visiting Staff prior to January 1, 1986.
4. In unusual circumstances, a member of this Staff may be granted admitting privileges subject to approval of an appropriate delineation of clinical privileges and attending physician coverage arrangements to assure patient safety and continuity of care.
5. In those instances where individual patients require the special and unique resources of the Hospital, members of the Visiting Staff may act as the

responsible attending only by the granting of temporary privileges upon recommendation of the Chief and the Chief of Staff.

6. Members of this staff category who wish to apply for appointment to the Active or Courtesy Staff shall do so in accordance with the provisions of ARTICLE V, SECTION E.

#### **SECTION E. The Honorary Staff**

1. The Honorary Staff shall consist of selected individuals who are no longer active in clinical practice in the Hospital, but whose past association with and service to the Hospital warrant recognition by continued membership on its Medical Staff.
2. Members of the Honorary Staff do not have privileges of admission or care of patients.

#### **SECTION F. The House Staff and Clinical Fellows**

1. The House Staff shall consist of residents appointed to Medical Staff membership in this category by the Patient Safety & Clinical Quality Committee upon recommendation, in turn, by the Chiefs of Departments, following consultation with the Associate Chiefs and the Medical Board. Such appointments are subject to review by the Board of Trustees as circumstances may warrant.
2. Clinical Fellows are Postdoctoral Fellows or subspecialty residents who have been appointed by Departments to provide patient care and to engage in research. They function as trainees and are appointed to Medical Staff membership in the same manner as House Staff.
3. Clinical Fellows who intend to function as attending physicians and who are qualified for Medical Staff membership must apply for and be granted Active, Courtesy or Visiting Medical Staff privileges before acting in an attending capacity. In these cases, the delineation of clinical privileges will specify which attending functions are authorized and which functions are considered in training.
4. House Staff and Clinical Fellow appointments to the Medical Staff are co-terminus with the training appointment. Physicians, dentist and podiatrists in these categories who wish apply for membership to another category of the Medical Staff must do so pursuant to Article V.

The various provisions of the Bylaws shall apply to members of the House Staff and Clinical Fellows only as specifically provided. Provisions relating to appeals, hearing and appellate review shall not apply to the House Staff and Clinical Fellows.

### **SECTION G. Provisional Appointments**

Initial appointments to the Medical Staff will be made on a provisional basis, in the Active, Courtesy and Visiting Staff categories and for Affiliated Health Care Professionals. The period of the provisional appointment shall ordinarily be for two years from the date of appointment. A period of focused professional practice evaluation for new members of the medical staff may be required and will occur during the provisional appointment. All individuals will be treated equally with respect to the length of provisional appointment unless there is justification to extend the provisional period and/or the period of focused evaluation.

#### **ARTICLE IV. AFFILIATED HEALTH CARE PROFESSIONALS**

Affiliated Health Care Professionals shall include designated health care professionals; including but not limited to audiologists, doctoral scientists, nurse anesthetists, nurse midwives, nurse practitioners, physician assistants, physicists, psychologists, surgical assistants and other Health Care Professionals certified or licensed by an appropriate body and such other individual practitioners as shall be designated from time to time by the Chief of Staff with approval of the Medical Board. Such individuals shall be appointed in one of the Departments of the Medical Staff, shall not have the privilege to admit inpatients, and shall serve patients who are the primary responsibility of members of the Medical Staff. Clinical privileges of the Affiliated Health Care Professionals shall be delineated by the appropriate Chief with the approval of the Chief of Staff. In each category, they shall be appointed by the Board of Trustees (or by the Patient Safety & Clinical Quality Committee if the appointment or reappointment is uncontested) after submission of an application and recommendation by the appropriate Chief, the Credentials Committee, the Medical Board and Patient Safety & Clinical Quality Committee. Members of this staff are not deemed to be members of the Medical Staff; the various provisions of these Bylaws and Rules and Regulations shall apply to the Affiliated Health Care Professionals only where specifically provided or where the context requires application. Provisions relating to hearings, appeals and appellate review shall apply to Affiliated Health Care Professionals.

Certain members of the Affiliated Staff are authorized to conduct medical screening examinations as defined under federal law. These include Certified Nurse-Midwives, who are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms. Also included are PAs, nurse practitioners and others who specifically request this authorization. Authorization to conduct medical screening examinations is granted only through an appropriately signed and approved delineation of clinical privileges.

A member of the Affiliated Staff who is required to have a sponsoring (or collaborating) physician may not exercise any clinical privileges if there no longer is a sponsoring physician. In the event that a member of this staff who is required to have a sponsoring physician no longer is sponsored by that physician, the member immediately shall notify the Chief of Staff and provide the name of the new sponsoring physician or be deemed to have resigned from the Staff.

## **ARTICLE V. STAFF MEMBERSHIP**

### **SECTION A. Selection of Medical Staff**

1. Yale-New Haven Hospital, a major source of hospital service in the community, recognizes as its first and foremost obligation for the training of house staff, and, as the primary teaching hospital for the Medical School, to provide an optimal environment for the education of medical students, house staff and postdoctoral fellows, which environment and programs contribute significantly to the ability to deliver excellent patient care. Physicians, dentists, and podiatrists who will be recommended for appointment will be those whose education, training, experience, professional competence and personal qualities enable them to provide excellent clinical care to their patients and qualify them to be directly involved in the formal teaching program. The standard of clinical care of each member of the staff must serve as an exemplary model for medical students and house officers. All applications for staff membership will be subjected to a critical review of clinical expertise.
2. The Board of Trustees, in order to fulfill its commitment to assure balanced use of Hospital resources, may impose restrictions upon or designate special circumstances for Staff selection. (ARTICLE V, SECTION C)
3. In clinical services in which the Hospital contracts for the provision of Hospital-based professional services including anesthesiology, diagnostic radiology, emergency medicine, laboratory medicine, pathology, therapeutic radiology, and other contracted professional services, appointment to the Medical Staff and access to Hospital resources is restricted to physicians who are members of the group under contract or who are designated by the Chief as adjunct members of the group so as to enable the service to fulfill its obligations for patient care, education and research.

### **SECTION B. Basic Qualifications**

1. Only those physicians, dentists, and podiatrists holding an appropriate current license and offering evidence that their training and/or experience, current competence, professional ethics and health status are adequate to assure that any patient treated by them will receive the optimal achievable quality of care shall be eligible for staff membership.
2. A member of the Medical Staff in the Active, Courtesy, and Visiting and Clinical Fellow categories and the Affiliated Health Care Professionals Staff shall:

- a. provide identity verification in accordance with Department of Physician Services policy;
  - b. be a graduate of an approved professional school or be a foreign medical or dental school graduate who has passed an appropriate qualifying examination; these and other qualifications will be verified according to current accreditation and other relevant standards;
  - c. continuously maintain valid malpractice insurance in not less than the minimum amounts as from time to time may be recommended by the President and Chief of Staff following review by the Medical Board and approval by the Board of Trustees, or provide other proof of financial responsibility in such manner as the Board of Trustees may from time to time establish; in addition, notify the Office of Physician Services, in writing, of any lapse in coverage (including any uninsured tail coverage period), reduction in coverage below Hospital required amounts and/or change in carrier;
  - d. attest to a satisfactory health status including, but not limited to, supplying evidence of required health testing (such as PPD), and evidence of recommended or mandatory vaccination(s);
  - e. demonstrate a satisfactory malpractice and claims loss history;
  - f. be able to demonstrate, where applicable, the appropriate use of the hospital resources;
  - g. identify satisfactory Medical Staff patient coverage arrangements to ensure patient safety when the attending is not available;
  - h. have admitted or cared for a number of patients in the Hospital inpatient and/or outpatient areas sufficient to allow evaluation of continuing competence by the Chief and/or Associate Chief of the Department. Absent sufficient patient care activity at the Hospital, verification of competence from another Hospital and/or from appropriate peers, acceptable to the Chief and Chief of Staff, must be supplied. Members of the Active, Courtesy and Visiting Staffs must also fulfill appropriate Departmental criteria for recredentialing, which, with the approval of the Chief of Staff, may include evaluation of patients cared for in other settings
3. At the time of application for appointment, each applicant shall answer the "Practice History Information" questions including whether or not the applicant has (a) been convicted of or charged with or pled guilty to any offense other than a minor traffic violation by any local, state or federal

authority, official or agency or foreign/international equivalent thereof, (b) been denied any license, certification, narcotics permit, hospital appointment or privilege, and (c) had any license, certification, narcotics permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily, (d) been the subject of any disciplinary action including allegations related to any form of impairment, disruptive behavior or unprofessional conduct, (e) have any condition that would compromise the ability to practice with reasonable skill and safety, and (f) are currently engaged in illegal drug use or dependent upon any controlled substance or alcohol. Information provided by applicants in conformance with this requirement shall be treated as confidential and shall be used only for purposes of credentialing and recredentialing in accordance with the provisions of these Bylaws.

Applicants attest that all statements, answers and information contained in their application are true, correct and complete to the best of their knowledge and attest that they understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for ceasing processing and/or denial of an application and/or subsequent termination of any privileges granted upon the basis of the application. Hearing rights will not apply in such instances.

4. In addition to those qualifications set forth above in Paragraphs 1, 2, and 3, a member of the Medical Staff in the Active, Affiliated Health Care Professional or Courtesy category shall meet all additional qualifications set forth in ARTICLE III, SECTION B of these Bylaws. Membership in the Active Medical Staff category also is subject to limitation by appropriate action taken in accordance with the provisions of ARTICLE V, SECTION C below. In addition, Medical Staff membership shall be granted and maintained based upon institutional needs to fulfill missions of service, education and research as determined by institutional and program planning processes.
5. In addition to those qualifications set forth in Paragraphs 1, 2, 3, and 4 above, Active or Courtesy members of the Medical Staff and Affiliated Health Care Professionals, shall:
  - a. occupy an office and be actively practicing in New Haven or a neighboring community<sup>1</sup>; or
  - b. at the time of application certify the intent, if appointed, to establish such practice within six months of the date of application.

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<sup>1</sup> For purposes of ARTICLE V “neighboring community” means one of the following towns: Ansonia, Beacon Falls, Bethany, Branford, Cheshire, Chester, Clinton, Deep River, Derby, Durham, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Madison, Meriden, Middlefield, Milford, Naugatuck, North Branford, North Haven, Old Saybrook, Orange, Oxford, Prospect, Seymour, Wallingford, Westbrook, West Haven, Woodbridge.

A member of the Department of Pediatrics is fully subject to all of the provisions of this section except the geographical restriction set forth in subparagraph a. A member of the Department of Pediatrics must be actively practicing within the State of Connecticut. A member of the Department of Pediatrics who does not meet the geographical restrictions must identify appropriate local Yale-New Haven Hospital Medical Staff coverage arrangements at the time a patient is admitted.

Physicians practicing remotely but providing care via telemedicine, teleradiology or in any other specialty to patients being cared for currently by or at the Hospital must be a member in good standing of the Medical Staff.

6. An applicant for membership on the Medical Staff in the House Staff category shall:
  - a. be a graduate of an approved medical, dental or podiatric school or be a foreign medical or dental school graduate who has passed an appropriate qualifying examination;
  - b. be licensed to practice in the State of Connecticut or be permitted to practice without license by statute or regulation;
  - c. have valid malpractice insurance in the minimum amounts required by the Board of Trustees;
  - d. be recommended by the appropriate Chief of Department;
  - e. be subject to the confidential disclosure required in ARTICLE V, SECTION B, paragraph 3 above.
  
7. The Chief of Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 and the Regulations of the Department of Health and Human Services implementing the Act. In order to fulfill these requirements, the Chief of Staff will report adverse actions when required and will obtain necessary information from the National Practitioner Data Bank in accordance with the law. The provisions of the Act and the Regulations, as they may be amended from time to time, hereby are incorporated into the Bylaws by this reference and to the extent possible shall be construed as being consistent with the provisions of these Bylaws and the Rules and Regulations.

### **SECTION C. Code of Conduct**

The objective of the Code of Conduct is to encourage optimum patient care by promoting a safe, cooperative, respectful and professional health care environment and to eliminate any behaviors that disrupt Hospital operations, adversely affect the ability of others to competently perform their jobs or have a negative impact on the confidence of patients and families in the Hospital's ability to provide quality care.

For purposes of this section, this Code of Conduct applies to the interactions of Medical and Affiliated Medical Staff with other Medical and Affiliated Medical Staff, House Staff, employees, patients and visitors.

The behavior of members of and applicants for membership on the Medical and Allied Health Professional Staffs constitutes an essential component of professional activity and personal relationships within the Hospital. Civil department fosters an environment conducive to patient safety and quality and the teaching of students. Consistent with the Code of Conduct,, in addition to the qualifications set forth above, a member of the Medical Staff or of the Affiliated Health Care Staff at all times shall demonstrate an ability to interact on a professional and respectful basis with each other, hospital staff, patients, visitors and others.

