JOHN DEMPSEY HOSPITAL

MEDICAL STAFF BYLAWS

Revised 12-06-21

MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF OF JOHN DEMPSEY HOSPITAL OF UCONN HEALTH

Revised copy

Adopted by the Medical Staff: November 3, 2021

Approved by the Clinical Affairs Subcommittee of the Board of Directors: November 18, 2021

Approved by the Board of Directors: December 6, 2021

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BYLAWS OF THE MEDICAL STAFF
OF THE JOHN DEMPSEY HOSPITAL
OF THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

PREAMBLE

WHEREAS, the John Dempsey Hospital of the University of Connecticut Health Center (hereinafter referred to as the Hospital) is a State-owned institution organized under the laws of the State of Connecticut and operated by the University of Connecticut; and

WHEREAS, its purpose, as the teaching hospital of the University of Connecticut, is to serve as a general hospital providing programs in patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and satellite facilities of the University of Connecticut Health Center, including patient homes when applicable, and for the education of medical and dental students, interns, residents, fellows, and other students assigned to the Hospital, and that it must accept and discharge this responsibility subject to the ultimate authority of the Board of Trustees of the University of Connecticut, and the cooperative efforts of the Medical Staff, the University Administration and the Governing Board (Board of Directors) are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians, and dentists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with the Bylaws.

All provisions of these Bylaws, Rules and Regulations shall be interpreted and applied so that no person to whom reference is made directly or indirectly shall, on the basis of race, color or national origin (in compliance with Title VI, Sect. 601 of the Civil Rights Act of 1964), or on the basis of sex (in compliance with Sects. 799A and 845 of the Public Health Service Act), be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity of the Medical Staff of the Hospital.

DEFINITIONS

1. Medical Staff means the formally organized self-governing body consisting of those physicians, dentists, podiatrists, and clinical psychologists who have been granted membership pursuant to the terms of these bylaws.
2. Governing Board means the University of Connecticut Health Center Board of Directors.
3. Clinical Affairs Subcommittee means the Clinical Affairs Subcommittee of the University of Connecticut Health Center Board of Directors. The Clinical Affairs Subcommittee also serves as the Joint Conference Committee. The UCHC Board of Directors delegate to the Clinical Affairs Subcommittee the authority to act on behalf of the Board to approve the following: 1) John Dempsey Hospital Human Resource Plan; 2) John Dempsey Hospital Performance Improvement Plan; and 3) Appointment, reappointment, temporary privileges, and changes in privilege control lists for John Dempsey Hospital Medical Staff; and that the Clinical Affairs Subcommittee will report decisions to the University of Connecticut Health Center Board of Directors.
4. Medical Board means the Medical Staff governing body defined under the provisions of Article XII of these Bylaws.
5. Vice President means Vice President for Health Affairs of the University of Connecticut Health Center.
6. Hospital Chief Executive Officer (CEO) means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.
7. Medical Dean means the Dean of the School of Medicine.
8. Dental Dean means the Dean of the School of Dental Medicine.
9. Practitioner means an appropriately licensed physician, dentist, podiatrist, clinical psychologist, advanced practice registered nurse, or professional staff permitted by law and by the hospital to provide patient care services in the hospital.
10. Independent Practitioner means an appropriately licensed individual permitted by law and by the hospital to provide patient care services without direct supervision, within the individual’s license, consistent with individually granted clinical privileges, and within the appointed department’s guidelines.
11. Clinical Service means an organized division of the Medical Staff, as defined under Article XI of these Bylaws.

12. Chief of Service means the individual responsible for an organized division of the Medical Staff, as defined under Article XI of these Bylaws.
13. Department Head means the Head of an Academic Department of the School of Medicine or of the School of Dental Medicine. A Department Head who is qualified for membership of the Medical Staff may or may not also be Chief of Service, i.e., an Academic Department and the corresponding Clinical Service may or may not be simultaneously headed by the same person. For the purpose of these Bylaws and to avoid misunderstanding, the role of Chief of Service should at all times be distinguished from that of Department Head.
14. Clinical Privileges means authorization granted by the Clinical Affairs Subcommittee to a practitioner to provide hospital-based patient care services within well-defined limits, based on the following factors as applicable: license, education, training, experience, competence, health status, and judgment.
15. Admitting Privileges means the right to admit patients to the Hospital as generally defined in Article VI, and as specifically defined in any Clinical Service guidelines as approved by the Medical Board.
16. Professional Staff means an appropriately licensed professional, who is not a physician, dentist, podiatrist, clinical psychologist, but who is qualified by academic and clinical training and is permitted by state law and the hospital to provide patient care services under the direction and supervision of a member of the medical staff.
17. House Staff means physicians participating in a sponsored training program as residents or fellows within the Hospital. A resident is an individual who has received a medical degree, dental degree, or podiatric degree and is participating in an approved graduate education specialty training program. A fellow is an individual who has completed residency training and the requirements for a first board certification and is participating in an approved graduate medical education subspecialty program.
18. UCHC means the University of Connecticut Health Center and includes the School of Medicine, School of Dental Medicine, John Dempsey Hospital, and UConn Medical Group.
19. Medical Staff year, for the purposes of these Bylaws, commences July 1st of each year and ends June 30th.
20. Active medical staff shall mean members of medical staff with current appointment and clinical privileges.
21. Advanced Practice Registered Nursing Staff means those practitioners who are appropriately licensed as advanced practice registered nurses (APRNs), permitted by law and the hospital to provide patient care services within the individual's license, consistent with individually granted clinical privileges, within departmental guidelines, and who have signed a collaborative agreement with a physician of a similar specialty. This definition does not include those categories of APRNs, including CRNAs, which are specifically excluded from the collaborative agreement by state law.
22. Collaboration, in reference to Advance Practice Nursing, means a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse.
23. Practitioner of Record includes medical staff members and advanced practice nursing staff members ordering and/or providing patient care services.

ARTICLE I. NAME OF ORGANIZATION

The name of this organization shall be the Medical Staff of the John Dempsey Hospital of the University of Connecticut Health Center.

ARTICLE II. PURPOSE OF ORGANIZATION

The purposes of the organization shall be:

A. To provide mechanisms to see that all patients admitted to or treated in any of the facilities or by any of the services or the Medical Staff of the Hospital, receive quality professional services.

B. To provide mechanisms to see that a high level of professional performance of all members of the Medical Staff, through the appropriate delineation of clinical privileges, is maintained by ongoing review and evaluation of each member's performance.

C. To provide the primary mechanism for accountability to the Governing Board for the quality of patient care services and professional ethical conduct of each practitioner holding membership and/or exercising clinical privileges.

D. To provide educational opportunities and maintain appropriate educational standards for undergraduate medical and dental students, interns, residents, fellows, and other allied health students, as well as, for practicing medical staff members, advanced practice nursing staff members and professional staff members, within the educational policies established by the respective faculties.

E. To provide a mechanism to discuss medical-administrative issues including any deliberation affecting the discharge of medical staff responsibilities.

F. To develop, adopt, and maintain bylaws, rules and regulations for the self-governance of the Medical Staff and to create a framework within which medical staff members can act.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege granted by the Clinical Affairs Subcommittee to professionally competent independent practitioners who continuously comply with the qualifications, standards and requirements set forth in these bylaws, rules and regulations of the Medical Staff, and other Medical Staff policies. Membership on the Medical Staff shall confer only such clinical privileges as have been specifically granted by the Clinical Affairs Subcommittee in accordance with these bylaws.

No physician, dentist, podiatrist, or clinical psychologist shall admit or provide medical or health-related services to patients in the hospital unless privileges have been granted in accordance with these bylaws.

Section 2. Qualifications for Membership

A. Only physicians, dentists, podiatrists, and clinical psychologists who:

1. document (a) current licensure issued by the State of Connecticut to practice allopathic medicine, osteopathy, dentistry, podiatry, or psychology; a current federal and state registration to prescribe controlled substances, except where the practitioner demonstrates that such registration is not required; (b) adequate experience, education, and training including completion of an approved training program or have practiced two years in a TJC accredited hospital in a non-training status; (c) current clinical competence; (d) good judgment; and (e) ability to perform clinical privileges requested;
2. are determined (a) to adhere to the ethics of their respective professions; (b) to work with others in the best interest of patient care; (c) to keep confidential, as required by law, all information or records received in the practitioner-patient relationship; and (d) to participate in and properly discharge those responsibilities determined by the medical staff;
3. maintain professional liability insurance or other evidence of liability as the Governing Board may establish;
4. are not excluded or sanctioned from participation in Medicare, Medicaid, or other Federal health care programs; shall be deemed to possess basic qualifications for membership on the medical staff.

B. The physician, dentist, or podiatrist shall obtain and maintain board certification recognized and approved by the John Dempsey Hospital Credentials Committee or be eligible for certification and become certified within the lesser of (i) the period of eligibility as defined by the respective board or (ii) within five years of completing residency and/or Credentials Committee-approved education/training. The Clinical Affairs Subcommittee may consider an extension when board regulations are in conflict with the bylaws. In those cases, however, there must still be a clear path to board certification. For those dentists practicing General Dentistry (where no recognized board certification exists), completion of one of the following is required: (i) a two-year Commission on General Dentistry (CODA) approved residency program or (ii) a one-year CODA approved residency program and one-year of hospital practice.

C. If board certification lapses, the staff member will retain membership and privileges, but must become recertified by the end of the next two testing cycles offered by the board. If recertification is not achieved within the two testing cycles immediately following the lapsed certification, membership and privileges will be terminated.

D. Active Staff, Affiliated Staff, and Refer and Follow Staff members must hold a faculty appointment at the University of Connecticut Health Center. Physicians, dentists, podiatrists, and clinical psychologists who have accepted letters of offer for faculty appointments may also be considered members of the Active or Affiliated Staff for purposes of attaining credentials, privileges, and/or health plan enrollments.

E. Acceptance of membership on the Medical Staff shall constitute the member's agreement that professional conduct shall be governed by appropriate ethical principles. All members of the Medical Staff shall pledge themselves to perform their duties in the best interest of their patient.

F. All medical staff members and others with delineated clinical privileges are subject to medical staff and departmental bylaws, rules and regulations, and policies and are subject to review as part of the organization's performance improvement activities.

G. All appointments to the Medical Staff shall be approved as detailed in Article VII.

Section 3. Basic Obligations of Individual Staff Membership

Each member of the Medical Staff shall:

A. provide patients with continuous high quality care meeting the professional standards of the medical and dental staff of this hospital;

B. demonstrate ability to provide adequate call coverage to provide continuous care to their patients;

C. abide by the Medical Staff bylaws, rules and regulations established by the Medical Board, other Medical Staff committees, and other rules of the hospital including but not limited to hospital policies, Safety Plan, Performance Improvement Plan, and Corporate Compliance Plan.

D. meet the general requirements of membership outlined in Section 2 as well as requirements of membership for the specific department to which the practitioner is assigned;

E. discharge in a responsible manner, tasks imposed by the medical staff, including committee assignments;

F. prepare and complete in timely fashion the medical records for all patients that the practitioner has provided care for in the hospital;

G. abide and be governed by generally recognized standards of professional ethics;

H. participate in continuing education programs as determined by the medical staff and as consistent with state law. If there is no state law that indicates the number of continuing education required for a state license type, then the practitioner is required to participate in continuing education to the extent required by his/her national certifying organization;

I. participate in the medical staff peer review process; and

J. meet the quality improvement standards established by the Joint Commission on Accreditation of Health Care Organizations and the hospital's quality improvement plan;

K. Inform the Medical Staff Office, within five working days, of any type of adverse action, including not only suspension or revocation of a license to practice, as well as sanctions, exclusions and any other adverse actions by private and governmental third party payers, health care organizations, federal and state drug regulatory agencies, and criminal law enforcement authorities.

Section 4. Term of Appointment

A. Initial appointments, reappointments, and revocations of appointments of the Medical Staff shall be made by the Clinical Affairs Subcommittee. The Clinical Affairs Subcommittee shall act in these regards only after there has been a recommendation from the Medical Board as provided in Article VIII of these Bylaws.

B. Appointment to the Medical Staff shall confer on the appointee only such privileges as granted by the Clinical Affairs Subcommittee.

C. Appointments to the Medical Staff shall be for no more than twenty-four months.

D. Initial appointments and new privileges to the Medical Staff shall be provisional for a period of two (2) years, or at the time of reappointment, whichever is first. Negative performance issues shall result in an evaluation of the practitioner by the Chief of Service and the Credentials Committee. If there are no performance issues, the provisional status will be converted to active status.

E. Reappointments shall be made biennially in the birth month of the applicant.

F. Medical Staff membership and clinical privileges shall be terminated: upon the resignation or retirement of the member from a faculty appointment; upon voluntary resignation from a medical staff appointment; or when membership is revoked in accordance with the procedures outlined in Articles XVIII and XIX.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

Section 1. Categories

The Medical Staff shall be divided into the following categories:

A. The Active Staff
B. The Affiliated Staff
C. The Resident Staff
D. The Refer and Follow Staff

Section 2. The Active Staff

A. The Active Staff shall consist of those physician, dentist, podiatrist, and clinical psychologist members of the Medical Staff who: 1) hold a faculty appointment in the School of Medicine or the School of Dental Medicine and are also employed by UCHC and eligible for fringe benefits under the UCHC Human Resources policies, or 2) have accepted letters of offer for a faculty appointment and will be employed by UCHC and eligible for fringe benefits, or 3) those community based practitioners who hold a faculty appointment and John Dempsey Hospital is their primary hospital (at least 80% of their hospital-based activity must be at JDH).

B. Members of the Active Staff shall be appointed to one primary Clinical Service, shall be eligible to vote, hold office as provided by Article X, of these Bylaws, and serve on all Medical Staff committees. Active Staff members shall be required to attend regular Medical Staff meetings as provided by Article XIII, of these Bylaws, and to attend appropriate Clinical Service and committee meetings as provided by Article XIV, of these Bylaws. Active Staff members shall attend patients within the scope of granted privileges.

Section 3. The Affiliated Staff

A. The Affiliated Staff shall consist of those physician, dentist, podiatrist and clinical psychologist members of the Medical Staff who hold a faculty appointment in the School of Medicine or the School of Dental Medicine, but do not meet all of the criteria for membership as an Active Staff.

B. Members of the Affiliated Staff shall be appointed to one primary Clinical Service and shall be eligible to serve as non-voting members on medical staff committees, and as an "at large" member of the Medical Board. Affiliated Staff members shall attend patients within the scope of granted privileges.

Section 4. The Resident Staff

A. The Resident Staff (House staff) shall consist of those postgraduate trainees who, by virtue of participation in the University of Connecticut School of Medicine and/or Dental Medicine or the University of Connecticut School of Medicine and/or Dental Medicine affiliated training programs, function within the John Dempsey Hospital. Resident Staff membership requires: compliance with established Graduate Medical Education policies and procedures; completion of GME Office credentialing; performance of duties within job descriptions; and annual performance assessment by their Residency Director. These policies and procedures shall be reviewed and approved annually by the Credentials Committee, Medical Board, and Board of Directors. In accordance with Connecticut State Statute (CGS 20-9 and 20-11a) and requirements of their respective training program, the Resident Staff may be granted clinical privileges to use restraints. The granting of these privileges must be recommended by the Chief of Service, Credentials Committee, and Medical Board and be approved by the Board of Directors.

