

**BYLAWS**  
**And**  
**RULES & REGULATIONS**  
**of the**  
**YALE-NEW HAVEN HOSPITAL, INC.**  
**for the**  
**MEDICAL STAFF**

**JANUARY 27, 1982**

**(Revised to September 19, 2012)**

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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. 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.

“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 of its locations and satellites.

“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. When participating in, or providing information to, a MEDICAL REVIEW COMMITTEE, in good faith and without malice, such individuals shall be indemnified.

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

“MEDICAL STAFF” means all physicians, dentists and podiatrists who are appointed to one of the following Medical Staff categories: Active, Courtesy, Visiting, Honorary, House Staff or Clinical Fellow.

“ORGANIZED MEDICAL STAFF” shall be defined as all of the physicians, dentists and podiatrists who are members of the “MEDICAL STAFF” and have been granted clinical privileges as provided in these Bylaws.

Only members of the “ORGANIZED MEDICAL STAFF” in the Active category are eligible to vote on the adoption of or amendments to these Bylaws and the associated Rules & Regulations and medical staff policies.

“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 holds the degree of Doctor of Podiatric Medicine and 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 XI, 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. PATIENT SAFETY & CLINICAL QUALITY COMMITTEE OF THE BOARD OF TRUSTEES**

In addition to those matters outlined in these Bylaws which specifically require referral to the Patient Safety & Clinical Quality Committee of the Board of Trustees, 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.

The Patient Safety & Clinical Quality Committee of the Board of Trustees regularly reviews patient safety and clinical quality metrics and related reports to ensure the provision of the highest quality, most effective patient care.

#### **Responsibilities:**

- To ensure a high quality medical staff through oversight of the appointment and re-appointment of its members
- To monitor quality assurance and quality improvement activities as they relate to medical care via periodic review of the professional performance, judgment and technical skills of Medical Staff members and leaders, and Department of Public Health (DPH) reportable and other serious adverse clinical events
- To provide appellate review in matters pertaining to Medical Staff appointment, re-appointment, discipline and/or dismissal from the Medical Staff when there is an unfavorable recommendation rendered by the Hearing Committee or, as applicable, to serve as the Hearing Committee.
- To review, critique, and recommend the Hospital Clinical Performance Improvement Plan.

## **ARTICLE IV. 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 Pediatric Network (Attending and Associate) Staff
  - d. The Visiting Staff
  - e. The Honorary Staff
  - e. The House and Clinical Fellows Staff
2. Members of each staff category shall limit the scope of their clinical activities to those specified in the delineated 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. If these resources become limited, the affected departments 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, Associate and Refer & Follow Physicians, Dentists and Podiatrists as follows:

- a. Attending Physicians, Dentists and Podiatrists shall be diplomats of U. S. specialty certifying boards identified below, as applicable for his/her practice or shall be approved under one of the exceptions described in "d" or "e" below. This requirement is not made retroactive for those serving as Attending Physicians or Dentists as of May 1, 1960.

Physicians

American Board of Medical Specialties (ABMS) certifying board  
 American Osteopathic Board

Dentists

American Board of Oral & Maxillofacial Surgery  
 American Board of Pediatric Dentistry  
 American Board of Orthodontics  
 American Board of Prosthodontics  
 American Board of Periodontology  
 American Board of Endodontics  
 American Board of Oral & Maxillofacial Pathology

Podiatrists

American Board of Podiatric Surgery (ABPS)

- b. Associate Physicians, Dentists and Podiatrists 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 VI, Section C 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 identified in "a" above within such period, the practitioner shall no longer be eligible for membership and privileges.

Staff members whose Board Certificates bear an expiration date shall successfully complete recertification no later than three years following such date to maintain 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. Refer & Follow is a membership-only Active staff category that shall consist of selected Physicians, Dentists and Podiatrists who are not clinically active in the Hospital inpatient or outpatient setting but maintain an active ambulatory practice and a strong relationship with the Hospital. Members of this category must meet the basic qualifications outlined in Article VI, Section B (Active Staff) with the exception of requirements related to inpatient hospital activity outlined in 2.g.

Members of the Refer & Follow category are expected to maintain a commitment to the clinical, educational and/or community service mission of the Hospital.

Members of this category typically include primary and ambulatory care practitioners and others who wish to access Hospital services and facilities for their patients by referral for admission and care and will not serve as the responsible physician for their patients requiring hospitalization. Members of the Refer & Follow category:

- i. may visit their hospitalized patients and view their medical records
- ii. may contribute pertinent information about their hospitalized patients in the medical record for reference by the attending who is responsible for the provision and management of hospital based care
- iii. may access the Hospital's electronic medical record and other information systems relative to their patients for continuity of care purposes
- iv. do not hold clinical privileges
- v. may not direct the care of their patients when hospitalized
- vi. may not write orders or progress notes or give verbal or telephone orders
- vii. may not perform any procedures
- viii. may attend and participate in Departmental and other Hospital meetings including educational meetings such as Grand Rounds and other CME activities
- ix. are required to pay Medical Staff dues
- x. are exempt from Ongoing Professional Practice (OPPE) and Focused Professional Practice Evaluation (FPPE)

Members of the Refer & Follow Category who wish to resume or begin hospital-based practice are eligible to apply for clinical privileges. Requests for clinical privileges will be reviewed individually relative to evidence of current competence and consistent with the relevant Sections of Article VI. Proctoring may be required.

- d. 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.
- e. Physicians, dentists and podiatrists who (i) are members in "good standing" of the Medical Staff of the Hospital of Saint Raphael as of the effective date of the Hospital's acquisition of the Hospital of Saint Raphael; and (ii) complete applications for appointment to the Medical Staff in accordance with Article VI, Section C no later than one year following such effective

date, shall be considered exempt from requirements (a) and (b) above for the Hospital's initial board certification and re-certification as described below.

A physician, dentist or podiatrist will not be considered to be in "good standing" on the Medical Staff of the Hospital of Saint Raphael if he or she is under investigation, on probation or subject to focused professional practice evaluation relative to specific issues pertaining to his or her clinical practice.

- i. Appointment: Applicants for initial appointment who have not attained initial certification in accordance with 2(a) above shall be appointed, as appropriate, to the Associate, Refer & Follow or Courtesy Staff and must achieve board certification consistent with 2(a) above within six (6) years of completion of residency or fellowship. Those who fail to achieve initial board certification by that time shall no longer be eligible for membership and privileges. This requirement shall not apply to individuals appointed to the Medical Staff of the Hospital of Saint Raphael prior to January 31, 1995.

Applicants for initial appointment who have previously held U.S. Board Certification consistent with 2(a) above that bore an expiration date that has lapsed, but who remain eligible for recertification, shall be appointed, as appropriate to the Associate, Refer & Follow or Courtesy Staff for a period not to exceed three years from the date of appointment to the Medical Staff by the Board of Trustees. If a staff member does not successfully complete recertification in accordance with 2(a) above within such period, the practitioner shall no longer be eligible for membership and privileges. This requirement shall not apply to individuals appointed to the Medical Staff of the Hospital of Saint Raphael prior to January 31, 1995.

Podiatrists initially appointed to the "Affiliated" Medical Staff of the Hospital of Saint Raphael may be boarded by either the American Board of Podiatric Surgery or the Podiatric Medical Association. Others must attain initial certification by the American Board of Podiatric Surgery as described in this subsection "i."

- ii. Reappointment: Individuals whose board certificates bear an expiration date shall be subject to the requirements set forth in 2(b) above except those whose initial appointment to the Hospital of Saint Raphael occurred prior to January 31, 1995.
3. Members of the Active Staff may vote in Medical Staff elections, on adoption or amendment of the Bylaws and associated Rules & Regulations and on issues presented at Departmental Committee meetings.
  4. Members of the Active Staff are eligible for election to serve as a Medical Staff Officer or, if a Community Physician, as a Member at Large of the Medical Board.
  5. 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.
  6. Members of the Active Staff 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 VI, SECTIONS A and B, but who do not meet the qualifications for appointment to the Active staff category as set forth in ARTICLE IV, 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 IV, SECTION B, Paragraph 2b, shall apply to members of the Courtesy Staff appointed after July 1, 1991.

### **SECTION D. The Pediatric Network (Attending and Associate) Staff**

1. Pediatric Network Attending and Associate staff shall consist of physicians, dentists and podiatrists who meet all of the basic qualifications for Medical Staff membership set forth in ARTICLE VI, SECTION A and B. The primary purpose of this category is to permit these members to provide care specifically to pediatric patients within the YNH Children's Hospital network.
2. Individuals who meet the requirements as specified in ARTICLE IV, SECTION B(a) are eligible for appointment as "Pediatric Network Attending"
3. Individuals who meet the requirements as specified in ARTICLE IV, SECTION B(b) are eligible for appointment as "Pediatric Network Associate"
4. Members of the Pediatric Network Staff are:
  - a. granted admitting and other privileges as appropriate based upon local physician coverage arrangements that assure patient safety and continuity of care;
  - b. willing to participate in teaching programs and to have their patients participate as part of teaching efforts;
  - c. willing to actively participate, when requested, in relevant committees;
  - d. may vote in committees to which they are appointed but may not vote in general medical staff meetings or general meetings of the department to which they are assigned;
  - e. not eligible to vote in Medical Staff elections;
  - f. not eligible to vote on adoption or amendment of Medical Staff Bylaws and Rules & Regulations;
  - g. not eligible to hold office
5. Requirements for, and exceptions to, specialty board certification and recertification described in ARTICLE IV, SECTION B, Paragraph 2, shall apply to members of this category
6. Nothing contained in the description above shall prohibit an Attending or Associate Member of the Pediatric Network Staff from consideration for Active Medical Staff membership if requirements for local patient coverage are fulfilled.

### **SECTION E. 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 the Visiting staff are not eligible to vote or hold office.
  3. Barring “unusual circumstances” as described in #5 below, members of the Visiting Staff are generally not eligible to participate in malpractice insurance programs sponsored by the Hospital.
  4. Members of the Visting Staff are not subject to the geographic qualifications for appointment specified in Article VI, Section B(5).
  5. Member of the Visiting 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.
  6. In unusual circumstances, a member of the Visiting 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.
  7. 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 such privileges upon recommendation of the Chief and the Chief of Staff.
  8. Members of the Visiting Staff who wish to apply for appointment to the Active or Courtesy Staff shall do so in accordance with the provisions of ARTICLE VI, SECTION G.

**SECTION F. 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 to admit or care for patients.

**SECTION G. 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 of the Board of Trustees 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, 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 Medical Staff membership and 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 to apply for membership to another category of the Medical Staff must do so pursuant to Article VI.

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. Consistent with the medical staff policy on Focused Professional Practice Evaluation (FPPE), a period of focused review is required for new members of the medical staff. 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 FPPE.

