BYLAWS OF THE

BOSTON MEDICAL CENTER CORPORATION

MEDICAL-DENTAL STAFF

As amended November 7, 2023

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ARTICLE I. NAME AND PURPOSE

The name of this organization shall be the Boston Medical Center Corporation Medical-Dental Staff (hereinafter referred to as the "Medical Staff") whose purposes shall be:

A. To provide and oversee the quality of medical and psychosocial care, treatment and services to patients of the Boston Medical Center Corporation;
B. To educate medical students, physicians and other health care professionals; and
C. To carry on other activities which serve the mission of the Boston Medical Center Corporation and the welfare of its patients.

ARTICLE II. DEFINITIONS

A. "Bylaws" shall mean these Medical Staff Bylaws.
B. "BORIM" shall mean the Board of Registration in Medicine for the Commonwealth of Massachusetts.
C. "BUSM" shall mean the Boston University School of Medicine.
D. "CEO" shall mean the Chief Executive Officer and President of the Hospital.
E. "CMS" shall mean the Center for Medicare and Medicaid Services.
F. "Executive Committee" shall mean the executive committee of the Medical Staff.
G. "Hospital" shall mean the Boston Medical Center Corporation, including all inpatient, extended care, ambulatory care or other services provided under the Hospital's license.
H. "Ex Officio" shall mean by reason of one's office, with voting rights, unless otherwise stated.
I. "President" shall mean the President of the Medical Staff.
J. "Trustees" shall mean the Board of Trustees of the Hospital.
K. "Peer" shall mean an individual who possesses the same licensure and has privileges in the same or similar areas.
L. "Licensed Independent Practitioner (LIP)" shall mean an individual permitted by Massachusetts law and by Boston Medical Center to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. It shall include, but not be limited to, acupuncturists, advanced practice registered nurses (APRNs) [certified registered nurse anesthetists, certified nurse midwives, certified nurse practitioners, and psychiatric clinical nurse specialists], chiropractors, dentists (including Full-Time Faculty Limited Licensed Dentists), licensed independent clinical social workers, licensed mental health counselors, optometrists, pharmacists, physician assistants, physicians, podiatrists, and psychologists.
M. "Medical Staff Membership" is a benefit conferred by the Trustees, upon recommendation of the Medical Staff, whereby professionally competent physicians, dentists, and other practitioners who qualify under these Bylaws, are organized into a body whose purposes are set forth in Article I.

N. “Appointment” shall mean the process whereby an individual is selected as a member of the Medical Staff. Unless specifically identified herein as initial or reappointment, it shall mean both.
O. “Clinical Privileges” or “Privileges” except as used in Article XII are defined as the authority granted to a LIP by the Trustees to provide patient care in the Hospital. They are Department specific and must be outlined on a Delineation of Clinical Privileges Form approved by the Trustees upon the recommendation of the Executive Committee.
P. “Credentialing” is the process whereby an applicant’s qualifications for Medical Staff membership or clinical privileges are collected, verified, and assessed. It serves as the foundation for objective, evidence-based decisions leading to: a) appointment to membership on the Medical Staff and/or b) recommendations to the Board of Trustees to grant or deny clinical privileges.
Q. “Focused Professional Practice Evaluation or FPPE” is an evaluation conducted in a time-limited period during which the Hospital evaluates a practitioner’s performance of clinical privileges and other activity that may affect quality of care and patient safety.
R. “Ongoing Professional Practice Evaluation or OPPE” is a program that allows the Medical Staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis.
S. “Privileging” is the process for: a) developing and approving Delineations of Clinical Privileges, b) evaluating applicant-specific information for competency obtained through credentialing, c) recommending the granting or denying of requested privileges to the Trustees based on this evaluation, d) notifying an applicant of privileging decisions and e) monitoring the use of privileges and quality care issues through FPPE and OPPE.
T. “Telemedicine” is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status (Source: American Telemedicine Association).

ARTICLE III. MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff does not confer clinical privileges. Membership may be granted by the Trustees, in their best judgment, upon recommendation by the Medical Staff. In granting membership, the best interest of the Hospital and patient care, along with Departmental needs, are taken into account.

SECTION 2. QUALIFICATIONS

Members and applicants for membership on the Medical Staff shall be licensed to practice independently in their respective professions in the Commonwealth of Massachusetts, unless otherwise indicated in Section 4 of this Article. Membership on the Medical Staff may be granted only to practitioners whose demonstrated experience, training and current competence, adherence to the ethics of his/her profession, good

reputation, ability to relate to patients and to work cooperatively with other staff members and employees is sufficient to assure the Trustees that any patient treated in the Hospital will receive appropriate patient care. A BUSM faculty appointment and certification by a specialty board are important qualifications but are not required for membership.

SECTION 3. RESPONSIBILITIES AND DUTIES OF THE MEDICAL STAFF

Each member of the Medical Staff, as applicable to the member's profession, shall:

A. Continuously meet the qualifications and requirements set forth in these Bylaws.
B. Provide patients with care which is no less than the generally recognized professional level of quality and efficiency regardless of their ability to pay.
C. Be governed by the codes of ethics as adopted by the member's professional specialty association.
D. Abide by the Bylaws and its Rules and Regulations, and the Hospital bylaws and policies, as they may be amended from time to time, including the Boston University Medical Center Patent Policy, the Boston Medical Center Intellectual Property Policy and Agreement, the Conflict of Interest Policy, the Conflict of Interest in Research Policy and the Policy on Scientific Misconduct in Research.
E. Discharge such staff, departmental, committee and hospital functions for which the member is responsible by appointment, election, or otherwise.
F. Prepare and complete in a timely manner the medical and other required records for all Hospital patients admitted or treated by the member. History and Physical Examinations:
    - Will be performed within the first 24 hours of the admission (inpatient, observation, surgical day care) or updated within the first 24 hours if performed up to 30 days prior to the admission/procedure.
    - Histories and Physicals generated outside of the Hospital will be accepted if the specific data or content listed in the Hospital's history and physical forms are included in the document.
    - At a minimum must include the following: Reason for admission/Chief Complaint; Details of the present illness; Medications and clinical reconciliation; Relevant past, social and family history; Allergies; Review of systems; Physical Examination; and the Assessment and Plan.
    - Except in an emergency when such a delay would constitute a hazard to the patient, in the case of all procedures requiring Anesthesia services (General Anesthesia, Regional Anesthesia, MAC, Deep Sedation or any procedure requiring the services of an Anesthesiologist or CRNA), or a high probability that the patient may require Anesthesia services based on an assessment of the risks associated with the procedure or patient, including but not limited to patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure, patients must have a full history and physical examination performed prior to the procedure by a designated privileged LIP or House Staff. The history and physical must be updated prior to the procedure to include an assessment of the patient addressing significant changes at the time of any procedure that requires a history and physical.

- For procedures that do not meet the criteria above, there shall be an abbreviated history and physical that is appropriate to the current problem, purpose of the encounter, or procedure. In the case of a scheduled follow-up visit, an update is required regarding those problems/diagnoses being dealt with at the encounter. In the case of a special visit for an acute/new problem, the history of that particular problem and any pertinent notation of background medical information is required.

G. Promptly notify the Department Chief and Chairperson of the Executive Committee of the revocation, suspension or loss of the member's professional license, the imposition of terms of probation or limitation of practice by any state, or loss of staff membership or privileges at any health care institution, whether voluntary or involuntary, or any audit, investigation or sanction by the CMS or any other action that would jeopardize his/her status as a participating provider in federal programs.
H. Provide continuous care and supervision of the member's patients.
I. Regularly attend, if a member of the Active staff, meetings of the Medical Staff.
J. Participate in the performance improvement initiatives of his/her service and the organization as requested by the Department, Division, or Section Chief.
K. Provide the Medical Staff Office (MSO) with renewed documentation needed to prove continuous qualification for staff membership or privileges upon expiration of previous documentation.

SECTION 4. CATEGORIES OF MEMBERSHIP

The Medical Staff shall consist of the Active Staff, the Associate Staff, the Courtesy Staff, the Honorary Staff, the Special Scientific Staff, the Special Clinical Staff, the House Staff, the Limited Courtesy Staff, and the Refer and Follow Staff. All procedures for appointment to the Medical Staff are applicable to individuals in administrative positions who wish to join the Medical Staff.

All members of the Medical Staff may attend Medical Staff meetings and participate in the educational programs given at the Hospital.

Subsection 1. Active Staff

The Active Staff shall consist of those physicians, dentists, podiatrists, and psychologists whose primary professional activity takes place at the Hospital. Members of the Active Staff may request delineated clinical privileges to be granted by the Board of Trustees. They may participate in teaching, vote, hold office, and, with the exception of psychologists, admit patients to the Hospital, if privileged.

Subsection 2. Associate Staff

The Associate Staff shall consist of those physicians, dentists, podiatrists, and psychologists whose primary professional activity takes place at one of the community health centers operating under the Hospital's license. Members of the Associate Staff may request delineated clinical privileges to be granted by the Board of Trustees. They

may participate in teaching, vote, hold office, and, with the exception of psychologists, admit patients to the Hospital, if privileged.

Subsection 3. Courtesy Staff
The Courtesy Staff shall consist of physicians, dentists, podiatrists, and psychologists whose primary professional activity does not take place at the Hospital or at one of the community health centers operating under the Hospital's license. The members of the Courtesy Staff may request delineated clinical privileges to be granted by the Board of Trustees. They may participate in teaching and, with the exception of psychologists, admit patients to the Hospital, if privileged. Courtesy Staff are not eligible to vote or hold office.

Subsection 4. Honorary Staff
The Honorary Staff shall consist of physicians, dentists, podiatrists, psychologists, and other practitioners who are no longer engaged in patient care but have had past staff membership at the Hospital, Boston City Hospital or University Hospital and who wish to be a part of the Hospital. Members of the Honorary Staff may not vote, hold office or admit or care for Hospital patients. Members of the Honorary Staff are not subject to the Appointment and Reappointment Procedures contained in Article IV herein and are not required to have a current state professional license. The hearing and appeals procedures in Article VII of these Bylaws shall not apply to the Honorary Staff.

Subsection 5. Special Scientific Staff
The Special Scientific Staff shall consist of individuals with a master or doctorate degree as appropriate, who are engaged in scientific activities but do not have delineated clinical privileges and have no direct responsibility for patient care. Members are not eligible to admit or care for Hospital patients, vote or hold office. Members of the Special Scientific Staff are not subject to the Appointment and Reappointment Procedures contained in Article IV or the hearing and appeals procedures in Article VII of these Bylaws.

Subsection 6. Special Clinical Staff
The Special Clinical Staff shall consist of professionals other than physicians, dentists, podiatrists and psychologists who may request delineated clinical privileges to be granted by the Board of Trustees. Unless otherwise stated, members of the Special Clinical Staff may not admit patients, vote, or hold office except as provided in Article IX, Section 1.