Section 5. The Refer and Follow Staff

A. The Refer and Follow Staff shall consist of those physician, dentist, podiatrist, and clinical psychologist members of the Medical Staff who hold a faculty appointment in the School of Medicine or the School of Dental Medicine. The Refer and Follow Staff may not hold clinical privileges, admit patients, or be allowed to make an entry in the patient

medical record. They may refer patients and follow their course of treatment through access of the medical record. All qualifications and requirements for membership unrelated to the delivery of care in these Bylaws (e.g., licensure, board certification, CMEs, etc.) shall apply to members of the Refer and Follow Staff. Members of the Active Staff and Affiliated Staff who do not perform sufficient clinical activity for competence to be established through the Ongoing Professional Practice Evaluation and who no longer qualify for the Active Staff or Affiliated Staff, may be eligible for the Refer and Follow Staff.

Members of the Refer and Follow Staff shall be appointed to one primary Clinical Service and shall be eligible to serve as non-voting members on Medical Staff committees. They may not serve as an at-large member on the Medical Board.

ARTICLE V. ADVANCED PRACTICE NURSING STAFF

Section 1. Nature of Advanced Practice Nursing Staff

A. Advanced Practice Nursing Staff shall consist of those registered nurses who through advanced nursing education, certification, and state licensure deliver patient care services as Nurse Practitioners or Clinical Nurse Specialists, with a collaborative process and agreement in place with a physician of a similar specialty.

B. APRN staff members shall have a mutually agreed upon written and signed collaborative agreement with the Clinical Chief of his or her clinical specialty or a designee. Collaborative agreements specify the level of direction if any, a Physician and APRN agree upon, the level of consultation and referral, a method to review outcomes, the level of schedule II and III narcotics, coverage in absence of the APRN, and a method of disclosure of patients.

C. Members of the APRN Staff shall be appointed to one or more Clinical Service and attend patients within the scope of granted privileges, and be subject to the policies and procedures of that department or division.

Section 2. Qualifications of Advanced Practice Nursing Staff

A. Only an APRN holding a Connecticut State license and certification from a national certifying body recognized by the State of Connecticut, and satisfying the qualifications as set forth in Article III and other sections of these Bylaws, shall be eligible to provide patient care services in the hospital. The Credentials Committee and Medical Board may establish additional qualifications required in conjunction with review by the Hospital Chief Nursing Officer, who may seek advice and review from appropriate members of the Advanced Practice Nursing Staff.

Section 3. Appointment, Reappointment and Clinical Privileges

A. APRN Staff must apply for appointment and reappointment to a Clinical Service with clinical privileges in accordance with Article VII of these Bylaws. The Clinical Affairs Subcommittee will grant appointment to the Clinical Service with privileges. Clinical privileges from the appropriate Privilege Control List will be agreed upon with the APRN Staff member and the Collaborating Physician. The recommended privileges will be reviewed and approved by the Clinical Chief and by the Credentials Committee. The Privilege Control List may be updated and changed as needed with consultation with the same Collaborating Physician named on the Collaborative Agreement, and with subsequent Credential Committee review and approval.

B. APRN Staff shall not have the privilege to admit patients or to vote. APRN Staff are required to participate in organizational performance improvement activities and must comply with all applicable Medical Staff Bylaws, Rules and Regulations.

Section 4. Disciplinary Action and Procedural Rights

A. In keeping with the appropriate bargaining agent's contract, these bylaws will not supersede the individual's employment contract on issues related to rank and status. The bargaining agent contract will not supersede requirements for APRNs as stated by Connecticut law for Advanced Practice Nursing, any Collaborative Agreement, or these Bylaws for practitioners' Rules and Regulations.

B. Provisions in Article XIX of these Bylaws relating to hearings and appellate review shall not apply to APRN Staff, but the mechanism for review will be as follows:

1. An adverse decision by the Clinical Chief regarding appointment, reappointment and/or clinical privileges may be appealed by the APRN. An ad-hoc committee appointed by the President of the Medical Staff will be formed with potential representation including, but not limited to, practitioners from the APRN's specialty, advanced practice nursing faculty, and the Hospital Chief Nursing Officer of the University of Connecticut Health Center. The APRN may discuss, and explain all concerns with the ad-hoc committee and the committee will make a recommendation. The recommendation of the ad-hoc committee will be reported by the Hospital Chief Nursing Officer to the APRN and the Chief of Service within 10 working days, and shall be explained in writing. After review of the ad-hoc committee recommendations, the Chief of Service will forward the recommendation of the ad-hoc committee with his/her own decision, including reasons for the decision, in writing, to the Medical Board for review. The APRN may opt to appear at the Credentials Committee or designated body with or without the Hospital Chief Nursing Officer. The recommendations of the Credentials Committee or designated group shall be forwarded to the Medical Board. After review, the Medical Board's decision shall be in writing. The APRN will have the right to appeal the Medical Board's decision to the Governing Board. The decision of the Governing Board, or its committee, shall be in writing and shall be final. If the APRN wishes at this point to grieve this decision through the bargaining agent, he or she will do so while suspended from clinical practice at the University of Connecticut Health Center.

2. Mutually agreed upon changes to the Collaborative Agreement will not be construed as disciplinary or as a loss of privileges.

3. Appointment and clinical privileges of the APRN staff shall automatically terminate in the event the APRN staff member's employment terminates, or the APRN agrees to terminate a collaborative agreement.

4. If an APRN is suspended, loses clinical privileges, terminates employment or a collaborative agreement, the Chief of Service and/or collaborating physician must provide for alternative coverage for the patients of the APRN.

ARTICLE VI. PROFESSIONAL STAFF

Section 1. Qualifications and Nature of Professional Staff

A. A Professional Staff member is an individual other than a member of the Medical Staff or Advanced Practice Nursing Staff who is qualified by academic and clinical training and who is licensed or certified by the State to perform patient care services under the direction of a member of the Medical Staff competent to provide such direction. The Credentials Committee and Medical Board may establish additional qualifications required of any particular discipline within the Professional Staff.

B. All Professional Staff shall be assigned to an appropriate clinical department or division and be subject to the policies and procedures of that department or division.

Section 2. Appointment, Reappointment and Clinical Privileges

A. The Professional Staff must apply for appointment and reappointment to a Clinical Service with clinical privileges in accordance with Article VIII of these Bylaws. Appointment to the Clinical Service with clinical privileges will be granted by the Clinical Affairs Subcommittee. Clinical privileges will be delineated by the supervising physician in consultation with the appropriate Chief of Service.

B. The Professional Staff shall not have the privilege to admit patients or to vote. They will be required to participate in organizational performance improvement activities and must comply with all applicable Medical Staff Bylaws, Rules and Regulations.

Section 3. Disciplinary Action and Procedural Rights

A. Provisions in Article XIX of these Bylaws relating to hearings and appellate review shall not apply to Professional Staff. In keeping with the appropriate bargaining agent's contract, the fair hearing and appellate review mechanism related to patient care, qualifications, rank, status, and standards of performance for Professional Staff shall be as follows:

B. Adverse decisions related to appointment, reappointment and/or clinical privileges may be appealed by the Professional Staff to the Chief of Service and appropriate Associate Vice President of the University of Connecticut Health Center. After review, the decision of the Chief of Service shall be explained in writing including the reasons for the decision and shall be reviewed by the Medical Board. The Professional Staff shall be permitted to appear at the Credentials Committee or body designated by the Chief of Service or the Medical Board. The recommendation of the Credentials Committee or designated body shall be forwarded to the Medical Board. After review, the Medical Board's decision shall be in writing. Barring resolution, the Professional Staff shall have the right to appeal the Medical Board's decision to the Clinical Affairs Subcommittee. The decision of the Clinical Affairs Subcommittee shall be in writing and shall be final.

C. Appointment and clinical privileges of the Professional Staff shall automatically terminate in the event the Professional Staff's employment by the hospital terminates or the Professional Staff is no longer supervised by a Connecticut licensed and registered physician competent to provide such direction and is a member of the Medical Staff.

D. Professional Staff are not members of the Medical Staff. However, the various provisions of these bylaws and the accompanying rules and regulations shall apply unless otherwise indicated.

ARTICLE VII. CLINICAL PRIVILEGES

Section 1. Clinical Privileges

A. A practitioner providing clinical services at the Hospital by virtue of Medical Staff membership, Advanced Practice Nursing Staff membership, Professional Staff designation, or except as provided in this Article VII, Sections 2 - 4 may, in connection with such practice, exercise only those clinical privileges specifically granted to him or her by the Clinical Affairs Subcommittee.

B. Such delineated clinical privileges define the practitioner's scope of patient care services that may be provided independently in the hospital. Clinical privilege lists shall be developed by the appropriate clinical service, and shall be approved by the Credentials Committee and Medical Board.

C. Applications for active and affiliated staff membership shall contain a request to the Chief of Service for the clinical privileges. The evaluation of such requests for privileges shall be based upon the applicant's education, training, experience, current competence, references and other relevant information, including an appraisal by the Chief of Service in which privileges are sought. The applicant shall have the burden of establishing his or her qualifications, competency, and ability to perform the clinical privileges requested. The clinical activities shall be commensurate with the needs of the Hospital and with its ability to provide the resources to support those activities. Clinical privileges are requested in conjunction with the appointment and reappointment process.

D. Practitioners who treat patients via telemedicine shall be credentialed through the John Dempsey Hospital Medical Staff if the hospital is on the receiving end of the telemedicine service.

Section 2. Temporary Privileges

A. Under the four circumstances below, temporary admitting and clinical privileges may be granted to an appropriately licensed practitioner after verified information (education, training, board certification, licensure and controlled drug registrations, hospital affiliations, malpractice history, disciplinary actions, government sanctions) supports a practitioner's qualifications, ability and judgment to exercise the privileges requested. Temporary privileges shall not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules and regulations and policies of the hospital and medical staff and has been oriented to the electronic clinical systems needed to provide and document care. If temporary privileges are granted, the practitioner shall act under the supervision of the Chief of Service, or designee, to which the practitioner has been assigned.

B. Temporary admitting and clinical privileges, or renewal of temporary privileges, may be granted for a time limited period after appropriate verification has been performed in accordance with policy and approved by the Credentials Committee Chair, Chief of Medical Staff, and Hospital CEO upon the written recommendation of the Chief of Service or designee in the following circumstances:

    1. Pending Application - After receipt of a written request and completed application, temporary privileges may be granted for a period not to exceed 120 days. Temporary privileges will be considered only when an application has been fully verified and is considered free of malpractice issues or other areas of concern.

    2. Care of Specific Patient(s) - After receipt of a written request for specific temporary privileges for the care of one or more specific patients, a practitioner who is not an applicant for staff membership, may be granted temporary privileges for a period of thirty (30) days with one renewal. A faculty appointment is not required. Such privileges shall be restricted to the treatment of not more than four patients. Extraordinary circumstances, including a specific patient admission greater than sixty (60) days, will be reviewed and processed as described above.

3. Education - After receipt of a written request to learn or teach specific procedure(s), a practitioner who is not an applicant for staff membership, may be granted the specific temporary privileges for a period of sixty (60) days with one renewal. A faculty appointment is not required.

4. Locum Tenens - After receipt of a written request for specific temporary privileges, a practitioner who is serving as a *locum tenens*, may be granted privileges for a period not to exceed one-hundred and twenty (120) days. These privileges shall not exceed the services as *locum tenens*, shall be limited to treatment of patients of the staff member for whom the practitioner is serving, but shall not entitle the *locum tenens* to admit patients other than patients of the Medical Staff member for whom services are being provided. The qualifications of a *locum tenens* shall be equal to the staff member being replaced.

C. The Chief of Medical Staff, or designee may at any time terminate a practitioner's temporary privileges. The termination also may be effected by any person entitled to impose summary suspensions under these bylaws. In the event of such termination, the practitioner's patients in the hospital shall be assigned to another practitioner by the Chief of Service responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

D. A practitioner shall not be entitled to the procedural rights afforded by these bylaws in the event that the practitioner's request for temporary privileges is refused or in the event that all or any portion of such practitioner's temporary privileges are terminated or suspended.

Section 3. Emergency Privileges

For the purpose of this Section 3, an "emergency" is defined as a condition in which serious permanent harm might result or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

A. In the case of an emergency, any active or pending member of the Medical Staff, or any individual authorized by the Chief of Medical Staff or designee, shall be permitted to do everything possible to prevent serious permanent harm or to save the life of a patient, using every facility of the Hospital necessary, including the calling for any necessary consultation.

B. When an emergency situation no longer exists, the patient shall be assigned by the appropriate Chief of Service, or in his or her absence, by the Chief of Medical Staff, to an appropriate member of the Medical Staff.

C. Emergency privileges performed by the practitioner must be documented and reviewed by the Chief of Service, or designee, within forty-eight hours.

Section 4. Revision of Clinical Privileges

A. A Medical Staff member, Advanced Practice Nursing Staff member, or Professional Staff may request revision of clinical privileges including increases and reductions, at the time of reappointment or at any other time.

B. Requests for increases in clinical privileges shall be made in writing on the prescribed forms including documentation of related experience, education, training, and current competence.

C. Requests for reduction in clinical privileges shall be accompanied by the member's statement regarding the reason for the decrease in privileges.

D. Processing of increases to clinical privileges shall include Chief of Service, Credentials Committee, Medical Board, and Clinical Affairs Subcommittee review and approval.

Section 5. Disaster Privileges

Objective

In the event of a disaster, the Medical Staff may be unable to handle immediate patient needs. To ensure optimum patient care and service delivery, it may be necessary to grant Disaster Privileges to practitioners not on the Medical Staff to help care for an unusually high number of patients.

Policy

During a disaster in which the Hospital Emergency Management Plan has been activated, the Chief of Medical Staff may, if the Hospital is unable to handle immediate patient needs, grant Disaster Privileges to those practitioners deemed qualified and competent, for the duration of the disaster situation. Granting of these Privileges shall be considered on a practitioner case-by-case basis and are not a "right" of the requesting provider. If the Chief of Medical Staff is unable to fulfill these duties, or to name a designee, the responsibility will pass to, in order of authority, the Emergency Medicine physician on duty, the Associate Chief of Medical Staff, the Clinical Service Chief of Surgery and the President of the Medical Staff.

When the disaster situation no longer exists, as determined by the Chief of Medical Staff or designee, the Disaster Privileges shall immediately terminate after a fully credentialed staff member can assume the delivery of patient care. Termination of Disaster Privileges shall not be considered corrective action and the practitioner shall not have rights to a hearing or appellate review.

Definition

A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demands for health care. (Source: American College of Emergency Physicians.)