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

Affiliated Health Care Professionals shall include designated health care professionals; including but not limited to audiologists, doctoral scientists, nurse anesthetists, licensed nurse midwives, nurse practitioners, physician assistants, radiology 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.

In each category, Affiliated Health Care Professionals 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 of the Board of Trustees. Members of this staff category 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 licensed nurse midwives, who are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms. Also included are physician assistants and nurse practitioners who specifically request this authorization. Authorization to conduct medical screening examinations is granted only through an appropriately signed and approved delineation of clinical privileges.

Nurse anesthetists, licensed nurse midwives, nurse practitioners, physician assistants and surgical assistants are required to have a supervising (or collaborating) physician who is a member of the Active Medical Staff or Pediatric Network Staff. Affiliated Staff in these professions may not exercise any clinical privileges without a supervising or collaborating physician and may only exercise privileges at the location(s) at which his/her supervising (or collaborating) physician is privileged to practice. In the event that a member of this staff who is required to have a supervising or collaborating physician no longer is sponsored by that physician, the member immediately shall notify the Department of Physician Services, provide the name of the new supervising or collaborating physician or be deemed to have voluntarily resigned from the Staff.

Affiliated Staff who practice in an outpatient setting only, are under the supervision, as required, of a member of the Medical Staff, and seek membership strictly for clinical support reasons (e.g. including, but not limited to, access to Hospital electronic medical records, conferences and meetings) may be granted Affiliated membership without clinical privileges. Affiliated Staff with membership and no clinical privileges shall be exempt from Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation requirements.

## ARTICLE VI. 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 VI, SECTION F)
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.
4. Notwithstanding any other provision of the Bylaws, or of the Rules & Regulations, the Hospital may require that the membership and clinical privileges of a physician, dentist or podiatrist be contingent upon, and expire simultaneously with, an 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 & Regulations and policies of the Medical Staff with respect to hearings, appeals, appellate review, etc. shall not apply.
5. All Community and University based members and Affiliated members of the Medical Staff, 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 (as applicable). Information will be forwarded to the appropriate Chief/Associate Chief for a recommendation as applicable.

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

## SECTION B. Basic Qualifications

1. Only those physicians, dentists, and podiatrists:
  - a. holding an appropriate unrestricted current license or State of Connecticut Medical School Permit (MSP);
  - b. having no history of conviction of Medicare, Medicaid or other federal or state governmental fraud or program abuse;
  - c. having no exclusion or preclusion from participation in Medicare, Medicaid or other federal or state governmental health programs;
  - d. having no conviction of any felony or misdemeanor relevant to Medical Staff responsibilities;
  - e. having no adverse professional review actions regarding appointment to a medical staff or clinical privileges for reasons related to clinical competence or professional conduct;

shall be considered eligible for membership.

Additionally, there must be evidence that training and/or experience, current competence, professional ethics and health status are adequate to assure that any patient treated will receive the optimal achievable quality of care in order for an applicant to be considered eligible.

2. A member of the Medical Staff in the Active, Courtesy, Pediatric Network and Visiting and Clinical Fellow categories and the Affiliated Health Care Professionals Staff shall:
  - a. provide identity verification in the form of a notarized U.S. passport or driver's license in accordance with Department of Physician Services policy;
    - be a graduate of a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), a dental school accredited by the Commission on Dental Accreditation (CODA) or a podiatric school accredited by the Council on Podiatric Medical Education (CPME) or be a foreign medical or dental school graduate who is certified by the Educational Commission for Foreign Medical Graduates (ECFMG);
  - b. continuously maintain valid malpractice insurance that will cover the member's practice at the Hospital 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 Department 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;
  - c. 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);

- d. demonstrate a satisfactory malpractice and claims loss history;
- e. be able to demonstrate, where applicable, the appropriate use of the hospital resources;
- f. identify satisfactory Medical Staff patient coverage arrangements in the location(s) in which privileges are sought to ensure patient safety when the Medical Staff member is not available;
- g. 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, Pediatric Network 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

The above and other qualifications will be verified according to current accreditation and other relevant standards.

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;
  - (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 his/her 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.

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 IV, 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 VI, SECTION F 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 and Courtesy members of the Medical Staff 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.

Affiliated Health Care Practitioners shall occupy an office and be actively practicing and have a supervising (or collaborating) physician agreement with a member of the Active, Courtesy or Pediatric Network Medical Staff.

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 and, as such, are subject to the requirements set forth in ARTICLES IV and VI .

6. An applicant for membership on the Medical Staff in the House Staff category shall:
  - a. be a graduate of an a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), a dental school accredited by the Commission on Dental Accreditation (CODA), a podiatric school accredited by the Council on Podiatric Medical Education (CPME), or be a foreign medical or dental school graduate who is certified by the ECGMG;
  - b. be licensed without restriction 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 VI, SECTION B, paragraph 3 above.

### **SECTION C. Responsibility of Applicants for Appointment / Re-Appointment**

All applicants, members and affiliated members of the Medical Staff are responsible for providing information deemed adequate for an appropriate evaluation of education, training, experience, current competence, ethics, personal qualities and qualifications to serve as an exemplary model for medical students and house officers and for resolving any doubts that arise regarding their qualifications during the appointment or reappointment process.

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<sup>1</sup> For purposes of ARTICLE IV “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.

Applications will be considered complete when all questions on the required forms have been thoroughly answered, all supporting documentation (including full responses from reference writers) has been supplied and all information has successfully been verified through primary sources consistent with regulatory requirements. A complete application may become incomplete if, during the credentialing process, it is determined that new, additional or clarifying information is required to confirm qualifications.

If an applicant for appointment or re-appointment fails to provide, or cause to be provided, any requested information, the application shall be deemed "incomplete" and processing will cease.

Any application for appointment or re-appointment that continues to be incomplete sixty (60) days after the applicant has been notified of additional information required will be deemed to have been withdrawn.

Applicants for appointment and re-appointment attest that all statements, answers and information contained in their application and supporting documents are true, correct and complete to the best of their knowledge. Any misstatement or omission from the application is grounds to cease processing the application. The applicant will be informed of the misstatement or omission and permitted to provide a written response. If, upon review, a misstatement or omission is determined to be immaterial and/or unintentional, processing will resume.

Applicants for appointment and re-appointment attest that they understand that falsification, misrepresentation or omission of any material fact(s) will be sufficient cause for ceasing processing of an initial application or automatic relinquishment of appointment and privileges without the right to request a hearing or appeal.

#### **SECTION D. 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 VI for which no time limit is specified shall be taken within reasonable periods of time, which generally shall not exceed one month.

#### **SECTION E. 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 reviewed by the Institutional Practice Quality and Peer Review Committee (IPQPRC) and referred to the Credentials Committee as deemed appropriate.

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

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 VI, SECTION A, Paragraph 2 above, will be in accordance with the following procedures:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.

6. 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.
7. The Board of Trustees shall take final action within sixty days after receipt of the recommendation from the Patient Safety & Clinical Quality Committee.
8. 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 VI, Section H, Paragraph 6.
9. 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.
10. 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 G. Application for Membership**

1. Subject to any limitation or moratorium pursuant to ARTICLE VI, SECTIONS A3 or F, applications for membership on the Medical Staff shall be made available via the Hospital website.
2. Applicants must apply for primary appointment in at least one of the Hospital Departments (See Article XI, 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.
4. 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.

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 available to each applicant.

## **SECTION H. 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. Once deemed complete consistent with ARTICLE VI, SECTION C, the application shall be referred to the Chief of the appropriate Department and, where applicable, to the Associate Chief for consideration.
2. The Chief of Department and/or, where applicable, the Associate Chief, shall evaluate, or cause to be evaluated, the character, qualifications and standing of the applicant. This review may include a personal interview with the applicant and shall include review of a confidential record to comply with the requirements of ARTICLE VI, SECTION B, Paragraph 3.
3. Following such evaluation 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 VI, SECTION B, and with the procedures specified in ARTICLE VI, SECTION E, Paragraphs 1, 2, 3 above. A completed application may be held in abeyance in accordance with the provisions of ARTICLE VI, SECTION F.
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 Medical Board Administrative Committee pursuant to paragraph 7 below.
7. The Credentials Committee, established in accordance with provisions of ARTICLE XVI, SECTION F, Paragraph f 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 application can be expedited, or to the Medical Board if not.

8. The Medical Board or the Medical Board Administrative Committee 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 the applicant was ineligible for any initially requested privileges, he/she is notified of the reason (i.e. lack of eligibility or adequate experience).

9. In the event that the Medical Board Administrative Committee decides not to act on an application, the matter will be referred to the next meeting of the Medical Board. The recommendation of the Medical Board, shall be forwarded to the Patient Safety & Clinical Quality Committee of the Board of Trustees. The Medical Board or Medial Board Administrative Committee may also determine that an application is incomplete and/or refer it back to the Credentials Committee or Department Chief or Associate Chief for further evaluation.
10. In the event that the Medical Board or the Medical Board Administrative Committee recommends approval of an application and the Patient Safety & Clinical Quality Committee of the Board of Trustees does not accept such recommendation, the Patient Safety & Clinical Quality Committee of the Board of Trustees 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 or may, in turn, refer it back to the Credentials Committee or Department Chief or Associate Chief for further evaluation.
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 of the Board of Trustees, stating its reasons for continuing to recommend approval. The Patient Safety & Clinical Quality Committee of the Board of Trustees thereupon shall reconsider the application. If, upon reconsideration, the Patient Safety & Clinical Quality Committee of the Board of Trustees 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 of the Board of Trustees continues to deem the application incomplete or the applicant ineligible, it shall transmit its 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. In the event that an application is denied in final action by the Board of Trustees, 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 VII.
15. All hearings and appellate reviews shall be conducted in accordance with the provisions of the Fair Hearing Plan, ARTICLE VII. 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 XV is inapplicable, and all hearings and appeals under this Article shall be subject exclusively to the provisions of the Fair Hearing Plan, ARTICLE VII.

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 VI, SECTION B, Paragraph 5, the Chief of Staff shall:
  - a. notify the applicant of that action;
  - b. determine when the conditions of ARTICLE VI, 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;
17. Consistent with the Medical Staff Policy on Focused Professional Practice Evaluation (FPPE), all new clinical privileges for members and Affiliated Staff are subject to a period of focused review.

#### **SECTION I. Procedure for Reappointment**

1. Unless specifically provided otherwise by the Board of Trustees (See Article VI, Section J.), all Hospital Medical Staff reappointments shall be made by the Patient Safety & Clinical Quality Committee of 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 and applicable, in a secondary Department/Section.
3. 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. 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);
  - b. proof of ongoing medical licensure as required by Article VI (B)(2).
  - c. 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);
  - d. review of Hospital activities and interactions;
  - e. review of participation in continuing medical education;
  - f. assessment of the appropriate use of hospital resources;
  - g. review of confidential information, including malpractice and claims losses

The Department of Physician Services shall be responsible for gathering data for reappointments.