The Code of Conduct is not in any way intended to interfere with a Staff member's right: (1) to express opinions freely and to support positions whether or not they are in disagreement with those of other Medical or hospital staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development; (3) to engage in good faith criticism of others; or (4) to voice objection or concern about hospital policies and procedures. It is, however, expected that all differences in opinion will be expressed in an appropriate forum and manner.

Examples of inappropriate conduct include, but are not limited to, the following:

- use of threatening, abusive or hostile language, comments or behaviors that belittle, berate, degrade, intimidate, demean and/or are threatening to another individual
- inappropriate physical contact or threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- Use of loud, profane, or similarly offensive language;
- derogatory comments or criticisms about the quality of care provided by the Hospital, another Medical Staff member, or any other individual made outside of an appropriate forum;
- impertinent or inappropriate comments (or illustrations) made in medical records or other official documents concerning the quality of care provided by the Hospital or another individual
- willful disregard of Medical Staff and Hospital requirements, Policies and Procedures, failure to cooperate on assigned responsibilities or an unwillingness to work collaboratively with others

- written or oral statements which constitute the intentional expression of falsehoods, or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others
- retaliation against any person who addresses or reports violations of the Code of Conduct

Examples of serious violations of the Code of Conduct include, but are not limited to:

- deliberate destruction of any hospital property
- possession of any unauthorized firearm or weapon
- gross immoral, fraudulent or indecent conduct
- Harassment: Yale New Haven Hospital prohibits all forms of unlawful and unacceptable harassment, including harassment due to race, religion, sex, national origin, age, marital status, sexual orientation and disability.

Sexual harassment is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subject to it or who witness it and is considered a serious violation of the Code of Conduct. Examples include, but are not limited to, the following:

- verbal: innuendoes, epithets, derogatory slurs, jokes, propositions, graphic commentaries, threats and/or suggestive or insulting sounds;
- visual: derogatory posters, cartoons or drawings; suggestive objects or pictures; leering and/or obscene gestures;
- physical: unwelcome physical contact including touching, interference with an individual's movement and/or assault;
- other: making or threatening retaliation as a result of an individual's negative response to harassing conduct

Violations of the Code of Conduct shall be referred to and investigated by the Institutional Practice Quality and Peer Review Committee (IPQPRC).

**SECTION D. Procedure for Implementing Departmental Plans for Staff Selection and Establishing Temporary Moratoriums on New Staff Appointments**

1. The designation by the Board of Trustees of limitations upon or moratoriums for either Staff appointment or for access to specific clinical privileges, as provided in ARTICLE V, SECTION A, Paragraph 2 above, will be in accordance with the following procedures:
  - a. A Chief, after consultation with, and review by, the Associate Chief where applicable, the Departmental Committee, the President and the Chief of Staff, may recommend to the Medical Board the categories of specialties, the number of members of the Department and/or the number of applicants for access to a specified clinical privilege that appropriately can be supported by resources available within the Hospital. Where the clinical privileges in question are available to applicants in more than one Department, the Chiefs of the respective services shall submit a joint plan. If agreement cannot be reached, the opinions of all the affected Chiefs shall be submitted. Any recommendation of limitation shall include a written statement of justification. The recommendation(s) of the Chief(s) shall be subject to the review and approval of the Medical Board, the Patient Safety & Clinical Quality Committee, and the Board of Trustees.
  - b. Any limitation on Departmental or Section size, or limitations on the number of Medical Staff members possessing a specific clinical privilege will not affect existing staff or privileges. Such a limitation, however, will affect a current Medical Staff member who does not yet possess a requested clinical privilege that has been limited.
  - c. If one or more Chiefs or Associate Chiefs believe that an immediate need exists for consideration of a moratorium, either for new staff appointments or for specific clinical privileges, such Chiefs or Associate Chiefs may, after consultation with the appropriate Departmental committee, submit a written request for a moratorium to the Chief of Staff. A request for a moratorium may also be made by the Chief of Staff after consultation with the affected Chief(s). The written request for a moratorium shall delineate the type and extent of any limit requested, whether it be for new staff appointments or for access to a specified clinical privilege, the evidence justifying the moratorium request, the goal to be achieved by the moratorium, and such other pertinent documentation or information, including evidence of review by the Departmental or Sectional Committee, its recommendation, if any, and the views of other Chiefs whose Department will be affected if any.

- d. The Chief of Staff shall, upon generation of or receipt of the request, immediately forward written notification of the request and its documentation to the President and to the Medical Board. The Chief of Staff shall also provide written notification to any applicant for appointment to the Medical Staff or any applicant for the specified additional clinical privilege whose application may be affected if the request for moratorium is approved.
- e. The Medical Board shall review the request for the moratorium within thirty days and shall forward its recommendation to the Patient Safety & Clinical Quality Committee.
- f. The Patient Safety & Clinical Quality Committee shall submit its recommendations to the Board of Trustees within sixty days of generation of or receipt of the recommendation by the Chief of Staff.
- g. The Board of Trustees shall take final action within sixty days after receipt of the recommendation from the Patient Safety & Clinical Quality Committee.
- h. If the Board of Trustees approves a moratorium as requested, unless otherwise specifically provided by the Board of Trustees, the moratorium shall apply to all new Medical Staff applications and/or all pending applications for the additional specified clinical privilege(s) that have not been forwarded by the Chief of Staff pursuant to Article V, Section E, Paragraph 6.
- i. The initial moratorium period will not exceed one year. To extend, modify or eliminate the moratorium, the Chief of Staff, or an affected Chief or Associate Chief may request an extension, modification or elimination that shall be processed in accordance with the provisions of this section.
- j. The Patient Safety & Clinical Quality Committee, at its discretion, may declare a moratorium on processing applications either for Medical Staff appointments or applications for specified clinical privileges, as the case may be, upon the receipt of the written request by the Chief of Staff. Candidates for appointment or for the privilege in question whose applications are pending or are received during the period of the moratorium shall be so notified by the Chief of Staff immediately, and their applications shall be processed upon denial of the moratorium by the Board of Trustees, or upon termination or non-renewal of the moratorium, whichever comes first.

## **SECTION E. Application for Membership**

1. Subject to any limitation or moratorium pursuant to ARTICLE V, SECTIONS A3 or C, applications for membership on the Medical Staff shall be made available via the hospital website or mail by the Office of the Chief of Staff. The appropriate Chief and Associate Chief, if applicable, shall be notified when an application for membership and privileges in his/here Department is released.
2. Applicants must apply for primary appointment in at least one of the Hospital Departments (See Article VIII, Section (A)(1)) and must apply to a specific Section within that Department if the applicant requests approval to practice the clinical function delineated within that Section. The primary appointment shall be chosen based on the applicant's primary training and experience and intended area of clinical practice. In addition, an applicant may request a secondary appointment in another of the Hospital Departments and Sections if appropriate based on training and experience.
3. Applications for membership and clinical privileges shall be filed on the prescribed forms, which shall record the biographical data (including social security number) of, and list the references for, the applicant. Education and training shall be verified. Assessment of current competence to perform the privileges requested by the applicant is evaluated through information provided by appropriate professional references which shall be obtained in accordance with Medical Staff policies. Performance with respect to the ACGME six general competences (Patient Care, Medical/Clinical Knowledge, Practice Based Learning & Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice) is taken into account in the evaluation of the applicant.
4. In the application, there shall be a statement read and signed by the applicant in which the applicant agrees to abide by the Medical Staff Bylaws and the Rules and Regulations and policies of the Medical Staff, by the signed statement delineating clinical privileges and by Hospital policies applicable to the applicant's activities; provided, however, that the submission of an application shall be deemed to constitute automatically such an agreement. A copy of these Bylaws and Rules and Regulations will be provided each applicant. Nothing in this section shall be deemed to create a right of an individual to an application; the release of applications shall be governed solely by these Bylaws, Rules and Regulations.

## **SECTION F. Procedure for Appointment of New Members of the Medical Staff**

1. Application for appointment to the Medical Staff shall be addressed to the Chief of Staff, and shall be accompanied by the required, non-refundable application fee. An application fee shall not be required of those applying to

the House Staff or Clinical Fellow categories. The completed application shall be referred to the Chief of the appropriate Department and, where applicable, to the Associate Chief.

2. The Chief of Department and/or, where applicable, the Associate Chief, shall investigate or cause to be investigated the character, qualifications and standing of the applicant. The investigation may include a personal interview with the applicant and shall include the completion of a confidential record to comply with the requirements of ARTICLE V, SECTION B, Paragraph 3.
3. Following such investigation and consultation, the application, together with the recommendations of the Chief and Associate Chief, shall be submitted to the Chief of Staff. If the recommendation is for approval, a statement delineating clinical privileges signed by the applicant and the Chief and, where appropriate, by the Associate Chief shall accompany the application. Should a difference of opinion arise between the Chief and the Associate Chief, the application, together with the written recommendations of each, shall be submitted to the Chief of Staff.
4. The process described in paragraphs 2 and 3 above must be completed within a maximum of twenty (20) business days. If the application requires Sectional recommendation, the Section shall have a maximum of ten (10) business days to make a recommendation. With or without such recommendation, the application will then be forwarded to the Chief for recommendation by the Chief and Associate Chief, if applicable. The Office of the Chief shall have a maximum of ten (10) business days to make a recommendation. After twenty (20) business days, even if all the recommendations have not been recorded, the application will be forwarded to the Office of the Chief of Staff for review. All applications lacking one or more Departmental/sectional approvals will undergo mandatory Credentials Committee review. The Credentials Committee may chose to interview those whose recommendations were withheld.
5. The Chief of Staff or his designee(s) shall review the completed application and certify its compliance with ARTICLE V, SECTION B, and with the procedures specified in ARTICLE V, SECTION E, Paragraphs 1, 2, 3 above. A completed application may be held in abeyance in accordance with the provisions of ARTICLE V, SECTION C.
6. The Chief of Staff or his designee(s) shall further review the completed application and shall either recommend approval or forward the application to the Credentials Committee. If approval is recommended, the application shall be forwarded to the Medical Board or the Administrative Committee of the Medical Board pursuant to paragraph 7 below.
7. The Credentials Committee, established in accordance with provisions of ARTICLE XV, SECTION F, Paragraph 1d of these Bylaws, shall review any

application in which approvals have been withheld pursuant to paragraph 4 above, in which the applicant's qualifications or delineation of clinical privileges are contested in any other way, in which exceptions from routine eligibility requirements are sought, and any other application received by it. In each case the Credentials Committee shall make a determination if the application is eligible for expedited review. The Credentials Committee shall then transmit its recommendation, to the Medical Board or the Medical Board Administrative Committee if the case can be expedited, or to the Medical Board if not.

8. The Medical Board or the Administrative Committee of the Medical Board shall review the recommendation of the of the Chief of Staff (or his designee(s)), and the recommendation of the Credentials Committee, if any, and, if it approves the application, shall make a formal recommendation to the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Patient Safety & Clinical Quality Committee thereupon shall consider the recommendation and, if it concurs, may grant final approval to the application.

Since this approval constitutes final action by the Board of Trustees, the Chief of Staff shall notify the applicant of the appointment including the approved privileges. If any initially requested privileges were denied, the applicant is notified of the reason for denial (i.e. lack of eligibility or adequate experience).

9. In the event the Administrative Committee of the Medical Board decides to recommend disapproval of an application, the matter will be referred to the next meeting of the Medical Board. The recommendation of the Medical Board, whether for approval or disapproval, shall be forwarded to the Patient Safety & Clinical Quality Committee.
10. In the event that the Medical Board or the Administrative Committee of the Medical Board has recommended approval of an application and the Patient Safety & Clinical Quality Committee does not accept such recommendation, the Patient Safety & Clinical Quality Committee shall return the application to the Medical Board with a statement of its reasons for such action. The Medical Board thereupon shall reconsider the application.
11. In the event that the Medical Board, after reconsideration, does not change its recommendation, it shall return the application to the Patient Safety & Clinical Quality Committee, stating its reasons for continuing to recommend approval. The Patient Safety & Clinical Quality Committee thereupon shall reconsider the application. If, upon reconsideration, the Patient Safety & Clinical Quality Committee concurs with the Medical Board, it shall transmit its favorable recommendation to the Board of Trustees. If, upon reconsideration, the Patient Safety & Clinical Quality Committee continues to recommend disapproval of the application, it shall transmit its unfavorable recommendation, along with the recommendation of the Medical Board, to the Board of Trustees.