Eligibility

In order to be considered for Disaster Privileges, the practitioner must complete a Disaster Privileging Form, provide a valid government-issued photo identification (e.g., driver's license, passport) and provide at least <u>one</u> of the following:

1. A current picture ID card from a healthcare organization that clearly identifies the person's professional designation
2. A current license to practice
3. Primary source verification of licensure
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other state or federal response organization or group.
5. Identification indicating that the individual has been granted authority to render patient care in disaster circumstances. Such authority having been granted by a federal, state or municipal entity.
6. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed professional during a disaster.

Granting of Privileges

Disaster Privileges shall be granted only after signature on the Disaster Privileging Form by the Hospital CEO or designee, who shall assign the practitioner to a Clinical Service based on the applicant's specialty and scope of practice.

Assignment of Duties and Oversight

The Clinical Service Chief or acting Chief during the disaster shall assign the practitioner clinical duties and shall oversee him/her during the disaster. Oversight may include personal observation, discussion with others involved in the care of the practitioner's patients, or medical record review.

Primary Source Verification

Primary source verification of licensure should begin as soon as the immediate situation is under control or within 72 hours from the time that disaster privileges were granted to a practitioner, whichever comes first. In extraordinary circumstances (e.g., internet or telephone communication systems are not operable, lack of resources), the verification process may extend beyond 72 hours, but should begin as soon as possible. In circumstances when primary source verification could not be completed within 72 hours, the hospital must document the following: the reason(s) that primary source verification could not be performed within 72 hours; evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and evidence of the hospital's attempt to perform primary source verification as soon as possible.

Assessment of Professional Practice

Within 72 hours after an individual has been granted disaster privileges, the Medical Staff will assess the professional practice of the practitioner and determine if he/she shall be allowed to continue to provide assistance based on its oversight. Such determination will be made by the Service Chief or Acting Service Chief. Termination of disaster privileges is not considered a Corrective Action and the practitioner shall not have rights to a hearing or appellate review.

ARTICLE VIII. APPOINTMENT AND REAPPOINTMENT

Section 1. Pre-Application Process

Applicants for initial Medical Staff Membership and clinical privileges shall be screened for minimum qualifications as required by these bylaws.

Section 2. Application for Appointment

Applications for appointment to the Medical Staff shall be made in writing to the Medical Staff Services Office on the prescribed forms and shall contain a request for clinical privileges. The applicant must provide all materials requested on the application. This application shall include, but not be limited to:

1. practice location(s);
2. qualifications including education, professional training, experience;
3. current Connecticut state licensure;
4. current Federal DEA, and Connecticut Controlled Substance Registration (if applicable);
5. specialty board certification or evidence of participation in board examination process (if applicable);
6. three peer references familiar with the applicant's current clinical competence and ethical character;
7. voluntary or involuntary termination of medical staff membership, licensure/registration, limitations, reductions, or loss of clinical privileges at another hospital;
8. current professional liability insurance;
9. involvement in any professional liability action including cases pending, open or closed including final judgments or settlements;
10. a pledge to abide by the Medical Staff Bylaws, Rules and Regulations;
11. a pledge to provide for continuous care of their patients;
12. evidence of current ability to exercise specific clinical privileges requested; and
13. an authorization for release of information and acknowledgment of immunity from liability.

Section 3. Verification of Information

A. The applicant is responsible for providing the information to satisfy the appointment and clinical privileging process.

B. Contents of the application will be verified by the Medical Staff Services Office from primary sources whenever feasible.

C. The Medical Staff Services Office shall transmit applications for membership and clinical privileges to the Chief of Service within a reasonable time after receipt of an application.

Section 4. Chief of Service Review

The Chief of Service shall review the requested medical staff appointment and clinical privileges documentation. The Chief of Service may meet the applicant to discuss any aspect of the application or request further information. After review, the Chief of Service shall submit a recommendation to the Credentials Committee regarding membership appointment and clinical privileges. If there is failure to recommend, the reason for such recommendation shall be documented by the Chief of Service and transmitted to the Credentials Committee. Initial APRN appointments and privileges will be reviewed by the Hospital Chief Nursing Officer, who may seek advice or review with appropriate members of the Advanced Practice Nursing Staff, prior to a Credentials Committee process. The Hospital Chief Nursing Officer will attest to the competence of the APRN and will report documented recommendations to the Chief of Service. The Chief of Service will present recommendations from the Hospital Chief Nursing Officer along with personal recommendations, to the Credentials Committee.

Section 5. Credentials Committee Review and Recommendation

A. The Credentials Committee shall determine when an application is deemed complete. Once an application is complete, it shall be processed by the Credentials Committee, Medical Board and Clinical Affairs Subcommittee within 120 days.

B. The Credentials Committee shall examine the evidence of the applicant's licensure, character, training, experience, current competence, malpractice issues, and ability to perform the clinical privileges. The Committee shall determine through the Chief of Service's recommendation, references, and other sources available whether the applicant meets the necessary qualifications for Medical Staff membership and clinical privileges requested. If the Credentials Committee is satisfied with the information received, the committee shall forward its recommendation to the Medical Board. In the case of an adverse recommendation, the Credentials Committee shall forward its recommendation to the Chief of Service before its recommendation is presented to the Medical Board.

Section 6. Medical Board Review and Recommendation

Upon receipt of the Credentials Committee's recommendation, the Medical Board shall review and make a recommendation on the applicant to the Clinical Affairs Subcommittee.

Section 7. Clinical Affairs Subcommittee Review and Action

The Clinical Affairs Subcommittee will make the final decision on credentialing issues. Applicants shall be notified of the decision in writing within 10 business days.

Section 8. Reappointment Process

A. Members of the Medical Staff shall be reappointed by the Clinical Affairs Subcommittee biennially in the member's birth month.

B. Prior to the expiration of biennial appointment, each Active, and Affiliated member of the Medical Staff, Advanced Practice Nursing Staff and Professional Staff shall be notified that their medical staff membership and clinical privileges will expire. Applications for reappointment shall be made in writing on the prescribed forms and forwarded to the office of Medical Staff Services within ten (10) days of receipt of this notice. Reappointment, renewal, and review of clinical privileges shall be based on similar criteria for appointment including ongoing monitoring of professional performance, judgment, clinical or technical skills, current competence, participation in continuing education, and organizational performance improvement activities.

C. When there is insufficient data to assess performance and competence, the member shall be required to submit evidence of current competence for clinical privileges requested. This may include: references from peers who can attest to the member's current competence, references from other hospital affiliations or documentation of continuing medical education, and/or evidence of performance improvement activities.

D. Applications for reappointment shall be processed in the same manner as initial appointment applications.

ARTICLE IX. LEAVE OF ABSENCE

Section 1. Voluntary Leave of Absence

A. A member of the Medical Staff shall retain membership status during a voluntary leave of absence if the leave is requested in writing by the member, forwarded and approved by the Chief of Service, and of duration less than the individual's biennial reappointment period.

B. A member of the Medical Staff, requesting a voluntary leave of absence extending beyond their reappointment period, shall reapply for membership and clinical privileges consistent with the reappointment process described in Article VIII, prior to their return to service. This reappointment process shall allow the Chief of Service, Credentials Committee, and Medical Board to ask questions relevant, and within the American with Disabilities Act parameters, to the individual's current competence and ability to perform clinical privileges held prior to the leave of absence.

Section 2. Involuntary Leave of Absence

A member of the Medical Staff, experiencing an involuntary leave of absence, shall reapply for membership and clinical privileges consistent with the reappointment process described in Article VIII, prior to their return to service. This reappointment process shall allow the Chief of Service, Credentials Committee, and Medical Board to ask questions relevant, and within the American with Disabilities Act parameters, to the individual's current competence and ability to perform clinical privileges held prior to the leave of absence.

ARTICLE X. OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

A. The President of the Medical Staff
B. The Vice-President/Secretary of the Medical Staff
C. The Chief of Medical Staff
D. The Associate Chief of Medical Staff

Section 2. Qualifications of Officers

Officers shall be members of the Active Staff at the time of nomination and election, or appointment and approval, and must maintain such status in good standing during this term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 3. Nomination of Officers

A. Candidates for the offices of President of the Medical Staff and of Vice-President/Secretary of the Medical Staff shall be nominated by the following:

1. A nominating committee appointed by the incumbent President which shall offer one or more nominees and whose membership shall consist of five members of the Active Staff and shall adhere to the following:
2. At least three Clinical Services shall be represented, one of which shall be a Dental Clinical Service;
3. One member shall represent the Medical Board; and
4. No member shall be an incumbent officer of the Medical Staff.
5. Additional candidates may be nominated by a petition signed by at least 20 members of the Active Staff representing at least three Clinical Services, and filed with the incumbent President at least 15 days prior to the annual meeting.

B. The names of all nominees and appointees for office in the Medical Staff shall be announced by the President at least 10 days prior to the annual meeting. The announcement shall be made by written notice to each member of the Active Staff.

Section 4. Election of the President and Vice-President/Secretary

A. The President and Vice-President/Secretary shall be elected at the annual meeting of the Medical Staff. Voting shall be restricted to members of the Active Staff, shall be presided over by the Chief of Medical Staff, and shall be conducted by secret ballot. Ballots listing alphabetically the names of all nominees by office shall be distributed, collected and counted by the Associate Chief of Medical Staff, assisted by two other members of the Staff. Prior to the collection of ballots, there shall be appropriate discussion in which any member of the Medical Staff may participate and during which the nominees may be asked to leave the room.

B. When there are three or more candidates for office, none of whom receives a majority of the total number of votes cast, then that nominee receiving the fewest number of votes will be considered eliminated from candidacy. Successive balloting, such that the nominee receiving the fewest number of votes is eliminated from candidacy, shall be conducted until a majority vote is cast for one nominee.

C. When two nominees receive equal numbers of votes and either election or elimination from candidacy is at issue, then successive balloting shall be conducted until the deadlock is broken.

Section 5. Appointment of the Chief of Medical Staff and Associate Chief of Medical Staff

Appointments to the offices of Chief of Medical Staff and Associate Chief of Medical Staff shall be made by the Medical and Dental Deans respectively with the concurrence of the Hospital CEO. The Chief of Medical Staff must be a medical doctor (M.D.) or doctor of osteopathy (D.O.).

Section 6. Terms of Office/Removal From Office

A. The President and Vice-President/Secretary shall serve a one-year term, commencing on the first day of the month following the annual meeting of the Medical Staff. The President and/or Vice President/Secretary may be removed from office at any time by a majority vote of a quorum consisting of one-third of the Medical Staff.

B. The Chief of Medical Staff and Associate Chief of Medical Staff shall serve so long as continuation of either officer in her or her office is deemed desirable by those responsible for making and approving such appointments.

C. Medical Staff officers may be removed from office at any time for conduct detrimental to the interests of the hospital or if suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of office, providing notice of the meeting at which such action takes place has been given in writing to such officer at least ten days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his/her own behalf prior to taking of any vote on his/her removal.

D. The Chief of Medical Staff and/or Associate Chief of Medical Staff may be removed from office at any time by the appropriate Dean or by a two-thirds vote of the Clinical Chiefs with the concurrence of the Hospital CEO in both cases.

Section 7. Vacancies in Office

A. Should a vacancy arise in the Office of President of the Medical Staff, the Vice-President/Secretary shall serve out the remaining term or until a special vote to elect a new President is called by the Chief of Medical Staff at the request of a majority of the Medical Board.

B. Should a vacancy arise in the office of Chief of Medical Staff or in the office of Associate Chief of Medical Staff, then the appropriate Dean shall appoint a successor within thirty (30) days after such vacancy arises.

Section 8. Duties of Officers

A. The President of the Medical Staff shall:

1. Call and preside at all regular and special meetings of the general Medical Staff.
2. Be responsible for the coordination and cooperation of members of the Medical Staff with the Hospital CEO in all matters of mutual concern to the Medical Staff and the management of the Hospital.
3. Be responsible for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

B. The Vice-President/Secretary of the Medical Staff shall:

1. Assume all duties and responsibilities of the President of the Medical Staff in that officer's absence, including serving out the remaining term of the President, should a vacancy arise in that office as provided in sub-paragraph A of Section 7 above.
2. Serve as a regular voting member of the Medical Board.
3. Be responsible for correspondence of the Medical Staff and for minutes of all meetings of the Medical Staff.

C. The Chief of Medical Staff shall:

1. Call, preside at and be responsible for the agenda of all regular and special meetings of the Medical Board.

2. Act on behalf of the Medical Dean or the Associate Dean for Clinical Affairs, in the day-to-day administration and coordination of the professional care activities of the members of the Medical Staff on the inpatient services of the Hospital.
3. Receive from the Vice President the policies of the Governing Board, transmit such policies to the members of the Medical Staff, and take appropriate steps to insure implementation of such policies.
4. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and for the implementation of sanctions where these are indicated.
5. Appoint committee members to all standing and multi-disciplinary Medical Staff committees in consultation with the Hospital CEO, the Associate Chief of Medical Staff and the President of the Medical Staff, subject to the approval of the Medical Board.
6. Represent along with the President of the Medical Staff the views, policies, needs and grievances of physician members of the Medical Staff to the Hospital CEO.
7. Implement among members of the Medical Staff the policies of the Governing Board and of the Medical Board, insofar as such policies pertain to the inpatient services of the Hospital.

D. The Associate Chief of Medical Staff shall**:**

1. Call, preside at and be responsible for the agenda of all meetings of the Medical Board in the Chief of Medical Staff's absence.
2. Act on behalf of the Dental Dean in the day-to-day administration and coordination of the professional care activities of dentist members of the Medical Staff on the inpatient services of the Hospital.
3. Assist the Chief of Medical Staff in enforcing the Medical Staff Bylaws, Rules and Regulations, in implementing sanctions where these are indicated, and in ensuring the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested, especially as regards dentist members of the Medical Staff.
4. Serve as a regular voting member of the Medical Board and as a regular voting member of the Clinical Affairs/Joint Conference Committee.
5. Make recommendations to the Chief of Medical Staff concerning all appointments of dentist members of the Medical Staff to standing, special and multidisciplinary Medical Staff committees.
6. Represent along with the President of the Medical Staff the views, policies, needs and grievances of dentist members of the Medical Staff to the Hospital CEO.
7. Assist the Chief of Medical Staff in implementing among dentist members of the Medical Staff the policies of the Governing Board and of the Medical Board, insofar as such policies pertain to the inpatient services of the Hospital.

ARTICLE XI. CLINICAL SERVICES

Section 1. Services

Clinical Services of the Medical Staff shall include:

A. Anatomic Pathology
B. Anesthesiology
C. Dentistry
D. Dermatology
E. Diagnostic Imaging and Therapeutics
F. Emergency Medicine
G. Family Medicine
H. Laboratory Medicine
I. Medicine
J. Neurology
K. Obstetrics and Gynecology
L. Orthopaedics
M. Pediatrics
N. Psychiatry
O. Surgery

Section 2. Organization of Clinical Services

Each Service shall be organized as a division of the Medical Staff as a whole. The Chief of Service shall be responsible for the overall supervision of clinical work within his or her Service and shall be responsible to the Medical Board for the functioning of that Service.

