MEDICAL STAFF BYLAWS
OF
LOWELL GENERAL HOSPITAL

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PREAMBLE

WHEREAS, Lowell General Hospital is a not-for-profit corporation organized under the laws of the Commonwealth of Massachusetts, and

WHEREAS, its purpose is to serve as a general hospital providing 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 must accept and discharge this responsibility, subject to the ultimate authority of the Hospital's Board of Trustees, and that the cooperative efforts of the Medical Staff, the President of the Hospital, and the Board of Trustees are necessary to fulfill the Hospital's obligations to its patients;

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

DEFINITIONS

The following definitions apply to the provisions of these bylaws for the medical staff. The definitions are in alphabetical order.

1. **ABMS** means the American Board of Medical Specialties

2. **ADVANCED PRACTICE PROVIDER** means a licensed nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, clinical nurse specialist, and physician assistant and any others recommended by the Medical Executive Committee and approved by the Board of Trustees.

3. **ALLIED HEALTH PROFESSIONAL** means an individual, other than a licensed physician, dentist, oral surgeon, or podiatrist, who exercises independent judgment within the area of their professional competence and who is qualified to render direct or indirect medical, dental, podiatric, or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. Such Allied Health Professionals shall include clinical psychologists, and any others recommended by the Medical Executive Committee and approved by the Board of Trustees. (Also see **Article Five** of these bylaws.)

4. **BOARD OF TRUSTEES** means the Board of Trustees of the Hospital.

5. **CHIEF EXECUTIVE OFFICER/PRESIDENT** means the individual appointed by the Board of Trustees as the Chief Executive Officer to act on its behalf in the overall executive and administrative management of the Hospital. The Chief Executive Officer, consistent with their responsibilities under the Bylaws of the Hospital, may designate a representative to perform their responsibilities under these Bylaws.

6. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the Board of Trustees to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to them.

7. **EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Board of Trustees.

8. **EX OFFICIO** means service as a member of a body by virtue of the office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

9. **FIFTH PATHWAY CERTIFICATE** refers to a foreign medical graduate who has completed an additional year in an accredited program as determined by the American Medical Association at a medical school in the United States.

10. **HOUSE STAFF** means residents, fellows, and medical students of an approved medical school with an affiliation with the Hospital.

11. **HOSPITAL** means Lowell General Hospital

12. **MEDICAL STAFF** or **STAFF** means that component on the hospital organizational chart that stands for all practitioners, as defined in number 15 below, who are appointed to membership and are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the hospital.

13. **MEDICAL STAFF MEMBER IN GOOD STANDING** or **MEMBER IN GOOD STANDING** means a practitioner who has been appointed to the medical staff or to a particular category of the staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws and related manuals or any other policies of the medical staff of the hospital.

14. **PHYSICIAN** means an individual with an M.D. or D.O. degree, who is licensed to practice medicine.

15. **PRACTITIONER** means, unless otherwise expressly provided, any physician, dentist, oral surgeon, or podiatrist, who either: (a) is applying for appointment to the medical staff and for clinical privileges; or (b) currently holds appointment to the medical staff and exercises specific delineated clinical privileges; or (c) is applying for or is exercising temporary privileges pursuant to the Medical Staff Bylaws.

16. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member or medical ancillary staff and exercisable subject to the ultimate authority of the board and to the conditions and limitations imposed in the Medical Staff Bylaws and related manuals and in other hospital and medical staff policies.

17. **MEDICAL STUDENT** means a person who has creditably completed not less than two years of study in a legally chartered school.

18. **MEDICAL SCHOOL** means a legally chartered school in any jurisdiction.

NOTE: Words used in these Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws and related manuals are for convenience only and not intended to limit or define the scope or effect of any provision of these Bylaws and related manuals.

ARTICLE ONE

NAME

The name of this organization shall be "The Medical Staff of The Lowell General Hospital."

The Medical Staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the Hospital to provide patient care services independently in the Hospital.

The Medical Staff is organized, self-governed and has the overall responsibility for the quality of the professional services provided by the individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body.

All medical staff members and all others with delineated clinical privileges are subject to medical staff and departmental bylaws, rules and regulations and policies.

All medical staff members and all others with delineated clinical privileges are subject to review and discipline as part of the organization's performance-improvement activities.

ARTICLE TWO

PURPOSES

THE PURPOSES OF THIS MEDICAL STAFF ARE:

a. To provide the best possible professional care of the sick and injured admitted to The Lowell General Hospital or treated in the Emergency or Outpatient departments, without regard to sex, gender, race, creed, national origin, or handicap;

b. To ensure that the professional performance of all practitioners authorized to practice in the Hospital, through the appropriate delineation of their clinical privileges and through the ongoing review and evaluation of their performance meets accepted standards of practice.

c. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

d. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Trustees and the President of the Hospital;

e. To initiate and maintain rules and regulations for self-government of the Medical Staff.

ARTICLE THREE

APPOINTMENT AND REAPPOINTMENT

SECTION 3.1 GENERAL QUALIFICATIONS

Every practitioner who seeks or enjoys Staff appointment must, at the time of application and initial appointment, and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and the Board of Trustees the following qualifications and any additional qualifications and procedural requirements as set forth in other sections of these Bylaws, the Rules and Regulations or in the Policies and Procedures Manual:

3.1-1 Licensure

A current valid license to practice medicine, dentistry, podiatry issued by the Commonwealth of Massachusetts for the privileges requested and/or granted. Licensure is verified with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate state licensing board or from any state licensing board if in a federal service. Verification of current licensure through the primary source Internet site or by telephone is also acceptable, if this verification is documented.

3.1-2 Professional Education and Training

Graduate of an approved medical, dental, or podiatric school or school of osteopathy, or certified by the Educational Council for Foreign Medical Graduates (ECFMG), or have a Fifth Pathway Certificate and have passed the Foreign Medical Graduate Examination in the Medical Sciences; and, satisfactory completion of an approved post-graduate training program.

For purposes of this Section, an "approved" school is one fully accredited during the time of the practitioner's attendance by the Liaison Committee on Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by a successor agency to any of the foregoing, or by an equivalent professionally recognized accrediting body. An "approved" post-graduate training program is one fully accredited throughout the time of the

practitioner's training by a professionally recognized national accrediting body, including but not limited to the American Medical Association, the American Osteopathic Association, the Commission on Dental Accreditation, the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by a successor agency to any of the foregoing, or by an equivalent professionally recognized national accrediting body, including but not limited to the American Medical Association, the American Osteopathic Association, the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

The requirement for satisfactory completion of approved post-graduate training shall be waived for any practitioner who was a Member of the Staff prior to the effective date of these Bylaws and may be waived by the Board of Trustees for any subsequent applicant if it deems such waiver to be in the best interest of patient care and if such waiver is endorsed by the applicable Department Chief, the Credentials Committee and the Medical Executive Committee.

3.1-3 Clinical Performance

Demonstrated by a practitioner's current clinical experience, clinical results, and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts and consistent with available resources. It is recognized that residents and practitioners who have recently completed training may not have had, at the time of the application and initial appointment to the Staff, the same extent of experience and therefore may not be able to document satisfaction of this qualification to the degree generally expected by the Medical Staff and Hospital, or to the same degree as current Staff Members at reappointment or new applicants who have been in practice for a period of time. However, they are expected to satisfy the overall intent of this provision for similarly situated practitioners and, as their practices develop, to demonstrate, by actual independent performance, their compliance in providing patient care services at an acceptable level of quality and efficiency given the current state of the healing arts and available resources.

3.1-4 Cooperativeness

Demonstrated ability at all times and under all circumstances to work with and relate to other Staff Members, members of other

health disciplines, Hospital management and employees, the Board of Trustees, visitors and the community in general, in a cooperative, respectful, and professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care.

3.1-5 Satisfaction of Membership Obligations

Satisfactory compliance with the basic obligations accompanying appointment to the Staff as set forth in **Section 3.2** below and equitable participation, as determined by the appropriate Staff and Board authorities, in the discharge of Staff obligations specific to Staff category.

3.1-6 Professional Ethics and Conduct

Medical Staff members shall adhere to generally recognized standards of medical and professional ethics. Medical Staff members shall demonstrate behavior at all times and under all circumstances that conforms to expectations described in the Hospital Disruptive Behavior policy. Medical Staff members shall seek appropriate consultation when medically necessary. Medical Staff members shall make arrangements such that they or their coverage can provide service-specific continuous care to their patients at Lowell General, including during times of unforeseen illness and/or disability. Medical Staff members shall state their coverage with full and complete contact information at the time of application and reapplication to the Medical Staff and, as necessary, provide timely updates to ensure all coverage information is current and accurate.

3.1-7 Disability

To be free of or have under adequate control so as to not impact the provision of patient care any significant physical or mental health impairment and to be free from abuse of any type of substance or chemical that affects cognitive, motor or communication ability in a manner, that interferes with, or presents a reasonable probability of interfering with, the qualifications required by **Sections 3.1-3** through **3.1-6.**

3.1-8 Verbal and Written Communication Skills

Ability to read and understand the English language, to communicate in writing and verbally in the English language in an

intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-9 Professional Liability Insurance

Professional liability insurance of a kind consistent with the practitioner's privileging risk classification and practice at limits set by these Bylaws.

3.1-10 Hospital and Community Need, and Ability to Accommodate

In acting on new applications for Staff appointment and clinical privileges, and on applications for changes in clinical privileges, in Staff appointment status, or in principal department, section or service affiliation, the Board of Trustees may also consider any policies, plans and objectives formulated by it concerning:

a. the Hospital's current and projected patient care needs and,

b. the Hospital's ability to provide the physical, personnel and financial resources that will be required if the application is acted upon favorably.

Recommendations from any of the applicable Medical Staff authorities may also be based, in whole or in part, on any said policies, plans and objectives.

3.1-11 Effects of Other Affiliations

No practitioner shall be automatically entitled to appointment or to the exercise of particular clinical privileges based on appointment or privileges at other institutions/facilities.

3.1-12 Nondiscrimination

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of: age; sex; gender; race; creed; color; national origin; a disability unrelated to the ability to fulfill patient care and required Staff obligations. However, the Staff may deny appointment on the basis of criteria related to the delivery of quality and efficient patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, or to community need.

3.1-13 Board Certification/Board Eligibility

Current Board Certification or Board Eligibility. Practitioner must be board certified or board eligible by the American Board of Medical Specialties or by the appropriate certifying organization/association applicable to the practitioner's training. The practitioner must achieve board certification in five years from the end of training. This requirement of Board certification or Board eligibility may be waived by the Medical Executive Committee, upon the recommendation of the Chief of the practitioner's department, under special circumstances, based upon the practitioner's training, experience and qualifications and/or the Hospital's need for practitioners in a specific specialty.

3.1-14 Maintenance of Certification (MOC)

The practitioner must maintain certification as dictated by the standards of the board of the appropriate discipline. This requirement of maintenance of certification may be waived by the Medical Executive Committee, upon the recommendation of the Chief of the practitioner's department, under special circumstances, based on the provider's demonstration of equivalent competency, training, experience and qualifications and/or the Hospital's need for practitioners in a specific specialty.

SECTION 3.2 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of their assigned Staff category, and each practitioner exercising Temporary and Emergency Privileges under these Bylaws shall:

- Provide their patients with continuous care at the level of quality and efficiency generally recognized as appropriate at facilities such as The Lowell General Hospital;
- abide by the Medical Staff Bylaws and related manuals, the Bylaws of the Hospital, and all other lawful standards, policies and rules of the Medical Staff and Hospital;
- discharge such Staff, committee, department, section, service, and Hospital functions for which the practitioner is responsible by Staff category assignment, appointment, election, or otherwise;

- prepare and complete, in a timely fashion, the medical and other required records for all patients the practitioner admits or in any way provides care to or in the Hospital; and

- pledge to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible.

Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for non-reappointment or for such other disciplinary action as deemed appropriate by the final action of the Board of Trustees pursuant to **Article Seven** of these Bylaws.

SECTION 3.3 TERM OF APPOINTMENT

3.3-1 Appointments to the Medical Staff and grants of clinical privileges cannot exceed a period of two (2) years, noting that:

a. new Members of the Staff are subject to an initial provisional period as provided in **Section 3.4 below**; and will be oriented to the hospital according to the policy, "Onboarding of New Medical Staff Members".

b. new Members of the Staff are placed in the appropriate reappointment cycle as determined by the Hospital's system of reappointment which may result in the re-appointment period immediately following initial appointment to the medical staff; and

c. The Board of Trustees, after considering the recommendations of the applicable departments, sections, and services, the Credentials Committee and the Medical Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges in general, for a Staff Member who has an identified health disability, for Staff Members who have reached a defined age, or for a Staff Member who has been the subject of disciplinary action; and

d. disciplinary action involving membership and/or clinical privileges may be initiated and taken in the interim under the appropriate provisions of these Bylaws and the related manuals;

and could lead to a reappraisal of the continuation of staff appointment and clinical privileges

e. in the case of a practitioner providing professional services by contract/employment, termination or expiration of the contract/employment may result in a shorter period of appointment or privileges if that is in effect under **Section 3.5-3** of this **Article**; and

f. if the Hospital adopts an administrative policy involving an exclusive contract or other exclusive arrangement for a particular service or services, any practitioner previously privileged to provide such services in the Hospital and who is not a party to the exclusive contract/arrangement may not do so as of the effective date of the exclusive contract/arrangement whether or not such date is a full two (2) years from the most recent granting to him of such privileges.

SECTION 3.4 PROCEDURES FOR APPOINTMENT, REAPPOINTMENT AND CONCLUDING THE FOCUSED PROFESSIONAL PRACTICE EVALUATION

The mechanisms for submitting, evaluating and making final decisions on applications for initial appointment, for conducting periodic reappraisals for reappointment to the Staff and for concluding or extending the focused professional practice evaluation are outlined in the Medical Staff Policies and Procedures Manual.

SECTION 3.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.5-1 Qualifications and Selection

A Practitioner or an Allied Health Professional who is or who will be providing specified professional services pursuant to a contract or employment with the Hospital must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of their category as any other applicant or Staff Member.

3.5-2 Effect of Appointment Termination or Clinical Privileges Restriction

Because practice at the Hospital is contingent upon continued Staff appointment and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use Hospital facilities is automatically terminated when Staff appointment expires or is terminated. Similarly, the extent of a practitioner's clinical privileges is automatically limited to the extent that pertinent clinical privileges are restricted or revoked. The effect of an adverse action against a practitioner's clinical privileges on continuation of the contract/employment is governed solely by the terms of the contract/employment arrangement and/or the Bylaws of the Hospital.

3.5-3 Effect of Contract/Employment Expiration or Termination

a. The effect of expiration or other termination of a contract/employment upon a practitioner's Staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract/employment with the Hospital and/or the Bylaws of the Hospital.

b. If the contract/employment arrangement is silent on the effect of expiration or other termination of a contract/employment upon a practitioner's Staff appointment and clinical privileges, the practitioner's appointment or clinical privileges may continue subject to the provisions of Article Three, but all terms of the contract/employment arrangement will be deemed terminated.

SECTION 3.6 MEDICO-ADMINISTRATIVE OFFICERS

3.6-1 Defined

A medico-administrative officer is a practitioner engaged by the Hospital, either full or part-time, in an administratively responsible capacity, whose activities also include clinical responsibilities such as direct patient care, teaching or supervision of the patient care activities of other practitioners under the officer's direction.

3.6-2 Staff Appointment, Clinical Privileges and Obligations

A medico-administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge Staff obligations

appropriate to their Staff category in the same manner applicable to other Staff Members.

3.6-3 Effect of Removal from Office or Adverse Change in Appointment Status or Clinical Privileges

a. The effect of the removal from their medico-administrative office on the officer's Staff appointment and clinical privileges, and the effect of an adverse action against an officer's Staff appointment (less than total revocation) or clinical privileges on continuance in his medico-administrative office, will be governed solely by the terms of the contract between the officer and the Hospital, if the contract addresses those points. An adverse action against appointment status or clinical privileges, as specified in **Article Seven**, that is not caused by removal from a medico-administrative office, entitles the officer to the internal remedies and procedural rights provided in **Article Eight** of these Bylaws.

b. In the absence of a contract or where the contract is silent on the matter, removal from office alone will have no effect on appointment status or clinical privileges, except that the practitioner may not, thereafter, exercise any clinical privileges for which exclusive contractual arrangements have been made; continuance in office following loss of Staff appointment is impermissible under **Section 7.2**; and the effect of an adverse action against clinical privileges on continuance in office will be determined by the President of the Hospital after soliciting and considering the recommendations of relevant components and officials of the Staff.

SECTION 3.7 CERTAIN ALLIED HEALTH PROFESSIONALS

Physician Assistants and Nurse Practitioners must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge staff obligations appropriate to their staff category in the same manner applicable to other staff members.

SECTION 3.8 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant to and member of the Medical Staff agrees that, when corrective action is initiated or taken pursuant to **Article Seven** of these Bylaws, or when the provisions of **Article Eight** of these Bylaws are implemented, they will exhaust the administrative remedies afforded in the applicable Sections of these Bylaws before resorting to formal legal action.

ARTICLE FOUR

CATEGORIES OF THE MEDICAL STAFF

SECTION 4.1 CATEGORIES

The selection of a category is meant to enhance the individual provider's relationship with the Lowell General Hospital community.

The categories of appointment to the staff shall be active, affiliate and honorary. Privileges are separate entities from Staff Categories of Appointment, and neither is a determinant of the other (See Article Six, Section 6.1).

SECTION 4.2 THE ACTIVE CATEGORY

4.2-1 Qualifications

An active staff member must be located (office or residence) in sufficient proximity to the Hospital to provide continuing care to their patients or to ensure availability to provide care within a reasonable time period, as determined by the Chief of the Department.

Members of the active category will be expected to:

1. Attend their specific section/department meetings; Department meetings remain worthwhile for gaining consensus, developing policies, education, networking and assisting in the credentialing process. Attendance at department meetings is strongly encouraged. For those who cannot attend the meetings, an electronic dispersal of minutes will be emailed to them. Acknowledgement of at least 75% of the minutes is required for reappointment. Minutes must be acknowledged by the end of each calendar year. Voting (or a proxy) at department meetings is only allowed for those who attend at least one meeting during each calendar year. For those that do not attend any department meetings, it is necessary to meet the chief of the department, or obtain a letter of support from a different hospital's chief, prior to any reappointment.

2. Attend the quarterly full medical staff meetings;

3. Provide, in a twelve month period, a minimum of twelve patient encounters, to include admissions, consults, procedures or

provide a contribution to the organizational and administrative affairs of the medical staff to the satisfaction of the Medical Executive Committee (i.e. committee participation).

In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules and regulations, and policies and procedures of the medical staff and hospital, the member may be appointed to another medical staff category if they meet the eligibility requirements for such category or the member may be given formal written warning that action is required to maintain active status.

4.2-2 Prerogatives

Members of the active category may:

1. Vote on all matters presented to the medical staff, section, department and committee(s) to which the member is assigned;

2. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws, rules and regulations, policies and procedures.

4.2-3 Responsibilities

Members of the active category shall:

Actively participate as requested or required in activities and functions of the medical staff, including but not limited to: quality improvement initiatives, performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of the other staff functions as may be required by these Bylaws or Hospital rules and policies;

Fulfill or comply with any applicable medical staff or hospital rules and regulations and policies and procedures.

Pay all staff fees and assessments.

SECTION 4.3 THE AFFILIATE CATEGORY

4.3-1 Qualifications

The affiliate category is reserved for the medical staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status. Each member must meet the same office and residence proximity requirements as set forth in Section 4.2 for the Active category.

4.3-2 Prerogatives

Members of the affiliate category:

1. May attend medical staff section/department meetings of which they are a member without vote, and any medical staff or hospital education program;

2. May serve on medical staff committees, other than the Medical Executive Committee, and may vote on matters that come before such committees;

3. Will not vote on matters before the entire medical staff or be an officer of the medical staff.

4.3-3 Responsibilities:

Members of the affiliate category shall:

Actively participate as requested or required in activities and functions of the medical staff, including but not limited to: quality improvement initiatives, performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of the other staff functions as may be required by these Bylaws or Hospital rules and policies.

Fulfill or comply with any applicable medical staff or hospital rules and regulations and policies and procedures.

Pay staff fees and assessments.

SECTION 4.4 THE HONORARY CATEGORY

The Honorary Category is restricted to those individuals recommended by the Medical Executive Committee and approved by the Board of Trustees. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff/section/department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

SECTION 4.5 RESIDENTS/FELLOWS

4.5-1 Qualifications for Residents/Fellows

A resident/fellow must be a graduate of an approved medical school and must be, and remain in, good standing in an approved residency/fellowship program based at the Hospital or with which the Hospital or sponsoring physician preceptor is affiliated. The preceptor must be a member of the Active or Affiliate staff of the Hospital. A resident's/fellow's affiliation terminates when their training is completed, unless they resign sooner or are dismissed from the program or from their affiliation with the Hospital.

4.5-2 Prerogatives of Residents/Fellows

A resident/fellow may:

a. provide services as set forth in the training protocols developed by the training program director;

b. if invited, attend meetings of the Staff and the department, section, or service to which they are currently assigned;

c. serve on committees when so appointed and vote at committee meetings if so specified by the appointing authority.

Residents/fellows have no other voting rights on the Medical Staff.

4.5-3 Obligations of Residents/Fellows

A resident/fellow must:

a. meet the basic obligations provided in **Article Three.**

4.5-4 Obligations of Preceptors

A Preceptor

a. shall notify the Medical Staff President of their intent to bring a resident/fellow on site and will be responsible for submitting their supporting documentation prior to affiliation;

b. is responsible for the professional conduct of the resident/fellow;

c. shall inform the resident/fellow of the normal standards of care and social conduct in this community.

d. The preceptor will supervise the resident/fellow.

4.5-5 Fellows may function at a lower level of practice for which they completed a residency and are fully licensed to practice.

SECTION 4.6 MEDICAL STUDENTS

4.6-1 Qualifications

a. The Medical Student must be a student in good standing in an approved medical, dental or podiatric school or school of osteopathy with proof thereof.

b. Provide evidence of liability coverage, at limits set by these Bylaws and Rules and Regulations under the school's general liability insurance policy.

c. Produce evidence of the willingness of an Active or Affiliate Member of the Medical Staff to act as preceptor.

4.6-2 Prerogatives of Medical Students

May write in a medical record. An appropriately privileged Medical Staff Member must countersign every entry in the medical record in a timely manner. Orders cannot be implemented without the countersignature.

a. May take part in the morning rounds and regular visit rounds and other clinical activity.

b. May, with the consent of the patient and the Attending Physician, see, evaluate, and examine patients.

c. May perform an initial medical history and physical examination that must also be countersigned by an appropriately privileged medical staff member.

e. Attend when invited, clinical, scientific and educational meetings of the Staff or a department, section, or service.

4.6-3 Obligations of Medical Student

a. Abide by the Bylaws, Rules and Regulations of the Medical Staff and the Hospital.

b. Refrain from any conducts or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

4.6-4 Obligations of Preceptors

The preceptor or their designee shall notify the Medical Staff President of their intent to bring a medical student on site and will be responsible for submitting the supporting documentation prior to affiliation.

a. The preceptor or their designee is responsible for the professional conduct of the student.

b. The preceptor or their designee shall inform the student to the normal standards of care and social conduct in the community.

c. The preceptor or their designee will supervise the student.

Supervision is defined as direct oversight of the activities and direct education of the student. This means being present in the hospital at all times when the student is on site and seeing patients. It means the physician is also expected to see the patient and do their own evaluation either in conjunction with or after the student evaluation of the patient. The student can write orders and notes in the chart, but all of them must be reviewed and signed in a timely fashion by the supervising physician. The supervising physician or their designee is responsible for all activities, behaviors, etc. of the student.

ARTICLE FIVE

ALLIED HEALTH PROFESSIONALS AND ADVANCED PRACTICE PROVIDERS

SECTION 5.1 DEFINITION OF ALLIED HEALTH PROFESSIONAL STAFF (AHP) AND ADVANCED PRACTICE PROVIDERS (APP)

The Allied Health Professional Staff Members and Advanced Practice Providers are individuals who:

a. are qualified by training, experience and current competence in a discipline which the Board of Trustees has determined by policy to allow to practice in the Hospital; and either

b. have a recognized, but limited, scope of practice within medicine and are licensed and permitted to provide services in the Hospital, under the supervision of a physician with privileges in the specialty.

SECTION 5.2 CATEGORIES OF ALLIED HEALTH PROFESSIONAL STAFF CURRENTLY AUTHORIZED TO FUNCTION IN THE HOSPITAL

The Medical Executive Committee shall recommend to the Board of Trustees those categories of Allied Health Professional Staff Members authorized to provide services in the Hospital.

5.2-1 Allied Health Staff include:
Assistant to Physician/Dentist
Audiologist
Operating Room Technician
Psychologist

SECTION 5.3 JOB DESCRIPTIONS, QUALIFICATIONS AND EXPERIENCE OF ALLIED HEALTH PROFESSIONAL STAFF MEMBERS

5.3-1 Job descriptions, duties, qualifications and/or responsibilities of a given Allied Health Professional shall be defined by the department responsible for the supervision of that practitioner, subject to the approval of the Medical Executive Committee and Board of Trustees. Duties and responsibilities must fall within the general recognized guidelines for that profession. There can be only one description per department per AHP type and specialty.

5.3-2 All Allied Health Professionals must follow and conform to the same procedures required for applications of physicians seeking staff privileges pursuant to the medial staff bylaws. The medical staff and Lowell General Hospital recognizes that it is not possible for AHPs to meet some of the defined elements of membership that are required of physicians. These would include but are not necessarily limited to board certification within a specialty or subspecialty that is equivalent to the certification that can be granted by a recognized board to an MD or DO, DDS or DPM. Nevertheless, the AHP applicant must maintain full licensure as defined by the state of Massachusetts and additional certification in the specialty as defined by their own recognized governing body or board (if that exists), or be able to demonstrate a minimum level of competency in that specific specialty.

SECTION 5.4 PREROGATIVES OF ALLIED HEALTH PROFESSIONAL STAFF

The prerogative of an Allied Health Professional Staff Member are

a. to exercise such clinical privileges as are specifically granted to them and consistent with any limitations stated in these Medical Staff Bylaws and related manuals, the policies governing the Allied Health Professional Staff Member's practice in the Hospital and any other applicable Medical Staff or Hospital policies;

b. To provide such specifically designated patient care services as are granted to them, under the degree of supervision or direction of a Medical Staff Member as specified in the grant of services and consistent with any limitations stated in the Medical Staff Bylaws and related manuals, the policies governing the Allied Health Professional Staff Member's practice in the Hospital and any other applicable Medical Staff or Hospital policies

c. To serve on committees when so appointed and with vote, if so specified by the appointing authority;

d. To attend, when invited, clinical, scientific, and education meetings of the Staff or a department, section, or service, when appropriate to their discipline;

e. To exercise such other prerogatives as the Medical Executive Committee, with the approval of the Board of

Trustees, may accord Allied Health Professional Staff Members in general or a specific category of Allied Health Professional Staff.

Section 5.5 OBLIGATION OF ALLIED HEALTH PROFESSIONAL STAFF

Each Allied Health Professional Staff Member shall:

a. meet the basic responsibilities required by Section 3.2 for Medical Staff Members;

b. retain appropriate responsibility and exercise judgment within their area of professional competence for the care and supervision of each patient in the Hospital for whom they are providing services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need to arrange a suitable alternative for such care and supervision;

c. participate, when requested, in quality assurance activities and in discharging such other functions as may be required from time to time;

d. When requested, attend clinical and education meetings of the Staff and of the department, section, or service with which they are affiliated;

e. As applicable, fulfill the attendance requirements of these Bylaws;

f. Refrain from any conduct or activities that are or could be reasonable interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

SECTION 5.6 TERMS AND CONDITIONS OF AFFILIATION

An Allied Health Professional Staff member shall be individually assigned to the clinical unit appropriate to their professional training and is subject to formal periodic reviews and disciplinary procedures as determined for their category.

An Independent Allied Health Professional Staff Member's exercise of clinical privileges within any clinical unit and a Physician-Directed Allied Health Professional Staff Member's provision of specified

services within any clinical unit are subject to the rules and regulations of that unit and to the authority of the unit's physician director. The quality and efficiency of the care provided by the Allied Health Professional Staff Member within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or the Hospital quality assurance/management/utilization review mechanisms.

SECTION 5.7 DEFINITION OF SCOPE OF PRIVILEGES/SERVICE DESCRIPTION

The scope of clinical privileges that may be exercised by any Allied Health Professional Staff Member shall be developed by the supervising physician and/or section/department chief with input from representatives of Hospital administration, if applicable. All scopes of privileges will be approved by the Credentials Committee, the Medical Executive Committee, and subject to the approval of the Board of Trustees. Guidelines for each category of Allied Health Professional Staff Members who are Hospital employees shall also be reviewed by the Chief Executive Officer, or his designee.

For each category of Allied Health Professional Staff, guidelines must include at least:

- the identification of categories of patients that may be seen;
- a description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the medical record;
- a definition of the degree of assistance that may be provided to a practitioner in the care of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required.

SECTION 5.8 CATEGORIES OF ADVANCED PRACTICE PROVIDERS CURRENTLY AUTHORIZED TO FUNCTION IN THE HOSPITAL

The Medical Executive Committee shall recommend to the Board of Trustees those categories of Advanced Practice Providers authorized To provide services in the Hospital.

Advance Practice Providers include:

Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Clinical Nurse Specialist
Nurse Practitioner
Physician Assistants

As of January 1, 2021, Nurse Practitioners may be licensed within Massachusetts to have full practice authority, however, these Lowell General Bylaws will supersede and be in addition to that authority granted by the state for practice within the LGH hospital system.

SECTION 5.9 JOB DESCRIPTIONS, QUALIFICATIONS AND EXPERIENCE OF ADVANCED PRACTICE PROVIDERS (APP)

5.9-1 Job descriptions, duties, qualifications and/or responsibilities of a given advanced practice provider shall be defined by the department responsible for the supervision of that practitioner, subject to the approval of the Medical Executive Committee and Board of Trustees. Duties and responsibilities must fall within the general recognized guidelines for that professions. There can be only one description per department per advanced practice provider type and specialty.

5.9-2 All advanced practice providers must follow and conform to the same procedures required for applications of physicians seeking staff privileges pursuant to the medial staff bylaws. The medical staff and Lowell General Hospital recognizes that it is not possible for advance practice providers to meet some of the defined elements of membership that are required of physicians. These would include but are not necessarily limited to board certification within a specialty or subspecialty that is equivalent to the certification that can be granted by a recognized board to an MD or DO, DDS or DPM. Nevertheless, the advance practice provider applicant must maintain full licensure as defined by the state of Massachusetts and additional certification in the specialty as defined by their own recognized governing body or board (if that exists), or be able

to demonstrate a minimum level of competency in that specific specialty as documented by their supervising physician (see section 5.9-2a and 5.9-3)

a. The definition of a minimum level of competency will be defined as having worked for at least one continuous year of a full time equivalent (minimum 36 hours/week) in the specific specialty or subspecialty A written letter from the supervising board-certified physician, or the Chief of the department attesting that the applicant meets the above requirement may be submitted as proof of competency. If the applicant has no specific experience in the specialty, then the rules and regulations as spelled out in Section 5.3 below must be followed. Any exceptions to these regulations must be in writing and approved by the Chief of the applicable department and the Medical Executive Committee.

b. If the advanced practice provider does not meet the scope of experience they will be subject to a probationary period.

5.9-3 It is recognized by the medical staff and Lowell General Hospital that APP applicants do not, by definition, go through the same training as physicians in a particular specialty or subspecialty. However, advance practice providers are recognized as serving a critical part of the health care team, and as such, the need for the advance practice provider to gain experience is recognized as critical with respect to patient safety and the delivery of excellent care.

a. Therefore, a new advance practice providers member of the staff must be closely supervised by a physician in the same specialty for a period of not less than one year. At the end of that year, the supervising physicians(s) and/or the Chief of the department must certify in writing that the advance practice provider has achieved a level of expertise to be able to function at the full level of the advance practice provider's job description. For the first year, it should also be noted that it is the expectation that the advance practice provider and the supervising physician(s) shall follow the same bylaws defined in section 5/14 relating to the education and supervision of advance practice providers.

b. If an advance practice provider has extensive experience but in a different specialty than for that which they are seeking privileges, they can apply for full privileges after a 6-month probationary period if recommended by their supervising physician and the chief of that specialty department.

SECTION 5.10 PREROGATIVES OF ADVANCED PRACTICE PROVIDERS

The prerogatives of an advanced practice provider are:

a. to exercise such clinical privileges as are specifically granted to them and consistent with any limitations stated in these Medical Staff Bylaws and related manuals, the policies governing the advance practice provider's practice in the Hospital and any other applicable Medical Staff or Hospital policies;

b. to provide such specifically designated patient care services as are granted to them, under the degree of supervision or direction of a Medical Staff Member as specified in the grant of services and consistent with any limitations stated in the Medical Staff Bylaws and related manuals, the policies governing the advanced practice provider's practice in the Hospital and any other applicable Medical Staff or Hospital policies

c. To serve on committees when so appointed and with vote, if so specified by the appointing authority;

d. To attend, when invited, clinical, scientific, and education meetings of the Staff or a department, section, or service, when appropriate to their discipline;

e. To exercise such other prerogatives as the Medical Executive Committee, with the approval of the Board of Trustees, may accord advance practice providers in general or a specific category of advance practice providers.

Section 5.11 OBLIGATIONS OF ADVANCE PRACTICE PROVIDERS

Each Advance Practice Provider shall:

a. meet the basic responsibilities required by Section 3.2 for Medical Staff Members;

b. retain appropriate responsibility and exercise judgment within their area of professional competence for the care

and supervision of each patient in the Hospital for whom they are providing services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need to arrange a suitable alternative for such care and supervision;

c. participate, when requested, in quality assurance activities and in discharging such other functions as may be required from time to time;

d. When requested, attend clinical and education meetings of the Staff and of the department, section, or service with which they are affiliated;

e. As applicable, fulfill the attendance requirements of these Bylaws;

f. Refrain from any conduct or activities that are or could be reasonable interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

SECTION 5.12 TERMS AND CONDITIONS OF AFFILIATION

An advance practice provider shall be individually assigned to the clinical unit appropriate to their professional training and is subject to formal periodic reviews and disciplinary procedures as determined for their category. An advance practice provider shall be entitled to the same procedural due process right as provided in the Fair Hearing Review process for advance practice providers and applicants, as set forth in Article 9 as set forth in these bylaws.

An independent advance practice provider's exercise of clinical privileges within any clinical unit and a physician-directed advance practice provider's provision of specified services within any clinical unit are subject to the rules and regulations of that unit and to the authority of the unit's physician director. The quality and efficiency of the care provided by the advance practice provider within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or the Hospital quality assurance/ management/utilization review mechanisms.

SECTION 5.13 DEFINITION OF SCOPE OF PRIVILEGES/SERVICE DESCRIPTION

The scope of clinical privileges that may be exercised by any advance practice provider shall be developed by the supervising physician and/or section/department chief with input from representatives of Hospital administration, if applicable. All scopes of privileges will be approved by the Credentials Committee, the Medical Executive Committee, and subject to the approval of the Board of Trustees. Guidelines for each category of advance practice providers who are Hospital employee shall also be reviewed by the Chief Executive Officer, or his designee.

For each category of advance practice provider, guidelines must include at least:

- the identification of categories of patients that may be seen;
- a description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the medical record;
- a definition of the degree of assistance that may be provided to a practitioner in the care of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required.

5.14 ALLIED HEALTH PROFESSIONAL (AHP) AND ADVANCED PRACTICE PROVIDER (APP) STUDENTS

5.14-1 QUALIFICATIONS

a. The students must be a student in good standing in an approved training program with proof thereof and there must be a signed agreement between Lowell General Hospital and the student institution.

b. Provide evidence of coverage under the school's professional liability insurance policy.

c. Produce evidence of the willingness of a Medical Staff Member to act as preceptor.

5.14-2 PREROGATIVES OF ALLIED HEALTH PROFESSIONAL AN ADVANCED PRACTICE PROVIDER STUDENTS

a. May write in a medical record. An appropriate Medical Staff Member must countersign in a timely manner, every entry in the medical record. Orders cannot be implemented without the countersignature.

b. Students may take part in the morning rounds and regular visit rounds and other clinical activity.

c. Students can, with the consent of the patients and the attending physicians, see, evaluate, and examine patients.

d. Perform initial medical history and physical examinations that must also be countersigned y an appropriately privileged Medical Staff Member.

e. Attend, when invited, clinical, scientific, and education meetings of the Staff or a department, section, or service, when appropriate to his discipline.

5.14-3 OBLIGATIONS OF ALLIED HEALTH PROFESSIONAL AND ADVANCED PRATICE PROVIDER STUDENTS

a. Abide by the Bylaws, Rules and Regulations of the Medical Staff and the Hospital.

b. Refrain from any conduct or activities that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

5-14-4 OBLIGATIONS OF PRECEPTORS

a. The preceptor of their designee shall notify the Medical Staff President of their intent to bring and Allied Health Professional Student or Advanced Practice Provider Student on site and will be responsible for submitting the supporting documentation prior to affiliation

b. The preceptor or their designee is responsible for the professional conduct of the AHP or APP Student.

c. The preceptor or their designee shall inform the AHP or APP student to the normal standards of care and social conduct in the community.

d. The preceptor of their designee will supervise the AHP or APP Student:

Supervision is defined as direct oversight of the activities and direct education of the student. This means being present in the hospital at all times when the student is on site and seeing patients. It means the physician is also expected to see the patient and do their own evaluation either in conjunction with or after the student evaluation of the patient. The student can write orders and notes in the chart, but all of them must be reviewed and signed in a timely fashion by the supervising physician. The supervising physician or their designee is responsible for all activities, behaviors, and conduct of, as well as documentation done by, the student.

ARTICLE SIX

DELINEATION OF CLINICAL PRIVILEGES

SECTION 6.1 EXERCISE OF PRIVILEGES

6.1-1 General

A practitioner providing clinical services at this Hospital by virtue of Medical Staff appointment or in a temporary privilege situation may, in connection with such practice and except as otherwise provided in **Section 6. 8** in an emergency, exercise only those clinical privileges specifically granted to him by the Board of Trustees or as provided in **Section 6.9** for Volunteer Disaster Privileges and **Section 6.10** for Temporary Privileges. Regardless of the level of privileges granted, each practitioner must pledge to provide or arrange for appropriate and timely medical care for their patients in the Hospital and to obtain consultation or coverage, when necessary, for the safety of their patient, or when required by the Rules or other Policies of the Staff, any of its clinical units, or the Hospital.

6.1-2 Exercise of Privileges

All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital have delineated privileges.

6.1-3 Admitting Privileges

All Active and Affiliate Medical Staff members of the Departments of Cardiology, OB/GYN, Orthopedics, and Surgery are automatically granted the privilege to admit patients. All Active and Affiliate members of the Department of Family Medicine, Internal Medicine, and Pediatrics choose the privilege to admit patients or choose Refer and Follow privileges in which case they admit to a hospitalist program. Active and Affiliate members in all other departments may not admit patients unless specifically granted the privilege to do so in accord with the Bylaws.

SECTION 6.2 BASIS FOR PRIVILEGES DETERMINATION

Clinical practice privileges shall be granted in accordance with prior and continuing education and training, prior and current experience, utilization practice patterns, current health status, and demonstrated current competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's

credentials file. Additional factors that may be used in determining privileges are those specified in **Article Three** of these Bylaws, patient care needs for the type of privileges being requested by the applicant, the geographic location of the practitioner, availability of qualified medical coverage in their absence, and an adequate level of professional liability insurance. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determinations.

The basis for privileges determinations for current Staff Members in connection with reappraisal, including conclusion of the provisional period or with a requested change in privileges, also include observed clinical performance, documented results of the Staff's quality assurance, risk management, and utilization review activities, and, in the case of additional privileges granted, evidence of appropriate training and experience supportive of the request.

A period of focused professional practice evaluation will be performed for all initial applicants requesting privileges, member of the medical staff requesting a new privilege, or when concerns regarding the provision of safe, quality care by a current medical staff member are raised. The period of review will be carried out in accordance with the Focused Professional Practice Evaluation Policy which is included in the Medical Staff Policies and Procedures.

SECTION 6.3 PROCEDURE FOR DELINEATING PRIVILEGES

The procedures by which requests for clinical privileges are processed are provided in the Medical Staff Policies and Procedures Manual.

SECTION 6.4 SPECIAL CONDITIONS FOR ORAL SURGEONS AND DENTISTS

6.4-1 Requests for clinical privileges from oral surgeons and dentists are processed in the manner specified in this Article.

6.4-2 Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Chief of the Department of Surgery.

a. An oral surgeon with the requisite qualifications may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient, but only in those instances where the patient has no known contraindications to the planned procedure.

b. In all other circumstances, a physician member of the Medical Staff with requisite privileges must perform a basic medical appraisal on an oral surgery or dental patient and must determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. Also a physician member of the medical staff with requisite privileges must be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization.

c. When significant medical abnormality is present, the final decision on whether to proceed with surgery must be agreed upon by the oral surgeon or dentist and the physician consultant.

The Chief of the Department of Surgery will decide the issue in case of dispute.

SECTION 6.5 SPECIAL CONDITIONS FOR PODIATRISTS

6.5-1 Requests for clinical privileges from podiatrists are processed in the manner specified in this Article.

6.5-2 Surgical procedures performed by podiatrists are under the overall supervision of the Chief of the Department of Surgery.

a. A podiatrist may initiate the process for admitting a patient, but a physician member of the Medical Staff with requisite privileges must perform a basic medical appraisal for each patient immediately after admission and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. Also a physician member of the medical staff with requisite privileges must be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization.

SECTION 6.6 SPECIAL CONDITIONS FOR HOUSE STAFF

Trainees in post-graduate training programs (*i.e.*, residencies, fellowships) shall be permitted to perform those services set out in training protocols developed by the applicable program directors. They shall, in the performance of those services, be subject to all applicable Rules and Policies of the Staff and Hospital, and of the department under which the services are provided, and to the authority of the department chief.

SECTION 6.7 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONALS

The policies and procedures governing the granting and performance of specified patient care services by Allied Health Professionals are set forth in **Article Eighteen** of these Bylaws.

SECTION 6. 8 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, but regardless of department affiliation, Staff category, or privileges. A practitioner providing services in an emergency situation that are outside their usual scope of privileges, is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

SECTION 6.9 VOLUNTEER DISASTER PRIVILEGES

Volunteer Disaster Privileges shall be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs.

During disaster(s) in which the Emergency Operation Plan has been activated, the Chief Executive Officer or Medical Staff President or their designee(s) has the option to grant volunteer disaster privileges to non-members of the medical staff. The individual(s) responsible for granting volunteer disaster privileges is identified, along with contingencies for alternates, should the need arise. No volunteer practitioner shall be automatically entitled to privileges. Volunteer disaster privileges are granted on a case by case basis.

1. The medical staff addresses the verification process as a high priority. The medical staff has a mechanism to assure that the verification process of credentials and specific privileges of individuals who receive volunteer disaster privileges begin as soon as the immediate situation is under control. The privileging process is identical to the process established under the medical bylaws for granting temporary privileges to fulfill an important patient need. If any problem or issue is identified with the verification of credentials, it must be brought to the attention of the key medical staff leader

identified in the Hospital Disaster Plan. Physicians being granted volunteer disaster temporary privileges are not allowed to perform tasks outside the specialty specific or scope of their practice, nor that they are not already approved for at another institution.

2. A physician who is a member of the medical staff and has been granted privileges at Lowell General Hospital will be assigned as a mentor to each clinical area utilizing volunteer licensed independent practitioners in order to orient the volunteer practitioners to the hospital and oversee their performance.

3. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner and before the chief executive officer or president of the medical staff or their designee(s) may grant volunteer disaster privileges, the hospital obtains their valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

    a. A current picture identification card from a health care organization that clearly identifies professional designation;

    b. A current license to practice

    c. Primary source verification of licensure

    d. Identification indicating that the individual is a member of a Disaster Medical Assistant Team (DMAT); the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP); or other recognized state or federal response organization or group.

    e. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.

    f. 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 independent practitioner during a disaster.

4. The emergency privileges granted during a disaster shall terminate immediately, when the emergency has officially ended by:

    a. a declaration of the state governor or other elected official, publicly announcing it and;

    b. the CEO or their designee(s) make the determination that the disaster has ended for the hospital and makes an official declaration.

SECTION 6.10 TEMPORARY PRIVILEGES

6.10-1 Conditions

Temporary Privileges may be granted only in the circumstances and under the conditions described in **Section 6.10-2**, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Special requirements of consultation and reporting may be imposed by the chief of the department, section, or service responsible for supervision. Under all circumstances, the practitioner requesting Temporary Privileges must agree, in writing, to abide by these Bylaws and related Manuals, Rules and Policies of the Staff, and those of the Hospital in all matters relating to their activities in the Hospital.

1. Temporary privileges shall be granted upon verification of
    - Current licensure
    - Relevant training or experience
    - Current competence
    - Ability to perform the privileges requested
    - Other criteria required by medical staff bylaws
    - The results of the National Practitioner Data Bank query have been obtained and evaluated ; and,

2. The applicant has:
    - a complete application
    - no current or previously successful challenge to licensure or registration
    - not been subject to involuntary termination of medical staff membership at another organization
    - not been subject to involuntary limitation, reduction, denial, or loss of clinical privilege.

6.10-2 Circumstances

Upon written recommendation of the Chief of the Department where the privileges will be exercised and the President of the Medical Staff or his designee, the CEO/President of the Hospital or their designee may grant temporary privileges in the following circumstances:

a. A completed application for privileges has been submitted, including a written justification requesting specific temporary privileges, that is awaiting review and recommendation by the Medical Executive Committee for approval by the Governing Body.

b. to fulfill an important patient care, treatment and service need, as determined with written justification by the Chief and CEO, President or designee(s) including but not limited to:

   i. a situation where a member physician becomes ill or takes a leave of absence and the applicant would need to cover their practice until the member physician returns

   ii. specific training and qualifications that are necessary for patient care that are not otherwise available among medical staff members.

c. Temporary privileges may be granted for a limited period of time not to exceed 120 consecutive days.

d. Temporary privileges are not to be used for other administrative processes such as:

   i. The applicant fails to provide all information necessary to the processing of their reappointment in a timely manner.

   ii. Failure to verify performance data and information in a timely manner,

e. Notwithstanding the provision of paragraph (d) above, if in a reappointment situation the failure to allow the practitioner to continue to practice care would present a critical clinical need as determined by the CEO/President of the Hospital or their designee(s),

temporary privileges may be granted.

6.10-3 Termination

The President of the Hospital, Chairman of the Medical Executive Committee, or Chief of the applicable department

- Must terminate any or all of the practitioner's Temporary Privileges on the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications or ability to exercise any or all of the Temporary Privileges granted; and

- may, at any other time, after consultation with the department chief responsible for supervision, terminate any or all of the practitioner's Temporary Privileges, provided that, where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose Summary Suspension under these Bylaws.

- In the event of any such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner by the chief responsible for supervision of the practitioner. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

SECTION 6.11 RESIGNATION

Any staff member may at any time resign from the medical staff by a written resignation submitted to his Chief of Service or Department Head and transmitted to the secretary of the Medical Executive Committee and Board of Trustees. A staff member who moves their practice out of state without submitting a formal resignation shall be notified that their membership will be terminated, with the exception of practitioners who have offices in New Hampshire.

A resignation cannot be rescinded after being presented to the Medical Executive Committee.

SECTION 6.12 LEAVE OF ABSENCE

Upon written request, a leave of absence for a specified amount of time not to exceed one year may be granted by the Medical Executive Committee for the purpose of additional training, military service, and illness, or for other reasons as deemed acceptable by the Medical Executive Committee. The member may request an extension for a specified period of time not to exceed six months at the conclusion of the

one-year period. The normal procedure for returning from an approved leave of absence shall be initiated by written request directed to the Medical Executive Committee. Reinstatement may be made to the same or different status at the discretion of the Medical Executive Committee.

The Chief of the Department must assess if there is enough clinical data to adequately determine competence and recommendation for reappointment, including health status. Reappointment from a leave of absence that exceeds 18 months requires reapplication to the Medical Staff for privileges. Members whose staff appointments expire during their Leave of Absence must reapply for staff privileges.

In cases where the Medical Executive Committee is not scheduled to meet in an appropriate timeframe, the President of the Medical Staff or their designee in conjunction with the President of the Hospital or their designee, may approve the request for a leave of absence or the request to conclude a leave of absence.

This is a temporary approval and will be presented at the next regularly scheduled meeting of the Medical Executive Committee for approval.

SECTION 6.13 EXPERIMENTAL, NEW, UNTRIED, OR UNPROVEN PROCEDURES/TREATMENT MODALITIES/INSTRUMENTATIONS

Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by the Clinical Research Review Committee. Any experimental or other new, untried, or unproven procedures/treatment modalities/instrumentations may be performed or used only after the regular credentialing process has been completed and the privilege to perform or use said procedures/treatment modalities/instrumentations has been granted to the individual practitioner. For the purposes of this paragraph, a new, untried, or unproven procedure/treatment modality/instrumentation is one that is not generalizable from an established procedure/treatment modality/instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same or similar complications, the same or similar indications, or the same or similar expected physical outcome for the patient as the established procedure/treatment modality/instrumentation.

ARTICLE SEVEN

CORRECTIVE ACTION

TYPES OF CORRECTIVE ACTION

Corrective action cases can be divided into three main groupings according to the type of infraction and the type of remedy imposed. These are Ordinary Corrective Action, corrective action requiring Summary Suspension, and corrective action requiring Automatic Suspension.

SECTION 7.1 AUTOMATIC SUSPENSION

Automatic Suspension is triggered when certain infractions are committed. Automatic Suspension shall be effective immediately upon the happening of such infraction. There shall be no due process provided for automatic suspension.

7.1-1 Licensure

1. Action by the Commonwealth of Massachusetts Board of Registration in Medicine revoking or suspending a Staff Member's license shall automatically suspend all the Practitioner's Hospital privileges. Similarly, action by a Commonwealth of Massachusetts agency with licensing authority over an Allied Health Professional revoking or suspending an Allied Health Professional's license shall automatically suspend all the Allied Health Professional's Privileges.

2. If the Staff Member's license is subsequently reinstated, the Practitioner or Allied Health Professional may reapply for privileges subject to any corrective action that may be initiated.

3. The expiration, lapse, or failure to present a current copy on or by the expiration date, of a Practitioner's or Allied Health Professional's license, shall result in the automatic suspension of medical staff privileges.

7.1-2 Felony Conviction

After conviction of any state or federal felony the Practitioner's or Allied Health Professional's Medical Staff membership and clinical privileges may be automatically revoked.

7.1-3 Controlled Substances Number (DEA Registration)

Practitioners or Allied Health Professionals whose registration with the Federal Drug Enforcement Agency (DEA) has been revoked or suspended shall have their authority to prescribe controlled substances automatically restricted.

7.1-4 Medical Records

An Automatic Suspension in the form of suspension of a Practitioner's or Allied Health Professional's clinical privileges, with the exception for Practitioners of continuing primary care of patients already in the Hospital, effective until medical records are completed, shall be imposed automatically after written warning of delinquency for failure to complete medical records within a period of time specified in the Medical Staff Rules and Regulations. Such a suspension shall not prevent emergency admissions strictly defined as those in which the patient's life or limb is in jeopardy. Privileges shall be automatically reinstated upon completion of all incomplete records.

7.1-5 Professional Liability Insurance

Failure to maintain and provide proof of the minimum amount of professional liability insurance shall result in automatic suspension of the Practitioner's or Allied Health Professional's Medical Staff appointment and clinical privileges.

SECTION 7.2 SUMMARY SUSPENSION

7.2-1 Procedure

1. The President of the Medical Staff, or the President of the Hospital after consultation with the CMO, may summarily suspend or restrict the admitting and/or clinical privileges, or specific admitting or clinical privileges, of any Practitioner or Allied Health Professional in the interests of patient care; to prevent imminent harm to any individual or the Lowell General Hospital or to prevent imminent or further disruption of the Lowell General Hospital's operations.

2. The President of the Medical Staff, the President of the Hospital, the Medical Executive Committee or the Executive Committee of the Board of Trustees each has

independent authority to summarily suspend a Practitioner or an Allied Health Professional, and such Summary Suspension shall become effective immediately upon imposition.

3. The President of the Hospital shall be notified of the Summary Suspension and shall notify the Practitioner or the Allied Health Professional and the Medical Executive Committee, in writing, that such action has been taken.

4. When the Summary Suspension becomes effective, either the President of the Medical Staff or the department chief must reassign the Practitioner's patients who are still in the Hospital to other providers for continuity of patient care after conferring with the patient as to any preference for a provider with appropriate clinical privileges.

7.2-2 Medical Executive Committee Responsibility

1. If the MEC determines that the summary suspension is appropriate, it will immediately notify the Practitioner or the Allied Health Professional, as appropriate, and the Board of Trustees and the suspension will remain in effect until the Board of Trustees final decision.

2. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request a hearing on the matter in accordance with Article 8. The hearing shall be convened within seven days of notification of the summary suspension. The MEC shall meet to determine whether to uphold or modify the summary suspension recommendation. An Allied Health Professional whose clinical privileges have been summarily suspended shall be entitled to appellate review on the matter in accordance with Article Nine.

3. After the hearing, in accordance with Article 8 if requested, the Medical Executive Committee can modify, maintain, or terminate the Practitioner's suspension. The Medical Executive Committee shall forward its recommendation to the Executive Committee of the Board of Trustees for final approval and the Practitioner's suspension will remain in force until the Board's final approval.

7.2-3 Procedural Rights

If after the hearing, the MEC does not recommend terminating the suspension, the Practitioner has the right to request an Appellate Review of the Suspension in accord with Article Eight. The Summary Suspension remains in effect, unless modified by the Medical Executive Committee, until the Board of Trustees reaches a final decision following the Appellate Review process.

7.2-4 Impaired or Disruptive Practitioners

Any Practitioner or Allied Health Professional who has been summarily suspended because of substance abuse or as a disruptive physician shall be referred to an appropriately monitored counseling and treatment program. Reporting of such action shall be in compliance with applicable statutes.

SECTION 7.3 ORDINARY CORRECTIVE ACTION

7.3-1 Defined

Whenever the activities or professional conduct of any Practitioner or Allied Health Professional with clinical privileges are considered not to meet expected standards of care in their specialty, or inconsistent with or harmful to good patient care and safety, or in violation of the Medical Staff and/or the Hospital Bylaws, Rules and Regulations, or Policies, or disruptive to the operations of the Hospital, corrective action against such Practitioner or Allied Health Professional may be requested by any individual with knowledge of such activities or professional conduct. A request may be made to any of the individuals identified and the manner described in Section 7.3-2, below.

7.3-2 Authority to Request Corrective Action

All requests for corrective action shall be in writing, shall be made to the President of the Medical Staff or the Chief Medical Officer and shall state the specific activities or conduct that constitute the grounds for the request. The President of the Medical Staff may vet the request and determine whether (potentially with the input of the Department Chief) to resolve the issue informally without the need for investigation, i.e., determining it doesn't need to go further.

7.3-3 Investigation Process

1. The President of the Medical staff in conjunction with the chief of the department may determine that the issue does not need any further investigation.

2. If the President of the Medical Staff determines that further investigation is warranted he will present the request to the Medical Staff Leadership (Past-President, President, President-elect and the CMO).

3. If the Medical Staff Leadership determines that further investigation is warranted and that such investigation could result in reduction or suspension of clinical privileges, then the President of the Medical Staff will present the request to the Medical Executive Committee (MEC) and appoint a MEC Ad Hoc Committee, as defined in 7.3.3-4, to begin an investigation, pending final approval by the MEC. Medical Staff Leadership may approve that an Ad Hoc Committee be appointed. Members will be appointed by the appropriate Chief and the President of the Medical Staff. Such Committee appointment will be presented at the next MEC meeting.

4. The President of the Medical Staff will present the complaint and any supporting evidence to the MEC at the next scheduled MEC meeting, where the MEC will make the final determination if an additional investigation is warranted. If the MEC agrees that an Ad Hoc Committee should be convened, the President of the Medical Staff, if not already done, will immediately appoint an Ad Hoc Committee comprised of 3-5 members from the following: the Medical Staff Leadership, the Chief of the Department, other medical staff members, and Director of Quality and Risk Management (with voice but no vote). External reviewers may be retained to provide support. After the MEC meeting, the President of the Medical Staff or Chief of the Department will notify the Practitioner or Allied Health Professional of the nature of the complaint and the formation of the Ad Hoc Committee.

5. The Practitioner or Allied Health Professional against whom corrective action has been requested shall have an opportunity for an interview with the MEC Ad Hoc Committee. At such interview, the Practitioner or Allied Health Professional shall be invited to respond to the request for corrective action. This interview shall not constitute a hearing, shall be preliminary in nature, and

none of the procedural rules provided in Article Eight of these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the committee and included with its report to the Medical Executive Committee. A member of the MEC Ad Hoc Committee will be designated to function as secretary, whose duties will include maintenance of minutes.

6. Within thirty (30) days of notifying the Practitioner or Allied Health Professional of the request for corrective action, the MEC Ad Hoc Committee shall make a report (to include but not limited to the following: a discussion of documents, interviews conducted, findings, and recommendations) of its investigation to the Medical Executive Committee except that the Medical Executive Committee may grant an extension of time for good cause shown. The recommendations of the MEC Ad Hoc Committee may be rejected, accepted, or modified by the MEC.

7.3-4 Disciplinary Sanctions

1. Following receipt of the MEC Ad Hoc Committee's report, the MEC shall take action upon the initial request. The Medical Executive Committee shall deliberate and make a recommendation for further action. The Practitioner or Allied Health Professional shall be notified of the MEC final recommendation. Further action, if it is deemed appropriate, may include, but is not limited to, rejection of the request for corrective action on the grounds that the request was unsubstantiated, acceptance of the MEC Ad Hoc Committee's recommendations; or modification of the MEC Ad Hoc Committee's recommendations. The Medical Executive Committee may recommend sanctions to include, but not be limited to, the following: Issuing a warning or a letter of probation; imposing a consultation requirement; reducing, suspending, or revoking clinical privileges; recommending that, in cases of summary suspension, clinical privileges be terminated, modified, or sustained; reducing Staff category or limiting Staff prerogatives relating to patient care; suspending or revoking Staff appointment.

7.3-5 Board of Trustees Responsibility

The Medical Executive Committee shall forward its recommendation to the Board of Trustees, which shall exercise final authority in all matters pertaining to corrective action. Except that it shall not act until the Practitioner has exercised or waived his or her hearing rights if the MEC recommendation entitles the Practitioner to a hearing. If the Medical Executive Committee rejects the request for corrective action, the President of the Hospital must inform the Board of this decision. The Board may accept, modify, or reject the Medical Executive Committee's recommendation. The Board of Trustees has authority to direct and/or conduct further investigation if deemed necessary and appropriate. When modifying or rejecting the Medical Executive Committee recommendation, the Board may impose all available sanctions or disciplinary actions that are available to the Medical Executive Committee. The Board of Trustees shall notify the Practitioner of its actions and the MEC of its final decision.

7.3-6 Procedural Rights

Any recommendation by the Medical Executive Committee or the Board of Trustees for restriction, reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected Practitioner to the procedural rights provided in Article Eight of these Bylaws which rights shall be the sole exclusive procedural rights available and the affected Allied Health Professional to the procedural rights provided in Article Nine of these Bylaws which rights shall be the sole exclusive procedural rights available. If the Practitioner requests a hearing as provided in Article Eight, such hearing shall take place and be completed prior to final action by the Board of Trustees.

ARTICLE EIGHT

FAIR HEARING AND APPELLATE REVIEW PROCEDURE APPLICABLE TO PRACTITIONERS

SECTION 8.1 RIGHT TO FAIR HEARING AND TO APPELLATE REVIEW

8.1-1 When any Practitioner receives notice of a recommendation by the Medical Executive Committee that, if ratified by decision of the Board of Trustees, will adversely affect the Practitioner's appointment to or status as a Member of the Medical Staff or the Practitioner's exercise of clinical privileges, the Practitioner shall be entitled to a Fair Hearing before the Fair Hearing Committee of the Medical Staff. If the recommendation of the Fair Hearing Committee of the Medical Staff, following such Fair Hearing, is still adverse to the affected Practitioner, the Practitioner shall then be entitled to an Appellate Review by the Board of Trustees before the Board of Trustees makes a final decision on the matter.

8.1-2 All Fair Hearings and Appellate Reviews shall be in accordance with the procedural safeguards set forth in this **Article Eight** so that the affected Practitioner is accorded all rights available under these Bylaws.

SECTION 8.2 REQUEST FOR FAIR HEARING OR APPELLATE REVIEW

8.2-1 The President of the Hospital shall provide prompt written Notice of Proposed Action to include that a professional review action has been proposed to be taken, the reasons for the proposed action, the Practitioner's right to request a hearing, by certified mail, return receipt requested. Such notice shall advise the Practitioner of their right to a Fair Hearing or an Appellate Review pursuant to **Article Eight** of these Bylaws, and specify that the Practitioner shall have thirty (30) days following the date of receipt of such notice within which to request a Fair Hearing or an Appellate Review, whichever is applicable. The Practitioner shall make a request for Fair Hearing or Appellate Review in writing to the President of the Hospital. In the hearing, the Practitioner has the right to: representation by an attorney or other person of his choice; have a record of the proceeding made (copies of which may be obtained by the Practitioner upon payment of reasonable charges); call, examine and cross-examine witnesses; present evidence deemed relevant by the hearing officer, regardless of whether such

evidence would be admissible in a court of law and submit a written statement at the end of the proceedings.

8.2-2 Practitioner's failure to request a Fair Hearing within the time and in the manner herein provided shall be deemed a waiver of Practitioner's right to a Fair Hearing and Appellate Review. The failure of a Practitioner to request an Appellate Review within the time and in the manner herein provided shall be deemed an irrevocable waiver of Practitioner's right to Appellate Review.

8.2-3 When the waived Fair Hearing or Appellate Review relates to an adverse recommendation of the Medical Executive Committee, the same shall thereupon become and remain effective against the Practitioner pending the Board of Trustees' final decision on the matter. When the waived Fair Hearing or Appellate Review relates to an adverse decision by the Board of Trustees, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Board of Trustees, provided for in **Section 8.7.** In either of such events, the President of the Hospital shall promptly notify the affected Practitioner of the Practitioner's status as described above by certified mail, return receipt requested.

SECTION 8.3 NOTICE OF FAIR HEARING

8.3-1 Within 30 days after receipt of a request for Fair Hearing from a Practitioner entitled to the same, the Medical Executive Committee or the Board of Trustees, whichever is appropriate, shall schedule and arrange for such a Fair Hearing and shall, through the President of the Hospital, issue a Notice of Fair Hearing to the Practitioner of the time, place, and date, by certified mail, return receipt requested. The Fair Hearing shall be scheduled no sooner than 30 days, nor more than 60 days from the date of the Fair Hearing Notice; provided, however, that a Fair Hearing for a Practitioner who is under suspension that is then in effect shall be held as soon as arrangements therefore may reasonably be made, but no later than 30 days from the date of receipt of such Practitioners request for Fair Hearing.

8.3-2 The Notice of Fair Hearing shall state in concise language the place, time and date of the hearing, which shall not be less than 30 days after the date of the notice and the list of witnesses, known at the time, (with an opportunity to revise/supplement) expected to testify on behalf of the professional review body; the acts, omissions, behavior, or conduct that will be examined, a list of specific or representative charts being considered, and/or the other

reasons or subject matter that established grounds for the adverse recommendation or decision, if applicable.

SECTION 8.4 COMPOSITION OF FAIR HEARING COMMITTEE

8.4-1 The Fair Hearing Committee of the Medial Staff shall be composed of not less than five (5) Members of the Medical Staff, appointed by the President of the Medical Staff in consultation with the Medical Executive Committee. One of the Members so appointed shall be designated as Chairman. No Staff Member, who has actively participated in the consideration of this action or who is in direct economic competition with the Practitioner shall be appointed a Member of this Fair Hearing Committee.

SECTION 8.5 CONDUCT OF HEARING

8.5-1 There shall be at least a majority of the Members of the Fair Hearing Committee present when the Fair Hearing is in session, and no Member may vote by proxy.

8.5-2 An accurate record of the Fair Hearing must be kept. The mechanism shall be established by the Fair Hearing Committee and may be accomplished by use of a court reporter or electronic recording unit.

8.5-3 Attendance of the affected Practitioner shall be required when the Fair Hearing is in session, unless good cause exists otherwise and is granted by the Fair Hearing Committee. A Practitioner who fails, without good cause, to attend such Fair Hearing shall be deemed to have waived all rights in the same manner as provided in **Section 8.2** and to have accepted the adverse recommendation or decision, and the same shall thereupon become and remain in effect as provided in said **Section 8.2**.

8.5-4 Postponement of a Fair Hearing beyond the time set forth in these Bylaws shall be made only upon the recommendation of the Fair Hearing Committee and the Medical Executive Committee.

8.5-5 The affected Practitioner shall be entitled to be accompanied by an attorney or other person of their choice.

8.5-6 A Hearing Officer shall preside over the Fair Hearing Committee, shall be appointed by the Medical Executive Committee, is an attorney, is not a member of the Fair Hearing Committee and has

no vote. The Hearing Officer shall establish and maintain the order of procedure during the Fair Hearing, to ensure that all participants have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

8.5-7 The Hearing need not be conducted strictly according to any rules of law that relate to the examination of witnesses, presentation of evidence, or otherwise. 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 that might make evidence inadmissible over objection in a civil or criminal proceeding. The Practitioner for whom the Hearing is being held shall, prior to or during the Hearing, be entitled to submit memoranda to the Fair Hearing Committee with copies to all representatives concerning any issue of procedure of fact and such memoranda shall become a part of the Fair Hearing record. In addition to this, at least ten days prior to the hearing each side shall send to the Fair Hearing Committee and to the other party a copy of the final witness list and a copy of all exhibits they intend to introduce. This will not preclude either party from introducing additional information at the time of the hearing.

8.5-8 The Medical Executive Committee, when its action has prompted the Hearing, shall appoint one of its Members or some other Medical Staff Member to represent it at the Hearing. The Board of Trustees, when its action has prompted the Fair hearing, shall appoint one of its Members to represent it at the Fair Hearing. It shall be the obligation of such representative, to present appropriate evidence in support of the adverse recommendation or decision. In order to reverse the adverse recommendation or action, the Practitioner shall have the obligation to persuade the Fair Hearing Committee, by clear and convincing evidence, that the reasons supporting the adverse recommendation or action lack any factual basis, or that such basis, or any action based thereon, is either arbitrary, unreasonable or not in compliance with applicable law. Within thirty (30) days of the conclusion of all testimony, both parties may submit simultaneously a written statement to the Fair Hearing Committee.

8.5-9 The affected Practitioner shall have the following rights:

i. representation by an attorney or other person of their choice.

ii. have a record of the proceeding made (copies of which may be obtained by the Practitioner upon payment of reasonable charges);
iii. call, examine and cross-examine witnesses;
iv. present evidence deemed relevant by the hearing officer, regardless of whether such evidence would be admissible in a court of law; and
v. submit a written statement at the end of the proceedings.

The Practitioner may be called and cross-examined by the representative of the Medical Executive Committee of the Board of Trustees. There is no right to discovery.

8.5-10 The Fair Hearing provided for in these Bylaws is for the purpose of examining on an intra-professional basis, matters bearing on the Practitioner's professional competency and conduct as a member of the appointed Medical Staff.

8.5-11 The Fair Hearing Committee may, without special notice, recess the Fair Hearing and reconvene the same for the convenience of the participants or for the purpose of the participants obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the Fair Hearing shall be closed. The Fair Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the Fair Hearing was convened.

8.5-12 Within fourteen (14) days after final adjournment of the Fair Hearing, the Fair Hearing Committee shall make and issue a written report and recommendation and shall forward the same with the Fair Hearing record and all other associated documentation to the Medical Executive Committee. The report may recommend acceptance, modification, or rejection of the adverse recommendation of the Medical Executive Committee. The Medical Executive shall consider the Fair Hearing Report and will prepare and submit a final recommendation to the Board of Trustees. A copy of the final recommendation will be provided to the Practitioner. If the final decision is still adverse, the procedure to be followed shall be as provided in Section 8.6.

8.5-13 A copy of the Medical Executive Committee's report and recommendation shall be delivered to the Practitioner and to their attorney, if represented, upon its issuance through the President of the Hospital, by certified mail, return receipt requested.

8.5-14 If the Practitioner seeks further review of the Medical Executive Committee's report and recommendation, the procedure to be followed shall be as provided in **Section 8.6** of these Bylaws.

SECTION 8.6 APPEAL TO THE BOARD OF TRUSTEES

8.6-1 Within fourteen (14) days after receipt of the Medical Executive Committee's report and recommendation, if it is still adverse to the Practitioner, the Practitioner may, by written notice to the Board of Trustees, delivered through the President of the Hospital by certified mail, return receipt requested, request an Appellate Review by the Board of Trustees. Such notice may request that the Appellate Review examine only Fair Hearing Committee report as supported by the Practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the Appellate Review. Permitting Oral argument will be left to the discretion of the Appellate Review Committee upon review of written statements from the parties.

8.6-2 If such Appellate Review is not requested within fourteen (14) days of receipt by the Practitioner of the Fair Hearing Committee report and recommendation, the affected Practitioner shall be deemed to have waived all right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in **Section 8.2**.

8.6-3 Within thirty (30) days after receipt of such notice of request for Appellate Review, the Board of Trustees shall schedule a date for such Appellate Review, including a time and place for said review and through the President of the Hospital, by written notice sent by certified mail, return receipt requested, notify the affected Practitioner of the same. The date of the Appellate Review shall not be less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the notice of request for Appellate Review, except that when the Practitioner requesting the Appellate Review is under a suspension which is then in effect, such Appellate Review shall be scheduled, if requested by the Practitioner, as soon as the arrangements for it may reasonably be made, but no more than thirty (30) days from the date of receipt of Practitioner's notice of request.

8.6-4 The Appellate Review shall be conducted by an Appellate Review Committee of the Board of Trustees. The Executive Committee of the Board of Trustees shall duly appointment members of this

committee which shall consist of at least three (3) but no more than five (5) members.

8.6-5 The affected Practitioner shall have access to the record of the Fair Hearing Committee. The Practitioner shall have thirty (30) days to submit a written statement to the Board of Trustees that shall specify the basis for the Practitioner's appeal and address any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Trustees, with an electronic mail copy to the Medical Executive Committee, through the President of the Hospital by certified mail, return receipt requested, at least three (3) days prior to the scheduled date for the Appellate Review. A statement may be submitted by the Medical Executive Committee in support of its recommendations and, if submitted, the President of the Hospital shall provide a copy thereof to the Practitioner at least three (3) days prior to the date of such Appellate Review by certified mail, return receipt requested and electronic mail.

8.6-6 The Board of Trustees appointed Appellate Review Committee shall review the Fair Hearing record and shall consider the written statements submitted pursuant to **Section 8.6-5** above, for the purpose of determining whether or not there is a reasonable basis on which to support the recommendation of the Medical Executive Committee. If oral argument is requested as part of the review procedure and granted by the Appellate Review Committee, the affected Practitioner shall be present at such Appellate Review, shall be permitted to address the Appellate Review Committee and shall answer questions by any member of the Appellate body. The Medical Executive Committee may also be represented by an individual who shall be permitted to address the Appellate Review Committee and answer questions put to them by any member of the Appellate body.

8.6-7 New or additional matters not raised during the Fair Hearing or in the Fair Hearing Committee report, nor otherwise reflected in the Fair Hearing record, shall be permitted at the Appellate Review at the discretion of the Appellate Review Committee.

8.6-8 If the Appellate Review is conducted by the Board of Trustees, it may, affirm modify, or reverse the Medical Executive Committee's recommendation, or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within fourteen (14) days. Such referral may

include a request that the Fair Hearing Committee reconvene to address specified issues.

8.6-9 If the Appellate Review is conducted by an Appellate Review Committee of the Board of Trustees, such Committee shall, within fourteen (14) days after the scheduled or adjourned date of the Appellate Review, either make a written report recommending that the Board of Trustees affirm, modify or reverse The Medical Executive Committee's recommendation or refer the matter back to the Medical Executive Committee for further review to address specific issues and to make any further recommendations. Within fourteen (14) days after receipt of such further review and recommendation after referral, the Medical Executive Committee shall make its recommendation to the Board of Trustees, as above provided.

8.6-10 The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided in this **Section 8.6** have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board of Trustees may be taken by a Committee of the Board of Trustees duly authorized to act.

SECTION 8.7 FINAL DECISION BY BOARD OF TRUSTEES

8.7-1 At its next meeting or within thirty (30) days after receipt of the Appellate Review Report, the Board of Trustees shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee and, through the President of the Hospital, to the affected Practitioner by certified mail, return receipt requested.

If the Board of Trustee's decision is in accordance with the Medical Executive Committee's last recommendation in the matter, the decision will be final, effective immediately and not subject to further Fair Hearing or Appellate Review.

If the Board of Trustees decision is contrary to the Medical Executive Committee's last recommendation in the matter, the Board of Trustees will notify the Medical Executive Committee of its decision and request a response within fourteen (14) days. The Board of Trustees will make its final decision after consideration of the Medical Executive Committee's response, with like effect and notice as first above provided in this **Section 8.7.**

8.7-2 Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one Hearing

and one Appellate Review of any adverse action against the Practitioner.

8.7-3 In matter relating to Hearings and Appellate Reviews, all Medical Staff Members and other Practitioners, and all appropriate Hospital personnel, including Members of the Board of Trustees and Hospital management, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided in **Section 16.4** of these Bylaws.

ARTICLE NINE

APPELLATE REVIEW PROCEDURE APPLICABLE TO ADVANCED PRACTICE PROVIDERS

SECTION 9.1 RIGHT TO APPELLATE REVIEW

9.1-1 When any advanced practice provider receives notice of a recommendation by the Medical Executive Committee that, if ratified by decision of the Board of Trustees, will adversely affect the advance practice provider's appointment to or status as a Member of the Staff or the advance practice provider's exercise of clinical privileges, the advance practice provider shall be entitled to appellate review as provided in this Article Nine.

SECTION 9.2 REQUEST APPELLATE REVIEW

9.2-1 An advance practice provider may request appellate review by making a written request to the Chief Medical Officer by certified mail, return receipt requested within ten (10) calendar days after the advance practice provider's receipt of the decision of the Medical Executive Committee. If no request for appellate review is made within such ten (10) day period, the decision of the Executive Committee shall become final.

SECTION 9.3 CONDUCT OF APPELLATE REVIEW

9.3.1 Appellate review shall be conducted on the written record on which the adverse recommendation is based, and upon such other written documentation as the parties may submit as provided in Section 9.3.3 below. The scope of review shall be limited to determining whether there is a reasonable basis on which to support the findings and conclusions of the Executive Committee.

9.3.2 Promptly after receipt of such a notice of request for appellate review, the Chief Medical Officer shall notify the Chair of the Board of Trustees of the request for appeal.

9.3.3 The party making the appeal and the party opposing the appeal each shall have access to all other material that was considered in making the adverse recommendation. The parties shall have the right to submit a written statement on their own behalf, in which those factual and procedural

matters with which the party agrees or disagrees and the reason for such agreement or disagreement shall be specified. The Chief Medical Officer, after consultation with the Chair of the Board of Trustees, shall advise the parties of the date by which their written statement must be submitted and to whom it should be submitted.

9.3.4 An Ad Hoc Committee consisting of at least three members of the Board of Trustees appointed for such purpose by the Chair of the Board of Trustees, shall review the record created in the proceedings and any statements provided pursuant to Section 9.3.3, above, for the purpose of determining whether or not there is reasonable basis on which to support the findings and conclusions of the Executive Committee. The Ad Hoc Committee shall at any time make rules it deems necessary to assure prompt, fair and expeditious handling of the appeal. The Ad Hoc Committee shall report its recommendations to the Board of Trustees.

9.3.5 Within sixty (60) days after the conclusion of the appellate review, the Board of Trustees shall make its final decision in the matter to either accept, reject or modify the Executive Committee's recommendation, and shall send notice of such decision, including a statement of the basis therefore, through the Chief Medical Officer, to the parties by certified mail, return receipt requested. If the decision is adverse to the advance practice provider, it shall be immediately effective and final, and shall not be subject to further review.

ARTICLE TEN

GENERAL STAFF OFFICERS

SECTION 10.1 GENERAL OFFICERS OF THE STAFF

The general officers of the Staff shall be the President, President-elect, immediate past President, and Secretary/Treasurer.

SECTION 10.2 QUALIFICATIONS

10.2-1 General officers must be Members of the Active Staff at the time of nomination and election, and remain Active Members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.2-2 A Staff member may not simultaneously hold two (2) or more general Staff offices or a general Staff office and the office of Department/Section Chief in this Hospital.

SECTION 10.3 ATTAINMENT OF OFFICE

10.3-1 Of President and Immediate Past President

The President attains office by automatic succession from the office of President-elect. The immediate past President attains office by automatic succession from the office of President.

10.3-2 Of President-elect and Secretary/Treasurer

a. Nomination: A Nominating Committee convenes at least two (2) months prior to the Annual Meeting at which an election for officers is to occur for the purpose of nominating one or more qualified candidates for each of the offices of President-elect and Secretary/Treasurer.

After nomination has been accepted by the nominee and at least two (2) weeks prior to the Meeting for the election of officers, the Secretary/Treasurer shall notify all Members of the Medical Staff of the names of proposed candidates. Additional nominations may be submitted by written petition signed by at least thirty-five (35) Members, filed

with the Secretary/Treasurer at least thirty (30) days in advance of the Annual Staff Meeting and accompanied by evidence of the candidates' willingness to be nominated. The Secretary/Treasurer finalizes the slate, including the names of those nominated by written petition, and transmits the same to the Medical Executive Committee for its approval prior to the list being presented for election at the Annual Meeting.

b. Election: The President-elect and Secretary/Treasurer are chosen, subject to Board approval and from among the candidates nominated under paragraph a. above, by election by majority vote cast by those Active Staff Members in good standing. Voting shall be by written ballot only, either in person at the meeting or by absentee ballot. There shall be no ballot other than the official ballot provided by the Secretary/Treasurer. Ballots for the election of general officers shall be distributed to any Member of the Active Staff by email if requested at least ten days prior to the annual meeting. Absentee ballots must be returned the Friday, prior to the scheduled meeting.

The ballots shall be collected and counted by the Medical Executive Committee, or a group of tellers authorized by the Medical Executive Committee. The Secretary/Treasurer or their designee shall be present at the counting of the votes including the absentee ballots.

If no candidate for a given office receives a majority vote on the first ballot, a run-off election is held immediately between the two candidates receiving the highest number of votes. Only Staff members present at the meeting will be permitted to vote in the run-off election. In the case of a tie vote, the election shall be decided by the flip of a coin and the person to whose favor it shall result shall be declared duly elected. The flip of the coin shall be performed by the President of the Medical Staff and witnessed by the Secretary/Treasurer of the Medical Staff or the immediate past President and by the nominees or their designated representatives.

SECTION 10.4 VACANCIES

10.4-1 In the Office of President

A vacancy in the office of President is filled by automatic succession of the President-elect, who serves the remainder of the unexpired term and his own full term as President.

10.4-2 In the Office of President-elect

A vacancy in the office of President-elect is filled by appointment of an acting officer by the Medical Executive Committee, subject to approval by the Board of Trustees. The acting officer serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in **Section 10.3**, provided, however, that the Medical Executive Committee may determine not to call a special election if a regular election for the office is to be held within 180 days, in which case the acting officer serves only until the election results are final and the elected member then assumes office immediately.

10.4-3 In the Office of Secretary/Treasurer

A vacancy in the office of Secretary/Treasurer is filled by appointment of an acting officer by the Medical Executive Committee, subject to the approval by the Board of Trustees, who serves the remainder of the unexpired term.

10.4-4 In the Office of Immediate Past President

A vacancy in the office of immediate past President is filled for the remainder of the unexpired term by appointment by the Medical Executive Committee. Consideration should be given in filling the vacancy to a prior Staff President.

SECTION 10.5 RESIGNATION

10.5-1 Any general staff officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the day of receipt or at any later time specified in it.

SECTION 10.6 REMOVAL FROM OFFICE

10.6-1 Removal of a general staff officer may be effected either:

a. By the Board of Trustees; or

b. By a two-thirds majority vote of the total Active Members in good standing. Such vote shall be taken at a special meeting called for that purpose and ratified by the Medical Executive Committee and the Board of Trustees.

10.6-2 Conditions for removal of staff officers

Such removal may be based upon failure to perform the duties of the position held as described in these Bylaws or upon conduct or behavior, which reflects unfavorably upon the office, or the Hospital.

SECTION 10.7 TERM OF OFFICE

The term of office of general staff officers is two (2) Medical Staff years. Officers assume office on the first day of the Medical Staff year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon an election or appointment. Each officer serves until the end of the term and until a successor is elected, unless the officer sooner resigns or is removed from office.

SECTION 10.8 ELIGIBILITY FOR RE-ELECTION

A general staff officer is eligible again for nomination and election to the position of President-elect after two (2) years have elapsed since the member held the office of Immediate Past President. The Secretary/Treasurer is eligible to succeed to the same position, but not for more than two (2) consecutive 2-year terms for a total of six years.

SECTION 10.9 FUNCTIONS OF GENERAL STAFF OFFICERS

10.9-1 Functions of the President of the Staff

The President of the Staff is the primary officer of the Medical Staff, the chief administrative officer of the Staff, and the Staff's representative in its relationships to others within the Hospital.

The President of the Medical Staff shall call and preside at all meetings of the Staff and the Medical Executive Committee, and

shall be a member ex-officio of all committees. He shall be responsible to the Board of Trustees for the Medical Staff organization of the Lowell General Hospital and maintain careful supervision over the clinical work in all departments.

10.9.2 Functions of the President-elect

Whenever the President of the Staff is unable - temporarily or permanently, to fulfill the duties of the office by reason of illness, resignation, removal, or other absence, the President-elect will succeed to the office of President. The President-elect is also responsible for those duties delegated to the office by the President of the Staff or by the Medical Executive Committee. The President-elect shall serve as the Chairman of the Performance Improvement Council and the Morbidity and Mortality Council.

10.9-3 Functions of the Secretary/Treasurer

The Secretary/Treasurer shall keep accurate and complete minutes of all meetings, call the meetings on order of the President, attend all correspondence, and perform such duties as ordinarily pertain to the office. The Secretary/Treasurer shall have charge of funds received from annual fees and any special assessments. In the temporary absence of the President and President-elect, the Secretary/Treasurer shall perform the duties of the President.

10.9-4 Functions of the Past President

The immediate past President will be an advisor to the President and to other officials and committees of the Medical Staff, and shall serve as a Member of the Medical Executive Committee and Chairman of the Bylaws Committee.

ARTICLE ELEVEN

DEPARTMENTS OF THE MEDICAL STAFF

SECTION 11.1 ORGANIZATION

The Medical Staff shall be organized into departments, sections, and services as follows:

11.1-1 Clinical Departments

- Anesthesiology
- Cardiology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics and Gynecology
- Oncology
- Orthopedics
- Pathology
- Pediatrics
- Psychiatry
- Radiology
- Surgery

11.1-2 Number of Members

Clinical departments shall have a minimum of four (4) Active Staff Members. Large departments may have clinical sections as delineated in 11.4

11.1-3 Clinical Services

- Oncology
- Pathology
- Radiology and Nuclear Medicine
- Urology
- Cardiology

SECTION 11.2 GENERAL PROVISIONS

Each department, section, and service shall:

a. be supervised by a chief, who shall function as specified in **Article Twelve;**

b. conduct its meetings as specified in **Article Fourteen**;

c. follow attendance requirements as specified in **Articles Four and Fourteen**;

d. establish criteria, consistent with the policies of the Medical Staff and the Board of Trustees, for the granting of privileges in the department, section, or service;

e. maintain a permanent record of its meetings, activities, and recommendations which shall be submitted to the Medical Executive Committee; and

f. establish, maintain, and amend, as necessary, policies and procedures to govern the day to day operation of the department, section, or service.

SECTION 11.3 ORGANIZATION OF ADDITIONAL DEPARTMENTS AND SECTIONS

Additional departments and sections of the Medical Staff may be organized by a majority vote of the Medical Executive Committee with the approval of the Board of Trustees.

SECTION 11.4 ORGANIZATION OF SECTIONS

Sections of special clinical interest, such as surgical or medical specialties, may be organized within a department for purposes of education, peer review, and self-government, provided the following requirements are met:

10.4-1 The section must elect a chief who is board-certified by an appropriate specialty board or possesses comparable competence,

as evidenced by comparable training, clinical experience, performance and professional conduct;

11.4-2 The section consists of a minimum of four Active staff members;

11.4-3 The section has regular, but not less than quarterly, meetings of its own, where minutes are kept in accordance with **Article Fourteen** of these Bylaws;

11.4-4 In addition to those functions described in **Section 12.8**, the Chief of a section shall be responsible for transmitting to the section's parent department quarterly reports summarizing the activities of the section.

SECTION 11.5 MEMBERSHIP IN DEPARTMENT, SECTIONS, AND SERVICES

Each Member of the Medical Staff shall be granted membership in one (1) Medical Staff department. Privileges may be granted in other departments, sections, services in which one is not a member through the credentialing process.

SECTION 11.6 FUNCTIONS OF CLINICAL DEPARTMENTS AND SECTIONS

The primary function of each clinical department and section shall be the establishment and operation of a patient care evaluation system for the department or section that is both fact finding and educational. This shall be accomplished, in part, as follows:

a. Regular but not less than quarterly meetings of each department and section shall be held;

b. Comparison of findings relative to patient care evaluation shall be made with the established criteria and, when necessary, recommendations made concerning the improvement of patient care;

c. Specific methods of review shall be established by each department and section upon approval of the Medical Executive Committee, but must include the following activities; develop, maintain, update and approval of ongoing departmental policies and procedures, chart review of selected cases, adequacy of documentation of professional services rendered, consideration of mortality, extended morbidity, unimproved patients, patients with nosocomial infections, complications or questionable diagnosis or

treatment, inadequate consultations, reports from the Medical Staff monitoring committees, and such other reports as are believed to be important for adequate patient care evaluation;

d. Each department and section shall cooperate with each service in matters of that service concerning Members of the department or section.

SECTION 11.7 FUNCTIONS OF CLINICAL SERVICES

11.7-1 The primary function of services shall be continuing analysis of the quality of their supportive roles to the clinical departments and sections. This shall be done by:

a. performance and analysis on a peer group basis of the physicians in the service;

b. analysis of the procedures performed by the service; and

c. maintaining policies and procedures for the service.

11.7-2 Other functions shall be to provide educational programs for the Staff and to cooperate with the educational programs of the Staff, departments and sections.

SECTION 11.8 ASSIGNMENTS

Assignment to a department, section, or service, for all Medical Staff Members and for other approved practitioners with clinical privileges, shall be made by the Board of Trustees upon recommendation of the chief of the department, section, or service, Credentials Committee, and the Medical Executive Committee.

ARTICLE TWELVE

DEPARTMENT, SECTION, AND SERVICE CHIEF

SECTION 12.1 QUALIFICATIONS

Each chief shall:

a. be a Member in good standing of the Active Staff and of the department, section, or service, as applicable.

b. be board certified by an appropriate specialty board, or possess comparable competence, as evidenced by comparable training, clinical experience, performance and professional conduct.

c. have demonstrated a high degree of interest in and support of the Medical Staff and Lowell General Hospital by their Staff tenure and their primary practice at the Lowell General Hospital.

SECTION 12.2 VOLUNTARY AND CONTRACT CHIEFS DISTINGUISHED

For the purposes of these Bylaws, a department, section, or service chief serving on a voluntary basis is referred to as a "voluntary chief" and one serving as such by contract or on some other full- or part-time basis with the Hospital is referred to as a "contract chief."

SECTION 12.3 ATTAINMENT OF OFFICE

12.3-1 Voluntary Department And Section Chiefs

Each voluntary chief shall be elected by the Active Members in good standing of their department, section, or service, subject to approval of the Medical Executive Committee and the Board of Trustees.

12.3-2 Contract Chiefs

Each contract chief is selected by the Board of Trustees or its designee after recommendation of the Medical Executive Committee, the Medical Staff, and the Hospital President.

SECTION 12.4 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION

12.4-1 Voluntary Chiefs

The term of office of voluntary chiefs is two (2) years, and they may serve no more than three (3) successive terms. The chiefs shall assume office on the first day of the Medical Staff year following their appointment, except that a chief elected or appointed to fill a vacancy assumes office immediately upon election or appointment. If appointed to fill a vacancy, the time served for this purpose will not count in determining the successive term limitation. Each voluntary chief serves until the end of their term and until a successor is elected, until they sooner resign or are removed from office.

12.4-2 Contract Chiefs

The term of office of a contract chief is as specified in their contract with the Hospital.

SECTION 12.5 RESIGNATION

12.5-1 Voluntary Chiefs

A voluntary chief may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified by the notice.

12.5-2 Contract Chiefs

Resignation of a contract chief is governed by the terms of the contract or other arrangement with the Hospital. If the contract does not address the issue, a contract chief may resign by giving written notice to the Medical Executive Committee and the Hospital President. Such resignation, which may or may not be contingent on formal acceptance, takes effect on the date of receipt or at any time specified by the notice.

SECTION 12.6 REMOVAL

12.6-1 Voluntary Chiefs

Removal of a voluntary chief may be affected by either (1) the Board of Trustees acting upon its own initiative; or (2) a two-

thirds majority vote of the Active Staff Members in good standing of the applicable constituent group, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and by the Board of Trustees.

12.6-2 Contract Chiefs

Removal of a contract chief is governed by the terms of the contract.

SECTION 12.7 VACANCIES

12.7-1 Voluntary Chiefs

When a vacancy in the office of a voluntary chief occurs, a special election shall be held, within fourteen (14) days, to choose a successor to fill the unexpired term. A majority vote of the Medical Executive Committee, stating that a chief is unable to fulfill the duties because of illness or other good cause, is sufficient to remove a chief from office, if it is ratified by the Board of Trustees.

12.7-2 Contract Chiefs

A vacancy in the office of a contract chief is filled by the Board of Trustees or its designee through appointment of an acting chief upon recommendation of the Medical Executive Committee. The acting chief serves pending completion of the selection process specified in **Section 12.3**.

SECTION 12.8 FUNCTIONS OF DEPARTMENT, SECTION, AND SERVICE CHIEFS

12.8-1 The responsibilities of each chief shall include the following:

a. Taking all reasonable steps to insure the highest performance of all professional and clinically related activities within their department, section, or service;

b. Being a Member of the Medical Executive Committee, as described in **Article Thirteen** of these Bylaws, giving guidance to the overall Staff policies of the Hospital, and making specific recommendations and suggestions regarding their own department, section, or service in order to ensure quality patient care;

c. Taking all reasonable steps to ensure adherence to the Hospital Bylaws and of the Medical Staff Bylaws, Rules, and Regulations, policies and procedures within their department, section, or service;

d. Taking all reasonable steps to ensure the implementation, within their department, section, or service, of actions taken by the Medical Executive Committee or of the Staff;

e. Transmitting to the Credentials Committee the recommendations of their department, section, or service concerning Staff qualifications, reappointments and the delineation of clinical privileges for all applicants for and Members of their department, section, or service;

f. Overseeing all teaching, education, and research programs in their department, section, or service;

g. Assisting in the preparation of such annual reports pertaining to their department, section, or service as may be required by the Medical Executive Committee, the Hospital President, or the Board of Trustees;

h. Establishing, together with the medical staff and administration, the type and scope of services required to meet the needs of patients and the hospital;

i. Developing and implementing policies and procedures that guide and support the provision of services in the department;

j. Recommending to the medical staff the criteria for clinical privileges in the department;

k. Assessing and improving the quality of care and services provided in the department;

l. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the hospital;

m. Integrating the department/section/service into the primary functions of the hospital;

n. The coordination and integration of interdepartmental and intradepartmental services;

o. Making recommendations for a sufficient number of qualified and competent persons to provide care/service;

p. The determination of the qualifications and competence of department, section or service personnel who are not licensed independent practitioners and who provide patient care services;

q The maintenance of quality assurance programs, as appropriate;

r. The orientation and continuing education of all persons in the department, section or service; and

s. Making recommendations for space and other needed resources needed by the department, section or service.

t. In Surgery, the Chief shall exercise general supervision over the Operating Suites and overall supervision of all surgical procedures performed in the Operating Room, Emergency Room, and Outpatient Department.

u The chief of a department, section, or service shall work with the nursing staff on nursing procedures when indicated.

12.8-2 In addition to the above functions, each department, section, and service chief shall:

a. Maintain continuing review of the professional performance of all Members with clinical privileges in their department, section, or service including peer review and report regularly thereon to the Medical Executive Committee; and at the time of reappointment, review the aggregate data provided on the peer review profile of each department/section member and provide a written comment addressing the results of the review on the reappraisal section of the reappointment form.

b. Be accorded the privilege of attending any regular

meeting of any standing committee of the Medical Staff. The chief shall have no vote, however, unless also an appointed member of the committee.

SECTION 12.9 SPECIAL COMMITTEES

The chief of a department, section, or service shall be empowered to delegate to a Member of the department, section, or service such non-executive duties as the chief would otherwise perform. Such committees shall exist for the study of problems in areas of responsibility falling within the purview of the department, section, or service and shall make specific recommendations to the department, section, or service. They shall confine their work to the specific purpose for which they are appointed, and they shall have no authority or power of action.

ARTICLE THIRTEEN

COMMITTEES

SECTION 13.1 GENERAL PROVISIONS

13.1-1 Committees shall be designated as:

a. The Medical Executive Committee;

b. Standing committees;

c. Special committees.

13.1-2 The President of the Medical Staff shall appoint the chairmen of all committees, except as otherwise provided in these Bylaws, including in 12.3. The President shall also appoint all committee members following the guidelines herein, after consultation with the elected or appointed chairmen.

13.1-3 Meetings shall be held and conducted as specified in **Article Fourteen**.

13.1-4 Additional standing committees may be formed by the Medical Executive Committee with the approval of the Board of Trustees.

13.1-5 Subcommittees may be formed by committees of the Staff as provided in this Article or as deemed necessary to carry out their functions.

13.1-6 The chairman of each committee shall be responsible for maintaining a permanent record of its meetings, action, recommendations, and attendance. Each committee of the Staff shall submit its records to the Medical Executive Committee for review, for action, and to be kept in the Medical Staff Coordinator's office.

SECTION 13.2 THE EXECUTIVE COMMITTEE

13.2-1 Composition

The Medical Executive Committee shall consist of:

a. the President as Chairman, the President-elect, the Secretary/Treasurer and the immediate past President,

b. four Members-at-large elected from the Active Staff, for two (2) year terms, which terms shall be staggered so that two Members-at-large are elected at each Annual Meeting;

c. all Department Chiefs, including but not limited to Anesthesiology, Cardiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics & Gynecology, Oncology, Orthopedics, Pathology, Pediatrics, Psychiatry, Radiology and Nuclear Medicine, and Surgery,

d. the Chairman of the Credentials Committee;

e. the President of the Hospital, with voice, but without vote;

f. the Chief Medical Officer or designee with voice, but without vote;

g. Voting members of the Medical Executive Committee are fully licensed physician members of the Active Medical Staff.

h. No Active Medical Staff member actively practicing in the hospital is ineligible for membership on the Medical Executive Committee solely because of their professional discipline or specialty.

13.2-2 Attainment of Office for Members-at-large

a. Nomination: Members-at-large of the Medical Executive Committee shall be nominated in the same fashion as General Staff Officers as described in **Section 10.3-2a.**

b. Election: Members-at-large of the Medical Executive Committee shall be elected in the same fashion as General Staff Officers as described in **Section 10.3-2b.**

c. Vacancies: A vacancy in the office of Member-at-large of the Medical Executive Committee is filled by appointment of an acting Member-at-large by the President of the Medical Staff, with approval of both the Medical Executive Committee and the Board of Trustees, and serves the remainder of the unexpired term.

13.2-3 Duties and Authority

The duties and authority of the Medical Executive Committee are to:

a. Represent and act on behalf of the Medical Staff in all matters, except for election of Staff officers, removal of Staff officers, and adoption and amendment of these Medical Staff Bylaws, and as provided by specific action of the Medical Staff;

b. Receive, coordinate, and act upon, as necessary, the written reports and recommendations of departments, sections, and services, and the standing committees and special committees directly responsible to it, and to hear oral reports from time to time as required or requested;

c. Coordinate or oversee coordination of the activities of and policies adopted by the Staff, departments, sections, and services, and other clinical units and committees;

d. Approve policies of the Medical Staff and monitor that such policies recommended by the departments, sections, and services, and other clinical units and committees are implemented;

e. Study and report to the Medical Staff on proposals for changes in these Bylaws;

f. Authorize the establishment of continuous quality improvement activities pursuant to Joint Commission standards and federal and state law;

g. Inform the Medical Staff on Joint Commission accreditation programs and the accreditation status of the Hospital;

h. Approve the appointment of chairs and members of standing committees (except as otherwise provided);

i. Make recommendation to the Board of Trustees, as required in these Bylaws, concerning matters relating to the following:

- appointments and reappointments of individual practitioners;
- categories of medical staff;
- department, section, or service assignments of individual practitioners;
- clinical privileges of individual practitioners;
- disciplinary action;
- the medical staff's structure;
- the mechanism used to review credentials and to delineate individual clinical privileges;
- the participation of the medical staff in organization performance-improvement activities;
- the Medical Executive Committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups;
- the mechanism by which medical staff membership may be terminated; and
- the mechanism for fair-hearing procedures;

j. Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Staff Members, including peer review initiating

investigations, and initiating and pursuing disciplinary action when warranted, as delineated in Article 7.

k. Account to the Board of Trustees, by written report, for the quality of medical care provided to patients in the Hospital;

l. Make recommendations to the President of the Hospital on medico-administrative, hospital management, and planning matters

m. Review the credentials of applicants for medical staff membership and delineated clinical privileges;

n. Organize the medical staff's performance-improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities;

o. Develop and review the mechanism by which medical staff membership may be terminated; and

p. Maintain and review the mechanism designed for use in fair hearing procedures.

q. Act for the medical staff in the intervals between medical staff meetings.

13.2-4 Meetings

The Medical Executive Committee meets at least monthly. It communicates its discussions and actions that affect or define Staff policies, rules, or positions by periodic summary reports made available to all Members of the Medical Staff.

SECTION 13.3 STANDING COMMITTEES

13.3-1 Establishment

There shall be such standing committees as necessary to conduct the business of the Medical Staff. The composition and duties of the committees shall be set forth in the Medical Staff Policy and Procedure Manual and subject to the approval of the Board of Trustees. All policies and procedures with respect to the establishment or dissolution of committees shall be set

forth in the Medical Staff Policy and Procedure Manual, as approved by the Board of Trustees.

a. The Cancer Committee at Lowell General Hospital will follow the requirements outlined in the most current Commission on Cancer, Cancer Program Standards. See the Medical Staff Policy and Procedure Manual for a full scope of duties.

SECTION 13.4 SPECIAL COMMITTEES

13.4-1 Establishment

Special committees shall be appointed from time to time as may be required to properly carry out the duties of the Medical Staff. Special committees shall be appointed by the Active Staff upon recommendation from the Medical Executive Committee or upon motion of the Active Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Active Staff. Committees shall not have power of action unless such is specifically granted by the motion that creates the committee.

ARTICLE FOURTEEN

MEETINGS

SECTION 14.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the business year will commence on January 1 of each year and expire on December 31 of that same year.

SECTION 14.2 MEDICAL STAFF MEETINGS

14.2-1 The Annual Meeting

The Annual Meeting of the Medical Staff shall be held the first (1st) Wednesday in December of each year. The day may be changed by the President of the Staff, if necessary.

14.2-2 Regular Meetings

Regular meetings of the Medical Staff shall include the Annual Meeting in December and on the first (1st) Thursday of the months of March, June, and September, at a time and place decided upon by the Medical Executive Committee. The President of the Medical Staff may change the day, if necessary.

14.2-3 Special Meetings

A Special Meeting of the Medical Staff may be called by the President of the Medical Staff, and must be called by the President at the written request of the Board of Trustees, the Medical Executive Committee, or within fourteen (14) days after receipt by him of a written request for same, signed by not less than one-fourth of the Active Staff, stating the purpose for such meeting.

SECTION 14.3 CLINICAL DEPARTMENT, SECTION, SERVICE, AND COMMITTEE MEETINGS

14.3-1 Regular Meetings

1. Clinical departments, sections, services, and committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments and its

sections, individually or in combination, and clinical services shall hold a minimum of quarterly meetings per year.

2. The frequency of committee meetings is as required by these Bylaws or the Medical Staff Policy and Procedure Manual.

14.3-2 Special Meetings

A special meeting of any department, section, service, or committee may be called by or at the request of the chairman or chief thereof, by the President of the Medical Staff or by one-third of the group's then Members, but not less than two (2) Members.

14.3-3 Executive Session

Any committee, department, section, or service may call itself into executive session at any time during a regular or special meeting. Only the voting Members of the applicable group may be present during said session, unless the presiding officer thereof invites, with the approval of a majority of the group, other individuals to attend. Minutes of each executive session shall be prepared that will include a record of attendance and the vote taken on each matter. The minutes shall be approved by the attendees and signed by the presiding officer. The minutes of each executive session will be maintained in a permanent file. NOTE: The chair of the Executive Session will assign someone to take minutes. The chair will review and sign the minutes.

SECTION 14.4 ATTENDANCE REQUIREMENTS

14.4-1 In addition to satisfying the special appearance requirements of **Section 14.4-2**, each member of the Active Staff is expected to attend the meetings of his own department, section, and service, and meetings of committees on which he serves. Regardless of their attendance at department, section, or service meetings, they must fulfill their obligations under Article 4.2 at a minimum. Failure to comply with attendance in standing or other committees, may result in corrective action leading to removal from such committee and to revocation of Medical Staff membership or reduction of Staff appointment.

14.4-2 A practitioner whose patient's clinical course of treatment is scheduled for discussion as part of regular quality review activities at a Staff, department section, service, or committee meeting may be notified and invited to present the case.

Whenever a Staff, department, section, or service education program or clinical conference is prompted by findings of quality assurance, risk management, utilization review or like monitoring activities, the practitioner whose patterns of performance prompted the program will be notified of the time, date, and place of the program, of the subject matter to be covered and of its special applicability to the practitioner's practices. The attendance of the involved practitioner is mandatory. Failure to attend, unless excused by the Medical Executive Committee upon a showing of good cause, may result in such corrective action as deemed necessary by the Medical Executive Committee or the Board of Trustees.

Whenever actual, apparent, or suspected deviation from standard practice is identified with respect to a practitioner's performance, the President of the Medical Staff or the applicable department, section, or service chief may require the practitioner to confer with him or with a standing or Ad Hoc Committee that is considering the matter. The practitioner will be given special notice of the conference at least seven (7) days prior to it, including the date, time, and place, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any such conference, unless excused by the Medical Executive Committee upon a showing of good cause, will result in a summary suspension of all or such a portion of the practitioner's clinical privileges as the Medical Executive Committee may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or the Board, as appropriate and as provided in Section 7.2 of these Bylaws.

SECTION 14.5 MEETING PROCEDURES

Notice, quorum, minutes, and agenda requirements for all meetings are set forth in the Medical Staff Policies and Procedures Manual.

ARTICLE FIFTEEN

THE CHIEF MEDICAL OFFICER

SECTION 15.1 QUALIFICATIONS

15.1-1 The Chief Medical Officer (CMO) shall:

- be a graduate of an approved medical school;
- be licensed to practice medicine in the Commonwealth of Massachusetts;
- meet the requirements and become and remain a Member in good standing of the Medical Staff;
- be qualified by professional experience and have demonstrated administrative ability for the position;
- be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position so as to positively influence fellow physicians.

SECTION 15.2 METHOD OF SELECTION AND APPROVAL

A Search Committee, consisting of the President of the Hospital and the President, President-elect, and past President of the Medical Staff, shall screen applicants, which may include nominees submitted by the Medical Staff, and make a recommendation to the President of the Hospital.

SECTION 15.3 TERM OF APPOINTMENT

The position may be either full-time or part-time, and the individual filling the position shall be reviewed annually by the President of the Hospital.

SECTION 15.4 RESPONSIBILITIES

15.4-1 Administrative

a. General

The Chief Medical Officer shall provide direction and support to departmental chairmen in the development of their programs and the expansion of the Medical Staff. This does not entail Staff supervision but acting as a catalyst for Medical Staff policies and procedures.

b. Liaison and Communications

The Chief Medical Officer shall maintain constant communication between Medical Staff, departments, committees, and others, to achieve objectives and avoid conflicts. He/she is responsible for recommending, to the proper bodies, the formation of policies as required by the Government and the Joint Commission, as they relate to the clinical practice of medicine in the Hospital.

c. Advisory

The Chief Medical Officer shall act in an advisory capacity to the Board of Trustees, the Chief Executive Officer, chiefs of departments, committees, and others on medico-administrative matters.

d. Supervision and Discipline

The Chief Medical Officer shall assist the Medical Staff and Administration in enforcing the Bylaws, Rules, and Regulations of the Medical Staff. He/she is responsible for assisting the departmental chiefs in monitoring the sanctions, where stipulated, for noncompliance and in presenting to the Medical Executive Committee those cases where disciplinary action may be recommended to the Board of Trustees.

e. Committee Assignments

The CMO shall be a Member of the Medical Executive Committee of the Medical Staff with voice, but without vote. He/she shall attend any meeting of any standing committee of the Medical Staff and shall attend as many as reasonable, with voice and no vote unless he is serving in the capacity as a member of the committee.

f. Planning

The CMO will participate as appropriate to the position in planning programs and budgetary affairs.

15.4-2 Patient Care

The CMO shall work with appropriate Staff committees to improve the quality of patient care.

15.4-3 Education

The CMO should assist in the development of an ongoing educational program.

The CMO shall be "The Graduate Program Director", and shall be responsible for:

- written descriptions of the role, responsibilities, and patient care activities of the participants,
- criteria by which the participant's supervising physician shall make decisions regarding the participant's involvement and independence in patient care activities
- rules and regulations, and policies that delineate privileges to participants who may write patient care orders, under which circumstances they may do so, and what entries, if any, must be countersigned by the licensed independent practitioner.

The CMO shall report at least bi-annually to the Medical Executive Committee on the training that occurs at the Hospital, about the safety and quality of patient care provided by, and the related educational and supervisory needs of the participants in the Graduated Education Program(s).

15.4-4 External Relations

The CMO may serve as liaison with other institutions, third-party payers and public health authorities. They should keep abreast of federal and state regulations affecting the practice of medicine and may act in a public relations' capacity with outside organizations. This may include community health planning programs and State and national organizations instrumental in developing health care policies and legislation.

15.4-5 Annual Report

The CMO may be asked to provide the Medical Staff with an annual report of their activities for a Quarterly Staff Meeting or for the Annual Meeting.

15.4-6 Other

Additional responsibilities may be assigned to the CMO by the President and CEO of the Hospital or their designee.

ARTICLE SIXTEEN

CONFIDENTIALITY, IMMUNITY, AND RELEASES

SECTION 16.1 SPECIAL DEFINITIONS

For purposes of this Article only, the following definitions shall apply:

a. "Information" means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications, whether in writing or oral form, relating to any of the subject matter specified in **Section 16.5**.

b. "Malice" means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

c. "Practitioner" means a Medical Staff Member or applicant.

d. "Representative" means the Board of Trustees of the Lowell General Hospital and any Committee thereof; the Hospital President, the Executive Vice President, or their respective designees; registered nurses and other employees of the Hospital; the Medical Staff Organization and any member, officer, clinical unit, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use, or disseminating functions.

e. "Third Parties" means both individuals and organizations providing information to any representative.

SECTION 16.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Medical Staff membership or applying for or exercising clinical privileges, or providing specified patient care services at the Lowell General Hospital, a practitioner:

a. authorizes representatives of the Hospital and the Medical Staff to solicit, obtain, provide, and act upon information bearing on the practitioner's professional ability, utilization practices, and other qualifications;

b. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article;

c. acknowledges that the provisions of this Article are expressed conditions to practitioner's application for, or acceptance of Staff membership and the continuation of such membership, and to practitioner's exercise of clinical privileges or provision of specified patient services at the Lowell General Hospital.

SECTION 16.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff, for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record.

SECTION 16.4 IMMUNITY FROM LIABILITY

16.4-1 For action taken

No representative of the Hospital or Medical Staff shall be liable to a practitioner for damages or other relief for any decision, opinion, action, omission, statement, or recommendation made within the scope of their duties as a representative, if such representative acts in good faith and without malice within the scope of their function,

has made a reasonable effort to obtain the facts of the matter as to which they act, and act in the reasonable belief that the action is warranted by such facts.

16.4-2 For providing information

No representative of the Hospital or Medical Staff, and no third party, shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff, or to any other health care facility or organization of health professionals concerning said practitioner who is or has been an applicant to or Member of the Staff, or who did or does exercise clinical privileges, provide specified services at this Hospital, provided that such representative or third party acts in good faith and without malice within the scope of their function and has made a reasonable effort to obtain the facts of the matter as to which they are providing information and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

SECTION 16.5 ACTIVITIES AND INFORMATION COVERED

16.5-1 The confidentiality and immunity provision of this Article applies to all information or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:

a. applications for appointment, clinical privileges or specified services;

b. periodic reappraisals for reappointment, clinical privileges, or specified services;

c. corrective or disciplinary actions;

d. hearings and appellate reviews;

e. quality assurance activities;

f. utilization review and management activities;

g. claims review;

h. profiles and profile analysis;

i. malpractice loss prevention;

j. other hospital, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

16.5-2 The information referred to in this Article may relate to a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect the quality or efficiency of patient care provided in the Hospital.

SECTION 16.6 RELEASES

Each practitioner shall, upon request of the Hospital, executive general and specific releases in accordance with the tenor and import of this Article, subject to such requirements including those of good faith and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under relevant State law. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed incomplete, and it will not be processed until said releases are provided.

SECTION 16.7 CUMULATIVE EFFECT

Provisions of these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State law and not in limitation thereof.

SECTION 16.8 SEVERABILITY

A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE SEVENTEEN

IMPAIRED PHYSICIAN PROGRAM

SECTION 17.1 MATTERS OF MENTAL AND PHYSICAL COMPETENCY

The President of the Medical Staff shall convene an Ad Hoc Peer Review Committee for matters of a physician's mental and physical competency. This Committee shall consist of at least three (3), but no more than five physicians, to include the chief of the appropriate department, who are members of the medical staff in good standing.

17.1-1 Reporting Requirement

In the event that circumstances suggesting a deterioration of a physician's level of physical or mental competency shall come to the attention of any medical personnel, it shall be the responsibility of that person to report it to the President of the Medical Staff.

17.1-2 Review by The Ad Hoc Peer Review Committee

Reports concerning physical or mental competency received by the President of the Medical Staff shall be reviewed with the Ad Hoc Peer Review Committee. If deemed advisable, a review of the physician's professional performance will be authorized and conducted by the Ad Hoc Peer Review Committee.

The Committee shall report its findings and recommendation to the President of the Medical Staff.

17.1-3 Confidentiality of Proceedings

The proceedings of the Ad Hoc Peer Review Committee shall be, so far as possible, confidential, but shall be retained as a permanent institutional record.

17.1-4 Notification of Physician Under Review

The physician under review shall be notified by the President of the Medical Staff of the recommendations by the Ad Hoc Peer Review Committee. The physician may then appear before the Ad Hoc Peer Review Committee to present any information deemed pertinent to the review.

17.1-5 Circumstances under Which Ad Hoc Review Committee Findings Are Reported to the Medical Executive Committee

If the Ad Hoc Peer Review Committee recommends further investigation of the physician's physical or mental competency, the President of the Medical Staff shall report the findings and recommendation to the Medical Executive Committee.

17.1-6 Medical And/Or Psychiatric Examination of Physician

The Medical Executive Committee may authorize and recommend a medical and/or psychiatric examination of the physician. Such an examination shall be carried out using appropriate consultants who are not members of the medical staff at the time of the action.

17.1-7 Medical And/Or Psychiatric Evaluation Report

The report of the medical and/or psychiatric evaluation will go to the physician under investigation, the President of the Medical Staff, and the Ad Hoc Peer Review Committee. The President of the Medical Staff will transmit the report to the Medical Executive Committee with such recommendations, if any, from the Ad Hoc Peer Review Committee.

17.1-8 Refusal to Cooperate

If the physician fails or refuses to cooperate with this process and the provisions of this Section, the Medical Executive Committee shall have authority to summarily suspend the physician and to begin the process of terminating the physician's appointment to the medical staff.

17.1-9 Final Determination by Executive Committee

A final determination of the physician's physical or mental competency shall be made by the Medical Executive Committee, notwithstanding the fact that the physician under review may have resigned pending the review proceedings. This may include specific recommendations for referrals to therapeutic programs when such is indicated and appropriate monitoring of the physician activities during and following treatment.

17.1-10 Limitations and Restrictions of Privileges

The President of the Medical Staff, after consultation with the Ad Hoc Peer Review Committee, may impose limitations or restrictions on the privileges of the physician under review. These may include, but are not limited to, a summary suspension, pending the ultimate decision of the Medical Executive Committee.

17.1-11 Utilization of Information During Reappointment Process

Reports of the Ad Hoc Peer Review Committee must be included in the information sent to the Credentials Committee at the time of reappointment for all physicians who have come under investigation since their last appointment and/or during the proceeding two year period.

17.1-12 Notification of Governing Body And/Or Massachusetts State Office of Professional Discipline

Copies of the findings will be sent to the Governing Body and/or the state licensing board and National Data Bank, if appropriate.

17.1-13 Hearing and Appellate Review Mechanism

The final action of the Medical Executive Committee is subject to the hearing and review provisions as provided in these Bylaws (**Article Eight**).

ARTICLE EIGHTEEN

TELEMEDICINE

Section 18.1 Definition

A "telemedicine practitioner" is a Licensed Independent Provider who provides official readings of images, tracings, or specimens through a telemedicine link. Consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner is encompassed in clinical privileging decisions.

The Originating Site in telemedicine is defined by the Joint Commission as the site at which the patient is located at the time the service is provided.

The Distant Site in telemedicine is defined by the Joint Commission as the site at which the practitioner providing the professional service is located.

Section 18.2 Credentialing and Privileging

18.2-1Originating Site

Each telemedicine practitioner who is responsible for the care of the patient via telemedicine link is subject to credentialing and privileging process of the originating site.

The originating site retains responsibility for overseeing the safety and quality of services offered to patients.

If a telemedicine practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient, the telemedicine is credentialed and privileged by Joint Commission standards and the bylaws, rules and regulations, and policies and procedures.

The telemedicine practitioner may be privileged at the originating site, using credentialing information from the distant site if the distant site is a Joint Commission- accredited organization. The originating site may use both the credentialing and privileging information from the distant site if all of the following requirements are met:

a. The telemedicine practitioner is privileged at the distant site for those services to be provided at the originating site.

b. The originating site has evidence of an internal review of the telemedicine practitioner's performance of these privileges and

receives from the distant site information useful to assess the telemedicine practitioner's performance of these privileges and information useful to assess the telemedicine practitioner's quality of care and services for use in privileging and performance improvement including the following:

1. All adverse outcomes related to sentinel events considered reviewable by the The Joint Commission that result from the telemedicine provided; and

2. Complaints about the distant site LIP from patients, LIP's, or staff at the originating site.

18.2-2 Originating and Distant Sites

The Medical Staffs at both the originating and distant sites recommend the clinical services to be provided by telemedicine practitioners through a telemedicine link at their respective sites.

The medical staff at the originating site evaluates the organization's ability to safely provide services on an ongoing basis. The medical staff at the distant site evaluates performance of those services as part of privileging, and as part of the reappraisal conducted at the time of reappointment or renewal or revision of clinical privileges.

18.2-1 Privileges

The medical staff recommends which clinical services are appropriately delivered by each telemedicine practitioner through this medium, in compliance with the Policies and Procedures of the Medical Staff, Clinical Privileges Delineation Policy.

The clinical services are consistent with commonly accepted quality standards.

ARTICLE NINETEEN

PUBLICATIONS AND PUBLICITY

If the Hospital is to be identified in any way with a practitioner's name, any Member of the Medical Staff who intends to make a communication to the lay public, by written or spoken word, on a subject concerning the Hospital, medicine, or the medical profession, must either first obtain permission to do so from the Medical Executive Committee and the President of the Hospital or accept responsibility for the propriety of their act.

Any Member of the Medical Staff must obtain the permission of the President of the Hospital prior to the publication of any material based on information obtained from patients during their course of treatment or stay at the Hospital.

ARTICLE TWENTY

RULES AND REGULATIONS

SECTION 20.1 STAFF RULES AND REGULATIONS

Subject to the approval of the Board of Trustees, the Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement, more specifically, the general principles found in these Bylaws. The principles outlined in **Article Twenty-one** of these Bylaws shall be followed in the adoption and amendment of the Rules and Regulations, except that the Medical Executive Committee may act for the Staff in adopting or amending the Rules and Regulations unless otherwise provided.

SECTION 20.2 DEPARTMENT RULES

Each department, section, or service will formulate their own written rules for the conduct of their affairs and the discharge of their responsibilities, all of which must be consistent with these Bylaws, the supporting manuals, the general Medical Staff Rules, and the Hospital Bylaws and policies. These rules will be reviewed by the department chief, Medical Executive Committee, and the Hospital President, or a designee, for such consistency, and approved by the Medical Executive Committee and the Hospital President, on behalf of the Board of Trustees.

SECTION 20.3 APPLICATION FEE

20.3-1 The Medical Executive Committee will establish the amount, if any, of the initial and reappointment application fee. Notice of fee will be given to the Staff at the time of application. If application fees are not paid within thirty (30) days of the initial assessment, a special notice of delinquency will be sent to the practitioner.

In an effort to enhance compliance with the Medical Staff Bylaws, the Medical Executive Committee established a late fee of $100.00 per month or part month for reappointment applications received past the deadline. Failure to render payment at that point shall, unless excused by the Medical Executive Committee for good cause, result in Summary Suspension of Staff membership and clinical privileges until the delinquency is remedied.

20.3-2 A Member of the following Staff categories is required, under these Bylaws, to pay application fees and assessments:

a. Active,

b. Affiliate

c. Allied Health Staff will be assessed the same fees as the Active Staff.

ARTICLE TWENTY-ONE

ADOPTION AND AMENDMENT

SECTION 21.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees holds the Medical Staff responsible for the development, adoption, and periodic review of Medical Staff Bylaws and related manuals, all of which must be consistent with Hospital policies and applicable laws and other requirements. Neither body may unilaterally amend the medical staff bylaws or rules and regulations. The Medical Staff Bylaws and related manuals shall be reviewed at least annually by the Medical Bylaws Committee, and may be reviewed more frequently when deemed necessary by the Medical Staff or appropriate authorities thereof. Suggestions for changes in the Bylaws shall be referred to the Medical Bylaws Committee which shall present its recommendations in timely fashion to the Medical Executive Committee for review and referral to the Staff. If deemed necessary, by a vote of greater than fifty percent (50%) of the total membership of the Active Staff at any regular or special meeting of the Medical Staff, the Active Staff may also propose adoption and amendment of Bylaws directly to the Board of Trustees. Except as provided in **Section 21.3**, the adoption and amendment of Medical Staff Bylaws require the actions specified in **Sections 21.2** and **21.3**. The principles expressed herein shall also apply to the adoption and amendment of the related manuals developed to implement, and cross-referenced in, various sections of these Bylaws, except the Medical Executive Committee may act for the Medical Staff, unless otherwise specified, in adopting or amending said manuals, subject to the approval of the Board. Further, if deemed necessary by a vote of greater than fifty percent (50%) of the total membership of the Active Staff at any regular or special meeting of the Medical Staff, the Active Staff may also propose the adoption and amendment of such related manuals directly to the Board of Trustees.

SECTION 21.2 MEDICAL STAFF ACTION

21.2-1 With Notice

In reporting to the Medical Staff on a proposed amendment, the Medical Bylaws Committee shall cause to be published an amendment within the terms of the original referring motion, together with any Bylaw which would be replaced or amended

if the proposed Bylaw were acted on favorably. A copy shall be furnished to each Member of the Active Medical Staff, by email at least fourteen (14) days in advance of the regular meeting of the Staff at which the amendment is to be voted upon. Such notice shall also be sent to the Medical Executive Committee. The Medical Bylaws Committee and Medical Executive Committee may make recommendations in favor of or in opposition to the proposed Bylaw and may recommend substitute amendments as well.

21.2-2 Without Notice

By 90% vote of the Members of the Active Staff present at a staff meeting, a proposal to amend the Bylaws may be made and acted upon at the same meeting. Without prior notice, as defined in **Section 21.2-1**, a 90% vote of the Members present shall likewise be required for adoption of such amendments.

21.2-3 Medical Executive Committee Action

If the Medical Executive Committee proposes to adopt a Bylaw, rule, regulation, policy, manual or amendment thereto, it must provide 30 days written notice of any such action to the Medical Staff. Any conflicts that arise between the Medical Staff and the Medical Executive Committee with regards to any actions in this Section 22.2 will be referred to a special combined committee for review and discussion. This special combined committee will be composed of at least two (2) representatives from the Medical staff and at least (2) two representatives from the Medical Executive Committee appointed by such committee. The special combined committee will be chaired by the past president who serves as the chair of the Bylaws committee. The special combined committee upon review of the conflict shall make a recommendation regarding the specific amendment to the Medical Staff

21.2-4 Emergency Amendment

If there is a documented urgent need for amendment of a Bylaw, rule, regulation, policy, manual or amendment thereto of the Medical Staff for legal or regulatory compliance, the

Medical Executive Committee may provisionally adopt such amendment without the required notice to the Medical Staff. The Board of Trustees may also provisionally adopt such amendment without the required notice. The Medical Executive Committee will immediately notify the Medical Staff of the provisional adoption of the amendment and the basis therefore. The Medical Staff will be given 30 days to review the amendment and comment thereon. If the Medical Staff approves the amendment, the amendment will stand. If the Medical Staff disapproves in writing of the adoption of the amendment, the procedures specified in Section 21.3-2 will be undertaken to resolve the issue. If the Medical Staff does not act upon the amendment, such amendment after the 30 days notice will be handled in accordance with Section 21.3-1 as if it received a Medical Staff recommendation. In addition, upon agreement of the Medical Staff and Medical Executive Committee, a revised amendment may be submitted to the Board of Trustees for approval.

SECTION 21.3 BOARD OF TRUSTEES ACTION

21.3-1 When Favorable to Medical Staff Recommendation

Medical Staff recommendations are approved upon the affirmative vote of a majority of the Board of Trustees. The effective date of such approved recommendations is on the date approved or at such later date as the Board may specify.

21.3-2 When Contrary to or Without Benefit of Medical Staff Recommendation

a. Notice to Staff

Whenever the Board of Trustees is contemplating either:

1. taking action on Bylaws or amendments thereto which are contrary to the recommendations of the Medical Staff; or

2. taking action on Bylaws or amendments thereto without having received a recommendation on the matter from the Medical Staff, the Board of Trustees shall, by written notice to the President of the Medical Staff inform the Staff of its

concerns, of the reasons therefore, and of the date by which the Staff's response is requested, which shall not be less than seven (7) nor more than sixty (60) days after the date of the notice.

b. Action Following Staff Response

If the Staff's response satisfies the Board of Trustee's concerns, the Board of Trustees shall act upon the matter in accordance with **Section 21.3-1**. If the Staff's response fails to satisfy the Board of Trustee's concerns, or if no Staff response is received within the specified time frame, the matter will be referred to a special combined committee for review, discussion, and report as provided in **Section 21.3-2c**. herein. This special combined committee will be composed of three (3) representatives each from the Medical Staff and Board of Trustees, appointed respectively by the Medical Staff President and the Chairman of the Board. The President of the Hospital will sit with this committee as an ex-officio member, without vote.

c. Action Following Special Combined Committee Review:

Within ten (10) working days after receiving a matter referred to it under **Section 21.3-2b**. above, the special combined committee described above shall convene to review, discuss, and prepare its written report on the matter. This shall be communicated to the Staff for consideration and response to the Board of Trustees within a specified time period. Board of Trustees action after receiving the Staff's response or after expiration of the response period without a Staff response, shall be effective as the final decision. The documents or amendments the Board of Trustees approved is effective as of the date of the Board of Trustees action or at such later date as the Board of Trustees may specify.

SECTION 21.4 TECHNICAL AND EDITORIAL CORRECTIONS

The Medical Executive Committee shall have the power to adopt such corrections to the Bylaws as are, in its judgment, technical, or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or corrections made necessary because of punctuation, spelling, or other errors of grammar or expression. Such corrections

shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Trustees within ninety (90) days of adoption by the Medical Executive Committee. The action to correct may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated by some reasonable mechanism and in writing/email to the Medical Staff and to the Board of Trustees.

SECTION 21.5 RECORDING OF BYLAW AMENDMENTS, CORRECTIONS INCLUDING TECHNICAL OR EDITORIAL.

Any new Bylaw(s) adopted and approved by the Medical Staff, Medical Executive Committee and the Board of Trustees, including amendments, as well as technical or editorial corrections, shall be recorded as an attachment to these Bylaws titled "Bylaw Amendments, Corrections." The correction(s) shall be recorded indicating the section and number of the Bylaw corrected and the approval date of the Medical Executive Committee. All members of the Medical Staff shall be notified and receive or be given access to a copy of the correction.

ARTICLE TWENTY-TWO

HISTORY AND PHYSICAL

SECTION 22. HISTORY AND PHYSICAL EXAMINATION

22.1 GENERALLY

A complete history and physical examination shall be generated in the medical record or dictated within 24 hours after admission of the patient. If dictated, the medical record must contain an admission note within 24 hours that provides pertinent findings from the history and physical examination. The attending practitioner must generate an admission note also within 24 hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. The history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a documented review of all systems.

Delegation is limited to the physician's assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of a LIP to be performed by a non-LIP the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

If it is determined that state law and regulation and professional practice acts allow delegation of the LIP history and physical examination, the exam can be delegated, provided:

- the medical staff and the organization have appropriate policies and procedures
- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- the non-licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the non-licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by medical staff bylaws, rules and regulations and policies and procedures
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific

qualified physician who countersigns, dates and retains accountability for the patient's medical history and physical examination.

- the person is specifically permitted by the organization to perform the history and physical either,
- as part of the supervising/delegating physician's privileges, or
- through an specific alternate process, such as that utilized by the organization for allied health practitioners

22.2 PREOPERATIVE DOCUMENTATION

22.2-1 HISTORY AND PHYSICAL EXAMINATION

A relevant history and physical examination is required on each in-patient and outpatient receiving conscious sedation or anesthesia other than local anesthesia. Except in an emergency, so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the medical record.

If the history and physical examination have been dictated but are not on the medical record at the time of surgery, an electronic entry must be placed before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, the anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) shall not administer anesthesia and shall not allow the surgery to proceed. In case of an emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with applicable sections of the Medical Staff Bylaws.

If it is determined that state law and regulation and professional practice acts allow delegation of the LIP history and physical examination, the exam can be delegated, provided:

- the medical staff and the organization have appropriate policies and procedures

- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the -licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by medical staff bylaws, rules and regulations and policies and procedures
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns and retains accountability for the patient's medical history and physical examination.
- the person is specifically permitted by the organization to perform the history and physical either,
- Cannot exceed their supervising physician's privileges ---as part of the supervising/delegating physician's privileges, or
- through an specific alternate process, such as that utilized by the organization for allied health practitioners

This delegation is limited to the physician's assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of a LIP to be performed by a non-LIP the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

A History and Physical which is performed up to or no more than 30 days before admission may be utilized provided it is updated to reflect the patient's status at the time of admission but prior to surgery. It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record augments, but does not replace the history and physical, which should document any and all diagnoses, an up to date exam, and any care beyond the normal labor care.

22.2-3 SHORT FORM

The Short Form History and Physical Examination, the template for which is present in the EHR, may be utilized for patients having a length of stay within 48 (forty-eight) hours. A short form history and physical examination may be utilized for Same Day Surgery patients. The short form shall contain all the elements required of a comprehensive history and physical examination and informed consent as described in the bylaws and Rules and Regulations.

22.2-4 30 DAYS BEFORE ADMISSION

If a history and physical examination have been performed within 30 days Before admission, a durable copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission. An addendum must be made even if there are no changes stating such.

BYLAW AMENDMENTS

1. Article Ten, Section 10.3-2a Increased the number of signatures on a written petition from 12 to 35.
   Approved MEC–10/16/2019, FMS- BOT–5/26/2020

2. Article Twenty-one, Section 21.3-2c. Allied Health Staff fees revised from paying late fees to being assessed the same fees as the Active Staff.
   Approved MEC–1/15/2020, FMS-3/4/2020, BOT–5/26/2020

3. Definitions – Allied Health Professional. Referenced Article Seventeen changed to Article Nineteen.
   Approved MEC-1/15/2020, FMS-3/4/2020, BOT-5/26/2020

4. Article Six, Section 6.12 Leave of Absence
   Provided a provision for approval of a leave of absence between Medical Executive Committee meetings. Approval for the leave must be by the President of the Medical Staff or his designee in conjunction with the President of the Hospital or his designee. The request will be presented at the next MEC meeting.
   Approved MEC – 3/17/2021, FMS-6/3/2021, BOT – 6/22/2021

5. Article Nineteen, Section 19.5 Obligations of Allied Health Professional Staff.
   Nurse Practitioners, Physician Assistants, CRNAs and CNMs will be invited to attend the March and September full medical staff meetings without vote.
   Approved MEC-5/19/2021, FMS-6/3/2021, BOT-6/22/2021

6. Article 13, Section 13.2-3 i. Duties and Authority
   Added the following as a result of the Joint Commission Survey.

   The Medical Executive Committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.
   Approved MEC – 10/20/2021, BOT-10/26/2021, FMS – 12/1/2021

7. Definitions revised Advance Practice Provider, Allied Health Profession, Removed Medical Ancillary Staff.
   Approved MEC – FMS – BOT – 6/22

8. Article Five revised
   Approved MEC – FMS – BOT – 6/22

9. Article 19 was incorporated into the revision of Article Five.
   Approved MEC – FMS – BOT – 6/22

10. Articles 20 through 23 were renumbered.
    Approved MEC – FMS – BOT – 6/22