12. The Board of Trustees shall receive and take final action on all recommendations in which the Patient Safety & Clinical Quality Committee recommends unfavorable action or in which there has been appellate review.
13. Upon final action by the Board of Trustees, the Chief of Staff shall notify the applicant in writing of the outcome of either appointment or disapproval as described in Paragraph #8. All appointments shall be effective from the date of final action by the Board of Trustees.
14. If the application is disapproved, the Chief of Staff shall notify the applicant including the reason for the denial. Such applicants shall be given an opportunity for a hearing in accordance with the provisions of the Fair Hearing Plan, Article VI.
15. All hearings and appellate reviews shall be conducted in accordance with the provisions of the Fair Hearing Plan, ARTICLE VI. These Bylaws shall be construed so as to entitle an applicant with respect to Medical Staff membership or privileges to only one hearing and appellate review. The Departmental Appeal procedure set forth in ARTICLE XIV is inapplicable, and all hearings and appeals under this Article shall be subject exclusively to the provisions of the Fair Hearing Plan, ARTICLE VI.
16. Upon approval by the Board of Trustees of an application for appointment contingent upon the establishment of an active practice as described in ARTICLE V, SECTION B, Paragraph 5, the Chief of Staff shall:
  - a. notify the applicant of that action;
  - b. determine when the conditions of ARTICLE V, SECTION B, Paragraph 5 have been fulfilled;
  - c. determine that, during the interval since the original application, no change has occurred to alter the acceptability upon which earlier favorable action was taken;
  - d. notify the President of the above.
17. Subsequent to notification of the President as required by ARTICLE V, SECTION E, Paragraph 14, d. above, the Chief of Staff shall transmit a written notice to the applicant as specified in ARTICLE V, SECTION E, Paragraph 13.

## **SECTION G. Procedure for Reappointment**

1. Unless specifically provided otherwise by the Board of Trustees,<sup>2</sup> all Hospital Medical Staff reappointments shall be made by the Board of Trustees on a rolling basis, but not less than biennially.
2. At least every two years, every member of the Medical and Affiliated Staffs shall be required to request reappointment in the primary Department/Section and if desired in the secondary Department/Section. A complete assessment process shall be conducted for each member of the Medical and Affiliated Staff who request reappointment. Criteria to be included in the assessment process shall include a satisfactory health status report submitted by the Medical Staff member including but not limited to supplying evidence of required health testing (such as PPD) and evidence of recommended or mandatory vaccination(s), and proof of ongoing medical licensure as required by Article V (B)(2)(b). Additionally, a review of existing and any newly requested clinical privileges for which focused evaluation was required shall be conducted including an evaluation of current performance competency based upon the ACGME six general competencies (Patient Care, Medical/Clinical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice). Review of Hospital activities and interactions, participation in continuing medical education, an assessment of the appropriate use of hospital resources, and a review of confidential information, including malpractice and claims losses shall also be undertaken. The Physician Services Office shall be responsible for gathering data for reappointments.

Candidates for reappointment must meet the same standards as those required for initial appointment and must document upon request their conformance with the qualifications needed for reappointment and must submit information adequate to allow a delineation of clinical privileges. Medical and Affiliated Staff members shall maintain an activity level determined by the Department to be adequate to allow departmental assessment of their performances. Physicians, Dentists and Podiatrists on the Active Staff shall be expected to attend a majority of Departmental patient review meetings as a criterion to be considered in the reappointment process. Where the primary and secondary appointments are in Sections of the same Department, with the approval of the Chief, the applicant may fulfill the conference/meeting requirements in either Section.

Compliance with (i) the provisions of these Bylaws and Rules and Regulations; (ii) policies of Departments and Sections that have been approved by Departmental or Sectional Committees that include equivalent University and Community representation in Departments or Sections with both

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<sup>2</sup> If an investigation or hearing is pending, the Trustees may wish to make the reappointment for a shorter period of time subject to the outcome of the proceeding.

University and Community members; and (iii) policies of Medical Staff and Medical Board Committees, also shall be used as a criterion for reappointment.

Whenever failure to supply information required for reappointment results in the lapse of Medical Staff appointment, the member shall be required to reapply for Medical Staff membership and clinical privileges in the same manner as one applying for initial appointment.

The reappointment application and materials will be forwarded to the Chief(s) for consideration. In Departments that have Associate Chiefs, the Chief shall consult with the Associate Chief in the assessment process. In Departments of more than 100 members, the Chief may delegate the responsibility for evaluation of reappointment to Section Chiefs if the latter are deemed more familiar with applicant qualifications. The Department shall have a maximum of thirty (30) business days to make its reappointment recommendation. If the application requires Sectional recommendation, the Section shall have a maximum of fifteen (15) business days to make a recommendation. With or without recommendation from the Section, the application will then be forwarded to the Chief for recommendation by the Chief and Associate Chief if applicable. The Office of the Chief shall have a maximum of fifteen (15) business days to make a recommendation. The recommendation shall include, as applicable, the results of the focused evaluation conducted for privileges that were newly approved at the time of the last re-appointment. In the event of a disagreement with respect to nomination for any reappointment, separate reports shall be submitted to the Chief of Staff and the Medical Board by the Chief and Associate Chief.

After thirty (30) business days, even if all the recommendations have not been recorded, the reappointment application will be forwarded to the Credentials Committee for consideration. All reappointment applications lacking one or more Departmental/Sectional approvals will undergo mandatory Credentials Committee review. The Credentials Committee may chose to interview those Chief, Section Chief and/or Associate Chiefs whose recommendations were withheld. The Credentials Committee shall function with respect to reappointment as required by Article V(E)(7).

The names of those members of the Medical and Affiliated Staffs nominated for reappointment shall be submitted to the Medical Board or the Administrative Committee of the Medical Board.

3. The Medical Board or the Administrative Committee of the Medical Board shall consider such nominations and, if it recommends reappointment without change, transmit its recommendations to the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Patient Safety & Clinical Quality Committee thereupon shall consider the recommendation and, if it concurs, may grant final approval to the application. Since this approval constitutes

final action by the Board of Trustees, the Chief of Staff shall notify the applicant of the reappointment including the approved privileges. If any privileges requested for renewal or newly requested privileges were denied, the applicant is notified of the reason for denial (i.e. lack of eligibility or adequate experience.). Newly approved privileges may be subject to focused evaluation. All reappointments shall be effective for no more than two years.

4. In any case in which a physician, dentist or podiatrist who is currently a member of the Medical Staff is not nominated for reappointment, or is nominated for appointment to a different staff category, or requested privileges are to be denied or reduced without the approval or agreement of the applicant, and the Medical Board or the Administrative Committee of the Medical Board contemplates recommending that such change in status be approved, or in the event that the Patient Safety & Clinical Quality Committee disagrees with a recommendation of the Medical Board, the procedure set forth in ARTICLE V, SECTION E, Paragraphs 7, 8, 9, 10, 11, 12, 13, 14, and 15 shall apply as appropriate.
5. If a physician or dentist who was an Active Staff member on February 28, 1983 is not reappointed an Active Staff member solely because of a failure to meet the qualifications set forth in ARTICLE III, SECTION B, Paragraph 1, such physician or dentist shall have the right to be appointed to the Courtesy Staff, but shall continue to have the same admitting privileges and access to Hospital resources as do members of the Active Staff, limited by the individual's delineation of clinical privileges.
6. The final action of the Patient Safety & Clinical Quality Committee of the Board of Trustees or the Board of Trustees (in contested cases) on reappointment shall be transmitted in writing by the Chief of Staff to each member of the Medical Staff consistent with Paragraph #3.

## **SECTION H. Temporary Privileges**

1. Temporary Privileges. Temporary privileges may be granted to a qualified candidate for Medical Staff membership by the Chief of Staff or his designee. A candidate shall not be considered qualified for temporary privileges until the application for privileges is complete. Temporary privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less.
  - a. On the occurrence of any event of a professional or personal nature which casts doubt on the candidate's qualifications or ability to exercise the temporary privileges granted, the Chief of Staff, in consultation with the appropriate Chief and, where applicable, the Associate Chief, may suspend or terminate the temporary privileges.

- b. A candidate shall have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges, failure of renewal of such privileges, or termination of such privileges.
2. Guest Privileges for visiting Medical Staff. The Chief of Staff, on request of the Chief, and either the Associate Chief or Chief of Section, may grant guest privileges. Guest privileges may be granted to recognize officially the professional credentials of a visiting physician, dentist or podiatrist who may be invited to participate in the delivery of patient care. They may also be granted in situations where the guest professional possesses skills that are required for patient care and cannot be supplied by current privileged members of the Medical Staff. Guest privileges shall be for a period not to exceed 30 days.
3. Guest privileges may not be granted or renewed more than three times in a calendar year. With the approval of the Chief of Staff, exceptions may be made for continuity of care purposes.
4. Guest privileges will be granted only after verification that the applicant's professional license and hospital privileges elsewhere are in good standing, and that malpractice insurance is in place and applicable at the Hospital. Other verifications may be required.
5. In the case of a Federal or State government or Hospital declared emergency and when resources of existing Hospital Medical Staff have been or are predicted to be exhausted, the Chief of Staff or his/her designee may grant Disaster Privileges to volunteer practitioners in accordance with Yale-New Haven Hospital Policy and Procedure for Disaster Privileges. The Connecticut Statewide Emergency Credentialing Program may be used to assist in the identification and contact of potential volunteers. Disaster privileges will terminate immediately upon identification of any adverse information about the practitioner, and/or in accordance with the Disaster Privileging Policy and Procedure. In any case, privileges will be granted only for the duration of the emergency.
6. In each instance, those granted temporary/guest privileges of any kind shall be reported the next regular meeting of the Medical Board or the Administrative Committee of the Medical Board, and then subsequently to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

## **SECTION I. Ethics and Ethical Relationships**

1. Each member of the Medical Staff by acceptance of appointment to the Medical Staff pledges to (a) refrain from fee splitting or other inducements relating to patient referral, (b) provide for continuous care of patients, (c)

refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a physician, dentist, or podiatrist who is not qualified to undertake this responsibility or who is not adequately supervised, (d) seek consultation whenever necessary, (e) obtain proper informed consent as a prerequisite to any procedure requiring informed consent including the identity of the operating surgeon or the responsible physician, and (f) comply with the Medical Staff Policy on Confidentiality. Failure to fulfill these and other obligations imposed by these Medical Staff Bylaws, Rules and Regulations shall constitute cause for dismissal from the Staff.

#### **SECTION J. Physician Health and Well-Being**

1. A member of the Medical Staff or the Affiliated Staff who is or may be unable to practice with reasonable skill and safety, regardless of the reason, shall be evaluated in accordance with relevant Medical Staff policy. The primary purposes of this Medical Staff policy are the remediation and rehabilitation of the clinician while at the same time emphasizing patient and staff safety.
2. The confidentiality of the practitioner involved shall be maintained to the extent possible and consistent with law, ethical obligations and patient safety.
3. If at any time during diagnosis, treatment or rehabilitation, it is determined that the practitioner is unable to safely perform the privileges granted, the matter will be forwarded to the Chief of Staff and Clinical Chief for appropriate corrective action.

#### **SECTION K. Leaves of Absence**

1. A leave of absence may be requested by a member of the Medical Staff in writing and may be granted by the Chief of Staff. The initial leave will not exceed one calendar year, and reappointment will be made through the mechanisms defined in Section F above. The Chief of Staff, upon request by the Medical Staff member may approve an extension of the leave for a second calendar year. Notwithstanding the above, a member of the Medical Staff will be placed on immediate involuntary leave of absence if appropriate malpractice insurance is not in place. The Office of Physician Services will confirm any leave of absence in writing to the Medical Staff member and to the relevant Department Chair. The Medical Staff membership and clinical privileges of practitioners who are absent for more than two years shall automatically lapse and the member shall be deemed to have resigned from the Medical Staff effective as of the end of the leave. If subsequently, the member requests to rejoin the Medical Staff, he/she shall be required to reapply in accordance with ARTICLE V, SECTIONS D. and E. Reappointment, if required, shall occur during the pendency of the leave. During the period of a leave of absence, the member shall not exercise clinical

privileges at the Hospital or hold office or serve as chair of a Committee, and all other membership rights and duties shall be inactive. Provisions relating to hearings, appeals, and appellate reviews shall not apply to the granting or lapse of leaves of absence.

2. In order to return from a leave of absence, the member of the Medical Staff must notify the Office of Physician Services in writing. In addition the member must provide proof of current licensure and valid malpractice insurance along with any other information needed which remained outstanding from the most recent Medical Staff reappointment.