Section 3. The Chief of Service

A. Each Chief of Service shall be a member of the Active Medical Staff qualified by training, experience and demonstrated ability for the position.

B. The Chief of a Clinical Service of the Medical Staff shall be either that person appointed by the Governing Board on the recommendation of the appropriate Dean of the corresponding University Department or that person appointed by the Governing Board on the recommendation of the appropriate Department Head with the approval of the Medical Board. The Hospital CEO shall approve recommendations for appointments as Chief of Service. In the event of unsatisfactory performance, the Hospital CEO is empowered to recommend removal to the Medical Board.

C. Recommendations to the Governing Board to appoint a Chief of Service other than Chair of the corresponding University Department, shall be subject to the approval of a two-thirds majority of the Clinical Chiefs; ordinarily, the vote of approval shall be conducted at a regular meeting of the Medical Board; and shall be by secret ballot. Ballots shall be distributed, collected, and counted by the Chief of Medical Staff. Failure to approve on the first ballot shall result in a second ballot if desired by the appropriate Department Head; failure to gain approval on the second ballot shall eliminate the appointee from candidacy. The Department Head may thereupon immediately offer another appointee for approval, or he or she may delay appointment until the next regular meeting of the Medical Board. If an appointee to the position of Chief of Service is not approved, then such position shall be considered vacant until such time as a successor is appointed and approved.

D. Each Chief of Service shall serve so long as his or her continuation is deemed desirable by those responsible for making and approving such appointments and so long as his or her membership on the Active Medical Staff is maintained (as set forth in Article VIII of these Bylaws).

1. If a Chief of Service is also Head of the corresponding University Department, such Chief may be removed from his or her position at any time by the appropriate Dean.

2. If a Chief of Service is someone other than the Head of the corresponding University Department, such Chief may be removed from his or her position at any time either by the Dean, the appropriate Department Head or by a two-thirds vote of the Clinical Chiefs with the concurrence of the Hospital CEO in all cases.

E. Should a vacancy arise in a Chief of Service position wherein the Chief of Service is the Head of the corresponding University Department, then the person designated to fill the corresponding University Department Head position shall act as Chief of Service. Such designation does not require Medical Board approval.

F. Each Chief of Service shall:

1. Be responsible for the conduct of all professional and clinically-related activities carried out by members of his or her Clinical Service and for medical-administrative related activities when no Medical Director is appointed.
2. Ensure continuing review of the professional performance of all practitioners with clinical privileges on his or her Service.
3. Be responsible for ensuring orientation of the Medical Staff Bylaws and the relevant electronic clinical systems needed to provide and document care.
4. Be responsible for enforcement of the Medical Staff Bylaws, Rules and Regulations within his or her Clinical Service.
5. Be responsible for implementation within his or her Service of actions taken by the Medical Board.
6. Be responsible for organizing and monitoring the continuing education program for their service, to include the establishment of criteria for reappraisal of staff members.
7. Assure that each member of the service is subject to the peer review activities of the department and the medical staff as a whole.
8. Transmit to the Medical Board recommendations concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his or her Service.
9. Participate in every phase of administration of his or her Service through cooperation with the management and other Services of the Medical Staff in matters affecting patient care, including personnel, space and resource recommendations, supplies, special regulations, standing orders and techniques. If a Medical Director is appointed within the Service, The Chief of Service and Medical Director will collaborate for these responsibilities in that area.
10. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her Clinical Service, as may be required by the Medical Board, by the Hospital CEO, by the Medical and Dental Dean, by the Vice President or the Governing Board.
11. Shall appoint an acting Chief of Service during any period of unavailability and shall notify the hospital operator of this appointment.
12. Shall act as Collaborating Physician for members of Advanced Practice Nursing Staff in the department, or designate collaborating physicians in collaboration with APRNs.

Section 4. Functions of Clinical Services

A. Each Clinical Service shall establish criteria consistent with the policies of the Medical Staff and of the Governing Board for the granting of clinical privileges. Such criteria must be approved by the Medical Board.

B. Each Clinical Service shall establish a Quality Improvement Committee responsible for conducting primary prospective and retrospective reviews of the records of discharged patients (and other pertinent sources of medical information relating to the patient care) and monitoring and participating in performance improvement activities for the purposes of selecting cases that will contribute to the process of developing criteria to assure optimal patient care. Such reviews shall be conducted monthly, shall be documented and should include a consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the care of the Service with unsolved problems.

Section 5. Division Chiefs/Medical Directors

A. A Division Chief shall be a member of the Active or Affiliated Staff appointed by the Service Chief to support and assist the Service Chief.

B. A Medical Director shall be a member of the Active Staff qualified by training, experience and demonstrated ability for the position.

C. The Medical Director for a hospital unit or hospital function (as defined by the Hospital CEO) shall be a member of the Active Staff appointed jointly by the Hospital CEO and Chief of Medical Staff, after consultation with the academic Department Chair, if applicable.

D. Medical Directors are appointed as needed to provide medical-administrative oversight for clinical programs or departments as needed to meet regulatory or licensure requirements, or to collaborate with organizational staff to ensure proper functioning of the unit. This is an administrative position and does not include the responsibility for direct patient care.

ARTICLE XII. COMMITTEES

Section 1. Primary Committees

A. General

The Clinical Affairs Subcommittee and the Medical Board function in some of their activities as a Medical Review Committee conducting peer review as defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time. When acting as a Medical Review Committee, the Board reviews and acts on recommendations from committees of the hospital or medical staff engaged in peer review and participates in the evaluation of the quality and efficiency of health services ordered and performed, including but not limited to review of the credentials, qualifications and activities of medical staff members or applicants; evaluating and improving the quality of health care services rendered; analyzing clinical practices within the hospital; reviewing studies of utilization and medical audits; reviewing studies of morbidity and mortality; and reviewing analyses of sentinel events or potential claims. When the Clinical Affairs Subcommittee, or its members, participates in these or similar studies, reviews, discussions and actions, it is a Medical Review Committee conducting peer review. It shall also be intended and understood that in order to properly and effectively carry out peer review activities, these medical review committees may from time to time require the assistance of others, including subcommittees, department chairs, service or division chiefs, committee and subcommittee chairs, officers of the Medical Staff, the Chief of Medical Staff, and other individuals, and outside experts and consultants, and it shall be expressly intended that when such other groups and individuals are engaged by a medical review committee to assist in a peer review function, such others are part of the proceedings of such medical review committees for the purpose of performing peer review. Proceedings of such peer review activities conducted by the Clinical Affairs Subcommittee, including data and information gathering and analyses and reporting by authorized individuals for the primary purpose of these peer review activities, as well as minutes and other documents from meetings or portions of meetings addressing peer review, shall be kept strictly confidential.

B. The Clinical Affairs Subcommittee

1. Composition: The Clinical Affairs Subcommittee shall consist of at least five (5) from the Board of Directors and five (5) from the Medical Staff. Three (3) of the five (5) voting members of the Medical Staff will be from the Medical Board. Of the remaining two (2) voting members, one (1) will be appointed by the School of Dental Medicine and one (1) will be appointed by the governing body of UConn Medical Group.

2. Term: Medical Staff members may serve a three-year term, renewable.

3. Vacant Seats: Vacant Seat from Medical Board: One (1) vacant seat will require the nomination of three (3) members of the Medical Board from which the Chair of the Clinical Affairs Subcommittee will select one (1) member. Two (2) vacant seats will require the nomination of four (4) members of the Medical Board from which the Chair of the Clinical Affairs Subcommittee will select two (2) members. Three (3) vacant seats will require the nomination of five (5) members of the Medical Board from which the Chair of the Clinical Affairs Subcommittee will select three (3) members.

   Vacant Seat from the School of Dental Medicine: A vacant seat requires the School of Dental Medicine to appoint a new member.

   Vacant Seat from the governing body of UConn Medical Group: A vacant seat requires the governing body of UConn Medical Group to appoint a new member.

4. Duties: The Clinical Affairs Subcommittee shall concern itself with matters of Medical Staff policy and practice, especially those pertaining to programs in patient care; it shall serve as the official point of contact between the Board of Directors, the Hospital CEO and the Medical Staff. It shall also have the following specific duties:

a. Accreditation. It shall be responsible for making recommendations to the Board of Directors regarding acquisition and maintenance of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation for which purpose it may call on key University, Health Center and Hospital personnel who are important in implementing the accreditation program. It shall identify areas of suspected non-compliance with JCAHO standards and shall make recommendations to the Medical Board and to the Board of Directors for appropriate action.
b. Safety and Disaster Planning. It shall be responsible for assuring that there will be development and maintenance of methods of the protection and care of Hospital patients and others at the time of internal and external disaster.
c. Performance Improvement. It shall be responsible for reviewing organizational performance improvement activities. It shall make appropriate recommendations for policy changes, resolution of problems, and identify opportunities for improvement in patient care.

C. Peer Review Committee

Composition: The Peer Review Committee shall consist of the same members of the Clinical Affairs Subcommittee and shall conduct peer review as defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time.

D. The Medical Board

1. Composition: The voting members of the Medical Board shall consist of the Chief of Medical Staff, the Associate Chief of Medical Staff, the President and the Vice-President/Secretary of the Medical Staff, and the Chiefs of the following Clinical Services: Anatomical Pathology, Anesthesiology, Dentistry, Dermatology, Emergency Medicine, Family Medicine, Laboratory Medicine, Medicine, Neurology, Diagnostic Imaging and Therapeutics, Obstetrics and Gynecology, Orthopaedics, Pediatrics, Psychiatry and Surgery Services; one at large member of Dental Clinical Services in addition to five representatives of the Medical Staff elected at large by the total voting Medical Staff at the annual meeting. The Associate Dean for Clinical Affairs**,** Hospital Chief Executive Officer or designee, Hospital Chief Operating Officer**,** and the Hospital Chief Nursing Officer shall be included as non-voting ex-officio members.

2. Duties: The duties of the Medical Board shall be:

a. To represent and act on behalf of the Medical Staff, in the intervals between medical staff meetings, in matters which concern physician and dentist members thereof, subject to such limitations as may be imposed by these Bylaws.
b. To coordinate and implement the professional and organizational activities and policies of the clinical services and medical staff.
c. To receive and act upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups and make recommendations concerning them to the Clinical Affairs/Joint Conference Committee or the Board of Directors.
d. To participate in the development of medical staff and hospital policy, practice, and planning.
e. To provide liaison between the members of the Medical Staff and Hospital management, and through the Clinical Affairs/Joint Conference Committee between the Medical Staff and Governing Board.
f. To recommend action to the Hospital CEO on matters of a medical-administrative nature, including review and comment on the Hospital budget.
g. To ensure that members of the Medical Staff are kept abreast of the accreditation program and informed of the accreditation status of the Hospital.
h. To establish the structure of the medical staff, the mechanism to review credentials and delineate clinical privileges, assessment of medical staff organizational improvement activities, termination of medical staff membership and fair hearing procedures, as well as matters relevant to the operation of an organized self-governing medical staff.
i. To review the findings and recommendations of the Credentials Committee and make recommendations to the Clinical Affairs Subcommittee regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action.
j. To take all reasonable steps to promote professionally ethical conduct and competent clinical performance of the part of members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

k. To develop the agenda for Medical Staff meetings.
l. To define and charge all standing and special committees of the Medical Staff not otherwise defined and charged in these Bylaws and to make recommendations to the Chief of Medical Staff concerning appointment of individual Medical Staff members to such committees.
m. To maintain compliance with policies and procedures of Health Center Institution Review Board.
n. To evaluate the medical care rendered to patients in the hospital.
o. To review the quality and appropriateness of services provided by contract practitioners**,** as well as services to be provided through telemedicine.
p. To establish systems to monitor the accuracy, confidentiality, and availability of organizational improvement, utilization review, peer review (quality and efficiency of services ordered or performed by health care professionals, clinical practice analyses), and all medical staff paperwork.

3. Meetings: The Medical Board shall meet nine to twelve times annually and maintain a permanent record of its proceedings and action. The agenda and minutes shall be circulated to the members of the Medical Board, Medical and Dental Deans, and Associate Dean for Clinical Affairs. Development of the agenda will be the responsibility of the Chief of Medical Staff, although any member of the Medical Board may include specific items at any time. A quorum for any meeting will be the voting members present, but shall not be less than seven (7) voting members of the Medical Board. In the event a practitioner is holding two positions of membership, his/her positions and vote shall be counted as one. All business will be transacted according to Robert's Rules of Order, Newly Revised.

4. At-large members will be nominated in the same manner as the President and Vice-President of the Medical Staff and will serve a one-year term.

5. Removal of Authority to Represent Medical Staff: In the event that the Medical Staff is concerned that the Medical Board is not representing its best interest, the Medical Staff has the right to revoke the authority of the Medical Board to act on its behalf either for a single issue or entirely. To initiate such an action, a special meeting of the Medical Staff will be convened in accordance with Article XIII of the Bylaws, at which time only Active Staff shall be eligible to vote. The Medical Board's authority shall be considered revoked if the vote is approved by a two-thirds majority of the Active Staff.

6. Removal from Medical Board Member for Cause: The Chief of Medical Staff and Associate Chief of Medical Staff may be removed from the Medical Board only by the appropriate Dean with the concurrence of the Hospital CEO. The President, Vice President/Secretary and At-Large Members may be removed by a majority vote at a convened special meeting of the Medical Staff in accordance with Article XIII of the Bylaws. A Chief of Service may be removed from the Medical Board only if his/her Chief of Service appointment is terminated. Ex-officio non-voting members may be removed from the Medical Board only if his/her appointment is terminated.

Section 2. Other Medical Staff Committees

A. General

1. Chairs and members of standing Medical Staff committees shall be appointed annually by the Chief of Medical Staff, with the concurrence of Hospital Administration, in accordance with established committee composition as set forth in this Article XII. All appointed Chairs shall be members of the Medical Staff and may be reappointed with no limitation in the number of terms they serve. An individual other than a member of the Medical Staff may be appointed Chair, by virtue of best qualifications, if recommended by the Chief of Medical Staff and approved by majority vote of the Medical Board.
2. The Associate Dean for Clinical Affairs**,** and Chief of Medical Staff, or their designees, may serve as ex officio members of any standing committee. All standing committees shall be advisory to the Medical Board.
3. The following Medical Staff Committees are Medical Review Committees conducting peer review as defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time: Credentials Committee, Pharmacy, Therapeutics, and Medication Safety Committee, Transfusion Committee, department committees and other structures within the departments, services or sections of the Medical Staff that engage in peer review activities, and

other subcommittees or subgroups formed by any one of the above. These Medical Review Committees have been established for the purpose of conducting peer review which shall include evaluating the quality and efficiency of services ordered or performed by health care professionals, performing practice analyses, conducting inpatient hospital and extended care facility utilization reviews, conducting medical audits, and performing ambulatory care reviews, and claims reviews. It shall be intended and understood that when performing these activities, these medical review committees shall, among other things, gather and review information relating to the care and treatment of patients for the purpose of evaluating and improving the quality of health care rendered, reducing morbidity or mortality, or establishing guidelines to keep within reasonable bounds the cost of health care. It shall also be intended and understood that in order to properly and effectively carry out peer review activities, these medical review committees may from time to time require the assistance of others, including subcommittees, department chairs, service or division chiefs, committee and subcommittee chairs, officers of the Medical Staff, the Chief of Medical Staff, and other individuals, and outside experts and consultants, and it shall be expressly intended that when such other groups and individuals are engaged by a medical review committee to assist in a peer review function, such others are part of the proceedings of such medical review committees for the purpose of performing peer review.