4. 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. (See Article VI, Section B.)
5. Medical and Affiliated Staff members shall maintain an activity level determined by the Department to be adequate to allow assessment of their performance and current competence.
6. 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.
7. 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 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 or an incomplete application (See Article VI, Section C) 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.

8. The reappointment application and materials will be forwarded to the appropriate Department Chief(s) for consideration. In Departments that have Associate Chiefs, the Chief shall include the Associate Chief in the assessment process.

In Departments with 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 FPPE conducted for privileges that were newly approved at the time of the last re-appointment.

In the event of a disagreement with respect to a recommendation for reappointment, the application shall be referred to the Medical Board via its Credentials Committee.

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 choose 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 VI, Section H.

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

10. The Medical Board or the Medical Board Administrative Committee 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 of the Board of Trustees 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 are not recommended for approval, the applicant is notified of the reason (i.e. lack of eligibility or adequate experience.). Newly approved privileges are subject to Focused Professional Practice Evaluation consistent with medical staff policy. All reappointments shall be effective for no more than two years.
11. 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 denied or reduced for reasons not related to administrative eligibility without the approval or agreement of the applicant, and the Medical Board or the Medical Board Administrative Committee contemplates recommending that such change in status be approved, or in the event that the Patient Safety & Clinical Quality Committee of the Board of Trustees disagrees with a recommendation of the Medical Board, the procedure set forth in ARTICLE VI, SECTION G shall apply as appropriate.
12. 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 IV, 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.
13. 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 J. Conditional Re-Appointment**

In the event that an investigation or hearing is pending and a Medical Staff or Affiliated Staff is due for re-appointment, a short-term conditional re-appointment may be granted, pending the conclusion of the process. Conditional re-appointments are subject to the same requirements and are approved through the same process as all other re-appointments as outlined in Section I.

#### **SECTION K. Temporary Privileges**

1. 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 consistent with ARTICLE VI, SECTION C. 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 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 or termination of such privileges.



2. Guest Privileges for visiting Medical Staff. The Chief of Staff, on request of the department Chief, and either the Associate Chief or Chief of the applicable Section, may grant guest privileges. Guest privileges may be granted to officially recognize 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 currently 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. Individuals seeking Guest privileges are required to submit an appropriate application and comply with the requirements set forth in the medical staff policy on Guest Privileges including satisfactory documentation of immunization status and attestation of having read and agreeing to comply with the Hospital's Infection Control, Standard Precautions, Bloodborne Pathogens Standards and Airborne precautions Policies and Procedures.
5. Guest privileges will be granted only after verification that the applicant's current competence, 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.
6. 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 Medical Staff 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.
7. In each instance, those granted temporary/guest privileges of any kind shall be reported the next regular meeting of the Medical Board or the Medical Board Administrative Committee, and then subsequently to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

#### **SECTION L. 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 Health 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 Department Chief for appropriate corrective action.

#### **SECTION M. 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, if required during the leave, will be made through the mechanisms defined in Section I 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 Department 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 voluntarily resigned from the Medical Staff effective as of the end of the leave. If the member subsequently requests to rejoin the Medical Staff, he/she shall be required to reapply in accordance with ARTICLE VI, SECTIONS F. and G.

During the period of a leave of absence, the member shall not exercise clinical privileges at the Hospital, hold office or serve as chair of a Committee. All other membership rights and duties shall also 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 Department 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.
3. As applicable based upon the reason and duration of the leave, the Chief of Staff or Medical Staff Health Committee may require a written evaluation from the practitioner's physician and/or other health care professionals to confirm that he/she is competent to return and practice the privileges requested with reasonable skill and safety.

#### **SECTION N. 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, fails to satisfy requirements to return from a leave of absence, 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 will be deemed to have resigned but not in good standing.

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

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.
- (g) when providing professional services at 1450 Chapel Street, to abide by the Ethical and Religious Directives for Catholic Health Facilities as published by the United States Catholic Conference (the "Directives"). Application of the Directives shall be as set forth in policies of the Medical Staff, as such policies may be modified from time to time in consultation with the Hospital's Catholic Heritage Committee and approved by the Board of Trustees.

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 P. Discipline and Dismissal from the Medical Staff**

1. 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.
2. Staff appointments may be revoked, suspended, or limited for due cause, including but not limited to:
  - (a) physical or mental disability;
  - (b) 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);
  - (c) failure to provide adequate patient care;
  - (d) exceeding the scope of an approved delineation of clinical privileges;
  - (e) prescribing controlled substances without the required state and federal authority; or
  - (f) 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.
3. Medical Staff privileges shall be considered automatically relinquished 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 VI, Sections F and G 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.

4. 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 VI, SECTION G.
5. 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.
6. Consistent with Article VII, 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. . After hearing the matter, the Hearing Committee 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 VII. 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.

7. Revocation or voluntary relinquishment of license to practice in Connecticut shall result in automatic relinquishment of a Staff member's appointment. Under these circumstances, provisions relating to hearings, appeals, and appellate reviews shall not apply.
8. The following shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership:
  - a. suspension of a license;
  - b. agreement with a governmental entity not to exercise a license to practice,
  - c. agreement with a governmental entity not to exercise a license or permit to prescribe controlled substances;
  - d. notice of exclusion / debarment from participation in Medicare, Medicaid or other federal health care program

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.

9. 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.
10. In the event that the privileges of a member of the Medical Staff are automatically relinquished or summarily suspended, the member shall be notified in writing and 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.

11. 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 Q. Investigations**

When concerns are raised regarding a practitioner's clinical practice, if he/she demonstrates behavior that is inconsistent with the Medical Staff Code of Conduct (Article VI, Section E) or if he/she violates acceptable ethical standards or Medical Staff or Hospital Bylaws, policies or Rules & Regulations, a review of the matter and circumstances may be indicated. These issues are generally evaluated by the Chief of Staff, Department Chief, Associate Chief, Section Chief or others as delegated by the Institutional Practice Quality and Peer Review Committee (IPQPRC) of the Medical Board and addressed with the practitioner. In some instances, following inquiry into the matter, referral is made to the (IPQPRC) for review. A Focused Professional Practice Evaluation (FPPE) may also be undertaken consistent with the Medical Staff FPPE Policy. All efforts are made to address and resolve these issues at one of these levels through collegial intervention.

In the event that interventions at this level are unsuccessful or concerns about a practitioner are of a very serious nature, an investigation may be initiated. After sufficient inquiry and validation that the issues identified are credible, the Chief of Staff, the IPQPRC, the Medical Board or the Patient Safety & Clinical Quality Committee of the Board of Trustees may recommend the investigation. Following unsuccessful documented attempts at collegial intervention, a Department Chief or Associate Chief may also request that any of the forgoing review a matter regarding a member of his/her Department for consideration of an investigation.

The IPQPRC, Patient Safety & Clinical Quality Committee of the Board of Trustees or Medical Board formally commences an investigation by making a resolution to do so. The matter may also be referred to the Credentials Committee. In such instances, the Credentials Committee will review the information available and may formally commence an investigation by making a resolution to do so. Resolutions must be approved by a majority of those present and voting. If the investigation is commenced by the IPQPRC, Medical Board or Patient Safety & Clinical Quality Committee of the Board of Trustees, the relevant group may conduct the investigation or choose to delegate it to the Credentials Committee.

None of the above shall be construed to limit the ability of the individuals authorized in Section M (5) of Article VI to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff whenever such action must be taken immediately in the best interest of patient care. In such instances, the process identified in Article VI, Section M, Number 5 shall follow.

The practitioner in question is notified in writing of the investigation, the steps that will be taken during the investigation, his/her responsibilities, rights and options and that he/she will have an opportunity to participate in the process before any final determinations are made.

The Committee identified to conduct the investigation shall be deemed to be the Investigation Committee. The Investigation Committee shall not include partners, associates or relatives of the individual being investigated and shall have the authority to review relevant documents and interview individuals with information pertinent to the matter at hand as well as the authority to use outside consultants, if needed. It may also require physical and mental examinations/evaluations of the individual under investigation.

The individual under investigation shall have the right to meet with the Investigation Committee, be informed of the allegations against him/her that form the basis of the investigation and discuss, explain or refute the evidence presented.

The investigative process of this committee is not considered a hearing and, as such, the individual under investigation shall not have the right to be represented by legal counsel during the proceedings.

At the conclusion of this process, the Investigation Committee shall submit its recommendation(s) to the Medical Board or Credentials Committee if the Investigation Committee is not the Credentials Committee. The individual under investigation is informed of the recommendation.

If the recommendation is adverse and the Medical Board concurs in whole, in part or modifies a recommendation that remains ultimately adverse, the individual under investigation shall be entitled to a Fair Hearing as described in Article VII.

#### **SECTION R. 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 ensuring that appropriately credentialed and privileged members of the Medical Staff provide coverage when the responsible Member of the Medical Staff is unavailable to his/her patients. It shall be the obligation of the House Staff to assist and be accountable to the responsible practitioner in caring for the patient.

## **ARTICLE VII. 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 of the Board of Trustees and to appellate review by the Patient Safety & Clinical Quality Committee or by the Board of Trustees arises under ARTICLE VI, SECTIONS H, I and M of the Bylaws. ARTICLE VII, 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 or documented hand delivery. 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 or documented hand delivery, 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 or documented hand delivery, 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 or documented hand delivery, 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 or is an associate, partner or relative, 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 Chair 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 be extended due to delay, repetition, or lack of appropriate deportment in the course of the presentation of a case.

#### **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 Chair 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 of the Board of Trustees 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 of the Board of Trustees 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 of the Board of Trustees, 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 VIII. 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 or an appropriate electronic means.

### 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 majority 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 Institutional Practice Quality & Peer Review Committee (IPQPRC) and Patient Safety & Clinical Quality Committee of the Board of Trustees.
3. Officers may convene periodic meetings 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 and to the administration of the Hospital 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 and a member of the Bylaws Committee. The Past Secretary shall also serve as a member of the Bylaws Committee.
6. The Past President shall also act as the Medical Staff Treasurer and serve as Chair of the Medical Board Finance Committee. 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 these funds via the Medical Board Finance Committee.
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, Medical Board Administrative Committee, IPQPRC, 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 and President Elect are invited to attend meetings of the Clinical Chiefs and Associate Chiefs and may be requested to assist in such Hospital activities as fund raising.