#### **SECTION L. Resignation from the Medical Staff**

1. Any member of the Medical Staff may resign at any time. Resignation may be in writing or may be deemed to have occurred when the member no longer meets eligibility criteria, has not requested a Leave of Absence from the Medical Staff or fails to complete his/her application for reappointment within required time frames.
2. A member of the Medical Staff is expected to have completed clinical and record-keeping responsibilities at the time of resignation. A physician, dentist or podiatrist who resigns from the Medical Staff without having completed and signed medical records and fulfilled other clinical responsibilities has resigned but not in good standing.

#### **SECTION M. Discipline and Dismissal from the Medical Staff**

1. Staff appointments may be revoked, suspended, or limited for due cause, including but not limited to physical or mental disability, failure to provide evidence of satisfactory health status, including evidence of mandatory vaccination(s) if required by state or federal agencies, impairment (regardless of cause), failure to provide adequate patient care, exceeding the scope of an approved delineation of clinical privileges, prescribing controlled substances without the required state and federal authority, or failure to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff or Hospital, including approved policies of Departments, Sections, and Committees.
2. Medical Staff privileges shall be automatically suspended if the member of the Medical Staff has not paid any required Medical Staff dues or assessments within 30 days of a second notification. The second notification shall be sent by certified mail, with a copy to the Chief and Chief of Staff. If the dues or assessments remain delinquent for 60 days, Medical Staff membership shall be terminated; in the event of termination of privileges under this section, reapplication pursuant to Article V, Sections D and E is required. Annual

Medical Staff dues and any assessments will be due and collected from all members of the Active and Courtesy Staffs; other categories are exempt..

3. Proposals to revoke or limit the appointment of a member of the Medical Staff for due cause shall be submitted to the Medical Board. The matter shall be considered by the Medical Board and shall thereafter follow as closely as possible the procedures set forth in ARTICLE V, SECTION E, Paragraphs 7, 8, 9, 10, 11, 12, 13, 14 and 15.
4. Any one of the following: the President, the Chief of Staff, a Chief, the Medical Board, the Executive Committee of the Board of Trustees, or the Board of Trustees shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff, and such suspension shall become effective immediately upon imposition.
5. In the event that all or a portion of the clinical privileges of a member of the Medical Staff have been summarily suspended, the member shall be entitled to a hearing before the Medical Board. After hearing the matter, the Medical Board may modify or terminate the summary suspension, or recommend that it continue. The Medical Staff member shall then be entitled to appellate review of the Medical Board's decision in accordance with the provisions of the Fair Hearing Plan, ARTICLE V. In the event that a summary suspension is upheld after completion or waiver of appellate review, unless provided otherwise in the final decision, the Medical Staff membership of the practitioner shall simultaneously terminate and there shall be no further right to a hearing or appellate review under these Bylaws.
6. Revocation or voluntary relinquishment of license to practice in Connecticut shall result in immediate termination of a Staff member's appointment. Suspension of a license, agreement with a governmental entity not to exercise a license to practice, or license or permit to prescribe controlled substances, or notice of exclusion/debarment from participation in the Medicare, Medicaid or other federal health care program shall be cause for automatic suspension of clinical privileges and Medical Staff membership. Under these circumstances, provisions relating to hearings, appeals, and appellate reviews shall not apply. This section shall not apply to the lapse of a narcotics license or permit under circumstances where the member does not require the license or permit to exercise clinical privileges and the member was not under investigation for a violation of the law. In the event a Medical Staff member is or becomes the subject of a voluntary or involuntary consent or other agreement or order by or with a licensing board or any other agreement or order by or with a private or governmental agency not to exercise some licensed activities, the Medical Staff member must supply a copy of the agreement to the Office of the Chief of Staff. Clinical privileges will be adjusted as necessary or required under the

agreement. Notice obtained or actions taken under this paragraph shall be reported to the Chief and to the Chief of Staff.

7. In the event that the privileges of a member of the Medical Staff are automatically or summarily suspended, alternate medical coverage shall be provided for the staff member's patients who remain in the Hospital. The desires of the patient should be considered. The Chief or Associate Chief shall be responsible for ensuring that such coverage is provided.
8. Provisions of these Bylaws relating to appeals, hearings, and appellate review shall not apply to loss of Medical Staff appointment and/or clinical privileges because of non-payment of required Medical Staff dues and/or assessments, nor for violation of Rule No. 18, Medical Records – Completion. The appeals, hearings and appellate review provisions are not applicable to loss of Medical Staff appointment or reduction or removal of all or part of approved clinical privileges for failure to have required state and federal authority to prescribe controlled substances, pursuant to a voluntary or involuntary agreement or order (see section 6 above) or for failure to provide satisfactory health information, including mandatory vaccination.

#### **SECTION N. Care of Patients**

The care of the patient is the responsibility of the physician, dentist or podiatrist in whose name the patient has been admitted or to whom the patient has been transferred. Members of the Medical Staff are responsible for providing for continuous care for their patients; this responsibility may be carried out by providing appropriately credentialed professional coverage when the responsible Member of the Medical Staff is unavailable. It shall be the obligation of the House Staff to assist and be responsible to the responsible practitioner in caring for the patient.

#### **SECTION O. Authority of the Board of Trustees**

The Board of Trustees may take any action it deems appropriate with respect to the members or officers of the Medical Staff whenever, in its sole judgment, the good of the Hospital or the best interest of the patients therein may render such action desirable.

#### **SECTION P. Agreements with Physicians, Dentists and Podiatrists**

1. Notwithstanding any other provision of the Bylaws, or of the Rules and Regulations, the Hospital may provide by agreement that a physician's, dentist's or podiatrist's membership on the Medical Staff and clinical privileges are contingent on and shall expire simultaneously with such agreement or understanding. In the event that an agreement has such a

provision or there is such an understanding, the provisions of these Bylaws, Rules and Regulations and policies of the Medical Staff with respect to hearings, appeals, appellate review, etc., shall not apply.

2. Members of the Medical Staff, whether University or Community based, must notify the Department of Physician Services in writing of any change in practice location, including a statement about new coverage arrangements, proof of malpractice insurance and new request for privileges. The delineation and change in practice information will be forwarded to the appropriate Chief/Associate Chief for a recommendation of approval or disapproval.

Changes in practice information must be submitted thirty (30) days prior to the anticipated practice change date. Individuals who fail to notify the Department of Physician Services of their relocation within the required time frame will be automatically suspended pending receipt of the required information and subsequent review and recommendation by the appropriate Chief/Associate Chief.

#### **SECTION Q. Time Limits**

Action on completed applications for appointment and re-appointment and requests for clinical privileges as well as all other actions required under this ARTICLE V for which no time limit is specified shall be taken within reasonable periods of time, which generally shall not exceed one month.

## **ARTICLE VI. FAIR HEARING PLAN**

### **SECTION A. Right to Hearing and Appellate Review**

The right to a hearing before the Medical Board or the Patient Safety & Clinical Quality Committee and to appellate review by the Patient Safety & Clinical Quality Committee or by the Board of Trustees arises under ARTICLE V, SECTIONS E, F and K of the Bylaws. ARTICLE VI, which sets forth the standards for such hearing and review, except for time limits, is procedural only and shall not be deemed to create any substantive rights or in any way modify substantive rights arising under the Bylaws.

### **SECTION B. Notices to and Requests from Appellants**

1. An appellant, who is entitled to a hearing or to appellate review, shall promptly be advised of such right by certified mail, return receipt requested. Where relevant, the appellant should be advised of Medical Staff status pending further action, or be provided with the basis for the adverse decision in order to prepare for a hearing or appeal. Hearings or oral argument should be scheduled as soon as possible after the receipt of a request by the appellant. However, the appellant should be given an adequate period of time within which to prepare. Therefore, the appellant should be consulted in regard to all scheduling matters.
2. Any appellant who has received notice of the right to a hearing or to appellate review of a decision shall request such hearing or appellate review in writing, by registered or certified mail, return receipt requested, addressed to the Chief of Staff, or shall be deemed to have waived the right to such hearing or appellate review. Such request shall be made within fifteen calendar days of the date the notice was mailed.
3. If the hearing has been requested on a timely basis, the appellant will be provided with a notice by certified or registered mail, return receipt requested, setting forth the place, time and date of the hearing, which date shall not be less than thirty days after the date of the initial notice of the right to a hearing unless an earlier date is requested by the appellant and agreed to by the Hearing Committee. In addition, the appellant shall be provided with a list of the witnesses, if any, expected to testify at the hearing on behalf of the body or individual making the adverse recommendation. The appellant shall be instructed to provide the Chief of Staff by certified or registered mail, return receipt requested, with a list of the witnesses, if any, expected to testify at the hearing on behalf of the appellant. Additional witnesses may be permitted to testify at the hearing at the discretion of the Hearing Committee.

### **SECTION C. The Hearing Committee**

The Hearing Committee shall be either the Medical Board or the Patient Safety & Clinical Quality Committee, as appropriate. Any member of a Hearing Committee who is presenting an adverse recommendation to the Hearing Committee shall abstain from voting as a member of the Hearing Committee or participating in its deliberations, and accordingly shall be deemed not to be a member of the Hearing Committee. In addition, any member of the Hearing Committee who is in direct economic competition with the appellant shall abstain from voting as a member of the Hearing Committee or participating in its deliberations, and accordingly shall be deemed not to be a member of the Hearing Committee.

### **SECTION D. Conduct of Hearing**

1. The hearing shall be conducted fairly, but is to be informal and not according to the rules of evidence. All reasonably relevant information should be heard or accepted in evidence as exhibits. The Chairman shall preside over the hearing and rule upon matters of procedure, assure that all participants have a reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of exhibits.
2. An accurate record shall be made, which, at the discretion of the Hearing Committee, may be by means of a stenographic transcript, or a recording device. If the appellant requests that the hearing be recorded by means of a stenographic transcript, the costs of the public stenographer shall be born equally by the appellant and the Hospital. Copies of the stenographic transcript may be obtained by the appellant upon payment of any reasonable charges.
3. The body which made the adverse recommendation shall designate a representative to present information in support of its decision. Such representative shall have the right to present witnesses, examine other participants in the hearing, and, at the discretion of the representative, make opening and closing statements. During the hearing and appellate review process, the representative shall be entitled to be represented by an attorney who shall represent the interests of the Medical Staff and the Board of Trustees.
4. At its discretion, the Hearing Committee may call its own witnesses or obtain expert assistance in connection with any matter pending before it. Any written reports by such experts shall be provided to all parties to the hearing.
5. Both sides are required to prepare their cases so that a hearing shall be concluded after a maximum of twelve hours of hearing, or three hearing sessions. Under extraordinary circumstances, the Hearing Committee in its sole discretion may depart from this requirement; however, a hearing shall not

## **SECTION E. Rights of the Appellant**

1. The appellant shall have the following rights:
  - a. to present all reasonably relevant information;
  - b. to call witnesses and examine witnesses produced by the representative of the adverse decision maker;
  - c. to be accompanied and advised by a member of the Medical Staff in good standing, or by a member of a professional society, or by an attorney; provided, however, that, if the appellant is to be accompanied, the Chairman of the Hearing Committee shall be promptly notified;
  - d. to make, at the appellant's discretion, opening and closing statements, and to submit a written statement at the close of the hearing.
2. If the appellant fails to appear at the hearing, the right to the hearing and to any subsequent appellate review shall be deemed to have been waived; provided, however, that the Hearing Committee, for good cause shown, may, in its sole discretion, continue the hearing. Good cause shall not include any circumstances reasonably avoidable.
3. After completion of the hearing, the Hearing Committee, as promptly as possible, shall prepare a written opinion setting forth its recommendations, including a statement of the basis for the recommendations. The written opinion shall be forwarded, together with all exhibits and, if available in whole or in part, the hearing record (including a copy of the stenographic or recorded record of the hearing), to the Patient Safety & Clinical Quality Committee or to the Board of Trustees, as appropriate. A copy of the written opinion also shall be provided to the appellant.
4. The foregoing procedures for a hearing are intended as guidelines for insuring the appellant a fair hearing and are not to be construed as establishing any rigid format for the hearing or action by the Hearing Committee.

## **SECTION F. Appellate Review**

1. Subsequent to an unfavorable recommendation by the Hearing Committee, the appellant is entitled to appellate review by the Patient Safety & Clinical Quality Committee or by the Board of Trustees, as determined by the Board of Trustees. Such action shall be taken on the basis of the available record, provided, however, that the appellant or the appellant's attorney upon timely

notice shall have the right to present a written statement and appear before the reviewing body for the purpose of oral argument. Statements and argument shall be confined to the record. The reviewing body may set reasonable time requirements on arguments and appellate review.