4. The proceedings of all Medical Review Committees, including data and information gathering and analysis and reporting by authorized individuals for the primary purpose of peer review activities, as well as minutes and other documents from meetings, shall be kept strictly confidential.
5. A quorum for any meeting will be a majority of the total voting members.

B. Pharmacy, Therapeutics, and Medication Safety Committee

1. Composition: The Pharmacy, Therapeutics, and Medication Safety Committee shall consist of, insofar as possible, representatives from the medical staff, pharmacy service, nursing service and hospital administration.
2. Duties: The Pharmacy, Therapeutics, and Medication Safety Committee shall: assist in the evaluation and formulation of professional practices and policies regarding the appraisal, selection, procurement, storage, distribution and administration of medications; review adverse drug events; perform ongoing review of the hospital formulary; and recommend policies, procedures, and practices to reduce errors in the medication process.
3. Meetings: The Pharmacy, Therapeutics, and Medication Safety Committee shall meet as often as necessary at the call of its chair, but at least once every two months. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

C. Credentials Committee

1. Composition: The Credentials Committee shall consist of, insofar as possible, not less than five members of the active medical staff selected on a basis that will ensure representation of major clinical specialties, medical staff clinical services, and hospital administration.
2. Duties: The Credentials Committee shall: evaluate the qualifications of each practitioner applying for initial appointment, reappointment, clinical privileges, or modification of clinical privileges, and in connection therewith, obtain and consider the recommendations of the appropriate Chief of Service.
3. Meetings: The Credentials Committee shall meet as often as necessary at the call of its chair, but at least once every two months. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

D. Medical Ethics Committee

1. Composition: The Medical Ethics Committee shall consist of, insofar as possible, representatives from the departments of medicine, surgery, ICU nursing service, legal, research, risk management, patient relations, and hospital administration.
2. Duties: The Medical Ethics Committee shall: serve in a consultative role in three areas: education, policy review, and case consultation. It will respond to requests for help from all staff members, patients or families when ethical dilemmas relating to medical issues arise.
3. Meetings: The Medical Ethics Committee shall meet as often as necessary at the call of its chair. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

E. Cancer Committee

1. Composition: The Cancer Committee shall consist of, insofar as possible, representatives from medical oncology, nursing, general surgery, pathology, diagnostic imaging, radiation oncology, otolaryngology, pharmacy, gastroenterology, urology, gynecology, cancer registry, nutritional services, performance improvement/quality assurance, social services, palliative care, and hospital administration. The Chair shall be appointed by the Chief of Medical Staff. There shall be a Physician Liaison with the American College of Surgeons appointed by the Chair.
2. Duties: The Cancer Committee shall: provide leadership as well as plan, initiate, stimulate and assess cancer related activity in accordance with the standards and responsibilities set forth through the Standards of the Commission on Cancer (current volume), Cancer Program Standards (i.e., cancer registry, annual report, cancer conferences.) Additionally, the Cancer Committee shall: conduct performance improvement and outcome studies; identify opportunities for improvement and recommend changes as needed; evaluate the need, methodology, and effectiveness of educational, preventative programs, detection, screening, and treatment programs; organize and coordinate information about and access to new services that are available, research protocols open for enrollment, patient accrual status, and other activities relevant to the care of cancer patients.
3. Meetings: The Cancer Committee shall meet quarterly or more often as necessary at the call of its chair with the concurrence of a majority of the committee members. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

F. Operating Room Committee

1. Composition: The Operating Room Committee shall consist of, insofar as possible, the Medical Director of the OR, and representatives from oral surgery, anesthesiology, orthopaedics, medicine, nursing service, and hospital administration.
2. Duties: The Operating Room Committee shall: advise on policies in the operating rooms and surgical procedure areas with particular reference to relationships among the services, use of equipment and facilities, surgical staff and hospital administration; review minutes of the OR Quality Committee and Comparative Effectiveness Committee to help direct the formation of policy and procedure toward providing optimum quality of care; and advise the Hospital CEO and Chief of Medical Staff on matters which cross surgical disciplines elsewhere within the Hospital to include activities in the Emergency Room, Intensive Care Units, designated surgical floors, surgical participation in resuscitation efforts, and other areas where policy and procedure may affect multiple departments.
3. Meetings: The Operating Room Committee shall meet as often as necessary at the call of its chair. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

G. Transfusion Committee

1. Composition: The Transfusion Committee shall consist of, insofar as possible, the Medical Director of the Blood Bank, and representatives from medicine, pediatrics, maternal fetal medicine, nursing, anesthesiology, surgery, obstetrics/gynecology, hematology/oncology, and hospital administration. A Resident from medicine and surgery will also be appointed to the committee as non-voting members and will serve one-year terms.
2. Duties: The Transfusion Committee shall: evaluate the appropriateness of blood and blood product transfusions; to assist in the development of policies and procedures for the screening, distribution, handling and administration of blood and blood components.
3. Meetings: The Transfusion Committee shall meet at least six times per year or more often as necessary at the call of its chair. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Board.

H. Utilization Management Committee

4. Composition: The Utilization Management Committee will be comprised of at least three (3) representative members from the specialties and sub-specialties of the medical staff as deemed appropriated. Providers from any specialty may be invited to the meetings as needed. Selected Physician Advisor(s) will also be members and the chairperson will be appointed by the Chief of Medical Staff with approval by the Chief Executive Officer. Non-physician members

may include representative from Finance, Nursing, Care Coordination, and/or Clinical Effectiveness and Patient Safety. Other participants will be invited as needed.

5. Duties: Establish and carry out the Utilization Management Plan in accordance with applicable state, federal and payer rules and requirements; Provide an annual review, evaluation and approval of the UR Plan; Oversee Utilization Management activities and make every effort to coordinate the patient's utilization requirements, health insurance coverage, acute hospital needs, and post-discharge needs for a maximum benefit for the patient; Adopt, develop, and/or modify standardized review criteria as appropriate, (i.e., InterQual); Conduct and analyze utilization review studies and other data designed to evaluate the appropriateness of hospital admissions and necessity of continued stay, lengths of stay, discharge practices and appropriate use of medical and hospital services and related factors which may contribute to the effective utilization of services; Identify utilization problems and recommend appropriate changes in procedures and Medical Staff practices which will results in more efficient utilization of services and resources; Review denied admissions and days of care or denied costs due to lack of medical necessity; Refer individual cases, where there is concern the quality of patient care has been compromised to the appropriated hospital or Medical Staff department; Assist in review activities performed by outside agencies as necessary and provide education regarding third party appeals in order to avoid denials.
6. Meetings: The Utilization Management Committee shall meet no less than once every two months.

Section 3. Committee Membership Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Chief of Medical Staff and approved by the Medical Board.

ARTICLE XIII. MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

Medical Staff meetings shall be held annually. The agenda of each meeting shall be developed by the President of the Medical Staff or upon the written call of at least 12 voting members of the Medical Staff and shall include reports of review and evaluation of the work done in the Clinical Services and their performance of the required Medical Staff functions. All business shall be transacted according to Robert's Rules of Order, Newly Revised.

Section 2. Special Meetings

A. The President of the Medical Staff may call a special meeting of the Medical Staff at any time, and shall call such meeting at his or her initiation within 15 days after receipt by him or her of a written request for same signed by not less than 25 members of the Active Staff and stating the purpose for such meeting.

B. The procedure for calling a special meeting shall be as follows:

C. Upon receipt of an appropriate written request as described above, the President of the Medical Staff shall at the earliest opportunity inform the members of the Medical Board of the receipt of such request and the stated purpose thereof, and shall seek the Medical Board's advice as to designating the time and place of such meeting within three days after the receipt of such appropriate written request as described above. The President of the Medical Staff shall notify in writing all members of the Medical Board as to the time, place, purpose and agenda of such meeting; within five days of being so informed, the Chiefs of Clinical Services shall be responsible for ensuring that such information is disseminated to every member of the Active and Affiliated Medical Staff assigned to their respective Services.

D. No business shall be transacted at any special meeting except that stated in the notice calling the meeting, and all business shall be transacted according to Robert's Rules of Order, Newly Revised, except when indicated otherwise in these Bylaws, as in Article XIV, Section 6., Rights of Ex-Officio Members.

Section 3. Quorum

The presence of a majority of the active membership of the Medical Staff at any regular or special meeting shall constitute a quorum for purposes of election of officers of the Medical Staff, and for all other actions, including amendment of these Bylaws and Rules and Regulations. Upon request, the Medical Staff Services Office shall make available an absentee ballot to those unable to attend.

Section 4. Attendance Requirements

Each member of the Active Medical Staff shall be required to attend the regular meeting of the Medical Staff. A member who is compelled to be absent shall promptly submit to the President of the Medical Staff, in writing, his or her reason for such absence. Unless excused for cause by the Medical Board said Board shall consider this grounds for corrective action leading to revocation of Medical Staff membership. Reinstatement of Medical Staff members whose memberships have been revoked because of absence from such meetings shall be made only upon application, and all such applications shall be processed in the same manner as application for initial appointment.

ARTICLE XIV. COMMITTEE AND CLINICAL SERVICE MEETINGS

Section 1. Regular Meetings

A. Committees: Members of committees may prescribe among themselves the time of regular meetings with no other notice necessary.

B. Clinical Services will hold regular meetings at least nine to twelve times annually to review and evaluate the clinical work of practitioners with privileges in the Clinical Services.

Section 2. Special Meetings

A special meeting of any committee or Clinical Service may be called by the chairperson or Chief of Service thereof, or by the Chief of Medical Staff, the committee chairperson or Chief of Service shall be required to call such a special meeting at the written request of one-third of the group's then members, but not less than two members.

Section 3. Notice of Meetings

Written or verbal notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to prescription shall be given to each member of the committee or Clinical Service not less than two days prior to the day of such meeting by the person calling the meeting.

Section 4. Quorum

A majority of the Active Medical Staff members of a committee or Clinical Service, but not less than two such members, shall constitute a quorum at any meeting.

Section 5. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or Clinical Service. Action may be taken without a meeting by unanimous consent in writing to such action signed by each member entitled to vote thereon.

Section 6. Rights of Ex-Officio Members

Ex-officio members, or members who serve by virtue of their office, shall only be eligible to serve during the time they hold such office. Persons serving under these Bylaws as ex-officio members of a committee shall, subject to such specific provision and constraints as imposed elsewhere in these Bylaws, have all rights and privileges of regular members except that, unlike Robert’s Rules of Order, they shall not be counted in determining the existence of a quorum nor do they have voting rights.

Section 7. Minutes

A. Minutes of each regular and special meeting of a committee or Clinical Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be reviewed, approved and signed by the presiding officer and copies thereof shall be provided to committee or Service members.

B. Signed copies of the minutes of each regular and special meeting of any committee or Clinical Service of the Medical Staff shall be promptly forwarded to the administrative support (Medical Staff Services Office) for the Medical Board for distribution and filing.

C. Each committee and Clinical Service shall maintain a permanent file of the minutes of each meeting.

Section 8. Attendance Requirements

Each member of the Active Medical Staff shall be required to attend not less than fifty per cent of all meetings of each Clinical Service and committee of which he or she is a member in each year. Failure to meet the foregoing attendance requirements, unless excused by such Service Chief or committee chairperson for good cause shown, may be grounds for corrective action, leading to removal from such Service or committee or to revocation of Medical Staff membership in the same manner and to the same effect as provided in Article XII, Section 4, of these Bylaws. Committee chairpersons and Service Chiefs shall communicate all requests for such corrective action through the Chief of Medical Staff to the Medical Board.

ARTICLE XV. IMMUNITY FROM LIABILITY

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

A. Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of the an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent of the law.

B. Such privilege shall extend to members of the Hospital's Medical Staff, to officers of the University administration, to the Governing Board, to other practitioners, to the Hospital CEO and his or her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article XV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Board or of the Medical Staff.

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

D. Immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

1. Application for faculty or Medical Staff appointments or clinical privileges;
2. Periodic reappraisals for faculty or Medical Staff reappointment or clinical privileges;
3. Corrective action, including summary suspension;
4. Hearings and appellate reviews;
5. Medical care evaluation;
6. Performance improvement;
7. Utilization reviews; and
8. Other faculty, Medical Staff, Hospital, Clinical Service or committee activities related to quality patient care and inter-professional conduct.

E. Acts, communications, reports, recommendations and disclosures referred to in this Article XV may relate to a practitioner's academic and professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

F. Each practitioner shall upon request of the Hospital, its Medical Staff or its Governing Board execute releases in accordance with the tenor and import of this Article XV, in favor of the individuals and organizations specified in paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Connecticut.

G. Consents, authorizations, releases, rights, privileges and immunities provided by Articles VII and Article VIII of these Bylaws for the protection of this hospital's practitioners, other appropriate representatives of the Hospital and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XV.

ARTICLE XVI. RULES AND REGULATIONS

Section 1. The Medical Staff Rules and Regulations

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting of the Medical Staff at which a quorum is present and without previous notice, or with appropriate notice at any special meeting at which a quorum is present, by a two-thirds vote of those present of the Active Staff, or by majority vote of the total Medical Board. Such changes shall become effective when approved by the Governing Board.

ARTICLE XVII. AMENDMENTS TO THESE BYLAWS

When necessary, the Medical Staff Bylaws, including the Rules and Regulations, as well as Medical Staff policies, shall be revised to reflect the hospital's current practices with respect to medical staff organization and functions. Proposals to amend these shall be submitted to the Medical Board.

Proposed amendments to the Bylaws and Rules and Regulations receiving Medical Board approval (majority vote) shall then be presented to the Medical Staff and the Governing Board. Amendments so made shall be effective when approved by the Medical Staff and the Governing Board. Neither the Medical Board nor the Governing Body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Notification of Bylaws amendments and revised texts of written material shall be provided to the entire Active Staff no less frequently than at the annual Medical Staff meeting.

Medical Staff policies require the approval of the Medical Board only. Medical Staff policies specific to the organization and administration of the Medical Staff are maintained in the Medical Staff Office Policy and Procedure Manual or Hospital Administration Manual.

If there is an urgent need to amend the Bylaws in order to comply with a law or regulation, the Medical Staff shall delegate to the Medical Board the authority to provisionally adopt, and the governing body to provisionally approve, an urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Board. The Medical Staff shall have the opportunity for retrospective review and comment on the provisional amendment and if there is no conflict between the Medical Staff and the Medical Board, the provisional amendment shall stand. If there is a conflict between the Medical Staff and the Medical Board over the provisional amendment, a revised amendment shall be submitted to the Governing Board.