If privileged to do so, APRNs may admit patients as inpatients. However, with the exception of Medicaid patients admitted by certified nurse midwives, patients covered by Medicare or Medicaid must be under the care of a doctor of medicine or osteopathy.

Subsection 7. House Staff
The House Staff shall consist of interns, residents, fellows, and psychology trainees. The sponsoring Chief shall be generally responsible for the supervision of House Staff and the professional standards and ethical conduct of persons in this category. The House Staff do not have delineated clinical privileges. All patient care given by members of the House Staff category shall be under the general supervision of members of the active or

courtesy staff designated by the Chief as described in the Residents' Roles and Responsibilities. Members of the House Staff may not admit patients, vote or hold office. Members of the House Staff are not subject to the Appointment and Reappointment Procedures contained in Article IV herein. The hearing and appeals procedures in Article VII of the Bylaws shall not apply to House Staff. The House Staff are subject to the hearings and appeals procedures contained in the Agreement between the Hospital and the Committee of Interns and Residents in effect from time to time.

Subsection 8. Limited Courtesy Staff
The Limited Courtesy Staff shall consist of Full-Time Faculty Limited License Dentists, as well as members of the House Staff who are permitted by their residency program, Department, Division, or Section and the Graduate Medical Education Office to moonlight at the Hospital or its licensed health centers. The members of the Limited Courtesy Staff may request delineated clinical privileges to be granted by the Board of Trustees, but they may not admit patients to the Hospital. Limited Courtesy Staff are not eligible to vote or hold office. Members of the Limited Courtesy Staff are subject to the Appointment and Reappointment Procedures contained in Article IV herein. The hearing and appeals procedures in Article VII are applicable to the Limited Courtesy Staff.

Subsection 9. Refer and Follow Staff
The Refer and Follow Staff shall consist of LIPs who wish to maintain a referral relationship with the Hospital, but do not intend to provide patient care or participate in supervision of trainees at the Hospital or at one of the community health centers operating under the Hospital's license. Members of the Refer and Follow staff may request a change to a staff membership category which includes eligibility for direct patient care at any time and be subject to the requirements of that category. The hearing and appeals procedures in Article VII of the Bylaws shall not apply to the Refer and Follow Staff.

Members of the Refer and Follow Staff, upon admission of patients for whom the Refer and Follow Staff member has care responsibility (i.e., primary, consultant or covering physician), a) may interview and examine that patient and b) may discuss care with the attending physician responsible for that patient's care in the Hospital. They may not provide direct patient care at the Hospital, serve as the physician of record, make care decisions, write orders, assist with procedures or order/prescribe medications. Members of the Refer and Follow Staff may not supervise trainees, vote, or hold office.

SECTION 5. NONDISCRIMINATION

The Medical Staff, in accordance with federal and state law, shall not discriminate on the grounds of race, color, religion, sex, gender identity, national origin, disability, sexual orientation, or age in determining eligibility for membership in, or appointment to, the Medical Staff.

SECTION 6. TERM OF MEMBERSHIP

1. Other than as provided below, all appointments to the Medical Staff and privileges shall be for a period not to exceed two (2) years.

ARTICLE IV. APPOINTMENT, REAPPOINTMENT, AND PRIVILEGING PROCEDURES

SECTION 1. APPLICABILITY

The procedures set forth in this Article IV apply to all applicants to the Medical Staff membership or privileges, with the exception of the Honorary Staff, House Staff and Special Scientific Staff. An application fee established by the Medical Staff must be paid at the time an application for appointment/initial privileges or reappointment/renewal of privileges is submitted to the MSO.

SECTION 2. INITIAL CREDENTIALING, APPOINTMENT AND PRIVILEGING PROCEDURE

1. All initial applicants for staff appointment or privileges shall request an application from the MSO. The application shall require detailed information concerning the applicant's professional qualifications. Applicants will have access to the Hospital Bylaws and Medical-Dental Staff Bylaws and its Rules and Regulations at the time of application.
2. All initial applicants for staff appointment or privileges shall complete the application for appointment, and sign or electronically sign under oath. The requirements of the application shall be as described below:
    a. Initial Appointment to the Medical Staff with Clinical Privileges
        i. Application for Initial Appointment/Initial Clinical Privileges, including all attachments
        ii. Delineation of Privileges Form
        iii. Photo of the applicant
        iv. Massachusetts professional license
        v. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
        vi. Massachusetts Controlled Substances Registration certificate, if applicable
        vii. Federal Drug Enforcement Administration (DEA) Certificate, if applicable
        viii. Proof of current malpractice insurance with minimum limits of I $1M/$3M
        ix. Clearance from Occupational and Environmental Medicine
        x. Application fee
        xi. Proof of current Basic Life Support (BLS) certification which must include a skills assessment. If a practitioner is physically unable to perform a skills assessment, a waiver of that requirement may be requested.

xii. Current CV with dates listed in MM/YYYY format

b. Initial Appointment to the Medical Staff without Clinical Privileges
   i. Application for Initial Appointment, including all attachments
   ii. Photo of the applicant
   iii. Massachusetts professional license
   iv. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
   v. Application fee
   vi. Current CV with dates listed in MM/YYYY format

c. Initial Clinical Privileges without Medical Staff Appointment
   i. Application for Initial Clinical Privileges, including all attachments.
   ii. Delineation of Privileges Form
   iii. Photo of the applicant
   iv. Massachusetts professional license
   v. Massachusetts Controlled Substances Registration certificate, if applicable
   vi. Federal DEA Certificate, if applicable
   vii. Proof of current malpractice insurance with minimum limits of $1M/$3M
   viii. Clearance from Occupational and Environmental Medicine
   ix. Application fee
   x. Proof of current Basic Life Support (BLS) certification which must include a skills assessment. If a practitioner is physically unable to perform a skills assessment, a waiver of that requirement may be requested.
   xi. Current CV with dates listed in MM/YYYY format

3. The completion or submission of an Application shall at no time be construed by the applicant as permission to practice his/her profession within the Hospital.
4. If the application is incomplete, MSO will notify the applicant of the missing information.
5. The applicant may be required to produce such additional information as is necessary for a proper evaluation of his/her character, ethics and other qualifications.
6. The applicant may be required to produce such additional information as is necessary for a proper evaluation of his/her current competence and ability to perform requested privileges, if applicable.
7. By applying, each applicant (a) affirms his/her willingness to appear for interviews; (b) agrees in advance to undergo a mental or physical examination if requested, and if there is a known mental or physical impairment, to provide evidence that the impairment does not interfere with the applicant's ability to perform the privileges requested, if applicable; (c) authorizes the Hospital to consult with members of medical staffs of other health care organizations and facilities with which the applicant has been associated and with others who may have information bearing on his/her competence, character, ethics and other qualifications; (d) consents to the Hospital's inspection of all records and documents that may be pertinent to his or her

licensure, specific training, experience, current competence, and ability to perform the privileges requested; (e) consents to all acts of employees and other agents or representatives of the Hospital and the Medical Staff in connection with the evaluation of the applicant and his/her credentials; (f) consents to all acts of all individuals and organizations who provide information to the Hospital concerning the applicant's qualifications for appointment or clinical privileges, including disclosure to the Hospital of information otherwise privileged or confidential; (g) pledges to provide for continuous care for his or her patients, (h) agrees to abide by the bylaws, rules and regulations and the policies of the Hospital and (i) will notify the Hospital if subjected to audit, investigation or sanction by the CMS or any other action that would jeopardize his/her status as a participating provider in federal programs; (j) authorizes a criminal background check and (k) discloses any familial relationship with an employee of Boston Medical Center, Boston University or Boston University Medical Group.

8. The applicant agrees to participate in and comply with the requirements of the Patient Care Assessment Program established by Hospital and filed with the BORIM pursuant to state law.
9. For applications that include a request for privileges, MSO shall attempt to obtain documented verification of the applicant's professional licensure, applicable certification and controlled substance registration, professional education, relevant training, current competence to perform the requested privileges, including two (2) peer references, other healthcare affiliations and malpractice claims history within at least the last ten (10) years, as relevant, and any other required information, including a query of the National Practitioner Data Bank.
10. For applications that do not include a request for privileges, documentation of current competence is not required. MSO shall attempt to obtain documented verification of the applicant's qualifications for membership, which includes all applicable items set forth in paragraph 9 above.
11. At least three (3) attempts will be made to obtain this information from the primary source(s) whenever feasible. If unable to obtain relevant information from any individual source, MSO will send notice to the applicant of the source(s) that have not responded. The applicant is responsible for having these verifications forwarded to MSO within ten (10) days of the date of this notice. If, after ten (10) days, the missing verifications have not been received, or have not been proven to be unobtainable, application processing will be suspended for a maximum of forty-five (45) days after which it shall be considered voluntarily withdrawn. The applicant shall be notified.
12. The Hospital will make reasonable efforts to obtain information required for credentialing, but the final burden for producing adequate information necessary for a satisfactory evaluation of the applicant's qualifications, as determined by the Medical Staff or Trustees, shall rest solely with the applicant.
13. If at any time additional information becomes required during application processing, the applicant shall be notified and responsible for providing such information to MSO within ten (10) days of notice.
14. The applicant may correct erroneous information. MSO will notify the applicant by written, electronic or verbal communication of discovery of any information

obtained during the credentialing process that varies substantially from the information provided by the applicant. The applicant will respond to the MSO in writing or by electronic communication. MSO will notify the practitioner via written, electronic or verbal communication of the receipt of the information. The communication noted above will be completed prior to the initiation of the approval process.

15. The applicant may review information obtained by the MSO to evaluate his/her application with the exception of references, recommendations or other peer review protected information.
16. The applicant has a right to be informed of the status of his/her application. Upon request, MSO will notify the practitioner, via written, electronic or verbal communication of his/her status including a list of items pending.
17. Initial applicants must appear in the MSO with a valid government issued identification, or have identity confirmed by a Hospital representative, before the completion of the appointment/privileging procedure.
18. Verified Applications will be forwarded to the Chief(s) or designee(s) responsible for investigating the character, qualifications, and standing of the applicant. The Department Chief, or designee, will review the application and make a recommendation on granting or denying appointment or any requested privileges.
19. The recommendation of the Department Chief, or designee, shall be presented to a member of the Credentials Committee for review. The Credentials Committee may further review and discuss the recommendation, and may request further clarification, investigation or substantiation of any details of concern to the Committee, if applicable.
20. Following Credentials Committee review, the recommendation on the Application shall be presented to the Executive Committee. The Chair of the Executive Committee may appoint a member of the Executive Committee or ask the sponsoring Department Chief to secure additional information where necessary, and the Application will then be deferred until a future meeting of the Executive Committee when the additional information is available. The Executive Committee shall make its recommendation to the Trustees. If the recommendation is adverse, the Executive Committee shall notify the applicant.
21. The Trustees shall act on the recommendations and shall send notice of all final decisions to MSO who will notify the Chiefs of the applicable Services and the applicants.
22. The Trustees may refer the matter back to the Executive Committee for reconsideration, stating the reasons therefor. The Executive Committee must make a subsequent recommendation. After receipt of such subsequent recommendation and new evidence in the matter, if any, the Trustees shall act upon the matter and inform MSO, who will notify the Chiefs of the Services concerned and the applicants.
23. The decision of the Trustees is final. The procedures set forth in Article VII of these Bylaws are not applicable to initial applicants who have been denied approval by the Trustees.
24. Applications shall be considered in a timely manner. While special circumstances may constitute good cause and warrant exceptions, the time period for routine

processing of initial applications will be no longer than one-hundred and eighty (180) days.

   a. MSO shall make a good faith effort to evaluate, review, and verify Applications within sixty (60) days from receipt of all necessary documentation.
   b. The Department Chief should review and make its recommendation within fifteen (15) days of receipt of all necessary documentation.
   c. The Credentials Committee should review and make its recommendations within fifteen (15) days of Departmental recommendation.
   d. The Executive Committee should review and make its recommendation within thirty (30) days of Credentials Committee review.
   e. The Trustees should review and make its final determination within sixty (60) days of receipt of Executive Committee recommendation.
   f. The applicant shall be notified of the Trustees decision within sixty (60) calendar days of the decision.

SECTION 3. RECREDENTIALING, REAPPOINTMENT AND REPRIVILEGING PROCEDURE

1. All renewal applicants shall complete the application for recredentialing, and sign under oath. The requirements of the application shall be as described below:
   a. Reappointment to the Medical Staff with Clinical Privileges
      i. Application for Renewal – Medical-Dental Staff, including all attachments
      ii. Delineation of Privileges Form
      iii. Massachusetts professional license
      iv. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
      v. Federal DEA Certificate, if applicable
      vi. Massachusetts Controlled Substances Registration certificate, if applicable
      vii. Proof of current malpractice insurance with minimum limits of $1M/$3M
      viii. Clearance from Occupational and Environmental Medicine
      ix. Application fee
      x. Proof of current Basic Life Support (BLS) certification which must include a skills assessment. BLS may be submitted at any time prior to the date of renewal of privileges. If a practitioner is physically unable to perform a skills assessment, a waiver of that requirement may be requested.
      xi. Current CV with dates listed in MM/YYYY format, if there have been substantive changes applicable to assessing qualifications since the last appointment or reappointment to the Medical Staff.
   b. Reappointment to the Medical Staff without Clinical Privileges
      i. Application for Renewal – Medical-Dental Staff, including all attachments

ii. Massachusetts professional license
iii. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
iv. Application fee
v. Current CV with dates listed in MM/YYYY format, if there have been substantive changes applicable to assessing qualifications since the last appointment or reappointment to the Medical Staff.

c. Renewal of Clinical Privileges Without Medical Staff Appointment
i. Application for Renewal of Privileges, including all attachments
ii. Delineation of Privileges Form
iii. Massachusetts professional license
iv. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
v. Federal DEA Certificate, if applicable
vi. Massachusetts Controlled Substances Registration certificate, if applicable
vii. Proof of current malpractice insurance with minimum limits of $1M/$3M
viii. Clearance from Occupational and Environmental Medicine
ix. Application fee
x. Proof of current Basic Life Support (BLS) certification which must include a skills assessment. BLS may be submitted at any time prior to the date of renewal of privileges. If a practitioner is physically unable to perform a skills assessment, a waiver of that requirement may be requested.
xi. Current CV with dates listed in MM/YYYY format, if there have been substantive changes applicable to assessing qualifications since the last date privileges were granted.

2. Applications must be submitted by the due date listed on the application. Failure to return the application by the due date without just cause may result in an additional late fee of $200.
3. Failure to submit an Application shall be considered grounds for a voluntary relinquishment of the individual's privileges and staff membership effective at the expiration of the current term.
4. The completion or submission of an Application shall at no time be construed by the applicant as permission to practice his/her profession within the Hospital beyond the expiration date of the current term.
5. The applicant may be required to produce such additional information as is necessary for a proper evaluation of his/her character, ethics and other qualifications.
6. The applicant may be required to produce such additional information as is necessary for a proper evaluation of his/her current competence and ability to perform requested privileges, if applicable.
7. By applying for recredentialing, each applicant (a) affirms his/her willingness to appear for interviews; (b) agrees in advance to undergo a mental or physical examination if requested, and if there is a known mental or physical impairment, to provide evidence that the impairment does not interfere with the applicant's ability to

perform the privileges requested; (c) authorizes the Hospital to consult with members of medical staffs of other health care organizations and facilities with which the applicant has been associated and with others who may have information bearing on his/her competence, character, ethical and other qualifications; (d) consents to the Hospital's inspection of all records and documents that may be pertinent to his or her licensure, specific training, experience, current competence, and ability to perform the privileges requested; (e) consents to all acts of employees and other agents or representatives of the Hospital and the Medical Staff in connection with the evaluation of the applicant and his/her credentials; (f) consents to all acts of all individuals and organizations who provide information to the Hospital concerning the applicant's qualifications for appointment and clinical privileges, including disclosure to the Hospital of information otherwise privileged or confidential; (g) pledges to provide for continuous care for his or her patients; (h) agrees to abide by the bylaws, rules and regulations and the policies of the Hospital; (i) will notify the hospital if subjected to audit, investigation or sanction by the CMS or any other action that would jeopardize his/her status as a participating provider in federal programs; (j) authorizes a criminal background check and (k) discloses any familial relationship with an employee of Boston Medical Center, Boston University or Boston University Medical Group.

8. The applicant agrees to participate in and comply with the requirements of the Patient Care Assessment Program established by the Hospital and filed with the BORIM pursuant to state law.
9. For applications that include a request for privileges, MSO shall attempt to obtain documented verification of the applicant's professional licensure, applicable certification and controlled substance registration, applicable relevant training, current competence, other healthcare affiliations within the last three (3) years, malpractice claims history for the last three (3) years and any other required information, including a query of the National Practitioner Data Bank.
10. For applications that do not include a request for privileges, documentation of current competence is not required. MSO shall attempt to obtain documented verification of the applicant's qualifications for membership, which includes all applicable items set forth in paragraph 9 above.
11. At least three (3) attempts will be made to obtain this information from the primary source(s) whenever feasible. If unable to obtain relevant information from any individual source, MSO will send notice to the applicant of the source(s) that have not responded. The applicant is responsible for having these verifications forwarded to MSO within ten (10) days of the date of this notice. If, after ten (10) days, the missing verifications have not been received, or have not been proven to be unobtainable, application processing will be suspended for a maximum of forty-five (45) days after which it shall be considered voluntarily withdrawn. The applicant shall be notified.
12. The Hospital will make reasonable efforts to obtain information required for credentialing, but the final burden for producing adequate information necessary for a satisfactory evaluation of the applicant's qualifications as determined by the Medical Staff or Trustees shall rest solely with the applicant.

13. If at any time additional information becomes required during application processing, the applicant shall be notified and responsible for providing such information to MSO within ten (10) days of notice.
14. The applicant may correct erroneous information. MSO will notify the applicant by written, electronic or verbal communication of discovery of any information obtained during the credentialing process that varies substantially from the information provided by the applicant. The applicant will respond to the MSO in writing or by electronic communication. MSO will notify the applicant via written, electronic or verbal communication of the receipt of the information. The communication noted above will be completed prior to the initiation of the approval process.
15. The applicant may review information obtained by the MSO to evaluate his/her application with the exception of references, recommendations or other peer review protected information.
16. The applicant has a right to be informed of the status of his/her application. Upon request, MSO will notify the practitioner, via written, electronic or verbal communication of his/her status including a list of items pending.
17. Processed applications will be forwarded to the applicable Chief(s), or designee(s), responsible for investigating the character, qualifications, and standing of the applicant. The Department Chief, or designee, will review the application and make a recommendation to MSO on granting or denying appointment and/or any requested privileges, which shall include the following:
    a. Attestation that OPPE has been reviewed and considered by the Department Chief or designee in making the decision to grant or deny appointment or privileges.
18. The recommendation of the Department Chief shall be presented to a member of the Credentials Committee for review. The Credentials Committee may further review and discuss the recommendation, and may request further clarification, investigation or substantiation of any details of concern to the Committee, if applicable.
19. Each reappointment and clinical privileges recommendation shall be based upon an evaluation of the member's current professional competence, encompassing the following, as applicable: provision of compassionate, appropriate and effective patient care by the review of clinical judgment in the treatment of patients; medical/clinical knowledge; practice-based learning and improvement by the review of the individual’s application of scientific evidence; interpersonal and communication skills by evaluation of the individual’s cooperation with Hospital personnel, and relations with other practitioners and general attitude toward patients, the Hospital and the public; professionalism, by the review of ethics and conduct, attendance at the Medical Staff meetings and participation in Medical Staff activities, and compliance with the Hospital Bylaws and with other applicable Hospital policies, these Bylaws and the Rules and Regulations of the Medical Staff; and systems-based practice by the individual’s ability to provide professionally recognized levels of care through efficient and economic use of hospital resources; and the sufficiency of the use of Hospital facilities as determined by the member's Chief.
20. Following Credentials Committee review, the recommendation on the application shall be presented to the Executive Committee.

21. After a review of the recommendation of the Credentials Committee, the Executive Committee shall make its recommendation to the Trustees. The Chair of the Executive Committee may appoint a member of the Executive Committee or ask the sponsoring Department Chief to secure additional information where necessary, and the application will then be deferred until a future meeting of the Executive Committee when the information is available. If the recommendation is adverse, the Executive Committee shall notify the applicant.
22. The Trustees shall act on the recommendations and shall send notice of all final decisions to MSO who will notify the Chiefs of the Services concerned and the applicants.
23. The Trustees may refer the matter back to the Executive Committee for reconsideration, stating the reasons therefor. The Executive Committee must make a subsequent recommendation. After receipt of such subsequent recommendation and new evidence in the matter, if any, the Trustees shall act upon the matter and inform MSO, who will notify the Chiefs of the Services concerned and the applicants.
24. The decision of the Trustees is final.
25. Applications for recredentialing shall be considered in a timely manner. While special circumstances may constitute good cause and warrant exceptions, the time period for routine processing of renewal applications will be no longer than one-hundred and eighty (180) days.
    a. The MSO shall make a good faith effort to evaluate, review, and verify applications within sixty (60) days from receipt of all necessary documentation.
    b. The Department Chief should review and make a recommendation within fifteen (15) days of receipt of all necessary documentation.
    c. The Credentials Committee should review and make its recommendations within fifteen (15) days of receipt of Departmental recommendation.
    d. The Executive Committee should review and make its recommendation within thirty (30) days of Credentials Committee review.
    e. The Trustees should review and make its final determination within sixty (60) days of receipt of Executive Committee recommendation.
    f. The applicant shall be notified of the Trustees decision within sixty (60) calendar days of the decision.

SECTION 4. EXPEDITED APPOINTMENT AND PRIVILEGING PROCEDURE

1. The Trustees may authorize a committee to make final decisions on its behalf as to the granting of membership and clinical privileges. The composition of any committee shall be set forth in the Hospital's bylaws and shall not be fewer than two (2) members of the Board of Trustees. A complete application is eligible for the expedited procedure described below, and consideration by the designated committee of the Trustees, <u>unless</u> the application contains:
    a. adverse recommendations or limitations;
    b. current challenges or previously successful challenges to licensure or registration;
    c. an involuntary termination of medical staff membership at any

organization;
d. an involuntary limitation, reduction, denial, or loss of clinical privileges;
e. a history of substance abuse;
f. a history of unprofessional conduct; or
g. an unusual pattern, or excessive number, of liability claims, regardless of outcome.

The Executive Committee may recommend to the designated committee of the Trustees that it use the expedited procedure for an application containing any of the factors in b-g above if (i) the applicant previously disclosed the factor(s) during an earlier credentialing process, (ii) the Board of Trustees then approved the applicant's privileges or appointment after consideration of the disclosure, (iii) the factor(s) are not subject to continued oversight (for example, by a monitoring plan or licensing board probation still in effect), and (iv) there has not been any change in the applicant's circumstances or performance related to the factor(s) since the Board of Trustees' decision.

2. The Credentials Committee's recommendation on the application shall be presented to the Executive Committee.
3. Upon recommendation of the Executive Committee, the application shall be presented to the designated committee of the Trustees.
4. The designated committee shall act on the recommendations and shall send notice of all final decisions to MSO who will notify the Chiefs of the Services concerned, the applicant and the Trustees.
5. The designated committee may refer the matter back to the Executive Committee for reconsideration, stating the reasons therefor. The Executive Committee must make a subsequent recommendation. After receipt of such subsequent recommendation and new evidence in the matter, if any, the designated committee shall act upon the matter and inform MSO, who will notify the Chiefs of the Services concerned, the applicant and the Trustees.
6. The decision of the designated committee is final. The procedures set forth in Article VII of these Bylaws are not applicable to initial applicants who have been denied approval by the Trustees.

SECTION 5. RESIGNATION

Resignation requests should be addressed in writing or by electronic communication to the MSO or the applicable Department Chief, who shall forward such resignations, with appropriate recommendations, to the MSO who compiles a list for the Executive Committee. Resignations which are accepted by the Executive Committee shall be effective at the time specified in the request, or if no time is specified, upon receipt of the request.

SECTION 6. DELEGATION OF AUTHORITY

A Chief may, in the exercise of such Chief's reasonable judgment, delegate his or her authority to take the actions contemplated in this Article IV.

SECTION 7. NONDISCRIMINATION

Privileging decisions will not be based on an applicant's race, ethnic/national identity, gender, gender identity, age, religion, disability, political beliefs, status as a veteran, or sexual orientation. To ensure that privileging is conducted in a nondiscriminatory manner, all adverse initial privileging decisions will be reviewed by the CMO or designee and adverse reprivileging decisions are subject to appeal as outlined in Article VII of these Bylaws.

ARTICLE V. CLINICAL PRIVILEGES

SECTION 1. GENERAL

Except in the case of an emergency as defined in Section 6 of this Article, any LIP who wishes to practice in the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Trustees. Upon recommendation of the Executive Committee, acting on behalf of the Medical Staff, the Trustees shall have final authority for granting, renewing, or denying clinical privileges. Clinical privileges shall be granted for a period not to exceed two (2) years.

Medical Staff membership alone carries no implicit clinical privileges. Eligibility for clinical privileges may be limited by the provisions set forth in Section 4 of Article III.

Each Department, and its Divisions or Sections if applicable, will be responsible for developing criteria which will be used for making objective decisions to grant or deny requests for clinical privileges.

Prior to the granting of a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame.

SECTION 2. PROFESSIONAL PRACTICE EVALUATION

Focused Professional Practice Evaluation (FPPE) is required for all initially granted privileges, including additions to existing privileges. FPPE is also required for deficiencies noted during the Ongoing Professional Practice Evaluation (OPPE).

OPPE is required to be performed on a regular basis on all practitioners with clinical privileges.

The Professional Practice Evaluation Policy may be obtained from the MSO.

SECTION 3. PROCEDURE FOR REVISING, ADDING OR CHANGING PRIVILEGES

A practitioner may request to have an increase or change in clinical privileges at any time. Whenever a practitioner desires to have an increase or change in his/her clinical privileges, he/she must request such privileges on a Delineation of Privileges Form that has been approved by the Executive Committee. If the desired set of privileges is new to the Hospital, the appropriate Department Chief, in conjunction with the Executive Committee, must first develop criteria that will be considered in recommending such privileges, or determine that existing criteria are sufficient. The requesting practitioner submits the Delineation of Privileges Form to the MSO.

The MSO will confirm that the requester's credentials are consistent with the criteria developed by the Department Chief for that set of privileges. This may be done by examination of existing credentials documentation or through verification of additional credentials. The applicant may be required to produce additional documentation as necessary for credentialing.

Thereafter, the procedure shall follow that as set forth in Article IV of these Bylaws.

When a request is awaiting review and recommendation by the Executive Committee or approval by the Trustees, the requester is eligible to be granted temporary privileges by the CEO or CEO's designee.

Once approved, the revised clinical privileges shall be effective until the end of the current period of the requester's existing clinical privileges.

If necessary, staff category may be changed upon completion of the procedure.

SECTION 4. TEMPORARY PRIVILEGES

Temporary privileges may be granted by the CEO or the CEO's designee upon recommendation of either the applicable Department Chief or the President of the Medical Staff under the following circumstances:

1. For a period not to exceed one hundred twenty (120) days or such other period established by the BORIM:
    a. On a case by case basis to fulfill an important patient care, treatment, or service need while the credentialing procedures set forth in these Bylaws are being performed for an applicant who has submitted a complete application for initial or additional clinical privileges, or
    b. When an applicant for initial or additional clinical privileges is awaiting review and recommendation by the Executive Committee or approval by the Trustees or committee, provided the application is complete and verified and there are no current or previously successful challenges to licensure or registration, the applicant has not been subject to involuntary termination of medical staff membership at another organization, and the applicant has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges.

2. For a period not to exceed thirty (30) days in any one year period or such other limit established by the BORIM for an LIP who is not seeking initial or renewed clinical privileges, but who wishes to have temporary privileges to provide or participate in patient care, treatment, or service.

The procedures for approving temporary privileges are as follows:

1. For a period not to exceed one hundred twenty (120) days or such other period established by the BORM:
    a. An applicant for initial or additional clinical privileges may request temporary privileges on a case by case basis to fulfill an important patient care, treatment, or service need, which cannot be met by currently privileged LIPs. The following provisions must be met:
        i. a complete application;
        ii. a query of the National Practitioner Data Bank;
        iii. verification of current Massachusetts licensure;
        iv. verification of current competence by considering peer recommendations and recent health care affiliations, where feasible;
        v. Department Chief recommendation of the privilege request; and
        vi. approval by the CEO, Chief Medical Officer (CMO) or designee.

        The initial credentialing appointment and privileging procedures will continue during the one hundred twenty (120) day temporary privilege period.
    b. When an applicant for initial or additional clinical privileges is awaiting review and recommendation by the Executive Committee or approval by the Trustees, temporary privileges may be requested provided the following provisions are met:
        i. there are no current or previously successful challenges to licensure or registration;
        ii. the applicant has not been subject to involuntary termination of medical staff membership at another organization;
        iii. the applicant has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges; and
        iv. approval by the CEO, CMO or designee.
2. For a period not to exceed thirty (30) days in any one year period or such other limit established by the BORM:
    a. For an LIP who is not seeking initial or renewed clinical privileges, but who wishes to have temporary privileges to provide or participate in patient care, treatment, or service. The individual requesting such privileges must provide:
        i. Application, which includes appropriate references to demonstrate competence.
        ii. Copy of privileges from the applicant's primary healthcare affiliation.
        iii. Photo of the applicant
        iv. Current CV with dates listed in MM/YYYY format

v. Delineation of Privileges Form
vi. Authorization and Release Form
vii. Massachusetts professional license
viii. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
ix. Massachusetts Controlled Substances Registration certificate, if applicable
x. Federal DEA Certificate, if applicable
xi. Proof of current malpractice insurance with minimum limits of $1M/$3M
xii. Clearance from Occupational and Environmental Medicine

b. The credentialing process includes:
   i. a query of the National Practitioner Data Bank;
   ii. verification of current licensure;
   iii. verification of current competence by considering peer recommendations and recent health care affiliations, where feasible;
   iv. Department Chief recommendation of the privilege request; and
   v. approval by the CEO, CMO or designee.

c. Professional Practice Evaluation is not applicable for this category of temporary privileges.

SECTION 5. EMERGENCIES

In a medical emergency, any LIP shall apply his/her professional expertise and judgment to preserve the well-being of the patient, regardless of any existing clinical privileges limitations; provided, however, that all care rendered in an emergency is within the scope of the LIP's license. A medical emergency is defined as an instance when the wellbeing of any patient is in danger and any delay in administering treatment would increase such danger.

SECTION 6. DISASTERS

When the Hospital's emergency disaster plan has been activated and existing medical staff members are not sufficient to meet immediate patient care needs resulting from an internal or external disaster, disaster privileges may be granted by the CEO, CMO, Medical Staff President or their designees.

In order for volunteers to be considered eligible to act as LIPs, the Hospital will obtain from each volunteer at a minimum a valid state or federal government issued photo ID (driver's license, passport) and at least one of the following.

1. A current hospital picture ID that clearly identifies professional designation;
2. A current license to practice;
3. Primary source verification of license;

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corp (MRC) and Massachusetts System for Advanced Registration of Volunteer Health Professional (MSAR) or other recognized state or federal organizations or groups;
5. Municipal, state, or federal ID of authority to render care, treatment, and services in disaster circumstances; or
6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a LIP during a disaster.

The CEO, CMO, Medical Staff President or their designee(s) will assume the following responsibilities relating to the granting of disaster privileges:

1. Selection of individuals to receive disaster privileges who have the requisite skills and appropriate identification as noted above;
2. Provision of distinctive identification to those granted disaster privileges which will enable hospital staff to readily identify them;
3. Assignment of such individuals to provide services under the supervision of the appropriate person as designated in the Hospital's disaster plan;
4. Primary source verification of licensure as soon as the immediate situation is under control and completed within seventy-two (72) hours from the time the volunteer presents to the organization; and
5. Initiation of process for verification of the credentials and privileges of individuals granted disaster privileges. Such verification process shall be deemed a high priority by the Medical Staff and shall be identical to the process employed for the granting of temporary privileges to fulfill an important patient care need.

Supervising physicians and nurses in the areas to which volunteer LIPs are assigned will monitor volunteer LIP performance and report any concerns to the CMO or his/her designee. The CMO or his/her designee may terminate temporary privileges at any time. The CEO, CMO, Medical Staff President or their designee(s) make a decision related to the continuation of the disaster privileges initially granted within seventy-two (72) hours based on information obtained through the verification process.

SECTION 7. TELEMEDICINE PRIVILEGES

1. Privileges to provide telemedicine or any form of telehealth, including remote patient monitoring, may be granted to a LIP by the Trustees, upon recommendation of the Executive Committee. If the site where the telemedicine service will be provided (distant site) is a Joint Commission–accredited hospital or ambulatory care organization, the credentialing and privileging decision of the distant site may be relied upon, provided that:
    a. The LIP is privileged at the distant site to perform the same services as will be provided at the Hospital.
    b. A listing of the LIP's privileges at the distant site is provided.
    c. The credentialing and privileging processes of the distant site meet:

        i. 42 CFR Part 482 - Conditions of Participation for Hospitals - §482.12 (a)(1 - 9) and §482.22(a)(1 – 4).
        ii. Compliance with Joint Commission hospital accreditation standards MS.06.01.03 (excluding EP2) through MS.06.01.07 or ambulatory care accreditation standard HR.02.01.03.
    d. There is a written agreement (contract) between the distant site and the Hospital or its agents (e.g. Chairs, Medical Directors, Clinical Service Chiefs) acting in accordance with these bylaws. The contract should include, at a minimum, the following:
        i. Confirmation that the distant site is a contractor of services to the Hospital.
        ii. The nature and scope of services provided by the distant site, including confirmation that the services permit the Hospital to be in compliance with the Medicare Conditions of Participation.
        iii. Expectations of the contracted services (may be an appendix).
        iv. Confirmation that LIPs undergo a criminal background check. In cases where confirmation cannot be given, the contract shall indicate that the Hospital will perform criminal background checks on the distant site's LIPs at the expense of the distant site.

2. All initial applicants for telemedicine privileges shall complete the application, and sign under oath. There is no application fee to apply for telemedicine privileges. The requirements of the application shall be as described below:
    a. Application for Telemedicine Privileges
    b. Delineation of Privileges requested at the Hospital
    c. Listing of current privileges at distant site
    d. Current Massachusetts professional license
    e. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
    f. Authorization and Release Form
    g. Information and Systems Confidentiality and Usage Agreement
    h. Proof of current malpractice insurance with minimum limits of $1M/$3M

3. The MSO will query the National Practitioner Databank and verify that the LIP holds current Massachusetts licensure.

4. Applications for initial telemedicine privileges will be reviewed by the CMO, or designee, who will make a recommendation on the granting or denying of privileges. The recommendation of the CMO will be reviewed by a member of the Credentials Committee. Thereafter, the application will be eligible for the expedited credentialing and privileging procedure described in Article IV, Section 4 and for temporary privileges, as described in Article V, Section 4. LIPs granted privileges for telemedicine are not appointed to the Medical Staff.

5. Professional Practice Evaluation information will be shared between the Hospital and the distant site. The responsibility for data collection and reporting under the most

current PPE guidelines falls to the Hospital Chair or agent who contracts for the service with the distant site. At a minimum, this information must include adverse outcomes related to reviewable sentinel events from the telemedicine services, as well as complaints from patients, other LIPs, and staff.

6. All applicants for renewal of telemedicine privileges shall complete the application, and sign under oath. There is no application fee to re-apply for telemedicine privileges. The requirements of the application shall be as described below:
   a. Application for Telemedicine Privileges
   b. Delineation of Privileges requested at the Hospital
   c. Listing of current privileges at distant site
   d. Current Massachusetts professional license
   e. Most recent BORIM application, including all attachments and explanatory material submitted with the application (physicians only)
   f. Authorization and Release Form
   g. Information and Systems Confidentiality and Usage Agreement
   h. Proof of current malpractice insurance with minimum limits of $1M/$3M

7. The MSO will query the National Practitioner Databank and verify that the LIP holds current Massachusetts licensure.

8. Applications for renewal of telemedicine privileges will be reviewed by the CMO, or designee, who will make a recommendation on the granting or denying of privileges. The recommendation of the CMO will be reviewed by a member of the Credentials Committee. Thereafter, application will be eligible for the expedited the credentialing and privileging procedure described in in Article IV, Section 4. LIPs granted privileges for telemedicine are not appointed to the Medical Staff.

9. The hearing and appeals procedures in Article VII of the Bylaws shall not apply to LIPs privileged only for telemedicine.

10. In cases where the distant site is not a Joint Commission–accredited hospital or ambulatory care organization, the credentialing and privileging process shall be as set forth in Article IV in its entirety.

ARTICLE VI. DISCIPLINARY ACTION

SECTION 1. SUMMARY DISCIPLINE

Whenever there are reasonable grounds to believe that the conduct or activities of a LIP pose a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the President, the Chief of the Department or Division, the Executive Committee, the CEO, the CMO, and the Trustees shall each have the authority to summarily terminate the appointment of such LIP or to summarily suspend or restrict all or any portion of the LIP's clinical privileges. The Executive

Committee shall promptly review such summary disciplinary action, and shall invite the affected LIP to meet with it as well as one (1) physician chosen by the LIP to act as that person's representative. It shall be the duty of the Committee to review and consider the reasons for the summary suspension and the explanation or justification, if any, offered by the LIP. If, following such review, the Executive Committee confirms and continues such action, the LIP shall be entitled to have the action further reviewed in accordance with Article VII.

SECTION 2. TERMINATION OR MODIFICATION OF PRIVILEGES

A Chief may recommend to the Executive Committee termination of the appointment of, or any reduction in the privileges of or a change in category of, any LIP within his/her Department or Division. It shall be the duty of the Executive Committee to review and consider the reasons for the recommendation and the explanation or justification, if any, offered by the LIP. Upon completion of its review, the Executive Committee shall forward its recommendation to the Trustees. If the Trustees approve the recommendation of the Executive Committee, the decision of the Trustees shall become effective forthwith. The LIP is then entitled to the procedures provided by Article VII. However, the special requirement of supervision and reporting may be imposed by a Chief upon any LIP within his/her Department or Division without the requirement for Executive Committee review or resort to the procedures set forth in Article VII.

SECTION 3. AUTOMATIC TERMINATION OF MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

An appointment to the Medical Staff, as well as all clinical privileges, shall be automatically terminated without recourse to the provisions of Article VII upon the occurrence of any of the following events:

1. Loss of a LIP's license to practice his or her profession in the Commonwealth of Massachusetts, or a restriction or condition of any sort placed upon such license by the BORIM or other applicable state licensing body; provided, however, that the placing of a member on probation by the BORIM or other applicable state licensing body and the imposition of only the standard conditions uniformly applied to all practitioners then being placed on probation by the BORIM or other applicable state licensing body shall not be the basis for automatic termination alone without the imposition of restrictions or conditions which in some way restrict the LIP's license or ability to practice medicine or to treat patients.
2. Failure to report to the Hospital any restriction, condition or probation imposed on a LIP's license by the BORIM or other applicable state licensing body within thirty (30) days of the imposition of such restriction, condition or probation.
3. Revocation or suspension for cause of a LIP's license or right to prescribe or administer any controlled substances.
4. Failure of a LIP without good cause to provide information as required in the Bylaws or appear at a requested meeting of any committee of the Medical Staff or Hospital in order to discuss proposed corrective action.

5. Termination of a written employment agreement with the Hospital or a Hospital related Faculty Practice Plan Corporation if the agreement provides that Medical Staff membership and privileges terminate upon termination of the agreement. The applicable Department Chair may request that membership or privileges not be terminated based on the needs of the Department.
6. A felony conviction in any court of the United States upon exhaustion of all appeals.
7. Debarment from participation in any federal programs.

SECTION 4. DELINQUENT MEDICAL RECORDS

Appropriate penalties, up to and including termination of employment, as set forth in the Rules and Regulations and Hospital policies, shall be imposed for failure to meet the Hospital's standards for appropriate and timely completion of medical records.

SECTION 5. AUTOMATIC ADMINISTRATIVE SUSPENSION OF MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

Clinical privileges and appointment to the Medical Staff may be administratively suspended for up to forty-five (45) days without report to the applicable Board of Registration unless required by law and without recourse to the provisions of Article VII automatically upon the occurrence of any of the following events:

1. Failure to renew an individual's license to practice his or her profession in the Commonwealth of Massachusetts prior to the expiration date of said license.
2. Failure to renew an individual's DEA Certificate prior to the expiration date of said certificate.
3. Failure to renew an individual's State Controlled Substance Certificate prior to the expiration date of said certificate.
4. Failure to submit current proof of health screening deemed acceptable to BMC Occupational and Environmental Medicine.
5. Failure to submit proof of current BLS certification within 45 days when requested.
6. Failure to submit proof of current malpractice insurance with limits of $1M/$3M.

If, at the end of the forty-five (45) day suspension, the individual has failed to remedy any of the above items or indicate that he/she no longer desires clinical privileges or Medical Staff appointment, the individual's clinical privileges and appointment to the Medical Staff, as applicable, shall be automatically revoked without recourse to the provisions of Article VII. Said revocation shall then be reported to the applicable Board of Registration within thirty (30) days of the revocation.

Additionally, for failure to complete the entire process for renewal of clinical privileges or reappointment prior to the expiration of the current term, clinical privileges and appointment to the Medical Staff, as applicable, will be administratively suspended for no more than the time required for two (2) meetings of a sub-committee of the Trustees or

one (1) scheduled meeting of the full Board of Trustees, depending on which body must approve the renewal of privileges or appointment, based on Article IV, Section 4.

If, at the end of the suspension, the individual has still not been renewed by the appropriate governing body, the individual's clinical privileges and appointment to the Medical Staff, as applicable, shall be deleted without recourse to the provisions of Article VII. Said deletion, however, shall not be reported to any Board of Registration unless required by law.

SECTION 6. AUTOMATIC ADMINISTRATIVE SUSPENSION OF INDIVIDUAL CLINICAL PRIVILEGES

Specific individual privileges may be administratively suspended for up to forty-five (45) days without report to the applicable Board of Registration unless required by law when any requirement for holding such privileges expires.

If, at the end of the forty-five (45) day suspension, the individual has failed to again meet any requirement, the specific privileges shall be automatically revoked without recourse to the provisions of Article VII. Said revocation shall then be reported to the applicable Board of Registration within thirty (30) days of the revocation.

ARTICLE VII. HEARINGS AND APPEALS

SECTION 1. RIGHT TO HEARING AND APPELLATE REVIEW

1. When any member of the Medical Staff, except those specifically excluded by the provisions of Article III, Section 4, receives notice of (a) a recommendation of a Department Chief or designee(s), or (b) a recommendation of the Executive Committee not based on a prior adverse recommendation by a Department Chief or designee(s), that, if ratified by the Trustees, will adversely affect the member's Medical Staff appointment, status or exercise of clinical privileges, the member shall be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Executive Committee following such a hearing is still adverse to the individual, the member shall be entitled to appellate review by an ad hoc Trustees' committee before the Trustees make a final decision on the matter.
2. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article to assure that the member is accorded all rights to which the member is entitled.
3. All notices and communications required by the provisions of this Article shall be in writing and shall be sent by certified mail, return receipt requested.

SECTION 2. REQUEST FOR HEARING

1. Prompt notice of any adverse recommendation or decision shall be given to a member who is entitled to a hearing or appellate review. Department Chiefs are

responsible for communicating their adverse recommendations and shall send copies thereof to the Executive Committee Chairperson. The Executive Committee Chairperson is responsible for notice of adverse Executive Committee recommendations. The CEO is responsible for notice of adverse decisions by the Trustees.

2. All notices shall advise the affected member of the right to a hearing or to appellate review, as the case may be, and shall specify that the member must request a hearing within thirty (30) days or appellate review within ten (10) days of the receipt of the notice concerning the adverse action taken.
3. Hearing requests shall be directed to the Executive Committee Chairperson. Appellate review requests shall be directed to the CEO.
4. A member's failure to request a hearing or appellate review pursuant to these Bylaws within the time and in the manner herein provided shall be deemed to be acceptance by the member of the decision and a waiver of the member's right to a hearing or appellate review.

SECTION 3. NOTICE OF HEARING

1. Within ten (10) days of receipt of a request for a hearing, the Executive Committee Chairperson or the Chair of the Board of Trustees, or in his/her absence, a Vice Chair, as the case may be, shall appoint an ad hoc hearing committee (the "Hearing Committee") which shall schedule the hearing and notify the member of the time, place and date so scheduled. The hearing shall be held as soon as the arrangements may reasonably be made, but not less than thirty (30) days from the date of the receipt of the request for hearing; provided, however, that a hearing for a member who has been suspended shall be held as soon as arrangements therefor may reasonably be made, but no later than ten (10) days from the date of receipt of the request for hearing.
2. The notice of hearing shall state in concise language the reason or reasons for the adverse recommendation or decision, the acts or omissions the member is charged with, a list of any specific representative charts being questioned and any other subject matter that served as the basis of the adverse recommendation or decision.
3. Where the hearing relates to a recommendation of a Department Chief or the Executive Committee, the Hearing Committee shall be composed of no fewer than five (5) members of the Medical Staff. Where the hearing relates to a decision of the Trustees, the Hearing Committee shall be composed of no fewer than three (3) members of the Medical Staff and three (3) Trustees. Each Hearing Committee shall appoint one (1) of its members to act as Chairperson. No person who has actively participated in the making of the adverse recommendation or decision, other than by voting as a member of the Executive Committee or as a Trustee, shall serve as a member of any Hearing Committee.

SECTION 4. CONDUCT OF HEARING

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

2. An accurate record of the hearing shall be kept by use of either a court reporter or an electronic recording unit.
3. The personal presence of the individual for whom the hearing has been scheduled shall be required. A member who fails without good cause to appear and proceed at the hearing shall be deemed to have waived all rights to a hearing and appeal and to have accepted the adverse recommendation or decision involved. The decision shall thereupon become final.
4. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Hearing Committee.
5. The affected individual shall be entitled to be accompanied by or represented at the hearing by a member of the Medical Staff in good standing.
6. The Hearing Committee Chairperson or his or her designee shall preside over the hearing and determine the order of procedure during the hearing, to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
7. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, and technical and scientific evidence relating to the issues may be introduced. The member for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda shall become a part of the hearing record.
8. Facts in support of the adverse recommendation or decision shall be presented by an appropriate representative of the Department, the Executive Committee or the Trustees, as the case may require. It shall be the obligation of such representative(s) to present appropriate evidence in support of the adverse recommendation or decision. Thereafter the affected member must establish, through an appropriate showing, that the stated grounds, reasons or charges resulting in the adverse action lack any factual basis or that such basis or any action based thereon is arbitrary, unreasonable or capricious.
9. The member and the member's representative shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the member does not testify on her or his own behalf, the member may be called and examined by the Department, Executive Committee, or Trustee representative as if under cross-examination.
10. The hearings provided for in this section are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, neither the member nor the member’s representative shall be represented at any phase of the hearing procedure by an attorney. The foregoing shall not be deemed to deprive the member or the member's representative of the right to legal counsel in connection with preparation for the hearing or for a possible appeal.
11. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of

obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed and the Hearing Committee shall, at a time convenient to itself, conduct its deliberations in private.

12. Within ten (10) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the member and the Executive Committee or Trustees, as the case may be. The report may recommend confirmation, modification, or rejection of the adverse recommendation.

SECTION 5. APPEAL TO THE TRUSTEES

1. Within ten (10) days after receipt of a notice of an adverse recommendation made or confirmed after a hearing as above provided, the member may, by written notice to the Trustees delivered through the CEO, request Trustee appellate review. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the member's written statement provided for below, and may also request that oral argument be permitted as part of the appellate review.
2. If appellate review is not requested within ten (10) days, the affected member shall be deemed to have waived his or her right to the same, and to have accepted such adverse recommendation or decision and the same shall become effective immediately.
3. Upon receipt of a notice of request for appellate review the Chair of the Board of Trustees or, in his/her absence, a Vice Chair shall appoint an ad hoc review committee (the "Review Committee") which shall schedule a date for such review, including a time, and place for oral argument if such has been requested, and shall, through its chairperson, notify the affected member and the Executive Committee of the same. No Trustee who served on the Hearing Committee may serve as a member of the Review Committee. The date of the appellate review shall be not less than fourteen (14) days, nor more than twenty-one (21) days, from the date of receipt of the notice of request for appellate review, except that when the member requesting the review is under suspension, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than ten (10) days from the date of receipt of such notice.
4. The Review Committee shall consist of no fewer than four (4) Trustees, one (1) of whom shall act as chairperson.
5. The affected member shall have access to the report and record (and transcription, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation. The member may submit a written statement on the member's behalf, in which those factual and procedural matters with which the member disagrees (and the reasons for such disagreement) shall be specified. This written statement may cover 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 Review Committee chairperson, with a copy thereof to the Executive Committee or the Hearing Committee, as the case may be, at least seven (7) days prior to the scheduled date for the appellate review. A rebuttal statement may be submitted to the Review Committee chair by the Executive Committee or the Hearing Committee prior to the review, with a copy thereof to the affected member.

6. The Review Committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph 5 of this section for the purpose of determining whether the adverse recommendation or decision against the affected member was justified and was not arbitrary, unreasonable or capricious. If oral argument is requested as part of the review procedure, the affected member shall be present at such oral argument and shall be permitted to speak against an adverse recommendation or decision. The Executive Committee or Hearing Committee shall also be represented by an individual or individuals who shall be permitted to speak in favor of the adverse recommendation or decision. Both the affected member and the Executive Committee or Hearing Committee representative or representatives shall answer questions put to them by any member of the Review Committee.
7. New or additional evidence not presented during the original hearing and not reflected in the record may be introduced by the affected member at the appellate proceeding only if the Review Committee, in its sole discretion, determines (1) that there was good cause for the failure to introduce such evidence at the original hearing, and (2) that such evidence is relevant to the issues and, if true, would tend to establish that the recommendation of the Executive Committee or Hearing Committee was clearly erroneous.
8. An affected member wishing to introduce such additional evidence shall submit to the Review Committee Chairperson, at least seven (7) days prior to the scheduled hearing, with a copy thereof to the Executive Committee or the Hearing Committee, a written request for leave to present additional evidence. The request shall fully detail the nature of the evidence, the reason (s) why the evidence was not presented at the original hearing and the relevance of such evidence to the issues of the case. If such evidence is documentary, the documents involved shall be attached.
9. No request for leave to submit additional evidence shall be considered or approved by the Review Committee unless it is made within the prescribed time and in the prescribed manner.
10. The submission of a request for leave to present additional evidence shall automatically postpone the appellate review until such time as the Review Committee has had the opportunity to consider and decide upon such request and any subsequent request of the Executive Committee or Hearing Committee for leave to submit rebuttal evidence.
11. If a request for leave to introduce additional evidence is timely presented, the Review Committee shall determine, within a reasonable time, which if any of the evidence it will consider, and the manner in which it is to be presented. The Review Committee's decision shall be communicated in writing to the member

and shall specify the condition and limitations governing the presentation of any such evidence. A copy of the decision shall be sent to the Executive Committee or Hearing Committee.

12. If leave is granted for the introduction of new evidence, the Executive Committee or Hearing Committee shall have the right to request leave to present rebuttal evidence. Such request shall be submitted to the Review Committee chairperson, with a copy thereof to the affected member within ten (10) days following receipt of the Review Committee's decision to accept new evidence. The request shall fully detail the nature of the evidence, including any proposed testimony. Any proposed documents shall be attached. The Review Committee shall act upon such request in the manner specified in subparagraph 11 of this section.
13. When all decisions regarding new evidence have been made and communicated to the parties, a new date shall be set for the review and for oral argument, if requested.
14. If the appellate review includes oral argument or a hearing on new evidence, participating parties may be accompanied by legal counsel. The role of any such counsel shall be strictly limited, however, to the presentation of a statement at the opening and/or closing of the proceeding. Only Review Committee members shall be allowed to address questions to the participants.
15. Within ten (10) days after final adjournment of the appellate review, the Review Committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Trustees. The report may recommend confirmation, modification or rejection of the adverse recommendation. The report may also include a request that the Executive Committee or Hearing Committee arrange for a further hearing to resolve disputed issues. Within ten (10) days after receipt of such recommendation after referral, the Review Committee shall make its recommendation to the Trustees as above provided.
16. Upon receipt of the final recommendation of the Review Committee, the Trustees shall make a final decision as provided in Article IV.

ARTICLE VIII. ORGANIZATION OF THE MEDICAL STAFF

SECTION 1. DEPARTMENTS, DIVISIONS, AND SECTIONS

The Medical Staff shall be organized into the following Departments. Changes in Departments are subject to Trustee approval. Department Chiefs may create or discontinue Divisions and Sections from time to time subject to Executive Committee approval.

1. Department of Anesthesiology
2. Department of Dermatology
3. Department of Emergency Medicine
4. Department of Family Medicine
5. Department of Medicine
6. Department of Neurology

7. Department of Obstetrics and Gynecology
8. Department of Ophthalmology
9. Department of Pathology and Laboratory Medicine
   The Department of Pathology and Laboratory Medicine consists of the Divisions of Anatomic Pathology and Laboratory Medicine
10. Department of Pediatrics
11. Department of Pharmacy
12. Department of Psychiatry
13. Department of Radiation Oncology
14. Department of Radiology
15. Department of Surgery
    The Department of Surgery consists of the: Department of Dentistry and Oral and Maxillofacial Surgery; Department of Neurosurgery; Department of Orthopedic Surgery; Department of Otolaryngology – Head and Neck Surgery; and the Department of Urology; and the Divisions of: Cardiac Surgery; General Surgery; Plastic and Reconstructive Surgery; Podiatric Surgery; Thoracic Surgery; Transplant Surgery; and Vascular and Endovascular Surgery.

SECTION 2. ADMINISTRATION

1. Each Department shall have a Chief who shall be appointed by and serve at the pleasure of the Trustees. All Chiefs shall be certified by an appropriate specialty board or shall have other demonstrated equivalency of competency to carry out the duties of a Chief as are acceptable to the Trustees. Division and Section Chiefs shall be appointed by and serve at the pleasure of the Department Chief and shall have such duties as the Chief shall assign.
2. Each Section, Division, and Department Chief shall be responsible to the applicable Department Chief as set forth in Section 1 for the overall conduct of the Section, Division, or Department. Each Chief is responsible for the following: all clinically related activities of the department; all administratively related activities of the department, unless otherwise provided for by the Hospital; continuing surveillance of the professional performance of all individuals in the department who have clinical privileges; recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department; recommending clinical privileges for each member of the department; assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the organization; the integration of the department or service into the primary functions of the organization; the coordination and integration of interdepartmental and intradepartmental services; the development and implementation of policies and procedures that guide and support the provision of care, treatment and services; the recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services; the determination of the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment and services; the continuous assessment and improvement of the quality of care, treatment and

services provided; the maintenance of quality control programs, as appropriate; the orientation and continuing education of all persons in the department or service; and recommendations for space and other resources needed by the department or service.

3. Each Department, Division and Section is responsible for Focused Professional Practice Evaluation of its members. They shall review all serious incidents that are life threatening, result in death, require patients to undergo significant additional treatment measures, or are reportable to the BORIM or the Department of Public Health of the Commonwealth of Massachusetts to determine whether, in the opinion of the Department, Division or Section, health care services were performed in compliance with the applicable standards of care, or whether a health care provider's actions call into question such health care provider's fitness to provide health care services. Participants in the Focused Professional Practice Evaluation process shall include licensed members of the Medical Staff with the same or similar privileges. In circumstances requiring further review, a panel will be appointed by the Department, Division or Section Chief or designee. Where there are no peers with similar privileges, a review will be conducted by an external peer referred by the Department, Division or Section Chief. At all times, the individual whose performance is being reviewed shall be offered full participation in the review process. The purpose of the review is to evaluate and improve the quality of health care rendered by providers of health care services at the Hospital.
4. Each Department, Division or Section is expected to conduct a monthly morbidity and mortality conference for the purpose of reviewing complications and deaths, including, but not limited to, those complications or deaths reviewed at Root Cause Analysis Meetings and Peer Review Meetings. The cases that meet mandated reporting requirements will be reviewed within seventy-two (72) hours following the incident. All other cases will be reviewed at the next regularly scheduled morbidity and mortality conference, but no later than sixty (60) days after the incident. The purpose of monthly morbidity and mortality conferences is to evaluate and improve the quality of health care rendered by providers of health care services at the Hospital.
5. Each Department, Division and Section is responsible for ongoing Professional Practice Evaluation of its members to identify professional practice trends that impact on quality of care and patient safety. Ongoing Professional Practice Evaluation includes, as appropriate to the Department, Division and Section: review of operative and other clinical procedure(s) performed and their outcomes, pattern of blood and pharmaceutical usage, requests for tests and procedures, length of stay patterns, morbidity and mortality data, practitioner's use of consultants, and other relevant criteria as determined by the Medical Staff.
6. Each Department, Division and Section is responsible for quality and patient safety in their areas.

<u>ARTICLE IX. OFFICERS</u>

SECTION 1. OFFICERS

1. The officers of the Medical Staff shall be a President, President-elect, Secretary/Treasurer, Past President, and four (4) representatives of the Medical Staff.
    a. The President, President-elect, Secretary/Treasurer, and Past President must all be members of the Active Staff or the Associate Staff.
    b. The Past President is the person who served as the President of the Medical Staff immediately prior to the current President, and if that person is unable or unwilling to serve, then the most recent past president willing to serve.
    c. Three (3) of the representatives must be members of the Active Staff or Associate Staff.
    d. One (1) of the representatives must be a member of the Special Clinical Staff.
    e. Each officer (except the Past President) shall be elected by majority vote of the combined Active, Associate, and Special Clinical staff for a two (2) year term (or until the officer's successor is elected). The President-elect assumes the office of President at the end of the President-elect's two-year term. No member may serve more than two (2) consecutive terms for the same office.
2. The President of the Medical Staff shall appoint a nominating committee which shall prepare a slate of candidates for the positions due to become vacant. Opportunity for nominations from the staff shall be provided by electronic communication.
3. The nominating committee shall conduct voting via electronic communication. The officers shall be elected by majority vote and presented at the next quarterly meeting.

SECTION 2. DUTIES

1. The President. The President shall call and preside at all Medical Staff meetings; serve on the Executive Committee; and appoint members to all Medical Staff committees.
2. The President-elect. The President-elect shall, in the President's absence, assume all of the President's authority, perform those administrative duties assigned by the President, serve as Vice Chair in the President's absence, and serve on the Executive Committee.
3. The Secretary/Treasurer. The Secretary/Treasurer shall notify members of and keep accurate and complete records of all Medical Staff meetings and is responsible for all Medical Staff funds. The Secretary/Treasurer shall serve on the Executive Committee.
4. The Elected Representatives shall serve on the Executive Committee.

SECTION 3. REMOVAL OF OFFICERS AND ELECTED REPRESENTATIVES

Officers and elected representatives who are not members in good standing of the active staff, or who fail to carry out the duties of the office in a responsible way may be removed upon a vote by motion at any Medical Staff meeting for which notice has been provided in accordance with the Bylaws. A majority of the active staff present at the meeting is required for removal.

SECTION 4. VACANCIES

If the office of the President becomes vacant, the President-elect shall immediately serve for the balance of the term. Other vacancies shall be filled by election at the next Medical Staff meeting upon recommendation by a nominating committee appointed by the President specifically for this purpose.

ARTICLE X. COMMITTEES

SECTION 1. THE EXECUTIVE COMMITTEE

Subsection 1. Members

The Executive Committee shall consist of the President, President-elect, Past President, and the Secretary/Treasurer of the Medical Staff; all Chiefs of Departments and Divisions listed in Article VIII, Section 1; the Section Chiefs or Medical Directors of Cardiology, Endocrinology, Gastroenterology, General Internal Medicine, Geriatrics, Infectious Diseases, Hematology/Oncology, Nephrology, Pulmonary/Critical Care, and Rheumatology; the CEO, the CMO, Associate CMO(s), the Chief Quality Officer (CQO), the Chief Operating Officer (COO), the Chief Nursing Officer (CNO), the Designated Institutional Official (DIO), the CEO of Boston University Medical Group , the Chair of the Boston University Medical Group Advanced Practice Provider (APP) Council, the Medical Director of Boston HealthNet, and the Dean of BUSM who shall serve ex officio; the four (4) representatives elected according to Article IX, Section 1; one (1) attending physician appointed by the President who is not an employee of the Faculty Practice Foundation, Inc., or any of its subsidiary corporations; and one (1) member of the house staff elected by the house staff, or one (1) elected alternate. Ten (10) members shall constitute a quorum, except for a meeting in which the removal of a member of the Executive Committee is being considered. At such meeting, a quorum shall consist of twenty (20) members.

Subsection 2. Governance

The CMO shall serve as Chair of the Executive Committee. The President of the Medical Dental Staff shall serve as Vice-Chair. The Executive Committee shall meet at least ten (10) times per year.

The Chair, with input from the Vice-Chair as necessary, shall establish the Agenda for each regularly scheduled meeting. The Vice Chair or any four (4) members of the committee may add an item to the agenda.

The Chair and the Vice-Chair of the Executive Committee may establish subcommittees and appoint members thereto as deemed necessary.

Notices of meeting for the Executive Committee may be sent by interoffice mail or electronic mail.

Subsection 3. Duties

The Executive Committee acts on behalf of the Medical Staff between Medical Staff meetings. The Executive Committee shall be generally accountable to the Trustees for the general standards evaluation and improvement of the quality of medical care, treatment and services rendered to patients in the Hospital and the determination of whether health care services were performed in compliance with these standards. The Executive Committee shall be charged with the responsibility for all policy matters relating to or concerning the clinical services of the Hospital not otherwise the responsibility of the Chiefs. The Executive Committee shall review and act on reports of Medical Staff committees, clinical departments, and other assigned activity groups; review the credentials and requested delineated clinical privileges of applicants for Medical Staff membership and/or clinical privileges; make recommendations regarding the mechanism designed to review credentials and delineate individual clinical privileges; make recommendations for medical staff membership and delineated clinical privileges; oversee the organization of the Medical Staff's Ongoing Professional Practice Evaluation and establish a mechanism to conduct, evaluate, and revise such activities; develop the mechanism by which Medical Staff membership and/or clinical privileges may be terminated; and create the mechanism designed for use in fair hearing procedures. The Executive Committee shall have general responsibility for the maintenance of professionally ethical conduct and competent clinical performance on the part of all health care providers and may make determinations of whether a health care provider's actions call into question such health care provider's fitness to provide health care services. The Executive Committee shall report its recommendations to the Trustees or to a designated committee of the Trustees, as the case may be, whenever requested to do so and shall maintain a permanent record of its proceedings and actions. In addition to any standing committees which perform similar functions, the Executive Committee shall act as a medical peer review committee.

Subsection 4. Conflict Resolution

Members of the Medical Staff may raise concerns on issues, including, but not limited to, proposals to adopt a rule, regulation or policy or amendment that may be in conflict with those of the Executive Committee. The following procedure shall be used to communicate and resolve such concerns:

1. An individual voting member or group of the voting membership identifying a conflict may communicate this concern to any of the elected representatives on the Executive Committee, either in writing or electronically.

2. The representative contacted will then confer with the other elected representatives about the conflict presented. If fifty percent (50%) or greater of the elected representatives agree that a significant conflict exists, this will be communicated to the Chair of the Executive Committee or designee.
3. The individual or group of members raising the concern about a conflict will be notified electronically of the action taken by the elected representatives.
4. The Executive Committee will discuss the issue brought to its attention by the elected representatives, and make a determination as to the appropriate action to take to address the conflict. The individual or group of members identifying the conflict will be notified of the Executive Committee's decision by one or more of the elected representatives, either in writing or electronically.
5. If the decision of the Executive Committee is not acceptable to the individual or group of members identifying the conflict, the individual or group will communicate this to an elected representative, in writing or electronically. The elected representative will communicate this to the Chair of the Executive Committee or designee.
6. The decision relating to the conflict will then be presented for consideration to the entire voting membership of the Medical Staff. An electronic vote about the decision will be conducted. A vote of two-thirds of the active voting membership will be required to overturn the decision of the Executive Committee.
7. The result of the vote is subject to approval by the Trustees.

Subsection 5. Removal of Members of Executive Committee

Members of the Executive Committee may be removed for failure to maintain their administrative position or good standing with the Medical Staff upon a vote by motion at any meeting of the Executive Committee for which notice has been provided according to these bylaws. A two-thirds (2/3) majority vote of those members present at the meeting is required for removal. At such meeting, a quorum shall consist of twenty (20) members.

SECTION 2. STANDING COMMITTEES

Except as otherwise provided: (a) the chairs of the standing committees described below shall be appointed by the President or designee; (b) standing committees shall meet, record minutes and report to the Executive Committee as requested by the Chair; and (c) the presence of a majority of voting members of each committee should constitute a quorum.

Subsection 1. Credentials Committee

The Credentials Committee shall consist of no less than three (3) members of the active Medical Staff. The Committee may also include Medical Staff members in other membership categories and clinical department representatives who are not

members of the Medical Staff. The Committee shall review the credentials, qualifications, and competency of all applicants for appointment and reappointment and make recommendations to the Executive Committee for the granting of privileges, appointments, and reappointments in accordance with the Bylaws.

Subsection 2. Graduate Medical Education Committee

The Graduate Medical Education Committee shall consist of the Residency/Fellowship Program Directors and elected members of the House Staff, and shall generally oversee the institutionally sponsored training programs. It shall be chaired by the Designated Institutional Official, and it shall review and recommend policies for the selection of house staff, the appointment of house staff positions among programs (consistent with the Residency Review Committee policies), the supervision of house staff, the evaluation and advancement of house staff, and the dismissal of house staff who demonstrate unsatisfactory performance. The Graduate Medical Education Committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of the participants in professional graduate education programs.

Subsection 3. Professional Practice Evaluation Committee

The Professional Practice Evaluation Committee shall consist of no more than ten (10) physician members of the Medical Staff and no less than two (2). The function of this committee shall be to assure that the hospital, through the activities of the medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessment and evaluations to improve professional competency, practice and care.

Subsection 4. Cancer Committee

The membership of the Cancer Committee will reflect current Commission on Cancer Standards. Membership is multidisciplinary, representing physicians from diagnostic and treatment specialties and non-physicians from administrative and supportive services. Cancer committee coordinators, who are responsible for specific areas of cancer program activity, are designated each calendar year. The cancer committee is responsible for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the program. Cancer-related diagnostic and treatment services are provided by or referred to physicians who are currently board certified (or the equivalent) in their medical specialty or are in the process of becoming board certified. Documentation of 12 annual cancer-related CME hours is required for all physicians who are not board certified or those in the process of becoming board certified who are involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee.

Subsection 5. Wellness Committee

The Wellness Committee shall consist of no less than three (3) members of the active Medical Staff. It shall implement a process to identify and manage matters of individual health for LIPs that is separate from the disciplinary function. The Committee is responsible for developing mechanisms for the following:

1. Education of LIPs and other organization staff about illness and impairment recognition issues specific to LIPs;
2. Self-referral by an LIP;
3. Referral by others and creation of confidentiality of informants;
4. Referral of the affected LIP to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
5. Maintenance of the confidentiality of the LIP seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
6. Evaluation of the credibility of a complaint, allegation, or concern;
7. Monitoring of the affected LIP and the safety of patients until the rehabilitation or any disciplinary process is complete and periodically thereafter;
8. Reporting to the organized Medical Staff leadership instances in which an LIP is providing unsafe treatment; and
9. Initiating appropriate actions when an LIP fails to complete the required rehabilitation program.
10. Education of the Medical Staff and other hospital staff regarding health issues.

SECTION 3. TEMPORARY COMMITTEES

The Executive Committee may establish such ad hoc or temporary committees as it deems necessary to carry out its purposes. The Chair of the Executive Committee shall appoint the members of ad hoc or temporary committees.

SECTION 4. CLINICIANS COUNCIL

Subsection 1. Members

The Medical Dental Staff officers will adopt a process for selecting members of the Clinicians Council from among the Medical Dental Staff membership. The process will provide for representation on the Council from each Department and, to the extent possible, each category of membership.

Subsection 2. Governance

The Medical Dental Staff President shall serve as Chair of the Clinicians Council. The Council shall meet at least four (4) times per year.

The Medical Dental Staff officers, in consultation with the Boston University Medical Group Chief Executive Officer and the Hospital Chief Medical Officer, shall establish the agenda for each meeting of the Clinicians Council.

Subsection 3. Duties

The Clinicians Council serves as a representative body for practitioners affiliated with the Hospital to advance issues and topics of interest important to the Medical Dental Staff membership. The Council promotes, develops, and supports the roles of physicians and other medical professionals at the Hospital.

The Chair of the Council shall meet regularly with the Boston University Medical Group Chief Executive Officer and the Hospital Chief Medical Officer to provide advice and consultation on programs and activities, including leadership development, training, mentorship, staff recognition, community outreach and volunteerism, workplace standards, work life issues, to support the Medical Dental Staff.

ARTICLE XI. MEETINGS

SECTION 1. MEETINGS

The annual meeting of the Medical Dental Staff shall be held each year on a date chosen by the President. Other meetings of the Medical Dental Staff may be called by the President, the Executive Committee, any ten (10) members of the active staff, or upon request of the Trustees.

SECTION 2. NOTICE

Electronic notification of Medical Staff meetings shall be sent to all members at least fourteen (14) days in advance of the date of the meeting. Special meetings require electronic notice at least seven (7) days in advance of the date of the special meeting. All notices shall state the date, purpose, time and place of such meetings.

SECTION 3. QUORUM AND VOTING

Twenty-five (25) members of the active staff, or three percent (3%) of the active staff, whichever is smaller, shall constitute a quorum at all meetings. When a quorum is present, voting at any meeting shall be by majority vote except as otherwise required by law or these Bylaws.

ARTICLE XII. PRIVILEGES AND IMMUNITY

The following shall be express conditions to any individual's application for, or exercise of, clinical privileges at the Hospital or Medical Staff membership.

A. Any act, communication, report, recommendation, or disclosure, with respect to any such physician, dentist, podiatrist, clinical psychologist or other health care professional, performed or made in good faith and without malice at the request of an authorized representative of the Hospital or any other health care facility for

the purpose of achieving and maintaining quality patient care in such facilities, shall be privileged to the fullest extent permitted by law.

B. Such privilege applies to the Hospital's officers, Trustees, employees and agents, the Medical Staff, and third parties, who supply information to any of the foregoing authorized to receive, release, or act upon same. For the purpose of this Article XII, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Trustees or the Medical Staff.
C. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations (6) utilization reviews and (7) other hospital, division, departmental, service or committee activities related to quality patient care and interprofessional conduct.
E. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to the health care professional's qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.
F. In furtherance of the foregoing, each Medical Staff applicant or member shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified herein, subject to the requirements of good faith and the absence of malice.
G. The consents, authorizations, releases, rights, privileges and immunities provided by Article IV hereunder in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.
H. Each committee constituted pursuant to the Bylaws which has any responsibility for (1) the evaluation or improvements of the quality of health care rendered by members of the Medical Staff, including the special clinical staff; (2) the determination whether health care services were rendered in compliance with the applicable standards of care; (3) the determination whether the costs of health care services were expended in compliance with the applicable standards of care; (4) the determination whether the costs of health care services rendered were considered reasonable in comparison with the costs of other providers of health services in the area; (5) the determination whether the actions of a practitioner call into question such practitioner's fitness to provide health care services; or (6) the evaluation and assistance of health care practitioners impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise shall be deemed to be medical peer review committees within the meaning of the provisions of M.G.L. Chapter 111, section 204.

ARTICLE XIII. AMENDMENTS

SECTION 1. RULES AND REGULATIONS

The Executive Committee shall make proposals to adopt or amend such rules and regulations or policies as it deems appropriate to meet the purposes of the Hospital and the Medical Staff subject to the approval of the Trustees. Any proposal shall first be communicated to the Medical Staff. The adoption of a policy or a rule/regulation, or amendment thereto, shall be communicated to the Medical Staff.

In cases of a documented need for an urgent amendment to rules and regulations or policies, the Executive Committee may provisionally adopt and recommend such amendment to the Trustees who may provisionally approve such amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Executive Committee. The Medical Staff will have the opportunity to approve such amendment at its next scheduled meeting. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment stands. If there is conflict over the proposed amendment, the procedure set forth in Article X, Section 1, Subsection 4 of these bylaws is implemented. If necessary, a revised amendment is then submitted to the Trustees for action.

The Medical Staff shall make proposals to adopt or amend such rules and regulations or policies as it deems appropriate to meet the purposes of the Hospital and the Medical Staff subject to the approval of the Trustees. Any proposal shall first be communicated to the Executive Committee.

SECTION 2. BYLAWS

The Bylaws may be amended by a two-thirds vote of the eligible voting staff present for such vote subject to the approval of the Trustees. The notice of the meeting to amend the Bylaws shall include a description of all proposed amendments. Voting by proxy is permitted.

ARTICLE XIV. ADOPTION

These bylaws, when adopted by the Medical staff, shall replace any previous bylaws and shall become effective when approved by the Trustees.

Approved by the Medical Dental Staff on October 13, 2023
Manishi A. Desai, MD
President ______________________________

Approved by the Board of Trustees on November 7, 2023
David Beck, Esq.
Clerk ______________________________