2. Upon request for appellate review, the appellant shall be entitled upon request, to copies of any documents in the record of the Hearing Committee, and, if available in whole or in part, a copy of the stenographic or recorded record of the hearing.
3. If appellate review has been before the Patient Safety & Clinical Quality Committee, it shall forward its recommendations to the Board of Trustees.
4. Subsequent to appellate review, the Board of Trustees shall take final action. The decision of the Board shall be reduced to writing and shall include a statement of the basis for the decision. The appellant shall be notified by the Chief of Staff of the Trustee's action, and shall be provided with a copy of the Trustees' decision.

## **ARTICLE VII. MEDICAL STAFF OFFICERS**

### **SECTION A. Composition**

1. The Medical Staff officers shall consist of a President, a Past President (who shall also act as Treasurer), a President-elect and a Secretary.
2. At all times:
  - a. two of the four officers shall be Community Physicians and two of the four officers shall be University Physicians and;
  - b. the officers of President-elect and Secretary shall be rotated biennially between Community and University physicians.

### **SECTION B. Nominations**

1. Nominations shall be made by a Nominating Committee consisting of the Past President, who shall serve as chairman, two former Presidents of the Medical Staff who no longer are serving as officers, and the Chief of Staff who shall serve ex officio without vote. In the event that the Past President and all former Presidents of the Medical Staff eligible to serve as members of the Nominating Committee are all Community Physicians or all University Physicians, the Chief of Staff shall appoint one of the three members of the Nominating Committee from among the members of the Active Staff, so that there always shall be representatives of both Community and University Physicians on the Nominating Committee.
2. The Nominating Committee biennially shall select two candidates for President-elect and two candidates for Secretary, such candidates to be selected so as to comply with the requirements of SECTION A, Paragraph 2 above.
3. The Medical Board may establish a mechanism for selecting additional candidates which shall be consistent with the provisions of SECTION A, Paragraph 2 above requiring equal Community and University participation.
4. Members of the Medical Staff eligible for nomination will be those who can be expected to remain members of the Attending Staff throughout their terms of office and who have demonstrated a primary commitment to, and involvement in, the affairs of the Hospital.

### **SECTION C. Election**

1. The Active Staff shall elect the officers by a plurality of mail ballots.

#### **SECTION D. Terms of Office**

1. The officers shall take office on the first day of September.
2. The Secretary shall serve for two years.
3. The Presidential officers shall serve for six years as follows:
  - a. the first two years as President-elect
  - b. the third and fourth years as President; and
  - c. the fifth and sixth years as Past President and Treasurer.

#### **SECTION E. Vacancies**

1. Should an office of the Medical Staff become vacant for any reason, the Medical Staff shall elect a replacement who shall come from the same group (Community or University) as the original officer.
2. The replacement officer shall serve out the term of the original officer.

#### **SECTION F. Removal of a Medical Staff Officer**

An officer of the Medical Staff may be removed from office by vote of the Medical Board.

#### **SECTION G. Duties**

1. Officers shall serve as members of the Medical Board and members of the Medical Staff Committees as appropriate.
2. The Medical Staff President and President elect shall serve as members of the Patient Safety & Clinical Quality Committee. The Secretary shall serve with the President and President-elect as a member of the Joint Conference Committee.
3. Officers shall convene periodic meetings, at least annually, of the Active Medical Staff for the purposes of education, information and discussion of matters of common interest.
4. Without regard to whether they are Community or University Physicians, officers shall represent and exercise all of their duties to the Medical Board, to the administration of the Hospital, and to the Joint Conference Committee as representatives of all members of the Medical Staff.

5. The Secretary shall be responsible for recording transactions of Medical Staff Meetings and shall serve as Chair of the Credentials Committee.
6. The Past President shall also act as the Medical Staff Treasurer. The Treasurer shall be responsible for collection of the annual Medical Staff dues, and for making recommendations to the Chief of Staff and the Medical Board for the use of the funds.
7. The Medical Staff President will work in a collaborative manner with the Chief of Staff and will review the agendas for Medical Staff leadership meetings, such as the Medical Board, Administrative Committee of the Medical Board, and Medical Staff meetings.
8. With the recognition that physicians actively engaged in patient care will give dimension to discussions about the Hospital's programs and planning, the President and President-elect of the Medical Staff will be invited to attend meetings of the Board of Trustees. In addition, the Medical Staff President will be asked to attend meetings of the Clinical Chiefs and Associate Chiefs and may be requested to assist in such Hospital activities as fund raising.

## **ARTICLE VIII. HOSPITAL DEPARTMENTS**

### **SECTION A. Departments**

1. The Medical Staff shall be organized in the following clinical hospital departments:
  - a. Anesthesiology
  - b. Child Psychiatry
  - c. Dentistry
  - d. Dermatology
  - e. Diagnostic Radiology
  - f. Internal Medicine, including general medicine and medical specialties
  - g. Laboratory Medicine
  - h. Neurology
  - i. Neurosurgery
  - j. Obstetrics and Gynecology
  - k. Ophthalmology
  - l. Orthopedics and Rehabilitation, including Podiatry
  - m. Pathology
  - n. Pediatrics
  - o. Psychiatry
  - p. Surgery, including general surgery and surgical specialties
  - q. Therapeutic Radiology
  
2. Departmental status shall be designated upon recommendation of the Medical Board to the Patient Safety & Clinical Quality Committee, and approval of the Board of Trustees. Designation of a new Hospital Department shall ordinarily follow such approval by the University.

### **SECTION B. Sections**

1. If, in the interest of Departmental organization, it is desirable to subdivide the clinical activities of a Department into formally constituted Sections, the Chief, and the Associate Chief, in the case of Departments with such position, may so recommend to the President with identification of the clinical scope of the proposed Sections. The President's recommendation will be forwarded to the Patient Safety & Clinical Quality Committee.
  
2. Section Chiefs and Associate Section Chiefs shall be members of the Active Staff as Attending Physicians and appointed by the Board of Trustees upon nomination to the Patient Safety & Clinical Quality Committee by a Committee composed of (a) the Chief of the Department involved, (b) the Chair of the corresponding department of the Medical School if such Chair at

such time is not the Chief of Department, (c) the Associate Chief, where applicable, (d) the Section Chief or Associate Section Chief, whoever shall be appropriate, depending on the vacancy to be filled, and (e) the President. Any of such five officers may appoint a substitute representative to be a member of the Committee. Section Chiefs usually will be University Physicians, and Associate Section Chiefs will be Community Physicians. The Board of Trustees shall reserve the right to reject a nomination of a Section Chief or Associate Section Chief which the Board of Trustees has reason to consider inappropriate. In the event of such rejection, the Committee shall continue to nominate until an appointment has been made.

3. Section Chiefs and Associate Section Chiefs shall be appointed annually by the Board of Trustees in the manner hereinbefore prescribed and shall be eligible for reappointment.
4. Any Section may, by vote of the majority of its Active members voting thereon, decide to establish or eliminate the position of Associate Section Chief, provided a majority of the Active community members of such Section vote in the affirmative.

### **SECTION C. Departmental and Sectional Meetings**

Each Department or Section shall meet monthly as a committee of the whole to review the care and treatment of patients served by the Hospital. This review shall include consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnosis or treatment and relevant reports originating from ongoing medical care audits. Members are expected to attend such meetings. Minutes or records shall adequately reflect the conclusions and recommendations of such meetings, and actions taken by such committees.

## **ARTICLE IX. CHIEFS OF DEPARTMENT**

### **SECTION A. Selection**

1. There shall be a Chief of each Department.
2. Chiefs usually will be individuals selected to be Chair of their respective Department in the Medical School. Criteria for selection will include a candidate's interest and expertise in clinical affairs, as well as an ability to manage the dual interests of Community and University physicians. Chiefs must be members of the Active Staff and certified as diplomates of their specialty board or be equivalently qualified.
3. Search committees for the selection of Chiefs shall be appointed by the University and shall have representation of the President and of the Medical Staff, including Community Physicians. The Dean will recommend the candidate for Chief to the President, who will submit the nomination, by way of the Patient Safety & Clinical Quality Committee, to the Board of Trustees for approval.
4. The Board of Trustees shall have the right to reject a nomination of a Chief that the Board of Trustees has reason to consider inappropriate. In case of such rejection, the University shall make a further nomination in the manner set forth above in SECTION A, Paragraphs 2 and 3 and continue to do so until an appointment has been made.
5. The Chief of the Department of Dentistry shall be selected in the following manner. The President, after consultation with the Chief of Staff and the Chief and Associate Chief of Surgery, shall nominate a candidate to the Patient Safety & Clinical Quality Committee. Upon approval by the Patient Safety & Clinical Quality Committee, the nomination shall be presented to the Board of Trustees, which shall either appoint the Chief or reject the nomination. In the case of rejection by the Board of Trustees, the President shall select a new nominee in the manner set forth herein.

### **SECTION B. Duties**

1. Acting within the policy expressed in these Medical Staff Bylaws and in accordance with the Rules and Regulations approved by the Board of Trustees, the Chiefs are responsible for aspects of the credentialing and recredentialing functions detailed elsewhere in these Medical Staff Bylaws. These responsibilities include recommending criteria for relevant clinical privileges, and evaluating initial and reappointment applications within their respective services. The Chiefs shall have the authority within their respective areas to

enforce the rules and regulations governing the professional care of the patients. The Chiefs will participate actively in the academic programs of the Medical School, will be responsible for supervision of the professional services rendered in and the House Staff assigned to the patient care areas under their respective jurisdictions, and will direct the development and implementation of departmental performance improvement, patient safety and quality control professional policies and programs.

2. The Chief is responsible for Departmental management. These responsibilities include activities designed to promote integration of the Department within the Hospital mission, coordination of interdepartmental and intradepartmental services, and making recommendations that support the provision of patient care, including Hospital-based training programs within the context of Hospital policies, objectives and available resources. The Chief or Associate Chief shall also be responsible for orientation of new Members of the Medical Staff to Medical Staff requirements.
3. When the Chief is to be unavailable, the Chief shall direct that one of the following perform the Chief's duties: the Associate Chief, the Assistant Chief, the Assistant Associate Chief, or by a designated member of the Active Staff approved by the Chief of Staff. In the event that the Chief is unavailable for a considerable length of time or is unable to make such designation, an Acting Chief shall be proposed by the President for approval by the Patient Safety & Clinical Quality Committee and Board of Trustees.
4. The Chief of the Department of Surgery shall be responsible for enforcing professional policies and procedures in the Operating and Cystoscopic Rooms , in consultation with the Associate Chief of Surgery and the Chiefs of Anesthesiology, Neurosurgery, Ophthalmology, Obstetrics and Gynecology, and Orthopedics and Rehabilitation. The development and modification of professional policies and procedures shall be the responsibility of an Operating Room committee, as defined in ARTICLE XV, SECTION F, Paragraph (1)..
5. The Chief of the Department of Obstetrics and Gynecology, in consultation with the Associate Chief, shall be responsible for enforcing professional policies and procedures in the Labor and Delivery Rooms. The development and modification of such policies and procedures shall be reviewed with the Departmental Committee and Chief of Staff prior to implementation.
6. Chiefs will be appointed annually following the performance assessment described in ARTICLE IX, SECTION C.
7. The Chief and, where applicable, the Associate Chief shall be responsible for a periodic appraisal of each member of the Medical Staff in the Department, including consideration of physical and mental capabilities. A method of appraisal shall be developed for each Department by its Chief and Associate

Chief and reported to the Medical Board. At the discretion of the Chief, and with the agreement of the Departmental Committee, detailed review of Departmental members may be on a two-year cycle, one-half of the Department to be reviewed each year.

8. After consultation with the Associate Chief, where applicable, and in conjunction with the Departmental Committee, the Chief will periodically assess Departmental programs, policies and needs; will initiate and develop Departmental plans, and will report to the Medical Board, the Chief of Staff and the President on these matters. This will include proposals on the appropriate mix and size of the Department (of both Community and University components), criteria for Medical Staff privileges in the Department, reviews of the quality of care, including assessments of individual performance; proposals for new programs; assessment of resource availability and utilization, and the need for additional resources, both financial and physical; and assessment of the relative importance of both current and new programs to the overall Hospital mission. The frequency of these reports will be determined by the Medical Board.
9. Except with respect to the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery, where the position of Associate Chief is mandated, the Chief will review with the Departmental Committee the need for, and the role of, an Associate Chief for the Department and recommend such to the Medical Board, if found desirable.
10. Following consultation with the Associate Chief, in the case of Community-based applicants, the Chief will approve all applicants for Medical Staff membership in the Department, considering both the standards of excellence, the needs of the Department and the ability of the institution adequately to support the applicant. Following action by the Chief, applications will be reviewed by the Credentials Committee in accordance with ARTICLE V.
11. Chiefs will be members of the Medical Board.