In the event of a public health and/or civil preparedness emergency declared pursuant to Connecticut or federal law, the Chief of Medical Staff or his/her delegate may suspend any applicable Bylaws for the duration of the public health or civil preparedness emergency in order to comply with or utilize any orders, declarations, regulations, or guidance issued by a government entity. The Chief of Medical Staff or his/her delegate shall notify the Medical Board of such action.

ARTICLE XVIII. CORRECTIVE ACTION

Section 1. Procedure

A. Any practitioner who violates any section of these Bylaws or Rules and Regulations may be subject to corrective action. It is considered a violation of these bylaws to reveal or otherwise allow to be made known information protected by any applicable federal or state rule or regulation pertaining to such matters including, but not limited to peer review, quality assurance, and practitioner information.

B. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such practitioner may be requested by the Chief of any Clinical Service, by the Chief of Medical Staff, by the chairman of any standing committee of the Medical Staff, by the Hospital CEO, by either Dean, by the Associate Dean for Clinical Affairs, by the Vice President, or by the Clinical Affairs Subcommittee. All requests for corrective action shall be in writing, shall be made to the Chief of Medical Staff as Chair of the Medical Board, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Medical Staff shall promptly notify all members of the Medical Board of all requests for corrective action received.

C. If the Chief of Medical Staff determines that the corrective action could be a reduction or suspension of clinical privileges, he/she shall convene a meeting of the Medical Board to confirm that such a possibility exists, and if so, the Medical Board shall direct the Chief of Service wherein the practitioner has such privileges to appoint an *ad hoc* investigation committee. Upon receipt of such request, the Chief of Service shall immediately appoint an *ad hoc* committee of peers to investigate the matter and report back to a convened meeting of the Medical Board within twenty (20) working days. The ad hoc committee shall consist of at least three practitioners, excluding the Chief of Service, of similar training and specialty as the practitioner under investigation. The ad hoc committee shall conduct an investigation of the practitioner in relation to the request for corrective action and provide a written report with recommendations to the Chief of Service. Prior to the making of such a report, the practitioner against whom corrective action has been requested shall be informed of the charges in writing and in a manner in which receipt can be verified (i.e., email or U.S. mail service) and shall have an opportunity for an interview with the ad hoc investigating committee. At this interview, the practitioner shall be allowed to discuss, explain or refute all charges. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the committee and included with the report to the Chief of Service. The Chief of Service will report to a convened meeting of the Medical Board and will include all relevant information pertaining to the practitioner and the ad hoc committee's findings including the practitioner's interview with the ad hoc committee, if applicable. In responding to corrective action requests, the Medical Board may recommend to reject or modify such request, to issue a warning, a letter of admonition or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended or revoked. If the recommended action involves a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Medical Board prior to making its recommendation to the Clinical Affairs Subcommittee. The appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the text or appendices of these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Board.

D. Within ten (10) working days following the receipt of the Chief of Service's report of investigation, the Chief of Medical Staff shall inform the Chair of the Clinical Affairs Subcommittee of the Medical Board's recommendation.

E. In the event that the subject for potential corrective action is a Clinical Chief then the Chief of Medical Staff shall perform those functions in these proceedings otherwise assigned to that Clinical Chief.

F. At the same time, and if such corrective action is ground for the state to suspend, revoke or restrict a physician's license to practice, as outlined in Section 20-13c of Chapter 370 of the General Statutes of Connecticut, it must be

reported to the Department of Public Health under Section 20-13d of Chapter 370, which sets forth the following grounds:

1. Physical illness or loss of motor skill, including, but not limited to deterioration through the aging process.
2. Emotional disorder or mental illness.
3. Abuse or excessive use of drugs, including alcohol, narcotics or chemicals.
4. Illegal, incompetent or negligent conduct in the practice of medicine.
5. Possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes.
6. Misrepresentation or concealment of a material fact in the obtaining of reinstatement of a license to practice medicine.
7. Violation of any provision of this chapter or any regulation established herewith.

Section 2. Summary Suspension

A. Any one of the following - the appropriate Dean, Associate Dean for Clinical Affairs**,** the Chief of the appropriate Clinical Service, the Chief of Medical Staff, the Hospital CEO, the Vice President for Health Affairs, the Clinical Affairs Subcommittee and the Governing Board or its Chair shall each have the authority, whenever action must be taken immediately in the best interest of patient safety in the Hospital to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

B. The Medical Board may recommend to the Clinical Affairs Subcommittee modification, continuance or termination of the terms of the summary suspension. If the Clinical Affairs Subcommittee approves the summary suspension, the affected practitioner shall be entitled to request a hearing and appellate review as outlined in Article XIX, but the terms of the summary suspension as sustained or modified by the Medical Board shall remain in effect pending a final decision of the hearing or appeal.

C. Immediately upon the imposition of a summary suspension, the appropriate Chief of Service, or in his or her absence, the Chief of Medical Staff, must provide for alternative medical or dental coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 3. Automatic Actions on Privileges

A. An action by the State Board of Medical Examiners that results in the revocation or suspension of a practitioner's license, shall automatically result in the revocation of the practitioner’s clinical privileges in the John Dempsey Hospital.

B. Failure to meet the minimum qualifications for membership outlined in Article III., Section 2., and incomplete or delinquent medical records, shall result in the automatic suspension of privileges. Automatic suspension may be a temporary loss of privileges which can be reinstated if the conditions that led to the suspension are corrected. Automatic suspension is not a corrective action that is subject to the procedure outlined in Section 1. of this Article.

Section 4. Protection from Liability

In matters relating to corrective action, all Medical Staff members and other practitioners, and all appropriate Hospital personnel, including members of the Governing Board, University officials, and Hospital management shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Article VII and Article VIII of these Bylaws.

ARTICLE XIX. HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and Appellate Review

A. When any practitioner receives notice of a decision of the Clinical Affairs Subcommittee which will adversely affect his or her appointment to or status as a member of the Medical Staff or his or her exercise of clinical privileges such practitioner shall be entitled to a hearing before an *Ad Hoc* Hearing Committee appointed by the Medical Board. If the decision of the Clinical Affairs Subcommittee following such hearing is still adverse to the affected practitioner, he or she shall then be entitled to an appellate review by the Board of Directors.

B. Only the following recommendations or actions are "adverse":

1. denial of appointment or reappointment;
2. suspension or termination of appointment;
3. denial of clinical privileges;
4. non-voluntary reduction, limitation, suspension, or revocation of clinical privileges;
5. imposition of a mandatory concurring consultation or co-admission requirement; and
6. imposition of a limitation or restriction that is defined as adverse during the provisional period, unless the limitation or restriction is imposed during the provisional period on all practitioners in that department who are granted those privileges.
7. a letter of reprimand

C. The following action shall take effect without hearing or appeal:

1. voluntary relinquishment of clinical privileges;
2. any consultation requirement, except one which requires mandatory concurrence by the consultant; and
3. required retraining, additional training, or continuing education.

D. Fair hearing and appellate review procedures set out in these bylaws apply only to issues relating to medical staff. The University of Connecticut School of Medicine and Dental Medicine have separate procedures for processing issues concerning faculty appointment. The two processes are mutually exclusive. If a practitioner's medical staff membership and clinical privileges are terminated because of lack of a faculty appointment, all reviews shall be conducted under the faculty code, and no review of the matter is available under these bylaws.

Section 2. *Ad Hoc* Hearing Committee

A. The Chief of Medical Staff shall be responsible for giving prompt written notice of an adverse decision by the Clinical Affairs Subcommittee to any affected practitioner by certified mail, return receipt requested.

B. If a practitioner fails to request a hearing to which he or she is entitled by the text of these Bylaws within thirty (30) calendar days after receipt of such notice the practitioner shall be deemed to have waived his or her right to such hearing.

Section 3. Notice of Hearing

A. Within seven (7) days after receipt of a timely request for hearing from a practitioner entitled to the same, Under Section 1 above, the Chief of Medical Staff shall schedule and arrange for such a hearing and shall notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than forty-five (45) days from the date of receipt of such practitioner's request for hearing.

B. The notice of hearing shall state in concise language that the hospital proposes to take a professional review against the practitioner, the reasons for the proposed action, the acts or omissions with which the practitioner is charged, a list of specific or representative charts or other supporting documentation for each ground or allegation, all other reasons or subject matter that were considered in making the adverse recommendation or decision, and that the practitioner shall have the right to review and copy any evidence relied upon.

Section 4. Composition of *Ad Hoc* Hearing Committee

A. Such hearing shall be conducted by an A*d Hoc* Hearing Committee that consists of a majority of peers of the affected practitioner. A peer is defined as someone whose practice is similar, but not necessary identical, to that of the affected practitioner. It must include no fewer than five members of the Medical Staff who are appointed by the Medical Board, with one of the members designated by the President of the Medical Staff as chairperson. The *Ad Hoc* Hearing Committee will also include at least one additional member of the Clinical Affairs Subcommittee appointed by its Chair. No member of the Medical Staff who has actively participated in the consideration of the matter leading up to the recommendation or action, is in direct economic competition with, or is personally related to the affected practitioner, shall be appointed as a member of this *Ad Hoc* Hearing Committee.

Section 5. Conduct of Hearings

A. Except as provided herein, there is no right of discovery in the hearing or any subsequent review. The practitioner shall be provided with access during reasonable working hours to any patient records or other Hospital documents (except as qualified below) cited in the notice of hearing and shall be permitted to copy those records and documents at practitioner's expense. The practitioner shall not, however, be entitled to access or copy medical peer review committee records or incident reports, but shall be provided with those portions of committee minutes that reflect the decision by the committee or board to impose the adverse recommendation or actions.

B. There shall be at least a majority of the members of the *Ad Hoc* Hearing Committee present when the hearing takes place, and no member may vote by proxy.

C. An accurate record of the hearing must be kept. This shall be established by the *ad hoc* hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

D. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her rights in the same manner as provided in Section 2 of this Article XIX and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

E. Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the majority approval of the *Ad Hoc* Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the *Ad Hoc* Hearing Committee.

F. The affected practitioner shall be entitled to be accompanied and/or represented at the hearing by a member of the Medical Staff in good standing.

G. The chairperson of the *Ad Hoc* Hearing Committee or his or her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

H. The hearing need not be conducted strictly according to rule of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held

shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. In reaching a decision, official notice may be taken by the *Ad Hoc* Hearing Committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The practitioner for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the *Ad Hoc* Hearing Committee. The committee shall also be entitled to consider any pertinent material contained on file in the John Dempsey Hospital and all other information which can be considered in connection with appointment to the Medical Staff and clinical privileges pursuant to these Bylaws.

I. The Chief of Medical Staff on behalf of the Medical Board shall appoint one of its members or some other Medical Staff member to represent it at the hearings at the *Ad Hoc* Hearing Committee, to present the facts in support of its adverse recommendation, and to examine witnesses. It shall be the obligation of such a representative to present appropriate evidence in support of the adverse recommendation or decision but the affected practitioner shall thereafter be responsible for supporting his or her challenge to the adverse recommendation or decision by an appropriate showing of evidence and proof that the charges or grounds involved lack any substantial factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

J. The affected practitioner shall have the following rights: to call and examine any witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

K. The affected practitioner, the Medical Board, and the Clinical Affairs Subcommittee may be represented at any phase of the hearing procedure by an attorney-at-law. Each party's attorney may be present at the hearing to advise the party, but may not present evidence, question or cross-examine parties or witnesses, or address or question the committee.

L. The *Ad Hoc* Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The *Ad Hoc* Hearing Committee may thereupon, at a time convenient to its members, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

M. Within seven (7) days after final adjournment of the hearing, the *Ad Hoc* Hearing Committee shall make a written report which includes a summary of procedures afforded, objections raised, findings and recommendations supported by references to appropriate bylaws provisions. The same shall be forwarded together with the hearing record and all other documentation to the Clinical Affairs Subcommittee. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Clinical Affairs Subcommittee.

N. The Clinical Affairs Subcommittee, when its action has prompted the above hearing, shall consider the recommendations of the *Ad* Hoc Hearing Committee and may accept, modify, or reject such recommendations. The practitioner shall be notified of the Clinical Affairs Subcommittee decision and if adverse, be given written notice of the right to request a Board of Directors Appellate Review.

Section 6. Board of Directors Appellate Review

A. Within thirty (30) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he or she may, by written notice to the Board of Directors delivered through the Vice President request an appellate review. The Board of Directors Appellate Review will be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below.

B. If a Board of Directors Appellate Review is not requested within thirty (30) days, the affected practitioner shall be deemed to have waived his or her right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately.

Section 7. Conduct of Appellate Review

A. The Board of Directors will examine the appeal for process and content and will respond to the appeal in writing within a reasonable amount of time. At its discretion, the Board of Directors or its designee may elect to mediate the appeal, conduct further investigation, and/or act on the appeal. If the Board of Directors or its designee elects to hold interviews or hearings, these may be held in public, only with the concurrence of the grievant. All parties to interviews and reviews may be represented.

B. The Board of Directors may affirm, modify or reverse the decision of the Clinical Affairs Subcommittee. Such decision will be transmitted to the affected practitioner by certified mail, return receipt requested.

Section 8. Protection from Liability

In matters relating to hearings and appellate review, all Medical Staff members and other practitioners, and all appropriate University personnel including members of the Governing Board, University officials and Hospitals management, shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Article VI and Article VII of these Bylaws.

ARTICLE XX. ADOPTION

These Bylaws together with the appended rules and regulations, shall be adopted at any regular meeting of the Medical Staff or at any special meeting called for such purpose. They shall replace any previous Bylaws, rules and regulations, and shall become effective when approved by the Governing Board of the Hospital.

The adopted Medical Staff Bylaws, Rules and Regulations, and policies shall not conflict with the Governing Body's Bylaws.

ARTICLE XXI. PROVIDER HEALTH PROGRAM

Section 1. Policy and Objective

To ensure optimum patient care and service delivery, the Medical Staff has developed a process to identify and manage matters of individual provider health. The Provider Health Program shall provide education about provider health, address prevention of physical, psychiatric and emotional illness, and facilitate confidential diagnosis, treatment and rehabilitation.

Section 2. Definitions

An *impaired provider* is one who is unable to carry out his/her professional duties with reasonable skill and safety because of a physical or mental illness, including functional and/or intellectual deterioration, loss of motor skill, or abuse of drugs and alcohol.

Impairment is any condition, regardless of cause, that interferes with one's ability to function as normally expected. Impairment may exist in one (1) or multiple domains including, but not limited to, psychomotor activity and skills, conceptual or factual recall, judgment, attentiveness, demeanor, and attitudes as manifested in speech or actions.

Two types of observations may lead to the conclusion that an individual is, or may be, impaired:

1. The individual manifests deterioration in functioning as compared to that previously observed.
2. The individual does not function at a level normally expected under the circumstances.