## ARTICLE IX. 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. Emergency Medicine
  - g. Internal Medicine, including general medicine and medical specialties
  - h. Laboratory Medicine
  - i. Neurology
  - j. Neurosurgery
  - k. Obstetrics and Gynecology
  - l. Ophthalmology
  - m. Orthopedics and Rehabilitation, including Podiatry
  - n. Pathology
  - o. Pediatrics
  - p. Psychiatry
  - q. Surgery, including general surgery and surgical specialties
  - r. Therapeutic Radiology
  - s. Urology
2. Departmental status shall be designated upon recommendation of the Medical Board to the Patient Safety & Clinical Quality Committee of the Board of Trustees, and approval of the Board of Trustees. Designation of a new Hospital Department shall ordinarily follow such approval by the University and the Hospital President.

### 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 of the Board of Trustees. Nomination shall be 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 X. 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 including the Ongoing and Focused Professional Practice Evaluation Processes. 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 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 unavailable, he/she shall direct that one of the following perform his/her duties: the Associate Chief or Vice Chair/Chief, the Assistant Chief, the Assistant Associate Chief, or 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 of the Board of Trustees 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 the Perioperative Executive Leadership Group, as defined in ARTICLE XVI, SECTION F, Paragraph (m).
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 X, SECTION C.
7. Except as noted in ARTICLE VI, SECTION I, Number 8 relative to Departments with greater than 100 Medical Staff members, the Chief and, where applicable, the Associate Chief shall be responsible for reappointment of each member of the Medical Staff in the Department, including consideration of current competence and physical and mental capabilities consistent with the process described in ARTICLE VI. Section I.
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 as needed 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 VI.
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 of the Board of Trustees. 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 of the Board of Trustees 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 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 or Vice Chief of Department. The President's recommendation shall be forwarded to the Patient Safety & Clinical Quality Committee of the Board of Trustees which, in turn, shall make its recommendation to the Board of Trustees, which shall take appropriate action.



## ARTICLE XI. 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 Board of 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 XII. 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 IV, 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 chair pro tem. The chair 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 XIII. 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: appointment and reappointment processes, committee performance, compliance with Joint Commission and State of Connecticut Department of Public Health licensure requirements as they pertain to medical practice and patient concerns regarding medical services.
  - b. Acts as an agent of the Institutional Practice Quality and Peer Review Committee (IPQPRC) between meetings to address issues of immediate concern having to do with Medical and Affiliated Medical Staff including, but not limited to, patient/family complaints, general competence, health/fitness to work, and compliance with the Medical Staff Code of Conduct. Reports actions taken, as appropriate, to the IPQPRC.
  - c. 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.
  - d. Administrative supervision of functioning of medical services through the Chiefs.
  - e. Assistance to elected Medical Staff officers in the discharge of their duties.
  - f. Coordination of house staff affairs on matters outside of departmental purview.
  - g. Overall medical responsibility for:
    - Medicolegal Affairs Office and Risk Management Program
    - Emergency Services
    - Operating Rooms
    - Other medical services as required

- h. 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 of the Board of Trustees. 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 of the Board of Trustees and the Board of Trustees.

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

### **SECTION A. SELECTION**

The Chief of Staff may recommend one or more members 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 XV. 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 VI, 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 lower levels 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. Concerning a decision of a 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 of the Board of Trustees 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 of the Board of Trustees.
- d. The Patient Safety & Clinical Quality Committee of the Board of Trustees 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 of the Board of Trustees 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.

<u>Level</u>	<u>From the Decision of:</u>	<u>May Appeal to Either (only one):</u>
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 XVI. 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 Medical Staff membership and clinical privileges;
  - c. To formulate and recommend medical policy;
  - d. To propose and recommend approval of Medical Staff Bylaws, Rules and Regulations and Medical Staff policies;
  - 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-four 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, Emergency Medicine, Laboratory Medicine, Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Rehabilitation, Pathology, Pediatrics, Psychiatry, Surgery, Therapeutic Radiology and Urology;
  - 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. Fourteen Community Physicians elected at large from the Active Staff, eligible to serve at least one term.
3. The fourteen Community Physicians elected at large shall be elected as follows:

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.

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.

Medical Board terms shall be three years, with a maximum of two consecutive terms.

Election shall be by mail or appropriate electronic ballot of community members of the Active Staff.

4. The Ambulatory Services Vice President, Administrative Director and Chief, YNH CH at Bridgeport, and designated GME Institutional Officer 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. Except for the Credentials Committee, Institutional Practice Quality & Peer Review Committee (IPQPRC), Finance Committee, and others where specific members are identified in Section F., members of the Medical Board standing committees shall be appointed by the Medical Board on nomination from the relevant Committee Chair.

Decisions on any issue concerning Medical Staff policy, Bylaws, Rules and Regulations (other than amendments to the Bylaws, Rules and Regulation (See Article XVI), 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 Medical Board Administrative Committee.

Decisions on all appeals under ARTICLE XV 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 the Medical Board 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 of the Board of Trustees.

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

1. The Medical Board will meet six times per year 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.
2. All of the actions of the Medical Board Administrative Committee 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 staff privileges in which appellate review may occur or in which an unfavorable action may be recommended.
3. The Medical Board Administrative Committee shall consist of the Chief of Staff, the President and Past President and Secretary 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.
4. 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**

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: provides Medical Staff oversight and coordination for all on and off campus outpatient services including clinics, school based clinics, operating rooms and radiology practices; maintains a current list of all Hospital outpatient sites of service; ; receives reports from all committees related to the above listed areas including but not limited to performance improvement and quality assurance, tissue and Operating Room/Endoscopy committee(s); ensures that the Ambulatory Service has appropriate membership on and communication with other relevant Medical Staff committee(s); ensures the consistency of Hospital policies and procedures throughout all on and off-campus outpatient facilities.

In addition to an annual report made to the Medical Board, the Committee shall report any concerns of an urgent nature as needed to the Medical Board.

Composition: Hospital Vice President for Ambulatory Services, who shall also serve as 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, outpatient Diagnostic Radiology (main campus and Ambulatory Services Division), outpatient Operating Rooms and GI procedure suites (main campus and Ambulatory Services Division), Laboratory Medicine, a representative number of Medical Directors from on and off campus Ambulatory sites, and other members of the Medical Staff and management staff as needed.

Meetings: Quarterly

b. **Bioethics Committee**

Charge: Separate Adult and Pediatric Bioethics Committees shall review and propose policies and guidelines that address ethical aspects of Hospital 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. Reports annually to the Medical Board.

Composition: Chairs of each Committee shall be appointed by the Medical Board; membership shall include representatives from the Attending and House Staffs, nursing, Religious Ministries; Legal & Risk Services; 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 compliance with the recommendations of accrediting and regulatory agencies; evaluate petitions for proposed amendments from the voting members of the organized medical staff; recommend to the Medical Board such revisions as are considered practical and necessary to update appropriately the Medical Staff Bylaws and Rules and Regulations as needed.

Composition: the Chief of Staff or his/her designee shall serve as Chair, Medical Staff Secretary and past Secretary; other members may include members of the Medical Staff and Hospital Administration and a representative of Legal & Risk Services.

Meetings: as necessary

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: Chair shall be the Physician Chief of the Smilow Cancer Hospital; Representatives include a broad array of community and university physicians from the following departments: adult and pediatric medical oncology, neuro-oncology, gynecologic oncology, surgical oncology, neurosurgery, thoracic surgery, orthopedics, diagnostic and therapeutic radiology, pathology, laboratory medicine and psychiatry; the Cancer Liaison

Physician to the ACOS, the Hospital Director of Quality Improvement and representatives from Hospital administration, nursing, social work, tumor registry, religious ministries, clinical nutrition, pharmacy and rehabilitation services.

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. Reports to the Medical Board as needed.

Composition: the Chair shall be the current President of the Medical Staff. Other members shall include, but not be limited to, the Hospital 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: As needed

f. **Credentials Committee.**

Charge: review applications for appointment to the Medical Staff and Affiliated Medical Staff referred to it by the Credentials Committee Sub-Committee 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, and with the candidate as deemed appropriate. 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 on a monthly basis. Upon delegation from an authorized entity as described in Article VI, Section Q, the Credentials Committee may also serve as the Investigation Committee in formal Medical Staff investigations.

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. **Finance Committee**

Charge: advises the Medical Board as to the management of funds collected through the medical staff dues including the following: recommends and revises guidelines for use of the funds; reviews requests for funding from the Medical Staff dues account and makes recommendations to the Medical Board. Provides annual and intermittent (as necessary) reports identifying which programs/projects meet requirements for funding.

Composition: immediate past five Medical Staff Presidents; the Immediate Past President shall serve as Finance Committee Chair; in the event that one of the members is not able to complete his/her responsibilities or unable to serve as a member, the President of the Medical Staff shall recommend a replacement to the Medical Board.

Meetings: annually or more frequently, as needed

h. **Emergency Service Committee.**

Charge: determines the scope of emergency services provided and develops, evaluates and updates associated policies and procedures for emergency care; recommends qualifications required for emergency services staff; plans, coordinates and evaluates delivery of patient care in the Emergency Service; plans, develops and implements patient care programs for improved quality of care in conjunction with community needs, resources and affiliated facilities; reports a summary of its activities to the Medical Board annually.

Composition: the Chief of Emergency Medicine shall serve as Chair; membership includes community and university based representatives of the Medical Staff, Nursing and the Hospital clinical service coordinator for emergency services.

Meetings: Quarterly

i. **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: the Designated Institutional Officer and Director, Graduate Medical Education shall serve as Chair; membership includes the Chief of Staff or his/her designee, Graduate Medical Education specialty and subspecialty program training directors, House Staff and Clinical Fellow representatives, representatives from Hospital Human Resources, Legal & Risk Services and other selected departments. Reports annually to the Medical Board.

Meetings: At least six times a year with additional meetings as required.

j. **Infection Control Committee.**

Charge: define, survey, correlate, review, evaluate, revise and institute whatever recommendations and policies are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; report a summary of activities annually to the Medical Board.

Composition: infection control officer shall serve as Chair; membership shall include representatives of the Medical and Hospital Staff including the director of occupational health a nurse epidemiologist and members of the Nursing, Environmental Services, Food and Nutrition, Pharmacy and Ambulatory Services Departments and Hospital Administration.

Meetings: monthly.

k. **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: the Chair shall be appointed by the Medical Board; membership shall include representatives from the Medical Staff, Clinical Information Services, Ambulatory Services, Nursing and Administration and the Director of Clinical Information Service.

Meetings: monthly.

l. **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 and report as needed.

Composition: the Chair shall be appointed by the Medical Board; membership includes representatives from the Medical and Affiliated Medical Staffs, Chief of Staff or his/her designee; Senior Vice President for Patient Services or his/her designee. Other Hospital staff may participate ex officio as appropriate.

Meetings: Meets as needed.

m. **Perioperative Executive Leadership Committee.**

Charge: plan, coordinate and evaluate delivery of surgical and anesthesia care and services in all Operating Rooms consistent with Hospital goals; ; develop, review and modify all relevant policies and procedures; monitor key performance efficiency indicators and recommend and implement changes; facilitate implementation of performance improvement initiatives; oversee and direct safety, quality, patient and surgeon satisfaction efforts; in conducting all activities involve Chiefs and other leaders of affected Departments such as, but not limited to Anesthesiology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics and Surgery reports twice a year to the Medical Board.

Composition: the Chief of Surgery and Senior Vice President responsible for Surgical Services shall be members and serve as Co-Chairs; other members shall include; the Chief Operating Officer, Chief of Staff, Chief of Anesthesiology, Associate Chief of Surgery, Vice President of Surgical Services, Medical and Nursing Directors of Perioperative Services, a representative from Performance Improvement, a representative from the Ambulatory Services off campus operative site(s); Chiefs of all areas that utilize the Operating Rooms and members of Medical, Nursing and Administrative Staffs as needed. Community and University surgeons will be represented.

Meetings: monthly

n. **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: the Chair shall be appointed by the Medical Board; membership shall include representatives from the Medical Staff and Hospital Departments of nursing, pharmacy, and Hospital administration.

Meetings: monthly.

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

Charge: (a) oversee the gathering and analysis of data and information among clinical departments of Hospital 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 Hospital 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; designates and appoints members or other Hospital personnel to evaluate and conduct root cause analyses as the Committee specifically authorizes or directs, including , but not limited to sentinel events and other significant unanticipated outcomes at the Hospital, reports the results of these activities to the Committee; (d) designates the Chief of Staff to act between meetings to address issues of immediate concern having to do with Medical and Affiliated Medical Staff including, but not limited to, patient/family complaints, general competence, health/fitness to work, and compliance with the Medical Staff Code of Conduct; (e) facilitate mechanisms for correction of problems identified; (f) assist the Hospital in maintaining compliance with the requirement of The Joint Commission; (g) 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; (h) 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; (i) initiates formal investigation of Medical or Affiliated Medical Staff consistent with Article VI, Section Q as indicated. 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. Reports quarterly to the Medical Board.



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: Monthly

p. **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. Reports annually to the Medical Board.

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: At least quarterly

q. **Pathology & 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 in which the physicians involved (surgeon, referring doctor or pathologist) have concerns that cannot be resolved by mutual discussion. Refer cases, based on Committee investigation, to the appropriate Department Chief for action. The Committee will review all cases of interpretive errors causing frozen section/permanent section discordance; major discrepancies between cytology and tissue sections; and summary quarterly reports on frozen section / permanent section discrepancies submitted by the Director of Surgical Pathology; and on cytology/surgical pathology discrepancies submitted by the Director of Cytology; report annually to the Medical Board summarizing activities of the Committee and actions taken by the Departments Chiefs.

Composition: the Chair shall be appointed by the Medical Board; membership includes Medical Staff representatives, including the Hospital Director of Quality Improvement and a representative from the Ambulatory Services Tissue Committee, as applicable.

Meetings: monthly.

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. At its discretion, escalates issues of concern identified by Sub-Committees to appropriate Medical Staff leaders and Department Chiefs and/or for discussion at the Medical Board or Medical Board Administrative Committee. More frequent reporting may be requested by the Medical

Board when a subcommittee is addressing issues of significant importance to the Medical Staff.

Composition: the Medical Staff President shall serve as Chair; other members include the Subcommittee chairs, Director of Hospital Quality Improvement, Chief of Staff or his/her designee, Medical Staff President Elect and Medical Staff Past President, Nursing leadership representative and other patient care services staff as needed.

Meetings: Semi-annually

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 Clinical Services Committee annually.

Composition: the Chair shall be appointed by the Medical Board; membership includes members of the Medical Staff and representatives from the departments of nursing, purchasing, engineering and Hospital administration.

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 a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be appointed by the Medical Board; membership includes members of the Medical Staff, the Nutrition Support Team, Hospital administration, nursing, pharmacy, and unit service management.

Meetings: monthly.

3. **Organ & Tissue Donation Committee**

Charge: Oversees activity related to all organ and tissue procurement activities and the relationship of the Hospital with the New England Organ Bank (NEOB). Responsible for the development and implementation of all related policies and procedures including, but not limited to, staff training and education and patient confidentiality and keeping all organ procurement policies and procedures current with applicable standards. Oversees performance improvement and quality assurance initiatives related to organ procurement. Oversees and manages the activities of representatives of the NEOB and transplant teams from other institutions when present at the Hospital.

Reports a summary of its activities annually to the Clinical Services Committee or more frequently as indicated relative to significant changes in policy and/or requirements.

Composition: the Chair shall be appointed by the Medical Board; membership shall include Medical Directors of the Pediatric, Neuro, Medical and Surgical Intensive Care Units; Medical Staff representatives from transplant surgery, neurology, internal medicine, emergency medicine and other specialties as applicable; representatives from nursing, social work, and religious ministries who are involved in the care of potential donors.

Meetings: monthly

**4. 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 a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be appointed by the Medical Board; membership includes members of the Medical Staff who utilize radioactive materials and radiology equipment including the Gamma Knife; representatives from nursing, Hospital administration, radiation safety, 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.

**5. 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 reports a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be appointed by the Medical Board; 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.

6. **Rehabilitation Committee.**

Charge: responsible for the scope of rehabilitation services offered, associated operation of the Department including all operational issues as well as appropriate number and qualifications of staff and quality assurance and performance improvement. Reviews (a) policies and procedures of the Department of Rehabilitation Services and Hearing, Speech, and Language; (b) services offered, (c) future plans and past performance, (d) capital budget needs ; (e) Quality Assessment/Quality Improvement reports; reports a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be the Medical Director of Rehabilitation Services, membership shall include representatives from the Medical and Nursing Staff; Hospital administration and the Director of Rehabilitation Services.

Meetings: Three times yearly.

7. **Respiratory Services Committee**

Charge: responsible for the scope of respiratory care services offered, associated operation of the Department including all operational issues as well as appropriate number and qualifications of staff; Departmental quality assurance and performance improvement initiatives. Reviews (a) and, as appropriate, modifies policies and procedures (b) services offered, (c) future plans and past performance, (d) annual capital budget needs; (e) Quality Assessment/Quality Improvement reports; reports a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be the Medical Director of Respiratory Services, membership shall include representatives from the Medical and Nursing Staff; Hospital administration and the Director of Respiratory Services.

Meetings: Three times yearly

8. **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. Develops procedures to acquire, retrieve and store tissue products; monitor use and proper storage and maintenance of tissues used in operating rooms; establish and maintain an appropriate electronic recordkeeping system for accountability and traceability of tissues used. Reports a summary of its activities to the Clinical Services Committee annually.

Composition: the Chair shall be appointed by the Medical Board; membership includes representatives from the Medical Staff, Laboratory Medicine, Perioperative Services, Legal & Risk Services and Hospital Administration.

Meetings: three times yearly

9. **Utilization Review & Discharge Planning Committee**

Charge: Develops, implements and evaluates relevant policies and programs for utilization management and discharge planning; activities include, but are not

limited to, appropriate reviews to expedite quality patient care and effective, efficient usage and delivery of resources, facilities and service; oversight of discharge planning activities to identify patients with continuing care needs and ensure proper coordination of services following discharge; development and implementation of screening procedures for early identification of patients at high risk for discharge planning; maintenance of current resource information about available post-discharge health and social facilities and services.

Composition: the Chair shall be the Medical Director of Utilization Review & Discharge Planning; other members include the Medical Director of Emergency Services, Associate Director, Clinical Effectiveness, manager of utilization review and discharge planning; representatives from Hospital departments of Patient Financial and Admitting Services, Legal & Risk Services and other members of the Medical and Hospital administrative Staff as needed based upon patient needs.

Meetings: monthly

In addition to the foregoing committees, the following Hospital departments listed below shall provide an annual report to the Medical Board which shall, at a minimum include the following: (a) updates concerning operational, policy, procedure and scope of service issues, (b) regulatory changes and (c) departmental performance improvement/quality assurance initiatives and results.

Diagnostic Radiology  
Laboratory Medicine

Other 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 XVII. AMENDMENTS**

### **SECTION A. Proposing Amendments**

Proposed amendments to the Medical Staff Bylaws, Rules & Regulations or medical staff policies are referred to the Medical Board, Medical Board Administrative Committee or Bylaws Committee of the Medical Board.

If 25% of the voting members of the Organized Medical Staff sign a petition to do so, they may propose amendments to the Bylaws, Rules & Regulations or medical staff policies by submitting their proposals in writing to the Bylaws Committee of the Medical Board. A representative(s) from the petitioning group will be invited to participate in the Bylaws Committee.

### **SECTION B. Medical Board Action**

All proposed amendments, regardless of source, shall ultimately be presented to the Medical Board. 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.

Two thirds of those present and voting at the Medical Board may recommend approval, disapproval, approve recommendations with modifications or refer proposed amendments in whole or in part to the Bylaws Committee for initial review or re-evaluation.

### **SECTION C. Voting by the Medical Staff**

All amendments approved by the Medical Board shall be submitted to the voting members of the Organized Medical Staff. Voting members shall be allowed a minimum of thirty (30) calendar days to respond to notification. Notifications shall be sent electronically. Failure to respond by thirty (30) calendar days after notification will be considered a vote for approval.

In the event that 25% or more of voting members signify disagreement with any of the proposed amendments, their concerns will be transmitted to the Bylaws Committee of the Medical Board for review. One or more representative from the dissenting group will be invited to participate in the Bylaws Committee.

If fewer than 25% of voting members voice objection, the amendments shall be forwarded for action to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

### **SECTION D. Patient Safety & Clinical Quality Committee of the Board of Trustees**

Amendments approved by the Medical Board and the voting members of the Organized Medical Staff shall be forwarded to the Patient Safety & Clinical Quality Committee of the Board of Trustees.

If the Patient Safety & Clinical Quality Committee of the Board of Trustees approves the amendments, they shall be forwarded to the Board of Trustees for final action.

In the event that the Patient Safety & Clinical Quality Committee of the Board of Trustees or the Board of Trustees modifies or disapproves any amendments proposed by the Medical Board and the voting members of the Organized Medical Staff, such modifications shall be returned to the Medical Board which may accept or reject the modifications.

If the Medical Board accepts the modifications, they shall be submitted once again to the voting members of the Organized Medical Staff as outlined in Section C. above.

If the Medical Board rejects the modifications, the amendment and arguments against the modifications shall be resubmitted to the Patient Safety & Clinical Quality Committee of the Board of Trustees or Board of Trustees.

If that group approves the amendment, the approval process will proceed.

If the group is the Patient Safety & Clinical Quality Committee of the Board of Trustees, the disagreement between it and the Medical Board shall be referred to the Board of Trustees. The matter will be referred to the Patient Safety & Clinical Quality Committee of the Board of Trustees if the Board of Trustees was the body that recommended the modifications that were not approved by the Medical Board.

**SECTION E: Approval Requirements**

The Bylaws which include the accompanying Rules and Regulations and medical staff policies may be changed or amended as described in Sections A through D above.

In addition, the Patient Safety and Clinical Quality Committee of the Board of Trustees or the Board of Trustees itself may initiate such changes.

**SECTION F. Affiliation Agreement with Yale University**

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 G: Effective Date**

Amendments shall be considered effective the date of the approval by the Patient Safety & Clinical Quality Committee of the Board of Trustee

**SECTION H: Non Substantive Edits**

Notwithstanding any of the above, the Medical Board is authorized to make non-substantive changes to the Bylaws, Rules & Regulations and medical staff policies relating to the organization of these documents including renumbering, grammar, spelling, typographical errors and similar technical revisions without approval of the voting members of the Organized Medical Staff.

## **YALE-NEW HAVEN HOSPITAL**

### **Rules and Regulations for the Medical Staff**

#### **ACCEPTANCE OF PATIENTS**

##### **Rule No. 1 Acceptance of Patients and Function of Special Services**

a. Acceptance of Patients

The Hospital shall accept for care patients suffering from all types of disease dependent only upon available facilities and personnel.

b. Special Services

The Hospital recognizes its commitment to special services such as organ transplantation and the trauma service; such special services shall function in accordance with requirements of relevant accrediting agencies.

#### **STAFF PRIVILEGES**

##### **Rule No. 2 Patient Care Privileges**

Only physicians, dentists and podiatrists who have been duly appointed to membership on the Medical Staff by the Board of Trustees, or those doctors<sup>2</sup> granted temporary privileges, and who are in good standing, are eligible to act as the attending physician for patients within the Hospital.

##### **Rule No. 3 Care of Family Members**

Members of the Medical Staff may not serve as the responsible attending of record for any member of their own family. Similarly, Medical Staff and Affiliated Medical Staff members may not schedule or perform operations or procedures on members of their own families in the operating rooms, procedure rooms or laboratories except in extreme emergencies when no other qualified member of the Medical Staff is available or with explicit approval by the Department Chief or Chief of Staff.

##### **Rule No. 4 Limitations of Professional Privileges**

All Members and Affiliates of the Medical Staff shall function within the scope of their approved delineated clinical privileges, with the understanding that it may not be safe or clinically appropriate to exercise all privileges in all Hospital sites or locations. Notwithstanding this general rule, in an emergency, a member or Affiliate of the Medical Staff may perform any medical or surgical procedure permitted by his or her respective training and experience and Connecticut license.

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<sup>2</sup> The terms Doctor and Practitioner are used synonymously and refer to both physicians and dentists.



The clinical practice at 1450 Chapel Street shall be consistent with the Ethical and Religious Directives for Catholic Health Facilities as published by the United States Catholic Conference (the "Directives"). Application of the Directives shall be as set forth in policies of the Medical Staff, as such policies may be modified from time to time in consultation with the Hospital's Catholic Heritage Committee and approved by the Board of Trustees.

In the event of a formally declared Hospital emergency ("Plan D"), Members and Affiliated members of the Medical Staff may be asked by the Chief of Staff or his/her designee to assist at the Hospital in a role atypical for his/her usual practice. In such cases and for the duration of the assignment, Members and Affiliated members of the medical staff shall be accountable directly to the Chief of Staff or his/her designee.

Requests for changes or additions to the current privilege delineation form(s) shall be made by or delivered to the Office of Physician Services. Modification of a delineation form must be reviewed and recommended by the relevant Chief, Section and Associate Chief if applicable, and the Chief of Staff. Requests to add a privilege or procedure that will be available in more than one specialty will be reviewed and recommended by all the affected Chiefs. Modifications will be approved by the Credentials Committee, Medical Board and Patient Safety and Clinical Quality Committee of the Board of Trustees. A member of the Medical Staff requesting an additional privilege must apply for that privilege and must be credentialed through the normal credentialing process.

Members of the Medical Staff appointed in the Department of Surgery may not practice elective gynecological surgery and members of the Medical Staff appointed in the Department of Obstetrics and Gynecology may not practice primary elective general surgery without the specific approval of the Medical Board.

All patients admitted for dental services shall be assigned to the Oral Surgical Section of the Department of Surgery. A history and physical examination pertinent to the admission must be performed and recorded by a physician or oral surgeon member of the Medical Staff, in addition to the dental history and examination recorded by the dentist. Admission history and physical examinations documented by a member of the house staff (excluding dental but including oral and maxillofacial surgery house staff), an advanced practice registered nurse or a physician assistant and validated by the responsible attending physician also satisfies this requirement. Dentists specifically privileged in dental anesthesiology are authorized to perform pre-operative history and physical examinations for dental procedures and to validate such exams performed by a member of the house staff (excluding dental but including oral and maxillofacial house staff), an advanced practice registered nurse or a physician assistant. Continuing medical supervision of the patient shall remain the responsibility of the attending physician of record.

Podiatrists who are currently board qualified or certified by the American Board of Podiatric Surgery (ABPS) and appropriately privileged to admit and/or provide operative care may perform the admission and/or pre-operative history and physical examination for their patients.

Patients admitted by podiatrists who are not currently board qualified or certified by the ABPS must have a consulting physician or another appropriately privileged podiatrist who is a member of the Active Medical Staff perform the admission history and physical and the preoperative history and physical as applicable.

Admission history and physical examinations documented by a member of the house staff, an advanced practice registered nurse or a physician assistant and validated by the responsible attending physician or appropriately privileged podiatrist also satisfy the admission history and physical requirement.

Patients with active medical conditions admitted by any podiatrist, regardless of ABPS status, must have a consulting physician who will follow the patient through the hospital admission and be responsible for

the treatment of such conditions during hospitalization. Appropriate physician consultation must be sought for the diagnosis and treatment of any medical conditions that arise during hospitalization.

#### **Rule No. 5 Privileges of Affiliated Health Care Professionals**

Individuals appointed to the Affiliated Health Care Professionals Staff shall participate in the management of patients under the supervision of a member of the Medical Staff. Specific activities of Affiliated Health Care Professionals shall be delineated by the Department Chief with the approval of the Chief of Staff.

#### **Rule No. 6 Reporting Requirements**

All members of the Medical Staff shall report immediately to the Chief of Staff the following: (a) loss (other than for routine non-renewal), suspension or any other action (including censure, reprimand and/or fine) taken regarding a professional license in Connecticut or any other state; (b) loss (other than for routine non-renewal), suspension or any other action taken with regard to state or federal authority to prescribe controlled substances; (c) loss (other than routine non-renewal), suspension or limitation (other than routine surrender of unused clinical privilege) of clinical privileges at another health care facility; (d) initiation of formal investigation at any other health care facility; (e) filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and (f) the filing of any criminal charge by state or federal authorities (other than a minor motor vehicle accident). These reporting requirements are in addition to the information that is collected at the time of initial credentialing and at recredentialing.

### **ADMISSION AND DISCHARGE OF PATIENTS**

#### **Rule No. 7 Admitting Principles**

No patient shall be admitted to the Hospital unless a provisional diagnosis has been stated and the admitting office has cleared the patient. There must be an order for hospital admission for all inpatients. The order may be completed by the attending physician, licensed nurse midwife or delegated to a member of the House Staff, an advanced practice registered nurse, or physician assistant. Admissions shall be assigned to patient divisions in accordance with Hospital policies.

#### **Rule No. 8 Protection of Patients**

Admitting Medical Staff shall give to appropriate Hospital personnel such information concerning their patients as may be required to enable the Hospital to protect the patient and other patients from possible sources of danger. Each member must have a coverage arrangement that assures continuity of care for the patient. This should be affected by means of an agreement with another appropriately credentialed and privileged member of the Medical Staff. Other coverage arrangements will require Departmental approval.

#### **Rule No. 9 Patient-Doctor Assignment**

A patient who does not request a specific physician or if the patient's personal physician or consultant cannot be identified, contacted or chooses not to provide inpatient care, shall be assigned to an appropriate member of the Active Staff. Assignment from the Emergency Service shall be based on the relevant Emergency Room Panels if applicable. If the assigned physician chooses not to accept responsibility for inpatient care, he/she will arrange for transfer of the responsibility to a physician with appropriate clinical privileges who agrees to provide inpatient care.

## **Rule No. 10 Discharges**

Patients shall be discharged only on the order of the responsible physician, dentist, or podiatrist. If the discharge occurs at an unanticipated time, a house officer, nurse-practitioner or physician assistant may obtain approval from the responsible member of the Medical Staff and complete the discharge order.

The responsible physician, dentist or podiatrist shall be obligated to communicate to a referring doctor all appropriate medical information, and shall provide the same information on approved forms to any institution or agency to which a patient is referred following discharge from the Hospital. In those instances in which a patient is to be transferred directly from the Hospital to another institution, the patient will not be permitted to leave the division until the transfer information, including a printed priority Discharge Summary has been completed.

Whenever possible and appropriate, a responsible physician should be identified who will provide follow-up care for each patient discharged from the Hospital. If that physician was not part of the house staff or attending team caring for the patient during the Hospital stay, or is not a member of the Hospital Staff, the attending physician must ensure that the follow-up physician is contacted. This follow-up physician must be informed of the course of the patient's hospitalization, the patient's discharge date, medications, and need for continuing care.

It is the responsibility of the attending physician, dentist, podiatrist, or licensed nurse midwife to plan discharge in a timely fashion. The discharge date must be coordinated with the house staff physicians, nursing staff, social workers and discharge planning staff. The nursing and discharge planning staff as well as the patient and patient's family, need to be informed of the anticipated discharge date as soon as possible. Patients and their families should be notified on the day prior to discharge of the scheduled discharge time so that transportation and support services can be arranged.

## **INPATIENT CARE**

### **Rule No. 11 Patient-Doctor Relationship**

Within 24 hours of a patient's admission or transfer to the inpatient service, the responsible attending physician, appropriately privileged podiatrist or licensed nurse midwife of record shall personally examine the patient, establish a personal and identifiable relationship with the patient if such was not established prior to the admission or transfer, and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment in the electronic medical record (EMR). In the event that the EMR is not functioning, documentation must be done on paper. Admission history and physical examinations documented by a member of the house staff, an advanced practice registered nurse, a physician assistant or a licensed nurse midwife and electronically validated by the responsible attending physician or appropriately privileged podiatrist satisfies the admission history and physical examination requirement.

The attending is responsible for continuing evaluation of the care of the patient and plans for treatment. The attending is responsible for ensuring communication to the patient of the treatment plan and realistic goals of care, as well as subsequent communication about significant variances from expected outcomes that occur during medical treatment or surgery.

**Rule No. 12 Medical Students**

Appropriately prepared medical students are permitted to function within the facility. Medical students function in the Hospital for educational purposes only and are not to be used for clinical service needs. Medical students always function under supervision, but the supervision need not necessarily be in-person. The type and intensity of supervision required is determined by responsible Medical staff, including housestaff.

Medical students may participate with the patient care team, may perform a history and physical examination and record progress notes in the electronic medical record. Such history and physical examinations and progress notes shall not be considered authentic unless they are validated by a qualified member of the Medical Staff. Patient care orders may be entered by medical students but remain in suspension until electronically signed by an authorized prescriber. Medical students are not responsible for, among other things, obtaining informed consent for procedures or surgery or disclosing adverse events or unanticipated outcomes to patients or family. Medical students may not dictate operative reports or discharge summaries, nor may they write limitation of treatment orders or restraint orders.

**Rule No. 13 House Staff**

The attending physician is responsible for supervising the performance of, and the care rendered by, the house staff in accordance with Medical Staff and departmental policies. Types of supervision can include, but are not limited to, in person, electronic or telephonic supervision, review of documentation, and submission and review of performance evaluations. In general, the supervising physician will determine the nature of the required supervision, based on the complexity of the patient care situation, the level of training and experience possessed by the resident, and departmental guidelines concerning graded resident responsibility and resident supervision.

Consistent with other Medical Staff Rules, the house staff may enter all types of diagnostic and treatment orders for patients, including but not limited to, orders for restraints. However, orders to limit life-sustaining treatment may be entered by house staff only with the approval and subsequent validation by the attending physician. House staff may not enter orders for oncology chemotherapy.

**Rule No. 14 Consultations**

It is the duty of the Chief of Departments and, in the major Departments, the Associate Chiefs, to see that members of the staff call consultants as needed. Such consultants should be qualified to give an opinion in their respective fields. Judgment as to the seriousness of the illness and the validity of diagnosis and treatment rests with the physician responsible for the care of the patient.

All inpatient consultations are the responsibility of an attending physician who will see and examine patients referred for consultation as dictated by the clinical urgency, but always within 24 hours, and document findings and recommendations. Initial consultation notes must be dictated or typed directly into the Hospital's electronic medical record. If documentation is provided by a member of the House Staff or a Clinical Fellow, the entry must be reviewed, edited if necessary, and electronically signed by the attending physician. The attending physician will define the frequency of follow-up, if any, and continue to document findings and recommendations until signing off the case.

In the event that a consultation results in the immediate performance of an operative procedure by the same attending physician, the consultation and operative reports may be combined and must be dictated immediately after the procedure. (See Rule#17)

Consultants may enter recommended orders in suspension for activation by the responsible physician. However, except in case of emergency, orders should not be entered by a consultant. This does not apply to preoperative orders.

All ambulatory consultations are the responsibility of an attending physician. The attending physician must personally provide the services if so requested by another attending physician. Departments/Sections may define types of consultations, which may be completed by members of the House Staff or Clinical Fellows -- of specified, training, experience, and PGY level --- without direct Attending involvement. Attending review of such cases must take place within 24 hours of consultation.

Except in emergency, consultations with one or more qualified physicians are required in: (1) all cases of abortion involving minors where the consent of the patient has not been obtained, and all cases involving the mentally retarded or incapable; (2) elective sterilization procedures on all cases involving mentally retarded or incapable persons; (3) cases on all services in which, according to the judgment of the physicians, (a) the diagnosis is obscure, or (b) there is doubt as to the best therapeutic measures to be utilized; and (4) when diagnostic or therapeutic interventions are beyond the privileges of the responsible physician.

#### **Rule No. 15 Informed Consent**

***(See also: Clinical Administrative Policy C-10: "Consent for Operation and Other Procedures)***

Except in emergency situations, the responsible physician, dentist or podiatrist shall obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate, including transfusion and the use of blood products, and provide evidence of consent through completion of the "Consent for Operation or Special Procedure (Form #1696). This form, signed by the patient and an authorized practitioner shall be placed in the patient's hospital record. The extent of information to be supplied by the practitioner to the patient shall include the specific procedure or treatment, or both, the purpose and benefits of the procedure, reasonably foreseeable risks, and reasonable alternatives for care or treatment. Consent must be obtained within ninety days prior to the procedure.

It is the responsibility of an attending surgeon to evaluate, examine and counsel patients and/or their legal guardians prior to elective surgical procedures. Documentation of these interactions in the form of an attending surgeon's preoperative evaluation note is required in advance of the day of elective surgery. This responsibility may not be delegated. Screening endoscopic procedures are excluded from this requirement.

In all surgical procedures the doctor in whose name the permission for operation is obtained shall participate in person as a member of the operating team and shall be present during the critical portion(s) of the procedure. Such participation shall not be delegated without the informed consent of the patient or the patient's authorized representative.

#### **Rule No. 16 Tissue Removed at Operation**

Tissue, and all foreign bodies including implants, removed at operation shall be sent to the Hospital pathologist who shall make such examination as may be considered necessary to arrive at a pathological diagnosis. The pathologist shall sign the report. Pathology department policy may exempt certain tissues from submission; however, under no circumstances may the entire surgical specimen be delivered to any outside agency.

In all instances where a patient's medical, surgical, oncologic, invasive radiological, or therapeutic radiologic course is based on a histological or cytologic examination performed in another institution, the responsible physician is expected to make arrangement for a timely review of such specimens in the Hospital prior to the commencement of the therapy planned. If emergency therapy is indicated, pathologic review should be obtained as soon as feasible thereafter.

## **Rule No. 17 Treatment and Patient Care Orders**

Within a reasonable time after appointment to the Medical Staff, all members of the Active and Courtesy staffs, all Affiliated Health Care Professionals and all House Staff and clinical fellows shall be trained in the use of the Hospital's electronic medical record. All orders for inpatient care and treatment shall be entered in the electronic medical record unless such system is inoperative. Initial admission diagnostic and treatment orders may be entered by the attending physician, dentist, podiatrist, or licensed nurse midwife or may be entered by house staff, a physician assistant, or nurse practitioner as appropriate. Orders shall be entered only with the approval or under the supervision of the doctor or licensed nurse midwife in charge of the patient. Once services are requested of a Hospital-contracted Department as defined in Article V, Section A(3), providers in that Department may enter orders relevant to the services requested or may revise previously entered orders in order to assure as much as possible that the providers requesting the services are provided with the diagnostic information or therapeutic outcome sought. Orders not entered by the attending physician shall be regularly reviewed by the attending physician.

In an emergency, an order may be dictated by a physician, dentist or podiatrist to a registered nurse, dietitian, pharmacist, or respiratory therapist. Verbal orders for the initial application of restraints for medical recovery, medications, and nutrition must be electronically signed within 24 hours by the prescriber or another physician directly responsible for the patient's care. Verbal orders for extending restraints for medical recovery beyond the initial 24-hour period must be electronically signed by the next calendar day. Any verbal order for restraints for violent or destructive behavior should be authenticated in the electronic medical record at the time of face-to-face evaluation of the patient, but must be authenticated no later than the age-determined expiration time for that order. Any orders to limit life-sustaining treatment must be in writing and/or entered into the electronic medical record and must be signed electronically by the attending after the order is printed from the electronic medical record. Any verbal orders exempt from mandatory authentication within 24 hours shall be electronically signed at or prior to the discharge of the patient.

The Pharmacy Department is authorized to dispense generic equivalents of brand name drugs unless the doctor writing the order specifies NO EQUIVALENT verbally to the pharmacist. At the time a patient is admitted to or discharged from a recovery room or critical care area, or transferred from one service to another, the patient's discharging and admitting physicians shall review all of the patient's current orders. The physician must choose which orders to discontinue or continue and must enter any new orders that are indicated at that time. It is the Medical Staff's responsibility to review all orders at least weekly. All Schedule II controlled drugs shall be renewed or discontinued after 7 days. All other medication orders must be renewed every 30 days.

Only a single individual diagnostic test may be ordered more than 24 hours in advance. Repetitive or standing orders for individual tests shall be discontinued automatically after 24 hours. Only patients on approved Human Investigation Committee protocols are exempt from this policy.

## **MEDICAL RECORDS**

### **Rule No. 18 Medical Records — Preparation**

With rare exceptions and time limitations, granted by the Chief of Staff all medical record documentation must be entered in the electronic medical record.

The text and signature(s) contained in all Hospital records shall be legible, dated and timed.

A medical history and physical (H&P) examination must be completed for all inpatient admissions; ambulatory patients receiving ongoing primary care or undergoing an invasive procedure involving sedation or anesthesia; or any other patient whose visit involves administration of medication or modification of medicines

prescribed. The required H&P content shall always include sufficient information necessary to provide the care and services required to address the patient's conditions and needs and thus may vary with the setting and type of care delivered.

Dentists, and podiatrists not privileged to perform a H&P, who admit patients must have a consulting physician who is a member of the Active Medical Staff. The consulting physician shall have responsibility for the admission history and physical and, as applicable, the preoperative history and physical. (See Rule #3)

Admission H&Ps documented by a member of the house staff, an advanced practice registered nurse or a physician assistant and validated by the responsible attending physician, appropriately privileged podiatrist or licensed nurse midwife satisfies this requirement.

- a. "Complete H&P" For inpatients and primary care patients the history shall include presenting symptoms or indication for procedure, past medical, surgical, family and social history (if nursing assessment needs supplementation), problem pertinent review of systems, allergies and current medications. An age-appropriate physical examination shall include vital signs, head and neck, heart and lung, abdominal, neurologic and mental status, extremity and skin exams. Relevant results of diagnostic tests, diagnostic assessment and plan for care shall also be included.
- b. "Focused H&P" For patients undergoing an invasive procedure involving sedation or anesthesia, the history shall include pre-operative diagnosis(es), indication for the procedure, medications, allergies, relevant co-existing disease processes, and pertinent review of systems. An age-appropriate physical examination shall include vital signs, cardiopulmonary system and those body areas necessary to safely perform the procedure and planned sedation/anesthesia. Appropriate laboratory data, a diagnostic assessment and plan for care shall also be included. This must be completed within 30 days of the procedure and an update, including cardiopulmonary exam, must be performed after admission and always prior to the procedure unless the history and physical is performed within 24 hours or less before the procedure. For anesthesia cases, a pre-operative note by the anesthesia attending satisfies the 24 hour update requirement.
- c. For other patients whose visit is expected to involve only administration of medication/infusions excluding general anesthetic and conscious sedation (e.g., local anesthetic) or a change in medication prescription (e.g., post-operative pain medication), an H&P is not required, but a medication and allergy list shall be documented. These medications/infusions may include, but are not limited to, the following: blood transfusion, chemotherapy, apheresis, remicaid, biphosphanates and other therapeutic infusions.

The final obligation for completion of the electronic medical record rests with the attending physician, dentist or podiatrist. For all inpatients, notwithstanding the requirements set forth in Rule #4, the attending physician, dentist or podiatrist is obligated at a minimum:

- a. To enter a note within 24 hours of admission or transfer containing a problem specific-history and physical examination, working diagnostic impression(s) and plan for treatment. (See Rule #11) . For emergency admissions, such entry shall justify the designation of emergency status.
- b. At the time of transfer to the care of another attending physician indicate in the entry the identity of the new responsible practitioner. In addition, a physician accepting transfer of a patient must change the attending of record designation in the YNHH clinical information system.
- c. Include a brief operative note entry in the medical record immediately after surgery. In addition, the responsible surgeon must dictate a complete operative note within one day after surgery, to be signed and filed in the medical record as soon as possible after surgery.
- d. Ensure that a daily progress note has been entered by a member of the house staff, affiliated staff or other member of the Medical staff. The attending must enter progress notes with a frequency that reflects appropriate attending involvement but at least every other day except in exceptional

circumstances as approved by the Chief of Staff. When the patient is stable and disposition/placement is the only active issue, the attending must enter a progress note at least once a week.

e. Dictate or cause to be produced as soon as possible after discharge and sign or countersign upon receipt a Discharge Summary for each patient discharged from the Hospital except in instances of:

- 1) Normal delivery of term pregnancy, with or without outlet forceps, providing that the ante partum and postpartum courses were completely uncomplicated.
- 2) Normal newborn, including both those not requiring admission to the Newborn Special Care Unit and those admitted to the Newborn Special Care Unit for 48 hours or less for observation only.

For the above listed exceptions, complete and sign, or cause to be completed and countersign, an appropriate discharge note.

Members of the House Staff are directly supervised by attending physicians and may obtain a clinical history, perform a physical examination, and enter these and appropriate progress notes in the electronic medical record. (See Rule #11) Individuals recording information in the permanent medical record shall identify themselves legibly by name and position.

For patients with a primary discharge diagnosis of a neoplastic disease, physicians must indicate the clinical or pathological (if available) TNM staging (or equivalent) in the electronic medical record on the designated AJCC staging form. This applies to both inpatients and ambulatory surgery patients.

The Medical Record and Clinical Information Committee will monitor compliance with these requirements. Where an audit of records determines that documentation requirements are not being met, the Committee will notify the responsible Member of the Medical Staff of the deficiencies. If after two such notifications, an audit within the same calendar year reveals continuing non-compliance, the Medical Staff member will be notified that his or her Medical Staff privileges have been summarily suspended pursuant to Article 5, Section K of the Bylaws. Restoration of clinical privileges may occur upon the presentation by the physician to the Chief of Staff or the Medical Board, as the case may be, of a satisfactory plan for appropriate and timely fulfillment of documentation responsibilities.

#### **Rule No. 19 Medical Records – Completion**

No medical record shall be filed until it is complete except on order of the Medical Record and Clinical Information Committee. All clinician notes within the electronic medical record designated as “incomplete” shall be considered complete twenty four hours after patient discharge. Any physician, dentist or podiatrist having an unfinished record seven days after discharge shall be so notified by mail. If there are extenuating circumstances (defined as illness and other unanticipated circumstances) the practitioner or his/her office shall notify the Medical Records Department. Planned absences such as vacations or attendance at conferences will not be considered as extenuating circumstances.

If there are none of these extenuating circumstances and the record has not been completed within 21 days of discharge a second letter will be sent to the responsible practitioner advising that his admitting privileges have been suspended.

If there are incomplete records remaining after 28 days of discharge, the responsible practitioner will lose privileges, restoration to be automatic upon completion of all records.

If the record has not been completed within 35 days of discharge, the practitioner’s Medical Staff appointment and clinical privileges will terminate. Provisions for termination of Medical Staff appointment and clinical privileges also shall apply to practitioners whose admitting privileges have been suspended three times in a year defined as the period from July 1<sup>st</sup> to June 30<sup>th</sup>.



Restoration of membership and privileges can be accomplished only by reapplication in accordance with the provisions of ARTICLE V of the Bylaws of Yale-New Haven Hospital for the Medical Staff. Copies of letters to the practitioner will be sent to the appropriate departmental Chief or Associate Chief, the Admitting Office, and the Chairman of the Medical Record and Clinical Information Committee. One copy will also be placed in the permanent medical staff file for consideration when suitability for future staff reappointment of such physicians and dentists is reviewed.

For those practitioners whose staff privileges have been suspended after the 28 day period, assignment of an alternate physician for care of the practitioner's inpatients will be in accordance with the provisions of ARTICLE V, SECTION K, Paragraph 7, of the Bylaws for the Medical Staff.

Restoration of admitting privileges can be accomplished only by completion of all available records assigned to the suspended physician, dentist or podiatrist. The Medical Record Department will notify the Admitting Office immediately by telephone if privileges have been restored. Written confirmation of this notice will be forwarded to the Admitting Office with copies to the Departmental Chief or Associate Chief, the Chief of Staff and the Chairman of the Medical Record and Clinical Information Committee.

The Medical Record and Clinical Information Committee will prepare and submit for each Medical Board meeting a list of practitioners whose privileges have been suspended and those who have been restored. The above rules apply to the records of all patients irrespective of service.

#### **Rule No. 20 Medical Records – Removal**

All Medical records are the property of the Hospital and except for those inactive records, which may be removed for off-site storage, shall be taken from the Medical Center only pursuant to proper court order or subpoena. In the event that a patient is readmitted, all existing previous records shall be made available for the use of the responsible practitioner. However, appropriate confidentiality requirements shall be observed.

### **GENERAL RULES AND REGULATIONS**

#### **Rule No. 21 Confidentiality**

Pursuant to state and federal law, including HIPAA, and Hospital policy, all medical records and patient-specific information, records of peer review and morbidity and mortality review proceedings, risk management material including incident reports, medical staff credentialing records and files, minutes of Medical Staff and Hospital meetings, and other confidential Hospital and Medical Staff records, data, and information, are the property of the Hospital and may not be used for purposes other than patient care, peer review, risk management, approved research, education, and other proper Hospital and Medical Staff functions. Such records, materials, files, minutes, and other confidential information (referred to below collectively as "confidential materials") 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 or specific requirements of law.

Access to confidential materials by members of the Medical and other Staffs of the Hospital, Hospital employees, and others, is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or some other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and therefore applies equally to information stored in hard copy form or electronically stored.

Sharing of and/or misuse of passwords or access to electronic medical records or other electronic systems that contain patient and/or other confidential material is prohibited. If the Hospital becomes aware

that an access code and/or password has been shared with another person, the authorized user will be required to immediately change passwords and will be given an oral and written warning. A second incident within a five year period shall result in an immediate suspension of all Medical Staff privileges for a period of twenty-five (25) days. A third incident within a ten year period of the date of the first warning shall result in termination from the Medical Staff. Medical staff privilege suspensions will be reported as required to the Connecticut licensing board(s) and/or the National Practitioner Data Bank.

In addition to the measures set forth in the above paragraph, any member of the Medical Staff who misuses, has improper access to, or alters, removes, or improperly uses confidential materials, is subject to appropriate disciplinary action or proceedings.

**Rule No. 22 Peer Review Materials; Studies of Morbidity and Mortality; the Protection of Documents**

In Connecticut, Peer Review is the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review. Both Peer Review and morbidity and mortality reviews are granted protections as long as the statutory criteria are met. Wherever possible, materials produced for or generated in these reviews should be clearly identified as peer review or M & M reviews, and circulation of these documents should be limited to that necessary to accomplish the necessary peer or morbidity and mortality reviews.

**Rule No. 23 Protective Clothing – Operation Areas**

All persons who enter the semi-restricted and restricted areas of the Surgical, Delivery or other appropriate operative or treatment areas shall wear approved, clean scrubs and cover head and facial hair. A surgical mask must be worn in restricted areas where open sterile items and equipment are in use. Additional protective attire shall be worn when exposure to blood or potentially infectious material is reasonably anticipated.

**Rule No. 24 Autopsies (See also: *Clinical Administrative Policy C:P-3: "Permission for Post-Mortem Examination"*)**

Every member of the Medical and House Staff is expected to request permission for autopsy unless the patient or family has previously declined permission.

**Rule No. 25 Departmental Rules**

Medical Staff members should refer to departmental rules and regulations for specific items pertaining to their respective departments. Where departmental and Medical Staff Rules & Regulations appear inconsistent, Medical Staff Rules & Regulations will supercede departmental rules.

**Rule No. 26 Human Investigation**

Research involving human subjects shall be so conducted as to assure that the welfare, health and safety of the subjects are paramount. Prior approval must be obtained from the Human Investigation Committee and patient's responsible physician. The Medical Staff member who is the Principle Investigator must notify the Credentials Committee of any new procedures, or investigational approaches to standard procedures, so the Committee can determine if further evaluation is necessary. Rights including the right of privacy, shall be preserved, and an informed consent shall be obtained from the patient or the patient's authorized representative.

**Rule No. 27 Responsibilities for Infection Prevention/Standard Precautions and Transmission Based Precautions**

Members of the Medical and Affiliated staff will comply with infection prevention policies, including but not limited to the Medical Staff policy regarding hand hygiene and contact precautions, the Hospital policy regarding natural and artificial fingernails and any sanctions that apply to any such policy. Routine hand hygiene is to be performed before and after any patient contact. Standard precautions are to be used in the care of all patients that will or may include contact with blood or body fluids. The responsible physician, nurse and/or hospital epidemiologist or a designee is to determine the need for additional transmission based precautions. Orders for such precautions are to be entered into the applicable electronic medical record and a note entered in the patient's chart delineating the reasons for initiating precautions. The hospital epidemiologist has final authority in determining the initiation and/or discontinuation of transmission based precautions.

In addition to the above, the Infection Control Committee through its Chair or physician members, is authorized to institute any appropriate control measures or studies when there is a reasonable possibility of danger to one or more patients or personnel.

**Rule No. 28 Revision Procedure**

These Rules and Regulations are considered a component of the Medical Staff Bylaws and, therefore, are revised in the same manner as outlined in Article XVII. Revisions recommended by the Medical Board and voting members of the Organized Medical Staff and reviewed by the Patient Safety & Clinical Quality Committee of the Board of Trustees and shall be effective upon approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.