### **SECTION C. Performance**

1. The performance of Chiefs will be reviewed annually by the President and reported to the Patient Safety & Clinical Quality Committee. This evaluation will be coordinated with periodic external assessments jointly made with the Medical School. Such annual assessments will include recommendations to the Patient Safety & Clinical Quality Committee regarding reappointment, as well as collaboration with the Dean regarding appropriate compensation arrangements. Assessments will include input from the Departmental Committee, other Chiefs, the Associate Chief, where applicable, the Chief of

Staff, the Executive Vice President, and others deemed appropriate to such reviews.

2. Chiefs shall be accountable to the President:
  - a. Through the Chief of Staff, for the performance of their professional responsibilities including performance improvement.
  - b. Through a Senior Vice President, working with assigned Administrative Clinical Coordinators, for their management responsibilities.

#### **SECTION D. Assistant Chiefs**

The Chief may recommend to the President a member of the Active Staff for appointment as Assistant Chief of Department. The President's recommendation shall be forwarded to the Patient Safety & Clinical Quality Committee which, in turn, shall make its recommendation to the Board of Trustees, which shall take appropriate action.

## **ARTICLE X. ASSOCIATE CHIEFS OF DEPARTMENT**

### **SECTION A. Selection**

1. There shall be an Associate Chief of each of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery. Any such Department may, however, by a vote of the majority of its Active Members voting thereon, decide to eliminate the position of Associate Chief, provided a majority of the Active Community Members of such Department vote in the affirmative and provided such action is approved by a vote of two-thirds of the Medical Board. Associate Chiefs and Associate Section Chiefs shall be members of the Active Staff as Attending Physicians, and will be Community Physicians.
2. Each Associate Chief must be qualified by training, professional experience and demonstrated ability.
3. Any other Department or any Section of any Department may, by the affirmative vote of the respective Departmental or Sectional Committee, create the position of Associate Chief of Department or Section.
4. The Associate Chief of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery shall be nominated by the Chief to the President and Trustees upon receipt of the recommendations of a search committee. There shall be a Search Committee for each such Department, appointed by the Chief after consultation with the Departmental Committee, whose membership shall be composed of Community Physicians and University Physicians in such proportion as the respective Departmental Committees of such Departments shall prescribe; provided, however, that the membership of Community Physicians on each such Search Committee shall be not less than one-third of the membership thereof. The Community members of each such Search Committee shall be chosen from a slate endorsed by the Community Active Staff. The Board of Trustees shall have the right to reject the nomination of an Associate Chief, which the Board of Trustees has reason to consider inappropriate. In case of such rejection, a further nomination or nominations shall be submitted until an appointment has been made.
5. Nominees for Associate Chief of any other Department or of any Section shall be selected in a manner agreed upon by the Chief and the Departmental or Sectional Committee and shall be recommended in the same manner to the President and the Board of Trustees by way of the Patient Safety & Clinical Quality Committee.

## **SECTION B. Duties**

1. Each Chief, subsequent to consultation with the Associate Chief and receipt of the recommendations of the Departmental Committee, shall prescribe the role and powers of the Associate Chief. The role and powers, thus defined, shall be submitted to the Medical Board for approval. In general, the Associate Chief will participate actively in the academic programs of the Department, and will be responsible to the Chief for:
  - a. supervision of professional services rendered by Community Physicians, including practice in the operating rooms, cystoscopy suite and the labor and delivery suite as appropriate;
  - b. participation in performance improvement initiatives;
  - c. execution of administrative responsibilities relating to the care of patients by Community Physicians; and
  - d. supervision of House Staff involved in caring for patients of Community Physicians.
2. Associate Chiefs of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery will be members of the Medical Board.

## **SECTION C. Performance**

1. The performance of an Associate Chief will be reviewed annually by the President and reported to the Patient Safety & Clinical Quality Committee. Such annual assessments will include recommendations to the Patient Safety & Clinical Quality Committee regarding reappointment. Assessments will include input from the appropriate Chief, the appropriate Departmental Committee, the Chief of Staff, the Executive Vice President, and others deemed appropriate to such reviews, including Community members of the Department whose Associate Chief is being reviewed.
2. Not less often than every five years, a Review Committee shall be appointed for each of the Departments of Medicine, Obstetrics and Gynecology, Pediatrics and Surgery, and such other Departments which have an Associate Chief, whose duties shall be to make recommendations to the President and Board of Trustees regarding the performance of the Associate Chief for such Departments, respectively. The membership of each such Review Committee shall be the same as that provided for the Search Committee with respect to the initial appointment of each Associate Chief. Consideration will be given to the inclusion of an outside consultant(s) to the review process. To the extent

practicable, such review will be done in conjunction with periodic departmental reviews.

**SECTION D. Assistant Associate Chief**

In the case of Departments with Associate Chiefs, the Chief, after consultation with the Associate Chief, may submit their joint recommendation for appointment of a Community member of the Active Staff as Assistant Associate Chief of Department to the President. The President's recommendation shall be forwarded to the Patient Safety & Clinical Quality Committee which, in turn, shall make its recommendation to the Board of Trustees, which shall take appropriate action.

## **ARTICLE XI. DEPARTMENTAL AND SECTIONAL COMMITTEES**

### **SECTION A. Role**

1. Departmental or Sectional Committees shall serve as an advisor to the respective Chiefs. Through regular meetings, their role is to review, initiate review and comment on the following:
  - a. Quality of care provided;
  - b. Need for and/or role of an Associate Chief;
  - c. Departmental policies; existing or proposed;
  - d. Departmental programs: strengths, weaknesses, omissions, duplications;
  - e. Departmental resources: facilities and manpower;
  - f. Concerns of members of the Department;
  - g. Specific Departmental criteria for evaluating fulfillment of commitment obligations set forth in ARTICLE III, SECTION B, Paragraph 1, which criteria shall be submitted to the Medical Board for approval.
2. The Committee will hear and decide appeals properly brought before it.

### **SECTION B. Membership**

1. Departmental Committees in the Departments of Medicine and Surgery shall initially be equally representative of the Community and University components, unless an alternative arrangement is approved by a majority of both Community and University Active Staff members present at a meeting of the Department called to act upon such an alternative plan. Since the Department of Medicine has developed a plan approved by both Community and University members, that plan shall be followed unless modified hereafter.
2. With respect to Sectional Committees and to Departmental Committees, other than for the Departments of Medicine and Surgery, the Chief shall propose, to a duly called meeting of all Active Staff Members of such Department or Section, a membership pattern and method of selection. When an arrangement has been approved by a majority of those Active Staff members present and voting, such plan shall be presented to the Medical Board for its consideration.

If the Medical board rejects the plan, the Department or Section shall prepare and submit an alternative plan.

Fair representation, taking into account facility usage patterns and the composition of the Department or Section, shall be the essential criterion to be applied by the Medical Board in judging the appropriateness of committee make-up.

### **SECTION C. Sectional Committees**

In Departments in which there are formally constituted Sections, it is appropriate for sections to have Sectional Committees to function in the same manner, vis-à-vis the Section Chief, as Departmental Committees do with the Chief.

### **SECTION D. Meetings**

Meetings of Departmental and Sectional Committees shall be held regularly and shall be chaired by the Chief, except when it considers an appeal from a decision of the Chief. When deliberating an appeal from a decision of the Chief, the Chief will not be a Committee member, and the Committee will appoint a chairman pro tem. The chairman pro tem should be from the staff component (Community or University) of which the appellant is a member. The Chief and the appellant will meet with the Committee to review the appealed decision.

## **ARTICLE XII. CHIEF OF STAFF**

### **SECTION A. Selection**

The Chief of Staff may be selected from Community Physicians, from University Staff or from outside the Medical Staff. The Chief of Staff shall be nominated by the President to the Board of Trustees, following consultation with a committee appointed by the President, which committee will include equal representation from Community and University components of the Medical Staff. The committee will identify individuals who possess the abilities and interest required to discharge successfully the responsibilities of this office.

### **SECTION B. Duties**

1. The Chief of Staff functions as the senior administrative officer of the Medical Staff. Successful performance of this key position will help insure effective Medical Staff functioning. This result will be accomplished by maintaining broad participation in Medical Staff affairs by Community and University Physicians, by frequent interaction with all elements of the Staff, especially those in leadership positions, i.e., Chiefs, Associate Chiefs and elected representatives, and by closely monitoring areas of special sensitivity, e.g., operating rooms and emergency service. Specific responsibilities include:
  - a. Management of Medical Staff affairs: staff application process, committee performance, compliance with Joint Commission on Accreditation of Healthcare Organizations and licensure requirements as they pertain to medical practice and patient concerns regarding medical services.
  - b. Representation of the Medical Staff: to the Board of Trustees, as a member of Hospital Management, in councils of Yale-New Haven Medical Center, Inc., and to various organizations, locally and statewide.
  - c. Administrative supervision of functioning of medical services through the Chiefs.
  - d. Assistance to elected Medical Staff officers in the discharge of their duties.
  - e. Coordination of house staff affairs on matters outside of departmental purview.

- f. Overall medical responsibility for:
  - Medicolegal Affairs Office and Risk Management Program
  - Emergency Services
  - Operating Rooms
  - Other medical services as required
  
- g. Communication with the Dean on matters of mutual interest.

**SECTION C. Reporting**

1. The Chief of Staff reports to the President and also has responsibility to report to the Board of Trustees regarding medical practice, through the Patient Safety & Clinical Quality Committee. The Chief of Staff's performance will be reviewed annually by the President and the Board of Trustees following consultation with appropriate members of the Medical Staff.
  
2. The Chief of Staff will be a member of the Medical Board and may be an ex officio member of the Patient Safety & Clinical Quality Committee, the Joint Conference Committee and the Board of Trustees.

## **ARTICLE XIII. ASSOCIATE CHIEF OF STAFF**

### **SECTION A. SELECTION**

The Chief of Staff may recommend a member of the Active Medical Staff for appointment as Associate Chief of Staff. The recommendation requires the concurrence of the President.

### **SECTION B. DUTIES**

The Associate Chief of Staff shall perform such administrative and Medical Staff functions as are delegated by the Chief of Staff. In the absence of the Chief of Staff, the Associate Chief of Staff shall assume the authority and responsibilities of the Chief of Staff.

### **SECTION C. REPORTING**

The Associate Chief of Staff reports to the Chief of Staff. Performance of the Associate Chief of Staff will be evaluated annually by the Chief of Staff, who shall consult with the President and other appropriate Hospital executive and clinical leaders.

## **ARTICLE XIV. DEPARTMENTAL APPEALS**

### **SECTION A. Access to Appeals**

In order to assure equity, all members of the Medical Staff shall have access to a mechanism through which decisions may be challenged which are perceived to be inappropriate or unfair. Except as otherwise provided in ARTICLE V, decisions of individuals or groups which deal with Medical Staff privilege, access to Hospital resources or departmental or Hospital policies may be appealed only after efforts to resolve disputes at the lowest level have been exhausted. Provision shall be made to stay the implementation of a decision pending the final determination of an appeal with respect thereto, except under emergency circumstances involving an immediate threat to the welfare or safety of patients or staff.

### **SECTION B. Procedure on Appeal**

1. The following steps will provide the framework for a timely and effective means of responding to grievances:

- a. From the decision of the Chief or any other departmental source, an appellant may appeal to either the Departmental Committee or to the Chief of Staff. After this step is exhausted, and if satisfaction is not found by the appellant or the Chief, the appeal is to the Medical Board.

In Departments with formal Sections, the appeal of a Section Chief's decision is either to the Sectional Committee or the Chief. If satisfaction is not found, the appeal is to the Chief of Staff or the Departmental Committee as delineated above.

- b. From the decision of the Chief of Staff, an appellant may appeal to the Medical Board.
- c. The Medical Board decision on an appeal will normally be the final step, if such decision is made with support of two-thirds or more of votes cast, unless the Patient Safety & Clinical Quality Committee chooses to review the decision. Decisions with less support than two-thirds will be automatically forwarded to and reviewed by the Patient Safety & Clinical Quality Committee.
- d. The Patient Safety & Clinical Quality Committee will serve as the Trustee (and final) step in the Appeal Process, with its decision subject to Board of Trustees approval. Upon request of any physician adversely affected by the decision being reviewed, the Patient Safety & Clinical Quality Committee shall obtain an independent written opinion

from a qualified, disinterested physician of its choice as to the reasonableness of the decision being reviewed in order to assist the Committee in its review of the decision.

2. In summary, an appellant will begin the grievance process at the appropriate level only after exhausting efforts to resolve the dispute with involved parties.

3.
 