A mandated reporter (CGS 19a-12e) is an acupuncturist, advanced practice registered nurse, athletic trainer, certified drug and alcohol counselor, chiropractor, dental hygienist, dentist, dietician/nutritionist, embalmer, funeral director, hearing instrument specialist, homeopathic physician, licensed alcohol and drug counselor, licensed clinical social worker, licensed nurse midwife, licensed practical nurse, marital and family therapist, occupational therapist, occupational therapist assistant, optician, optometrist, master's level social worker, natropathic physician, paramedic, physical therapist, physical therapist assistant, physician assistant, physician/surgeon, physician/surgeon-DO, podiatrist, professional counselor, provisional faculty dentist, psychologist, radiographer, registered nurse, respiratory care practitioner, speech and language pathologist, veterinarian and medical resident.

The state sanctioned provider *Assistance Program* allows, under many conditions, confidentiality and protection of licensure while compliant with the rehabilitation contract.

Section 3. Reporting Suspected Impairment

Reports of suspected impairment shall be submitted either to the Department of Public Health or to the state approved assistance program, if the person suspecting impairment is a mandated reporter as defined under CGS 19a-12e.

Reports of suspected impairment shall also be submitted to the Chief of Medical Staff or designee in his/her absence. This report does not replace or dispose of the obligation to report under CGS 19a-12e. Reports are encouraged and accepted from the impaired provider (self-reporting), other providers, nurses, and other hospital staff and may be either written or verbal. The Chief of Medical Staff will document verbal reports. Anonymous reporting is discouraged, but will be accepted.

Section 4. Imminent Harm

The Chief of Medical Staff, Chief of Service, and Hospital CEO may immediately suspend a provider from patient care activities pending further evaluation, if the situation appears to represent an immediate threat to the safety of patients or others.

Section 5. Provider Health Committee

The Provider Health Committee is a standing committee that shall meet on an ad-hoc basis and consist of one (1) Chairperson and three (3) physicians, appointed by the Chief of Medical Staff. The Committee is a Medical Review Committee of the Medical Staff engaged in peer review as defined in Section 19a – 17b of the Connecticut General Statutes.

Section 6. Preliminary Evaluation of the Suspected Impairment

Upon receiving a report of suspected impairment, the Chief of Medical Staff shall within one (1) business day, select two (2) members of the Provider Health Committee to conduct a preliminary evaluation of the reported impairment. The evaluation shall be completed within three (3) business days of their notification.

The evaluation will include discussion with the alleged impaired provider, interview of appropriate Hospital staff, review of documented complaints, and review of the provider's Credentials File. The results of the evaluation shall be reported to the Chief of Medical Staff within one (1) business day of the completed evaluation.

Meanwhile, the Chief of Medical Staff ensures that either the DPH or the State's Provider Assistance Program has been made aware of the concern.

Section 7. Evaluation by the Provider Health Committee

When the results of a preliminary evaluation indicate imminent danger to personnel or patients, appropriate action, including summary suspension, will be taken.

The Chairman shall have five (5) business days to convene the Committee, conduct an investigation, and make recommendations to the Chief of Medical Staff. As soon as possible, the Chief of Medical Staff shall communicate the results of the investigation and the recommendations to the provider:

If no impairment has been found, further investigation and appropriate action may be taken if it appears that the original report was made in bad faith or with malice.

If impairment cannot be ruled out, the Chief of Medical Staff may implement any recommendations made by the Committee. This shall include a required referral for medical or therapeutic evaluation, treatment and/or rehabilitation and any requirements for clinical monitoring until such time that the Committee is satisfied that impairment is not present.

If impairment is found, the Chief of Medical Staff may require or impose conditions for continued Medical Staff membership and privileges pending a decision by the DPH or the Assistance Program. This may include verification by an appropriate health care provider that the provider is fit to carry out his/her responsibilities with reasonable skill and safety, formal referral to, and evaluation by, the State Assistance Program, random drug/alcohol screening for a prescribed period of time, or other items the Program deems necessary.

If impairment is found, the Chief of Medical Staff may also suspend Medical Staff membership and/or reduce or restrict clinical privileges based on the recommendations of the Committee.

Section 8. Educational Role

The Committee shall, from time to time, provide educational opportunities regarding health issues, including not only impairment but wellness and burnout.

ARTICLE XXII. FOCUSED REVIEW OF PRACTITIONER'S COMPETENCE

Section 1. Policy and Objective

The Medical Staff has a process that defines the circumstances requiring a Focused Review of a practitioner's competence by peers. The primary purpose of this Focused Review is not disciplinary, but to improve a practitioner's performance through assessment and feedback.

Section 2. Existing Review Mechanisms

Information resulting in a Focused Review may come from a variety of existing review mechanisms including:

1. Complaints
2. Department peer review
3. Outcomes review
4. Complication rate
5. Near miss analysis
6. Morbidity and mortality conference
7. Medical Staff Committee reviews (e.g., Transfusion Committee, etc.)

Section 3. Determining the Need for a Focused Review from Complaints

Written complaints regarding competence from patients, staff, or fellow practitioners should be forwarded to the Division Chief, Chief of Service, Department Chair, or Chief of Medical Staff who will determine whether one or more complaints merit a Focused Review.

Section 4. Determining the Need for a Focused Review from Other Sources

If information from any other existing review mechanism listed in Section 2. shows a pattern of problems, errors, or rates (e.g., complications, morbidity, mortality, etc.) that is significantly beyond peers, the practitioner should be considered for Focused Review by the Division Chief, Chief of Service, Department Chair, or Chief of Medical Staff.

Section 5. Focused Review Panel and Timeline

The Focused Review Panel will be appointed by the Chief of Service, unless the Chief of Service is the practitioner being reviewed. In that case, the Department Chair or Chief of Medical Staff will appoint the Panel. The Panel will include at least one (1) peer within the specialty of the practitioner under review and at least one (1) peer outside his/her specialty. The Panel will be convened within twenty (20) working days from the determination that a Focused Review is needed, and will always solicit input from the practitioner.

Completion of the Focused Review, including feedback to the practitioner, Division Chief, Chief of Service, Department Chair, and Chief of Medical Staff will take no longer than ninety (90) days from when the Focused Review Panel is convened.

Section 6. External Peer Review

External peer review is required:

1. in the absence of an in-house peer within the same specialty.

2. if the Focused Review Panel determines it needs an outside opinion.
3. if requested by the practitioner under review.

Section 7. Outcome of Focused Review

Information obtained through a Focused Review that demonstrates a need for a change in a practitioner's performance will be used to develop a plan to improve his/her performance. In addition, information obtained through a Focused Review may be used to initiate corrective action pursuant to Article XVIII of the Bylaws. Any such corrective action process may occur concurrently with or following a Focused Review, and may occur even if the Focused Review is discontinued for any reason. Any relevant information that is not peer protected may also be used to develop hospital-wide performance improvement initiatives.

JOHN DEMPSEY HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

Section 1. Admission, Discharge, and Transfer of Patients

A. All patients shall be admitted only by Active or Affiliated members of the Medical Staff, and shall be assigned to the clinical service or section concerned in the treatment of the disease which necessitated admission. Every patient admitted to JDH or on observation status must be seen by an attending practitioner at least once during the admission. Notwithstanding the foregoing, this requirement does not apply to patients who have been admitted and leave against medical advice or who otherwise require immediate discharge because a higher level of care is medically necessary. All members of the Active Staff or Affiliated Staff in the following clinical services shall hold admitting privileges: Dentistry, Emergency Medicine, Family Medicine, Medicine, Neurology, Obstetrics and Gynecology, Orthopaedics, Pediatrics, Psychiatry (excluding clinical psychologists) and Surgery. Members of the Active Staff or Affiliated Staff in Anesthesiology, Dermatology, and Diagnostic Imaging and Therapeutics may admit only if specifically indicated on their privilege control list.

B. Except in emergency, no patient shall be admitted in the Hospital until after an appropriate reason for admission has been stated, and the consent of the appropriate clinical service. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

C. Any practitioner admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

D. Every patient admitted for inpatient care must have a medical history taken and an appropriate physical examination by a qualified practitioner. Dentists and podiatrists may perform the entire medical history and physical examination for the inpatient care of their patients if they have been granted the privileges to do so by virtue of their training and credentials. If a dentist or podiatrist has not been granted admission history and physical privileges, he or she may only perform the history and physical examination that relates to dentistry or podiatry. In this case, they are responsible for obtaining an appropriate medical history and physical examination by a qualified practitioner. Physician Assistants, Residents, Fellows, and Medical Students may take medical histories and perform physicals under the supervision of a qualified physician. The qualified physician retains the accountability for the patient's medical history and physical examination.

E. The Adult Intensive Care Unit is considered a closed unit signifying that only adult intensivists and cardiologists may admit patients to the Adult Intensive Care Unit.

F. The management of the patient's general medical condition is the responsibility of a qualified practitioner with appropriate clinical privileges. Such management may include collaboration with other practitioners and/or through multidisciplinary treatment plans.

G. Only attending physicians may discharge patients from the Emergency Department. Advanced practice registered nurses and Physician Assistants may discharge patients from the Urgent Care Center.

H. Under certain circumstances, including but not limited to the need for definitive care, patient condition, and/or need for another level of care, the request for internal or external referral or transfer may occur. It shall be the responsibility of the attending practitioner to manage the medical condition of the patient during this transfer and to inform other treating practitioners of this referral or transfer.

I. Patients undergoing any procedure for which intravenous sedation is administered and/or for which a separate patient consent is required, shall be assessed by a qualified practitioner prior to the procedure. Such assessment shall include the review of: the patient's history and physical status, diagnostic data, risks and benefits of procedures, potential complications, potential need to administer blood or blood components, and patient's consent.

Section 2. Consultations

A. Only practitioners with clinical privileges may provide consultation services, unless the consultation has been ordered by the court, is an emergency as defined in VII.3., or in situations where no treatment or physical examination is to be provided by the consulting practitioner.

B. Essentials of a Consultation by a Credentialed Consultant: A consultation by a credentialed consultant includes a review of the patient's medical data, may include a physical examination, and must include a written opinion signed by the consultant in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

C. Essentials of a Consultation by a non-Credentialed Consultant: Consultation by a non-credentialed consultant may only include review of the patient's medical record and discussion with the patient. No examination is permitted and no notation is to be made in the medial record. The attending physician may observe the consultation by the non-credentialed consultant.

D. Responsibility for Requesting Consultations: The patient's practitioner is responsible for requesting consultations when indicated. It is the responsibility of the practitioner to evaluate the consultant's recommendations and modify the management plan, if appropriate, in the context of the overall situation. It is the duty of the Chiefs of Service to ensure that members of the staff call consultants as needed.

E. Psychiatric consultation is required for all patients who have attempted suicide or who have self-administered chemical overdoes.

F. All inpatient consultations must be completed and documented in the medical record with twenty-four (24) hours of the notification of the consult of the request.

Section 3. Coverage by Outside Physicians

A. All outside practitioners providing coverage at John Dempsey Hospital require admitting and clinical privileges.

B. A designated outside covering practitioner should be fully aware of the nature of the arrangement and be available.

C. If coverage is to be provided other than here at John Dempsey Hospital (transfer required), that should be understood from the outset by indicating the other institution's name in parentheses on the call schedule in the Emergency Department and with the operators.

D. If coverage involves the use of equipment or ancillary personnel, the covering practitioner should be sufficiently oriented to our system to allow timely care without undue confusion or delay.

Section 4. Medical Records

A. The following principles shall pertain to the maintenance of records. Any deficiencies will be monitored on discharge by the Health Information Management Department. Those in non-compliance will be referred to the Chief of Medical Staff office. The Chief of Medical Staff will review non-compliance issues, recommend appropriate action(s) to resolve deficiency problems, and be responsible for assuring compliance with medical record policies and procedures.

   1. The patient's practitioner shall create a medical record for each patient. Specifically, the physician, dentist, or APRN staff member shall document a chief complaint(s); personal history, family history, history of the present illness; report of the physical examination; special reports such as consultations; provisional diagnosis; report of diagnostic, medical, surgical or therapeutic treatment; for OB - antepartum, labor and delivery records; for alcohol treatment program - a medical and psychosocial discharge summary; pathological findings; progress notes; final diagnosis; condition on discharge; after-visit summary, discharge note with discharge medications and

instructions. Medical records may, with the approval of the Health Information Management Department Director, be transported out of the Health Information Management Department to facilitate timely record completion. No medical record can be permanently filed within the department until it is completed.

2. A history and physical must be completed no more than thirty (30) days before admission or no more than twenty-four (24) hours after admission. If a patient is undergoing a procedure requiring sedation and/or general anesthesia, then the history and physical must completed prior to the procedure. Any existing history and physical greater than thirty (30) days old, must be redone. For a history and physical less than thirty (30) days old, a note documenting that the history and physical has been reviewed, and documenting any salient changes shall be written. The attending practitioner shall review and approve (authenticate) the history and physical examination and any note of review pursuant thereto.

3. On all emergency patients, histories and physicals shall be recorded within twelve (12) hours after admission. The attending practitioner shall review and authenticate the history and physical examination. The authentication shall consist of the attending physician's outline of the salient points in the history, physical, and management plan.

4. On non-emergency admissions, charts shall contain a provisional diagnosis and plan by the attending physician written no more than seven (7) days prior to the admission, and/or within twenty-four (24) hours after admission, but in any case prior to surgery. A medical note, written by an external/referring practitioner may be used for a provisional diagnosis however, the attending physician must outline the salient points in the history, physical, and management plan.

5. Operative reports shall be dictated or written immediately after surgery. A handwritten note will be kept in the record until the dictated note has been transcribed and signed.

6. The attending practitioner will write appropriate progress notes. Attending practitioners will document the care they specifically provide or supervise. Counter-signing another person's note is insufficient. In no instance may the interval between practitioner's progress notes exceed three days for non-critical or daily for critical patients. The attending practitioner is responsible for documenting in the medical record any meaningful change in a patient's condition or therapeutic plan, including any respective assessment. This may be delegated to residents, fellows, advanced practice registered nurses (APRNs) and physician assistants (PAs).

7. The Problem List, core data base, or multidisciplinary progress notes may be used by all health practitioners to summarize all issues being treated or addressed during the patient's hospital stay.

8. Patients shall be discharged only upon written order by the attending practitioner and when the after-visit summary is completed by the house officer/attending practitioner responsible for his care. Notwithstanding the foregoing, if a patient has been admitted and leaves against medical advice or is immediately discharged because a higher level of care is medically necessary, the discharge may occur prior to the attending practitioner's authentication of the written discharge order or completion of after-visit summary. At the time of discharge, the responsible physician, dentist, or APRN staff member shall see that the record is complete, state his final diagnosis, secondary diagnosis, all operative procedures, condition on discharge, and discharge medications on the after-visit summary. The discharge summary must be dictated and signed within seven (7) days post discharge.

B. Incomplete Records

1. Any practitioner using the facilities of the University of Connecticut Health Center and/or its Hospital, having an unfinished (incomplete) record seven (7) days after becoming available may have privileges suspended for having a delinquent record(s). The individual will be notified of the suspension in writing.