<u>Level</u>	<u>From the Decision of:</u>	<u>May Appeal to Either:</u>
		(only one)
1.	Section Chief	Sectional Committee or Chief
2.	Sectional Committee or Chief	Departmental Committee or Chief of Staff
3.	Departmental Committee or Chief of Staff	Medical Board
4.	Medical Board	Patient Safety & Clinical Quality Committee

## **ARTICLE XV. MEDICAL BOARD**

### **SECTION A. Duties**

1. Subject to review and approval by the Board of Trustees, the duties of the Medical Board shall be:
  - a. To monitor quality of care;
  - b. To evaluate and recommend clinical privileges and membership on the Medical Staff;
  - c. To formulate and recommend medical policy;
  - d. To propose Medical Staff Bylaws, Rules and Regulations;
  - e. To discharge responsibilities essential to maintaining accreditation and licensure, including the appointment of and monitoring of Medical Staff committees; and
  - f. To advise Management regarding assignment of beds, operating rooms and other clinical resources.
2. Regardless of practice orientation, a broad institutional perspective is required of all Medical Board members to assure responsible deliberation and decision making.

### **SECTION B. Membership**

1. The total membership of the Medical Board shall be forty with an equal number of Community and University Physicians. If the number of Departments represented by Chiefs changes, then the number of members elected at large will change equally.
2. The membership of the Medical Board shall consist of:
  - a. The Chiefs of the Departments of Anesthesiology, Child Psychiatry, Dermatology, Diagnostic Radiology, Laboratory Medicine, Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Rehabilitation, Pathology, Pediatrics, Psychiatry, Surgery and Therapeutic Radiology;

- b. The elected officers of the Medical Staff, namely, the President, Past President (Treasurer), President-elect and Secretary;
  - c. The Associate Chiefs of the Departments of Medicine, Surgery, Pediatrics and Obstetrics and Gynecology;
  - d. The Chief of Staff, the Chief of Dentistry, the Senior Vice President for Patient Services and the Executive Vice President; and
  - e. Twelve Community Physicians elected at large from the Active Staff, eligible to serve at least one term.
3. The twelve Community Physicians elected at large shall be elected as follows:
- a. The three Presidential officers shall constitute a Nominating Committee, unless Community Physicians are a minority of the Presidential office. In such case, the President of the Medical Staff shall add Community Physicians so that this group is a majority. The Community senior Presidential officer shall be Chairman of this Committee. Consideration shall be given by such Nominating Committee to the desirability of broad representation of the various Departments on the Medical Board and its Administrative Committee.
  - b. The Nominating Committee shall nominate as many persons to fill vacancies as it deems appropriate. A procedure may be established by the Medical Board to provide for additional nominations.
  - c. Medical Board terms shall be three years, with a maximum of two consecutive terms.
  - d. Election shall be by mail ballot of community members of the Active Staff.
4. The Chief of the adult ED and the Hospital Ambulatory Services Vice President shall be ex officio members (without vote) of the Medical Board. The Medical Board may appoint other ex officio members as needed. Ex officio members of the Medical Board are non-voting.

**SECTION C. Organization and Voting**

- 1. The President of the Medical Staff shall serve as Chair of the Medical Board, and the President-elect of the Medical Staff shall serve as Vice Chair.
- 2. Members of the Medical Board standing committees shall be appointed by the Medical Board on nomination of a committee consisting of the Past President

of the Medical Staff, who shall serve as Chair, one Department Chair and one at-large-member. The Department Chair and at-large-member shall be elected by the Medical Board for staggered two-year terms.

Decisions on any issue concerning Medical Staff policy, Bylaws, Rules and Regulations (other than amendments to the Bylaws, Rules and Regulation (See Article XVIII), Departmental Criteria for evaluating fulfillment of commitment obligations, and matters involving contested Medical Staff privileges must be approved by two-thirds of those present and voting, except that the responsibility for recommending approval of uncontested applicants for membership on the Medical Staff may be delegated to the Administrative Committee. Decisions on all appeals under ARTICLE XIV require a two-thirds vote of those present and voting in order to uphold the original decision of two-thirds of the entire membership of the Medical Board. Other matters, including approval of uncontested Medical Staff appointments and reappointments may be approved by a simple majority by those present and voting at either the Medical Board or its Administrative Committee

3. Any appeal decision which has not been approved by two-thirds or more of those present and voting will be automatically referred to the Patient Safety & Clinical Quality Committee.

#### **SECTION D. Meetings and Attendance**

1. The Medical Board will meet quarterly unless called more frequently by the Chair, Chief of Staff or by petition of twenty-five per cent or more of the Medical Board membership.
2. Two-thirds of the membership of the Medical Board shall constitute a quorum.
3. Attendance at Medical Board meetings is not assignable for voting purposes. A substitute may attend a meeting but may not vote and will not count in the quorum.

#### **SECTION E. Medical Board Administrative Committee**

1. The Medical Board Administrative Committee shall act on behalf of the Medical Board between meetings of the Medical Board with respect to administrative and routine matters, for example, monitoring committee review and approval of the uncontested Medical Staff appointments. All of its actions will be reported to the Medical Board through meeting minutes. It will not have authority to decide issues which require the vote of two-thirds of the Medical Board, i.e., Medical Staff policy, Bylaws, Rules and Regulations, and

2. The Medical Board Administrative Committee shall consist of the Chief of Staff, the President and Past President of the Medical Staff, three Chiefs and three of the at-large Medical Board members (all six elected by the Medical Board) and the Executive Vice President of the Hospital.

The President of the Medical Staff shall be Chair of the Medical Board Administrative Committee, and the Past President of the Medical Staff shall be Vice Chair. The Committee shall meet monthly, except when the full Medical Board is meeting that month, and upon call of the Chair. Two-thirds of the membership shall constitute a quorum. Action, including action on uncontested Medical Staff appointments and reappointments shall be taken by a vote of a majority of those present and voting. Attendance is non-assignable.

## **SECTION F. Committees**

1. Appointment of and charge to ad hoc and standing committees shall be made by the Medical Board. These Committees may include finance, nominating and other committees established to manage the internal administrative business of the Medical Board, as well as those listed below. All committees should be appropriately representative of the Medical Staff. The membership of each committee, together with its charge, shall be incorporated in the permanent records of the Medical Board, and a copy shall be distributed to the members of the Committee.

The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications or activities of the Medical Staff and Affiliated Health Care Professionals or applicants for admission hereto, (e) reporting variances to accepted standards of clinical performance by, and in some cases to, individual practitioners and (f) for such additional purposes as may be set forth in the charges to each committee. The Medical Board may also create subcommittees which report to the Standing Committees.

### **a. Ambulatory Services Committee**

Charge: provide Medical Staff oversight and coordination to off-campus operative, endoscopic and radiology Hospital services, if any; coordinate Medical Staff Committee needs and receive reports from non-main campus operative, endoscopy and radiology committees,

including but not limited to QA, tissue and the off campus OR committee(s); to insure that the Ambulatory Service has appropriate membership on and communication with other relevant Medical Staff committee(s); to determine which Service specific policies will be implemented in the Ambulatory Service and monitor the consistency of Hospital core policies in the off-site facilities.

The Medical Board shall determine which off site facilities shall be subject to the oversight of this committee. In addition to the annual report made to the Medical Board, the Committee shall report to the Medical Board when it adds or deletes sites subject to the jurisdiction of the Committee.

Composition: Hospital Vice President for the Ambulatory Services, , who shall be the Chair of the Committee, two representatives from the Department of Surgery (one member appointed by the Chief of Surgery and the other appointed by the Associate Chief of Surgery), representation from the Office of the Chief of Staff, Regulatory Preparedness/Quality Assurance, Infection Control, Ambulatory Nursing, Ambulatory Diagnostic Radiology, all Medical Directors at the Ambulatory sites, and other members of the Medical Staff as needed.

Meetings: Monthly.

b. **Bioethics Committee**

Charge: Separate Adult and Pediatric Bioethics Committees shall review and propose policies and guidelines that address ethical aspects of Hospitals practices; to provide consultation on individual adult and pediatric cases where ethical issues have been raised; to design and make available to the Hospital staff educational and other resources regarding medical ethical issues.

Composition: members of the Attending and House Staffs, nursing, Religious Ministries and administrative staffs; Hospital counsel; and other members deemed appropriate.

Meetings: Monthly; consultations as required.

c. **Bylaws Review Committee.**

Charge: review the Medical Staff Bylaws and Rules and Regulations with consideration to be given to compliance with the recommendations of accrediting and regulatory agencies; recommend to the Medical Board such revisions as are considered practical and necessary to update appropriately the Medical Staff Bylaws and Rules and Regulations.

Composition: members of Medical and Administrative Staffs; Hospital Counsel.

Meetings: as required.

d. **Cancer Committee.**

Charge: coordinate clinical cancer activities to a degree consistent with the American College of Surgeon's standards for approval; oversee the Tumor Registry; report at least annually to the Medical Staff concerning the activities of the Registry, including analysis of data on survival and end results for various types of cancer; report a summary of its activities to the Medical Board annually.

Composition: subcommittee of the Executive Committee of the Yale Cancer Center, an NCI-designated Comprehensive Cancer Center. Representatives include the Cancer Liaison Physician to the ACOS, the Director of the Quality Assurance Program at YNHH, community physicians, and a broad array of departments including: surgery, medical oncology, diagnostic radiology, radiation oncology, pathology, administration, nursing, social services and cancer registry.

e. **Conflict of Interest Committee**

Charge: review conflict of interest issues relative to all members of the Medical and Affiliated Medical Staff. On an annual basis, Medical and Affiliated Staff will be required to document relationships with external vendors, agencies, companies, suppliers or other organizations in which they are involved or receive real or in kind compensation that also have a relationship with the Hospital. Consistent with the terms of the "Conflict of Interest Policy", this Committee will review those arrangements and address them accordingly in consultation with the Medical Board as indicated.

Composition: the Chair shall be the current President of the Medical Staff. Other members shall include, but not be limited to, the YNHH Director of Corporate Compliance, a representative from Legal & Risk Services, and members of the Active Medical Staff appointed by the Chair with equal representation between Community and University constituencies.

Meetings: Quarterly

f. **Credentials Committee.**

Charge: review applications for appointment to the Medical Staff or Affiliated Staff referred to it by the Credentials Committee Subcommittee and the Chief of Staff or his designee(s); review concerns

of the Chiefs and Associate Chiefs, as applicable; review matters such as, but not limited to, competence/performance, results of ongoing professional practice review and violations of the Code of Conduct referred by the Institutional Practice Quality and Peer Review Committee; conduct personal interviews of candidates for appointment or reappointment at its discretion; conduct a personal interview with the Chief and Associate Chief in instances of disapproval of an application by the Chief or Associate Chief or both. In the event of the intent of the Committee to recommend disapproval of an application, personal interviews shall be held with the Chief or designee and Associate Chief, if appropriate, and with the candidate. Between reappointment cycles, review the status and appropriateness of clinical privileges when referred by the Institutional Practice Quality and Peer Review Committee, the Department Chief, Associate Chief or Chief of Staff. Receive monthly reports as to the results of focused professional evaluations conducted on Medical Staff members. At the request of the Institutional Practice Quality and Peer Review Committee or Chief of Staff, review selected reappointment applications; review new/proposed changes to delineation of clinical privileges form(s); recommend appropriate action to the Medical Board or the Medical Board Administrative Committee relative to all activities.

Composition: shall include, but not be limited to, one member from each of the Departments of Medicine, Diagnostic Radiology, Obstetrics and Gynecology, Pediatrics, Psychiatry, Surgery, and Nursing Administration. Except for Nursing and Diagnostic Radiology, these representatives shall alternate between University and Community groups. The Secretary of the Medical Staff shall serve as Chair. Except for the Secretary, Nursing Administration and Diagnostic Radiology members, members shall be nominated by the appropriate Chief and Associate Chief. The Nursing Administration member shall be nominated by the Senior Vice President for Patient Services. The Diagnostic Radiology member shall be nominated by the Chief of Diagnostic Radiology. The term of appointment of each member shall be two years. The Chief of Staff or his designate shall participate ex officio.

Meetings: monthly.

- g. **Emergency Service Committee.**  
Charge: plan, coordinate and evaluate delivery of patient care in the Emergency Service; plan, develop and implement patient care programs for improved quality of care in conjunction with community needs, resources and affiliated facilities; report a summary of its activities to the Medical Board annually.
- Composition: members of Medical, Nursing and Administrative Staffs.
- Meetings: as required.
- h. **Graduate Medical Education Committee.**  
Charge: Monitor and advise on all aspects of resident education, as required by the ACGME. Responsibilities include, but are not limited to, oversight of program job descriptions, progressive responsibilities during training, and monitoring quality and safety of patient care, treatment and services provided by participants in the GME programs.
- Composition: Graduate Medical Education and subspecialty program training directors, representatives of the House Staff and Clinical Fellows Staff, Human Resources, Legal and other selected staffs, Director of Graduate Medical Education and the Chief of Staff or his designee. Reports annually to the Medical Board.
- Meetings: At least quarterly with additional meetings as required.
- i. **Infection Control Committee.**  
Charge: define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; report a summary of its activities to the Medical Board annually.
- Composition: infection control officer and other members of the Medical Staff including director of personnel health; nurse epidemiologist; members of Nursing, Housekeeping, Food and Nutrition, Pharmacy Services, Ambulatory Services and Administrative Staffs.
- Meetings: monthly.

j. **Medical Record and Clinical Information Committee.**

Charge: advise the Medical Board and, where appropriate, administration and medical personnel in matters pertaining to medical records and clinical information; establish criteria and approve new systems and changes to existing computerized and non-computerized systems used for the collection, storage, retrieval, and release of patient specific medical information on all patients of the Hospital to ensure patient confidentiality and appropriate access; approve changes in format and usage of the medical records; implement the provisions of the Rules and Regulations that pertain to the charge of the Committee; develop guidelines for safeguards to be incorporated into systems to prevent breach of confidentiality; develop a program for continuing review of medical records as to adequacy and quality of content; provide a written report monthly to the Medical Board on matters related to delinquent medical records and, when appropriate, report problems in compliance with guidelines approved by the Medical Board. Report a summary of Committee activities to the Medical Board annually.

Composition: members of Medical, Ambulatory Services, Nursing and Administrative Staffs; director of Clinical Information Service.

Meetings: monthly.

k. **Medical Staff Health Committee.**

Charge: To establish and maintain a mechanism for educating Medical Staff and trainees to recognize the signs and symptoms of potential or actual health impairment among colleagues; to assist in identifying such potential or actual health impairment; to implement Medical Staff policy when incidents of actual or potential health impairment require evaluation; make recommendations to the Medical Board regarding Medical Staff Health policy changes.

Composition: Members of the Medical and Affiliated Staffs, Senior Vice President for Medical Affairs or designee; Senior Vice President for Patient Services or designee. Other Hospital staff may participate ex officio as appropriate.

Meetings: As needed

l. **Operating Room Committee.**

Charge: plan, coordinate and evaluate delivery of patient care in the main campus Operating Room Suite; develop, review and modify professional policies and procedures in consultation with the Chiefs of Anesthesiology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Rehabilitation, and Surgery, the Director of Operating Rooms and the Nursing Director of Perioperative

Services; work with the Chief of Surgery and any delegated Medical, Nursing and Administrative Staff with management responsibilities; reports annually to the Medical Board.

Composition: members of Medical, Nursing and Administrative Staffs, including a representative from the Ambulatory Services off campus operative site(s) if any, with attention to representing each surgical service and Community and University surgeons.

Meetings: monthly

m. **Pharmacy and Therapeutics Committee.**

Charge: recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to drugs; recommend programs designed to meet the needs of the professional staff of the Hospital for complete current information on matters related to drugs and drug practices; report a summary of its activities to the Medical Board annually.

Composition: members of Medical, Nursing, Pharmacy, and Administrative Staffs.

Meetings: monthly.

n. **Institutional Practice Quality and Peer Review Committee**

Charge: (a) oversee the gathering and analysis of data and information among clinical departments of YNHH and the committees of the Medical Staff for purposes of: evaluating and improving the quality of health care services ordered or delivered by health care professionals; studying and reducing morbidity and mortality; conducting medical audits; considering the appropriate utilization of institutional resources; and analyzing clinical practices. In some circumstances, malpractice claims review may also be conducted. (b) receive reports from Medical Staff committees and sub-committees and YNHH departments, services, and sections conducting peer review; (c) review complaints and concerns related to practitioner performance and behavior as well as reports of incidents as appropriate; and designate and appoint members or other YNHH personnel to investigate and conduct root cause analyses, as the Committee specifically authorizes or directs, of events, including , but not limited to sentinel events and other significant unanticipated outcomes at YNHH, and to report the results of these activities to the Committee; (d) facilitate mechanisms for correction of problems identified; (e) assist YNHH in maintaining compliance with the requirements of The Joint Commission; (f) report to the Medical Board and the Patient Safety & Clinical Quality Committee of the Board of Trustees regarding institutional concerns

related to patient safety and practitioner performance; (g) refer issues, as applicable, having to do with credentialing, privileging and violations of the Code of Conduct to the Credentials Committee or, as appropriate, Medical Staff Health Committee, for deliberation. Such functions as described herein shall be peer review activities of the Committee, as defined in Connecticut General Statutes § 19a – 17b(a)(2) and shall be kept in strict confidence. The Committee shall carry out such additional quality improvement activities as it deems appropriate.

Composition: President of the Medical Staff who shall serve as Chair, President Elect of the Medical Staff, Chief of Staff or representative of Chief of Staff's Office, Legal and Risk Services Department representative, two community based members of the Medical Board and two Department Chiefs. Additional members may be added at the discretion of the Hospital Chief of Staff or the President of the Medical Staff.

Meetings: Quarterly

o. **Resuscitation/Rapid Response Review Committee:**

Charge: To review all Code 5 and Code 7 events to assure appropriate pre-emergency use of rapid response teams and adherence to ACLS/PALS resuscitation guidelines. Analyze and report outcomes of resuscitation and rapid response calls. Create and implement policies that optimize resuscitation training and patient outcomes. To evaluate the areas to which Code response is provided and requests for extension of the Code response to non-served areas. To provide quality assurance and peer review to aspects of the Code and rapid response function. To report to the Medical Board annually..

Composition:

The Chair shall be a member of the Active Medical Staff and appointed by the Medical Board. The Committee membership shall include, but not be limited to, representatives from the Departments of Anesthesiology, Surgery, Internal Medicine (including Hospitalist Team), Nursing, Chief residents in Medicine and Pediatrics Pharmacy, Protective Services, Respiratory Therapy, and Performance Management.

Meetings: Meeting shall occur at least quarterly.

p. **Tissue Committee:**

Charge: review indications for surgery in all cases in which there is an apparent major discrepancy between the preoperative and pathologic diagnoses; establish a screening mechanism, based on predetermined

criteria, to review cases which involve no specimens; maintain liaison with the Medical Quality Assurance Department; refer cases, based on Committee investigation, to the appropriate Department Chief for action; report annually to the Medical Board summarizing activities of the Committee and actions taken by the Departments Chiefs.

The Committee will also review any case in which the pathology reading has concerned the referring physician or surgeon. The Committee will review any discrepancies between frozen and permanent sections, as well as discrepancies between Cytology and tissue sections.

Composition: members of the Medical Staff, including the Medical Director of Quality Assurance and a representative from the Ambulatory Services Tissue Committee, if any.

Meetings: monthly.

q. **Transfusion & Tissue Banking Committee:**

Charge: To periodically establish and review criteria for the transfusion of blood and blood components and to conduct transfusion audits; to work to ensure the continual availability of a safe and adequate blood supply for the care of Hospital patients; to make transfusion medicine study findings known to the clinical services; and to review the results of transfusion error and accident monitoring and make recommendations for corrective action. Report annually to the Medical Board.

Composition: members of Medical and Administrative Staffs.

Meetings: semi-annually.

r. **Clinical Services Committee:**

Charge: To coordinate the activity of its subcommittees described below; report annually to the Medical Board with a summary of the activities of the various subcommittees. More frequent reporting may be requested by the Medical Board when a subcommittee is addressing issues of significant importance to the Medical Staff.

Composition: Subcommittee chairs, Director of YNHH Quality Improvement, representative from the Office of the Chief of Staff, Medical Staff President, President Elect and Past President, Nursing leadership representative and other patient care services staff as needed.

Meetings: Quarterly

Subcommittees:

**1. Equipment and Products Standards Committee.**

Charge: advise administration and Director of Purchasing on matters relating to purchase of medical and surgical equipment and supplies; report a summary of its activities to the Medical Board annually.

Composition: members of Medical, Nursing, Purchasing, Engineering and Administrative Staffs and other selected departmental representatives.

Meetings: monthly.

**2. Nutrition Committee.**

Charge: reviews, and/or makes recommendations on nutrition standards of practice, policies and procedures, and monitors the quality of patient care related to medical nutritional therapies (diet/nutritional support), nutrition education and patient satisfaction with meals; selects and approves all enteral products and tube feeding systems; approves enteral and parenteral nutrition formularies; reports to the Medical Board annually.

Composition: members of the Medical Staff, the Nutrition Support Team, administrators, dietitians, nurses, pharmacists, and unit service managers.

Meetings: monthly.

**3. Radiation Safety Committee.**

Charge: assure compliance with the regulations of the Nuclear Regulatory Commission, the Department of Environmental Protection, the Department of Transportation, and other City, State, or Federal agencies regarding the use, transportation, and disposal of all sources on ionizing radiation; assure that all Hospital staff who are occupationally exposed to ionizing radiation are properly trained and monitored; recommend procedures that will reduce the radiation exposure of Hospital staff and patients to as low as reasonably achievable; establish procedures and methods for the safe storage and disposal of radioactive wastes; recommend disciplinary action for Hospital Staff who disregard rules for the safe use of ionizing radiation; review amendments to the Hospital's Broad Human Use By-Product Materials License (NRC); review applications and issue in-house authorizations for the conduct of clinical research

protocols which use radioactive materials or other sources of ionizing radiation and which have prior approval of the Human Investigation Committee; review the credentials of and issue letters of authorization to attending physicians whose clinical practice entails the prescription and application of radioactive materials to Hospital patients; report annually to the Medical Board.

Composition: Medical Staff users of radioactive materials and radiology equipment including the Gamma Knife, Nursing, Administration, representative of Radiation Safety Office, and other members as required to be in accordance with NRC rules and regulations, Subpart B, 10 Code of Federal Regulations, Section 35.34(f).

Meetings: quarterly.

#### **4. Radioactive Drug Research Committee (RDRC).**

Charge: pursuant to prior approval by the Radiation Safety Committee and the Human Investigation Committee, approve protocols for use of radioactive drugs when such drugs are recognized as safe and effective and when they are not used for therapeutic or diagnostic purposes; approve consent forms where appropriate; report adverse drug reactions to the FDA; submit an annual report to the FDA no later than January 31st of each year and report annually to the Medical Board

Composition: all members of the RDRC shall be members of the RSC, shall number no less than five, and shall include a physician trained in Nuclear Medicine, a radiopharmacist, and a health or medical physicist. Membership of the RDRC shall be in accordance with FDA rules and regulations, Title XXI, Chapter I, Part 361.1 (c), Code of Federal Regulations.

Meetings: quarterly.

#### **5. Rehabilitation Committee.**

Charge: review (a) policies and procedures of the Department of Rehabilitation Services and Hearing, Speech, and Language; (b) scope of services offered, (c) future plans and past performance, (d) annual capital budget request; (e) review Quality Assessment/Quality Improvement reports; (f) report annually to the Medical Board.

Composition: members of Medical and Nursing Staffs; Administration; Director of Rehabilitation Services.

Meetings: Three times yearly.

In addition to the foregoing committees, departmental and multidisciplinary peer review, morbidity and mortality review, and quality assurance committees also shall be established as appropriate for the purposes set forth above and for such other purposes as are deemed necessary.

**SECTION G. Committee Policies**

Policies developed by committees shall be consistent with the provisions of the Bylaws and Rules and Regulations. Upon approval by the Medical Board, Committee Policies shall be effective and binding on all members of the Staff.

**SECTION H. Additional Authority of Committees**

Committees shall exercise such additional authority as may be specifically provided by other provisions of these Bylaws, Rules and Regulations, or as may be authorized by the Medical Board.

## **ARTICLE XVI. PATIENT SAFETY & CLINICAL QUALITY COMMITTEE**

In addition to those matters outlined in these Bylaws which specifically require referral to the Patient Safety & Clinical Quality Committee, the Committee at the direction of the Board of Trustees, shall concern itself with all matters relating to the Medical Staff and the medical services provided by the Hospital.

## **ARTICLE XVII. AMENDMENTS**

### **SECTION A.**

These Bylaws and the accompanying Rules and Regulations may be changed or amended by action of the Board of Trustees upon the recommendation of a majority vote of those present and voting at a meeting of the Medical Board, or a recommendation of the Patient Safety & Clinical Quality Committee, or by the Board of Trustees on its own initiative.

### **SECTION B.**

No change in or amendment to these Bylaws and the accompanying Rules and Regulations shall be inconsistent with the Affiliation Agreement between Yale and the Hospital dated March 22, 1965 as amended from time to time.

### **SECTION C.**

Proposals for Bylaws and Rules and Regulations changes or amendments shall be distributed to members of the Medical Board at least 7 days in advance of the meeting at which they will be considered.