2. A complete record includes dictation and signature on: operative reports, after-visit summary, discharge summary, death pronouncements and discharge notes and any other portion of the medical record deemed incomplete.
3. In accordance with the approved Medical Staff Bylaws and Rules and Regulations, a hospital patient's medical record shall be deemed delinquent if any of the following pertain:

    a. After-visit summary has not been completed and signed at the time of the patient's discharge, death, or discharge against medical advice.
    b. Discharge summary is not dictated, transcribed, signed, and noted in the patient's medical record within seven (7) days of the availability of the record.
    c. Operative reports are not dictated within twenty-four (24) hours of surgery and signed in the patient's medical record within seven (7) days of the availability of the record.
    d. Other designated portion of the record is deemed incomplete on the part of the physician.

C. Notification System

1. The Health Information Management Department will identify delinquent medical records by the following characteristics:

    a. Deficiency type
    b. Individual responsible for completion
    c. Date of deficiency

2. The Health Information Management Department will maintain a record of the time period of attending practitioner notification for each deficiency. The attending practitioner and the House Officer will receive written warning of the record's deficiency status starting from when the record becomes available for completion. The deficiency status will advise of any impending suspension. If there is a failure to complete after 30-days of availability, the Chief of Medical Staff is required to suspend the attending practitioner, which would prohibit scheduling admissions or elective procedures.

3. Notification of the suspension will be given in writing to:

    a. The Attending Practitioner
    b. The Attending Practitioner's Chief of Service
    c. Medical Staff Office
    d. The Hospital Departments of:
        1. Admitting
        2. Emergency Room
        3. Health Information Management Department
        4. Operating Room

4. When the suspension has been removed, following the medical record(s) completion, the Health Information Management Department will notify the Chief of Medical Staff who will inform the appropriate parties of the reinstatement of the practitioner's privileges.

D. General Records Policy

1. All original medical records and reports contained therein, are the property of the Hospital and may be removed from its jurisdiction and safekeeping only by court order, subpoena, or statute. Copies of the original record may be released only through the Health Information Management Department. In the case of psychiatric records, permission from an attending practitioner in Psychiatry may be required in conjunction with this regulation. Such permission shall be obtained by the Health Information Management Department.

2. In the case of re-admission, all previous records shall be available to the attending practitioner upon request.

3. Access to all medical records of all patients shall be afforded to Medical Staff practitioners and Advanced Practice Nursing Staff in good standing for bona fide study and research. Requests for medical records or medical record information must be in writing and consistent with preserving the confidential nature of personal information concerning the individual patients.

4. All operations performed shall be fully described by the operating surgeon or assisting house officer in the operative report.

5. Medical records shall be delivered to the clinics, hospital floors, and the emergency room for patient care purposes.

6. The covering physician or Chief of Service or designee may sign reports for another practitioner in that service when extenuating circumstances warrant. The reason for a substitute signature must be written as an addendum to the report.

7. The use of signature stamps on medical records or documents will not be permitted.

8. The use of symbols and abbreviations other than those approved by the Medical Staff will be actively discouraged.

9. All medical record forms in use must be approved.

10. All medical records must be completed not later than thirty (30) days following patient discharge.

11. All written entries made in the medical record should include the date and time of the note and be legibly authenticated by the health professional indicating professional designation.

12. All verbal and telephone orders should be signed by the practitioner within twenty-four (24) hours.

13. To facilitate record completion, medical records of patients discharged before Noon will remain at the nursing station until 10:00 AM the following day.

14. To preserve the confidentiality of psychiatric records, the Health Information Management Department will determine limits to the availability of the records.

Section 5. Orders

A. Standing orders shall be signed by the physician or dentist for each admission. Standing Orders shall not replace or cancel those written for the specific patient.

B. All orders for treatment shall be in writing or through the electronic physician ordering system where applicable. In an emergency, an order shall be considered in writing if dictated by the responsible physician or dentist or his/her designee to a graduate nurse or other certified professional with Medical Board approval in their respective areas. The order must be signed by the practitioner or his/her designee within twenty-four (24) hours. Orders shall be written only by the physician or dentist in charge of the patient or by his/her designee.

Section 6. Pharmacy

The Department of Pharmacy of the University of Connecticut Health Center provides a broad range of pharmaceutical services as an integral part of an interdisciplinary approach to health care delivery. A complete description of these activities, along with guidelines and requirements for practitioners can be found in the Pharmacy Policy and Procedure Manual.

Section 7: Policies on Submission of Surgical Specimens

A. Surgical Specimens Exempt From Gross Examination

1. Placenta: The product of a normal pregnancy and vaginal delivery which is grossly normal on examination by the attending obstetrician.
2. Foreskin: Uncomplicated circumcision on newborns up to the first year of life.
3. Femoral head: Any femoral head surgically removed with preoperative diagnosis of osteoarthritis with the sole purpose of utilization for transplantation by the Bone Bank.
4. Routinely removed Hickman Catheters.
5. Routinely removed Myringotomy tubes.
6. Routinely removed urethral stents.
7. Normal, carious or peridontally diseased teeth and normal bone or soft tissue incidentally removed from non diseased areas.
8. Orthopaedic prosthesis considered medical devices need not be sent to pathology if intact except in cases where documentation of mechanism of hardware failure is deemed vital or necessary to the diagnosis, treatment or serves as some medical/legal foundation for a particular case. The operative note must specifically state that the hardware was removed and intact.
9. Normal tissue which is excised to relieve a mechanical irritation need not be sent for pathological review unless the pathologic evaluation both microscopic and macroscopic are of value in making the diagnosis of, or aiding the practitioner in providing the treatment of the patient.
10. Lens tissue from cataracts.

B. Surgical Specimens Requiring Gross Examination <u>Only</u>

1. Infant hernia sacs
2. Osteoarthritic bone and shavings from procedures such as meniscectomy
3. Rib removal for operative exposure
4. Tissue and cartilage obtained during laminectomy for spondylosis or spinal stenosis
5. Traumatically injured digits
6. Scar tissue removed incidentally during another procedure
7. Kidney and urethral stones

C. ALL OTHER SPECIMENS SHOULD BE SUBMITTED TO SURGICAL PATHOLOGY FOR BOTH GROSS AND MICROSCOPIC EVALUATION.

Section 8. Miscellaneous

A. Discussions at monthly departmental meetings as provided in Article XI of the Bylaws shall constitute a thorough review and analysis of the clinical work in the Hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, and results of treatment from among significant cases in the Hospital at the time of the meeting and significant cases discharged since the last meeting. Reports from the Medical Board and from other departments should be communicated to the members of the departments at these meetings.

B. Mass Casualty Assignments: Committees on Disaster Planning and Cardiopulmonary Resuscitation will plan and coordinate these activities. Specific direction should be taken from the plan. All members of the Medical Staff shall be assigned to posts, either in the Hospital, an auxiliary hospital or in mobile casualty stations and it is their responsibility to report to, and remain at their assigned stations.

C. If any questions as to the validity of admission to or discharge from one of the intensive care units should arise, that decision is to be made through consultation with the Director of the appropriate ICU or a designated member of that committee or Chief of Medical Staff. In similar circumstances, concerning admission to or discharge from the Cardiac Care Unit, the appropriately designated member of the Department of Medicine is to be consulted.

D. It will be the responsibility of each clinical service to develop operational guidelines for that service. These operational guidelines shall be approved by the Medical Board.

E. As a requirement of clinical privileges, attending staff must leave their telephone number or their covering practitioner with the Communications Department.

Section 9. Autopsy

A. Every physician member of the Medical Staff is expected to be actively interested in securing autopsies.

B. All autopsies shall be performed by members of the Division of Anatomic Pathology or a designated, qualified physician.

C. Physicians shall seek informed consent from the next of kin or legal agent of the deceased. Informed consent shall, as a minimum, explain what constitutes a routine autopsy. The informed consent process shall determine all exceptions to routine autopsy so that the spirit and intent of the person giving the consent can be followed by the Division of Anatomic Pathology.

D. The Pathologist from the Division of Anatomic pathology shall inform the attending practitioner of the provisional cause of death. This should be recorded in the medical record within forty-eight (48) hours and the complete pathological report should be made a part of the record within three (3) months.

Section 10. Restraints

A. The use of restraints within the hospital shall be driven not by patient diagnosis, but by comprehensive individual assessment that concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion.

B. Orders for restraints and/or seclusion must indicate the time of the order and duration for each use of restraint and/or seclusion, and reflect restraint policies/procedures.

C. In cases of patients with psychiatric disabilities, orders can be written only by a physician.

D. In cases of patients with psychiatric disabilities, orders can be initiated by a nurse practitioner or physician assistant in emergency circumstances, acting on behalf of a physician who has been granted the clinical privilege.

E. In all other cases, orders can be written by a physician or licenses independent practitioner.

Section 11. Disruptive Practitioner

Objective

To ensure optimum patient care and service delivery by promoting a safe, cooperative and professional health care environment that prevents or alleviates to the extent possible, conduct which: disrupts the operation of John Dempsey Hospital and/or clinics; affects the ability of others to properly perform their job; and/or creates a "hostile work environment."

Other Jurisdiction

This policy does not supplant either any Human Resources or Public Safety policies related to allegations of inappropriate behavior or required reports (e.g., Risk Incident Report, Violence Incident Report, etc.).

Policy

For the purposes of this policy, practitioner includes any credentialed member of the Medical Staff, Advanced Practice Nursing Staff, and Professional Staff.

This policy is designed to address disruptive or potentially disruptive behavior by a practitioner. It is the policy of John Dempsey Hospital that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the University of Connecticut Health Center Board of Directors, Administration, and Medical Staff require that all practitioners conduct themselves in a professional, competent and cooperative manner. If a practitioner fails to conduct himself/herself appropriately, the matter shall be addressed in accordance with the following guidelines and procedures. It is the intention that this policy be enforced in a firm, fair and equitable manner. This policy does not address, however, behaviors covered by the Physician Health Program policy.

Corrective Action

Any single incident, or pattern, of disruptive behavior may lead to corrective action against the practitioner as outlined in Article XVIII. However, the process described in this policy is not a prerequisite for the Chief of Medical Staff to invoke the corrective action process.

Definition

Disruptive behavior is an act, or pattern of actions by an individual which adversely affects a practitioner, employee, or team to the degree it may impede their ability to deliver quality patient care and/or perform a designated function or duty. That a practitioner's behavior is unusual, unorthodox or different is not sufficient to justify disciplinary action nor alone does it imply that a practitioner is disruptive. Disruptive behavior includes, but is not limited to, such behavior as:

1. Verbal attacks or threats directed at other practitioners, employees, volunteers, patients or visitors
2. Impertinent, demeaning, inappropriate or intimidating comments directed at other practitioners, employees, volunteers, patients or visitors
3. Impertinent, demeaning or inappropriate comments written in the patient's medical record or other official document
4. Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence
5. Profane language
6. Intimidating behaviors such as threatening posture and throwing objects

Documentation of Disruptive Behavior

Anyone who observes behavior by a practitioner that disrupts the operation of the hospital and/or clinics, or jeopardizes patient care, shall document the incident in a written narrative report submitted to the Chief of any Clinical Service, Chief of Medical Staff, the chairman of any standing committee of the Medical Staff, the Hospital CEO, any Dean or Associate Dean, the Vice President, the Clinical Affairs Subcommittee, Human Resources, or Public Safety. The documentation shall include:

1. the date and time of the behavior;
2. the names of those involved and how they were involved;
3. the circumstances that precipitated the situation;
4. a description of the behavior limited to factual, objective language as much as possible;
5. the perceived consequences, if any, of the behavior as it relates to patient care or operations; and
6. record of any action taken including date, time, place, and name(s) of those intervening.

Such a report shall be forwarded to the Chief of Medical Staff and to the Chief of Service.

Meeting with the Practitioner

1. A meeting shall be arranged between the practitioner and the Chief of Medical Staff. If the Chief of Medical Staff is not available or has a conflict of interest, the Associate Chief of Medical Staff will assume all related duties. At the discretion of the Chief of Medical Staff, the meeting may include the Chief of Service, or be delegated to the Chief of Service.

2. A practitioner who refuses to meet with the Chief of Medical Staff or the Chief of Service (if delegated by the Chief of Medical Staff) shall be subject to corrective action as outlined in Article XVIII.

3. At the meeting, the practitioner shall be presented with the allegation(s) and offered an opportunity for denial or admission of the incident(s). The Chief of Medical Staff shall remind the practitioner that disruptive behavior is subject to corrective action as outlined in Article XVIII.

4. If the practitioner admits to the alleged behavior(s), he/she may submit a written explanation/qualification/rebuttal. The Chief of Medical Staff shall take appropriate action which may include verbal reprimand, written reprimand, or the initiation of the corrective action process as outlined in Article XVIII. The meeting with the practitioner shall be documented and a letter shall be sent to the practitioner confirming the substance and outcome of the meeting. The Chief of Medical Staff's letter and the practitioner's letter, if one was submitted, will become part of the practitioner's Medical Staff file. Application for removal of the letters to the Office of Public Records Administrator cannot be made before five (5) years have elapsed.

5. If the practitioner denies the allegation, the matter shall be investigated by the Chief of Medical Staff, who will determine whether or not it is reasonable to believe that the incident(s) occurred as alleged.

6. If the Chief of Medical Staff determines that it is not reasonable to believe that the incident(s) occurred as alleged, the matter shall be dismissed with no documentation of the dismissal filed in the practitioner's Medical Staff file.

7. If the Chief of Medical Staff determines that there is reason to believe that the incident(s) occurred as alleged, the practitioner shall, again, be required to meet with the Chief of Medical Staff. He/she may submit a written explanation/qualification/rebuttal. The Chief of Medical Staff shall take appropriate action which may include verbal reprimand, written reprimand, or the initiation of the corrective action process as outlined in Article XVIII. The meeting with the practitioner shall be documented and a letter shall be sent to the practitioner confirming the substance and outcome of the meeting. The Chief of Medical Staff's letter and the practitioner's letter, if one was submitted, will become part of the practitioner's Medical Staff file. Application for removal of the letters to the Office of Public Records Administrator cannot be made before five (5) years have elapsed.

Section 12. Treating Self and Family Members

Policy

Practitioners should not perform diagnostic or therapeutic procedures which require privileges or use of those areas of UCHC in which the Medical Staff has jurisdiction, on themselves or members of their family except:

1. For a minor condition
2. In an emergency situation
3. When another qualified practitioner is not readily available

Prescribing

Practitioners should not write a prescription for themselves or family members for narcotics, controlled drugs, psychotropic drugs, or any drugs that are addicting or habituating, that violates standard of care, and that are not recorded in a maintained medical record and controlled substance record.

Definitions

Family Member: A spouse, partner, parent, child, sibling, grandparent, or grandchild of the practitioner; or a parent, child, sibling, grandparent, or grandchild of the practitioner's spouse; or any other individual in relation to whom the practitioner has personal or emotional involvement that may render the practitioner unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions.

Minor Condition: Generally, a non-urgent, non-serious condition that requires only short-term, routine care and is not likely to be an indication of, or lead to, a more serious condition.

Emergency: A situation where an individual is apparently experiencing severe pain or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided.