

Bylaws
of the Medical Staff
of the
Brigham and Women's
Hospital
(Effective new date: March 2023)

CONTENTS

ARTICLE I: PURPOSE6

ARTICLE II: ORGANIZATION OF THE MEDICAL STAFF6

 Section 1: Departments6

 Section 2: Brigham and Women’s Physicians Organization, Inc. (BWPO)9

ARTICLE III: MEMBERSHIP9

 Section 1: Qualifications9

 Section 2: Board Certification9

 Section 3: Annual Fee11

 Section 4: Ethics and Ethical Relationships12

 Section 5: Term of Appointment12

 Section 6: Equal Opportunity12

 Section 7: Balanced Use of Hospital Resources12

 Section 8: Procedures for Appointment and Reappointment13

 Section 9: Temporary and Disaster Privileges20

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF21

 Section 1: The Medical Staff21

 Section 2: Active Staff21

 Section 3: Affiliate Staff22

 Section 4: Adjunct Staff23

 Section 5: Senior Consulting Staff23

 Section 6: Honorary Staff24

 Section 7: Research Staff25

 Section 8: Visiting Staff25

 Section 9: House Staff, Clinical Fellows and Research Fellows25

 Section 10: Consultative Staff26

 Section 11: Courtesy Staff27

 Section 12: Graduate Assistant Staff28

 Section 13: Clinical Consulting Staff28

 Section 14: Change in Staff Category29

 Section 15: Advanced Practice Professionals31

ARTICLE V: DISCIPLINARY ACTION.....	31
Section 1: Definitions.....	31
Section 2: Grounds for Disciplinary Action	32
Section 3: Initiation of Disciplinary Action Process.....	33
Section 4: Summary Action.....	33
Section 5: Automatic Revocation, Restriction or Suspension	34
Section 6: Referral of Research misconduct allegations.....	36
Section 7: Referral of Certain Matters to Mass General Brigham Institutional Review Boards and Human Research Affairs.....	37
Section 8: Hospital Acceptance of Fact Findings	37
Section 9: Preliminary Inquiry.....	38
Section 10: Recommendation Concerning Appropriate Disciplinary Action,	38
if any	38
Section 11: Right to Hearing	40
Section 12: Board of Trustees Review	41
Section 13: Reporting of Disciplinary Actions	42
ARTICLE VI: MEDICAL STAFF HEALTH PROGRAM	42
Section 1: Objectives	42
Section 2: Definition of “Affected Medical Staff Member”	42
Section 3: The Program.....	43
ARTICLE VII: PHYSICIANS’ COUNCIL	45
Section 1: Membership.....	45
Section 2: Medical Staff Representation on Physicians’ Council; Co- Chairs; Co-Chair Elect.....	45
Section 3: Functions of Physicians’ Council	46
ARTICLE VIII: MEETINGS	46
Section 1: General Meeting of the Medical Staff.....	46
Section 2: Quorum and Voting	47
Section 3: Special Meetings	47
ARTICLE IX: COMMITTEES	47
Section 1: Committees of the Medical Staff	47
1.1 Standing Committees	47

1.2	Other Committees.....	48
1.3	General Provisions Regarding Medical Staff Committees	48
1.4	Medical Staff Executive Committee.....	48
1.5	Medical Staff Credentialing Committee.....	51
1.6	Cancer Committee.....	51
1.7	Quality Assurance/Risk Management Committee.....	52
	Section 2: Department Committees	52
	ARTICLE X: PATIENT CARE ASSESSMENT.....	52
	Section 1: Patient Care Assessment Program.....	52
	Section 2: Care Improvement Council	52
	Section 3: Patient Care Assessment Coordinator	53
	Section 4: Patient Care Assessment Plan.....	53
	Section 5: Medical Peer Review Committee.....	53
	Section 6: Procedure for Investigation and Resolution of Reports Concerning Health Care Providers..	54
	ARTICLE XI: POLICIES AND PROCEDURES.....	55
	Section 1: General.....	55
	Section 2: Medical History and Physical Examination	55
	Section 3: Supervision of Trainees.....	55
	ARTICLE XII: AMENDMENTS.....	55
	ARTICLE XIII: MISCELLANEOUS	56
	Section 1: Severability.....	56

THE BRIGHAM AND WOMEN'S HOSPITAL, INC.
BYLAWS OF THE MEDICAL STAFF

ARTICLE I: PURPOSE

The purpose of the organization is to bring medical staff members who practice at the Hospital together into a cohesive body to promote high quality patient care, research and medical education in order to meet the needs of the community it serves. To this end, among other activities, it will assist in screening applicants for staff membership, review privileges of members, evaluate and assist in improving the work done by the staff, and offer advice and assistance to the Chief Medical Officer and President.

ARTICLE II: ORGANIZATION OF THE MEDICAL STAFF

SECTION 1: DEPARTMENTS

1. The medical staff shall be divided into the following Departments as determined and approved by the Board of Trustees:

- Anesthesiology, Perioperative and Pain Medicine
- Dermatology
- Emergency Medicine
- Medicine (including medical sub-specialties)
- Neurology
- Neurosurgery
- Pediatric Newborn Medicine
- Obstetrics and Gynecology
- Orthopedic Surgery (Podiatry)
- Pathology
- Physical Medicine
- Psychiatry
- Radiation Oncology
- Radiology
- Surgery (including surgical sub-specialties and Dentistry)

2. The President with the concurrence of two-thirds (2/3) of the Department

Chairs may recommend the creation of a new Department. This recommendation shall be forwarded to the Board of Trustees for action. The Board of Trustees may also on its own initiative create or discontinue a Department.

3. If, in the interest of departmental organization, it is desirable to subdivide the activities of a Department into formally constituted divisions, the Chair of the Department may so recommend to the Chief Medical Officer with identification of the scope of the proposed division(s). The Chief Medical Officer will forward the proposal with his/her recommendation to the Board of Trustees for action.
4. Each Department shall be headed by a physician appointed by the Board of Trustees in consultation with the President, and the Chief Medical Officer. Said appointment shall be based on criteria approved by the President, the Chief Medical Officer, and the Board of Trustees. Each Department Chair must be certified by the appropriate American specialty Board of Medical Specialties (or comparable competence affirmatively established through the credentialing process), and shall maintain such certification for the duration of his/her tenure as Department Chair. The Department Chair shall have corresponding oversight and responsibilities within the Brigham and Women's Physicians Organization (BWPO). The responsibilities of the Department Chairs shall be carried out in concert with the functions and objectives of the Hospital, the BWPO and Brigham and Women's Health Care, Inc. ("BWHC"). The Department Chairs shall be responsible for:
 - Clinical and administrative activities of the Department
 - Oversight of professional performance of Department staff members, including but not limited to orientation and continuing education
 - Recommending criteria for clinical privileges relevant to the care provided by the Department to the medical staff
 - Recommending clinical privileges for members of the Department
 - Coordination and integration of interdepartmental and intradepartmental services
 - Development and implementation of relevant policies and procedures
 - Continuous assessment and improvement of the quality of care, treatment and services, including but not limited to maintenance of quality control programs
 - Determining qualifications and competence of Department personnel who are not licensed independent practitioners
 - Assessing and recommending to hospital leadership Department needs including but not limited to space and other resources
 - Formulating and directing educational, research and clinical activities within the Departments.

Furthermore, BWHC may from time to time appoint at the BWHC level a Chair to oversee the integration of a Department or Division at the Hospital and its counterpart at the Brigham and Women's Faulkner Hospital ("BWFH") and/or other BWHC affiliates, and the ongoing operation of the consolidated Department or Division. The relative authority and responsibilities of the BWHC Chair and the Hospital shall be delegated and described as necessary in appropriate documents.

5. Deputy, Vice, Associate or Assistant Department Chairs shall be appointed upon recommendation by the Chair of the Department with approval by the President and the Chief Medical Officer.
6. Division Directors shall be appointed upon recommendation by the Chair of the Department with approval by the President and Chief Medical Officer.
7. All Medical Staff members shall have a primary departmental affiliation. Except as otherwise specifically approved by the Chief Medical Officer, the primary departmental affiliation must coincide with the medical staff member's residency (or equivalent) training. In appropriate instances with the approval of the concerned Department Chairs, the Medical Staff Credentialing Committee, and the Medical Staff Executive Committee, joint appointments to more than one Department may be made. In no instance, however, shall such individuals have more than one vote in Medical Staff affairs.
8. Physicians, dentists, psychologists, chiropractors and podiatrists responsible for patient care at BWH shall be conferred staff titles within their Department upon nomination by its Chair and approval of the Medical Staff Executive Committee as follows:
 - (a) Associate xxxx (xxxx equals Anesthesiologist, Chiropractor, Dentist, Dermatologist, Physician, Neonatologist, Obstetrician/Gynecologist, Orthopaedic Surgeon, Pathologist, Psychiatrist, Psychologist, Radiation Oncologist, Radiologist, Neurologist, Neurosurgeon or Surgeon as appropriate) – the usual entry level onto the staff of an individual who has completed residency and fellowship training (e.g., Associate Anesthesiologist).
 - (b) xxxx – the usual grade reached by mature, well-known staff members who have established regional or national reputations (e.g., Anesthesiologist).
 - (c) Senior xxxx – reserved for those staff members who have achieved international stature and distinction in their field and/or who have rendered unusual and conspicuous service to BWH (e.g., Senior Anesthesiologist).

For those staff members without patient care responsibilities, staff titles will be conferred as follows: (a) Associate xxxx, Department of yyyy (e.g., Associate Biochemist, Department of Radiology); (b) xxxx, Department of yyyy (e.g., Biochemist, Department of Radiology); (c) Senior xxxx, Department of yyyy (e.g., Senior Biochemist, Department of Radiology).

SECTION 2: BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC. (BWPO)

The BWPO is the physician organization and faculty practice plan affiliated with the Hospital. The Hospital and the BWPO have common clinical Departments, as described in Section 1 of this Article II, each of which is headed by a single Chair with corresponding responsibilities to the Hospital and the BWPO. Members of the BWPO are members of the Medical Staff of the Hospital in staff categories as are defined in these Bylaws. The BWPO serves as a vehicle for organization, communication and representation of members of the Hospital's Medical Staff.

ARTICLE III: MEMBERSHIP

SECTION 1: QUALIFICATIONS

The Medical Staff shall consist of physicians, dentists, psychologists, chiropractors and podiatrists who are licensed to practice in the Commonwealth of Massachusetts unless otherwise specified in these Bylaws, and other qualified personnel. Members of the Medical Staff shall be competent in their respective fields and worthy in terms of professional ethics and behavior. They shall meet and continue to meet the requirements in Article IV concerning the categories of the Medical Staff for which they apply, and all the applicable standards, criteria and policies of their respective Department and the Medical Staff, the Bylaws and policies and procedures of the Medical Staff, and the Bylaws and applicable policies of the Hospital, BWHC and Mass General Brigham, Incorporated ("Mass General Brigham"), and any condition or restriction imposed on any appointment or privilege granted by the Hospital in the credentialing or disciplinary action process.

A member of the Medical Staff holding clinical privileges shall maintain in force malpractice insurance coverage in an amount and with a carrier acceptable to the Hospital.

SECTION 2: BOARD CERTIFICATION

Each physician, dentist, chiropractor and podiatrist who is an applicant for initial appointment to the Active Staff shall be certified by the appropriate American

specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association, the National Board of Chiropractic Examiners, or the American Podiatric Association, and shall maintain such certification for the duration of his/her medical staff membership. Exceptions to this requirement are as follows:

- (a) Physicians, dentists, chiropractors and podiatrists who are already members of the Active Staff on December 31, 2006 shall be exempt from this requirement unless otherwise required by law.
- (b) Physicians, dentists, chiropractors and podiatrists whose specialty and practice at the Hospital does not include a specialty for which there is an appropriate Board certification available, as determined by the Medical Staff Credentialing Committee in conjunction with the Chief Medical Officer.
- (c) Physicians, dentists, chiropractors and podiatrists who are applicants for initial membership to the Active Staff, and who have completed all specialty training required to take their Board examination, but are not yet Board certified, may be granted membership and/or privileges on the Active Staff subject to a requirement that they obtain certification within five (5) years of completion of the requirements necessary to take their Board examination. In such a case, the applicant will be informed at the time initial membership and/privileges are granted that he or she will be required to show proof of successful completion of specialty board certification within a specified period of time.
- (d) In the event that a physician, dentist, chiropractor or podiatrist who is an applicant for initial appointment to the Active Staff is not board certified and will not be able to meet the requirements for obtaining Board certification as specified in subsection (c) above, but holds particularly outstanding credentials, this requirement may be waived by the Board of Trustees upon written recommendation of the Department Chair, the Chief Medical Officer, the Medical Staff Credentialing Committee and the Medical Staff Executive Committee.
- (e) A deadline for Board certification may be extended or waived by the Board of Trustees upon written recommendation of the Department Chair, the Chief Medical Officer, the Medical Staff Credentialing Committee and the Medical Staff Executive Committee in the case of an applicant with outstanding credentials, or in compelling circumstances.
- (f) In the event that the Board certification requirement has been waived or extended for a given applicant, his or her application will otherwise remain

subject to the same review criteria and approval process as would apply if there were no waiver.

SECTION 3: ANNUAL FEE

Except as otherwise provided in this Section, effective January 1, 2021, all members of the Active Staff, Affiliate Staff, Adjunct Staff, and Clinical Consulting Staff shall be required to pay an annual (calendar year) appointment fee in the amount of \$500.00. A written invoice for the fee shall be sent to affected Staff each year in January at least thirty days prior to the due date, and shall specify acceptable methods and means of payment in accordance with applicable policies and procedures. The first year fee for an individual who becomes a member of the Medical Staff after January 1 shall be calculated on a pro rata basis. There shall be no partial year refunds for members of the Medical Staff who leave the Staff prior to the end of the calendar year.

In the event that payment of the annual fee has not been made within thirty (30) days of the due date, the Medical Staff member shall be sent written notification advising him/her that unless payment is received within thirty (30) days of said written notification, his/her Medical Staff appointment and privileges shall be immediately and automatically suspended. In the event that the Staff member does not make payment of the annual fee within thirty (30) days of his/her suspension, the Staff member's appointment and privileges shall be immediately and automatically revoked, and the Staff member must reapply for appointment as an initial appointee. The method and means of notification to the Staff member pursuant to this paragraph shall be in accordance with applicable policies and procedures.

The suspension or revocation of appointment and privileges pursuant to this Section does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the Staff member to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to summary action, preliminary inquiry, hearings, and Board review. Further, as a suspension or revocation of privileges pursuant to this Section does not constitute a disciplinary action, it shall not be reported to the Board of Registration in Medicine or the National Practitioner Data Bank as such.

The provisions of this Section 3 shall not apply to members of the Medical Staff who are also members of the BWPO, or who are employed by affiliated institutions and maintain an appointment and privileges at the request of BWH for the purpose of providing consultative or attending services. Those individuals who hold a

medical staff appointment at both BWH and BWFH shall be required to pay only one annual fee.

SECTION 4: ETHICS AND ETHICAL RELATIONSHIPS

The principles and codes of ethics as adopted and amended by the American Medical Association, the American Dental Association, the American Psychological Association, the American Chiropractic Association and the American Podiatric Medical Association, as well as applicable policies of the Hospital, BWPO, BWHC and Mass General Brigham shall guide the professional conduct of the members of the Medical Staff.

SECTION 5: TERM OF APPOINTMENT

Appointments to the Medical Staff shall be made by the Board of Trustees upon recommendation of the Medical Staff Credentialing Committee and the Medical Staff Executive Committee for a period of not longer than two years.

SECTION 6: EQUAL OPPORTUNITY

No qualified applicant shall be rejected from membership in the Medical Staff on the basis of race, ethnicity, gender, creed, religion, color, national origin, age, disability, pregnancy, veteran status, sexual orientation or gender identity or expression.

SECTION 7: BALANCED USE OF HOSPITAL RESOURCES

The Board of Trustees, or committee thereof, in order to fulfill its commitment to assure balanced use of Hospital resources, may impose restrictions upon or designate special conditions for Staff selection.

- (a) Depending upon the clinical and academic needs of the individual Departments and the availability of Hospital resources, membership in any Medical Staff category in a Department or part thereof may be limited in number or closed to new applicants by the Board of Trustees, or committee thereof, upon the recommendation of the Chair of the Department and the Medical Staff Executive Committee.
- (b) Each Departmental Chair, after consultation with Division Directors, the Departmental Executive Committee, the Chief Medical Officer and the President or his designee, shall regularly review the clinical and academic needs of the Department and the availability of Hospital resources, and recommend

whether membership in any Medical Staff category or part thereof should be limited or closed. If a Department Chair wishes to propose any such limit or closure, the Chair shall submit a written recommendation to this effect to the Medical Staff Executive Committee. Any recommendation approved by the Medical Staff Executive Committee will be forwarded to the Board of Trustees, or committee thereof, for final action.

- (c) Any limit on the size of or closure of membership in any category of the Medical Staff in a Department or part thereof will apply prospectively only to new applicants for membership in the affected category or part thereof and will not affect existing members of the affected category or part thereof.
- (d) If any moratorium is imposed pursuant to this section on prospective membership in any category or part thereof of the Medical Staff in any Department, no applications for appointments to the positions covered will be evaluated during the moratorium. Persons whose applications are not reviewed due to such a moratorium are not entitled to the preliminary inquiry, hearing and Board review process available pursuant to Article V.

SECTION 8: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

A. Procedures for Initial Appointment to the Medical Staff

1. Mass General Brigham Centralized Credentialing Office

The Mass General Brigham Centralized Credentialing Office (“Mass General Brigham CCO”) shall maintain a centralized electronic data base and shall, upon an effective date to be designated by the Hospital, perform all credentialing functions requisite to Medical Staff appointment at the Hospital, including gathering and maintenance of credentialing materials, primary source verification and National Practitioner Data Bank queries. The Hospital, through its Departments, medical staff committees and Trustees, shall remain solely responsible for all recommendations and decisions regarding medical staff appointment and privileges.

2Application

- (a) Applications for membership to the Medical Staff shall be presented to the Chair of the relevant Department in the form and manner prescribed by the

Hospital. An applicant shall set forth his or her qualifications and references and signify his or her agreement to abide by the Bylaws and policies and procedures of the Medical Staff, the Hospital, BWPO, BWHC and Mass General Brigham . The Mass General Brigham CCO shall obtain and verify all required credentialing information in accordance with Section 8A(1).

- (b) Applicants for clinical privileges shall provide evidence of current Massachusetts licensure or a pending application for Massachusetts licensure.
- (c) Applicants for clinical privileges must submit copies of their most recent Massachusetts licensure application forms including all attachments and other explanatory materials submitted with the application.
- (d) References shall be provided by individuals knowledgeable about the applicant's competence, ethics and character.
- (e) Each applicant must provide verifiable information relative to medical, dental, psychological, chiropractic or podiatric education and training.
- (f) Each applicant must provide the names of all health care facilities with which the applicant has been associated and the reasons for discontinuance of these associations.
- (g) Applicants shall agree to the release by the facilities with which they have been associated of any information which is relevant to the assessment of their ethics, character or competence to practice medicine.
- (h) Applicants shall provide information about malpractice insurance coverage and a listing of all malpractice claims pending or closed during the previous ten (10) years.
- (i) Applicants shall agree to the release to the Hospital by their malpractice liability insurance carriers of information as to claims or actions for damages, whether or not there has been a final disposition.
- (j) Applicants shall provide a description of any pending, threatened or final disciplinary or other adverse action (whether voluntary or involuntary), as defined in Article V, Section 1, by any healthcare facility, professional organization, or licensing or regulatory agency.
- (k) Each applicant shall authorize the Hospital and its agents to exchange information with any other health care facility and with any professional

organization with which the applicant is or was associated, regarding any pending, threatened or final disciplinary or other adverse action (whether voluntary or involuntary) as defined in Article V, Section 1.

- (l) Each applicant must agree to undergo a mental or physical examination prior to or during the term of his/her appointment if requested by the Medical Staff Credentialing Committee, the Medical Staff Executive Committee, the Board of Trustees, the Chief Medical Officer or the applicant's Department Chair, and if there is a known mental or physical impairment to provide evidence that the impairment does not interfere with the applicant's competence or ability to practice medicine.
- (m) Applicants shall provide evidence that the Commonwealth of Massachusetts requirement for continuing education has been met (or waiver received).
- (n) Each applicant for clinical privileges shall complete a delineation form, specifying the areas in which he/she seeks privileges, and provide such supporting documentation of competence in these areas as requested by the Hospital.
- (o) Prior to review pursuant to Section 8.A.3 below, the Chair of any Department may recommend that the President of the Hospital or authorized designee (said authorized designees include but are not limited to the Chief Medical Officer, the Associate Chief Medical Officer and the Chair of the Medical Staff Credentialing Committee) grant, and the President or her/his authorized designees may grant, preliminary privileges for a limited period of time not to exceed that which is allowed by the Board of Registration in Medicine pending credentialing to any applicant with current Massachusetts licensure who satisfies the criteria for Category 1 Applicants as described in Section 8A. 3. (f) below and for whom the Chair has received his/her: (1) most recent application for a license to practice medicine, dentistry, podiatry, chiropractics or psychology, as applicable in Massachusetts; (2) Drug Enforcement Administration number; (3) evidence of malpractice insurance; (4) any information required pursuant to the Hospital's health screening policy of subsection l above; (5) appropriate references; and (6) results of the queries to the National Practitioner Data Bank and the Criminal Offender Record Information, and has found them satisfactory.

3 Application Review and Investigation

- (a) The Chair of each Department shall transmit the application to the Credentials Committee of the Department, which shall review the character, qualifications, and standing of the applicant.
- (b) The review of each application shall include inquiries of each health care facility with which the applicant has been associated during the past ten years, regarding the health care facility's assessment of professional skills, and information regarding any pending or final disciplinary or other adverse action, and any other information relevant to the applicant's character (including personal conduct and behavior), professional competence or professional conduct and behavior. With respect to applicants for clinical privileges, these inquiries shall also cover clinical skills and malpractice claims pending or closed during the previous ten (10) years.
- (c) The names of the applicants to a particular Department may be circulated among the members of that Department. Comments on the applicant from Staff members may be made to and should be considered by the appropriate Departmental Credentials Committee prior to its decision.
- (d) The Departmental Credentials Committee shall make the appointment decision concerning all applications by those individuals who are not seeking clinical privileges. The Departmental Credentials Committee shall submit through its Department Chair a report of all other applications it recommends for approval to the Medical Staff Credentialing Committee. All applications shall be accompanied by the completed application forms, all references obtained, and evidence of the verification of relevant data.
- (e) Every recommendation for appointment by the Departmental Credentials Committee shall include a recommendation concerning appropriate staff category and, with respect to applicants for clinical privileges, a delineation of any privileges recommended. The recommendation of the Departmental Credentials Committee for those applicants seeking clinical privileges shall be forwarded to the Medical Staff Credentialing Committee.
- (f) Following a review of the applications and the report submitted by the Departmental Credentials Committee, those applicants who satisfy criteria adopted by the Medical Staff Credentialing Committee, the Medical Staff Executive Committee and the Board of Trustees or committee thereof ("Category 1 Applicants") shall be reviewed by an expanded Medical Staff Credentialing Committee which includes at least one (1) representative from the Medical Staff Executive Committee with the authority to act on behalf of the Medical Staff Executive Committee.

- (g) The expanded Medical Staff Credentialing Committee shall prepare a recommendation concerning such Category 1 Applicants. Category 1 Applications recommended for approval by the expanded Medical Staff Credentialing Committee shall be transmitted to the Board of Trustees. Applications recommended for denial or approval with limitations by the expanded Medical Staff Credentialing Committee shall be transmitted along with all relevant application materials to the full Medical Staff Executive Committee for review.
- (h) The Board of Trustees at its next scheduled meeting shall either accept the recommendation of the expanded Medical Staff Credentialing Committee with respect to such Category 1 Applicants or shall deny or refer such applicants to the full Medical Staff Executive Committee for review. The Board of Trustees shall state the reasons for its decision to deny or refer any such Category 1 Application. In the event that the Board of Trustees votes to deny an application for reasons related to the applicant's professional competence or to a complaint or allegation regarding any violation of law, regulations or bylaw, the applicant shall be given notice of his or her right to a hearing in accordance with Article V, Section 11. In the event the Board of Trustees votes to approve a Category 1 Application for reappointment with or without any limitations or additional requirements, or to deny an application for a Category 1 Applicant for reasons other than those stated in the preceding sentence, such vote will be the final action by the Hospital with respect to the appointment, and the applicant shall not be entitled to any of the procedural rights provided in Article V of these bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearing and Board review.
- (i) The appointment and privileges requested for such Category 1 Applicants shall be effective upon approval by the Board of Trustees. Provided, however, that in the absence of a meeting of the Board of Trustees or in the absence of a quorum at such meeting, upon recommendation by the Chief Medical Officer or his designee, an ad hoc or standing committee consisting of at least three (3) members of the Board of Trustees may approve the appointment of a Category 1 Applicant for a period not to exceed four (4) months.
- (j) The Board of Trustees shall consider any such appointments approved by the ad hoc or standing committee at its next regularly scheduled meeting, and shall accept, reject or refer the recommendation with respect to such appointments in the manner described in section (h) above.

- (k) Following a review of the applications and the report submitted by the Departmental Credentials Committee, those applicants who do not satisfy criteria adopted by the Medical Staff Credentialing Committee, the Medical Staff Executive Committee and the Board of Trustees or committee thereof (“Category 2 Applicants”) shall be reviewed by the Medical Staff Credentialing Committee.
- (l) The Medical Staff Credentialing Committee shall prepare a recommendation with respect to each such Category 2 Applicant it reviews, and shall submit such recommendation with all relevant application materials to the Medical Staff Executive Committee.
- (m) On receipt of the report of the Medical Staff Credentialing Committee, the Medical Staff Executive Committee shall recommend that each Category 2 Application submitted to it be accepted, deferred, or denied. Where a recommendation to defer is made, it must be followed by one to accept or deny the applicant within a reasonable time, in no case to exceed three (3) months.
- (n) In the event that the Medical Staff Executive Committee recommends approval of a Category 2 Applicant, the recommendation shall be transmitted to the Board of Trustees for consideration.
- (o) In the event that the Medical Staff Executive Committee recommends denial of an application for appointment of a Category 2 Applicant for reasons related to the applicant’s professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw, the applicant shall be given notice of his or her right to a hearing in accordance with Article V, Section 11. In the event the Medical Staff Executive Committee recommends a denial of a Category 2 Application for reasons other than those stated in the preceding sentence, the recommendation shall be transmitted to the Board of Trustees for consideration.
- (p) The Board of Trustees at its next scheduled meeting shall either accept the recommendation of the Medical Staff Executive Committee transmitted to it, or shall reject or recommit the recommendation for further consideration, stating the reasons for such rejection or recommitment.
- (q) In the event that the Board of Trustees votes to deny an application for appointment for a Category 2 Applicant who has previously been approved by the Medical Staff Executive Committee for reasons related to the applicant’s professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw, the applicant shall be given notice of his or her right

to a hearing in accordance with Article V, Section 11. In the event the Board of Trustees votes to approve an application for appointment with or without any limitations or additional requirements for a Category 2 Applicant who has previously been approved by the Medical Staff Executive Committee, or to deny an application for a Category 2 Applicant who has previously been approved by the Medical Staff Executive Committee for reasons other than those stated in the preceding sentence, such vote will be the final action by the Hospital with respect to the appointment, and the applicant shall not be entitled to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearing and Board review.

- (r) The appointment and privileges requested for such Category 2 Applicants shall be effective upon approval by the Board of Trustees. Provided however, that upon recommendation by the Medical Staff Credentialing Committee and the Chief Medical Officer or his designee, an ad hoc or standing committee consisting of at least three (3) members of the Board of Trustees may approve the appointment or reappointment of a Category 2 Applicant for a period not to exceed four (4) months in order to allow for additional review and evaluation of such applicant. The Board of Trustees ad hoc or standing committee may condition its approval on the imposition of any limitations, restrictions or additional requirements it deems appropriate.

B. Procedures for Reappointment to the Medical Staff

1. Requests for reappointment to the Medical Staff must be submitted in the form and manner approved by the Hospital. The application shall include all information, releases and assurances required of initial applicants, except that the inquiry to health care facilities specified in Section A.3.(b) above shall be limited to those health care facilities with which the applicant has been associated during the past three years. The Partners CCO shall obtain and verify all required credentialing information in accordance with subparagraph 8A(1).
2. The completed reappointment form must be submitted to the Chair of the member's Department. The Chair or the Departmental Credentials Committee, through the Mass General Brigham CCO, shall verify licensure status, required reports from other health care facilities, and other relevant information provided by the member.
3. Reappointment to the Medical Staff shall be contingent upon an appraisal of the Medical Staff member's character, qualifications, and standing by the Chair of the relevant Department in conjunction with the Departmental Credentials

Committee. Such appraisal shall include, as applicable, a review of the member's professional and clinical performance, utilization and quality assurance data, malpractice claims, disciplinary or other adverse actions, patient complaints and/or patient satisfaction data, professional conduct and behavior, continuing education, attendance at Staff and Committee meetings, and compliance with the applicable standards, criteria and policies of their respective Departments, the Medical Staff, the Hospital, BWPO, BWHC and Mass General Brigham, the Bylaws and policies and procedures of the Medical Staff, the Bylaws of the Hospital, and any condition or restriction imposed on the member's appointment.

4. The recommendations of the Department Chairs will be forwarded to their Departmental Credentials Committees. The relevant Departmental Credentials Committee shall make the reappointment decision concerning all those individuals in the Department who are not seeking clinical privileges. The recommendations of the Department Chairs and Departmental Credentials Committees concerning all other applicants in the Department for reappointment will be forwarded for review and action pursuant to the same process and according to the same schedule applicable to applicants for initial appointment.

SECTION 9: TEMPORARY AND DISASTER PRIVILEGES

- (a) The credentialing requirements set forth in Section 7 above do not apply when the Hospital grants temporary privileges in accordance with the regulations of the Massachusetts Board of Registration in Medicine or disaster privileges in accordance with Hospital policy.
- (b) Temporary privileges may be extended to any qualified physician, dentist, psychologist, chiropractor or podiatrist and Advance Practice Provider who is not a member of the Medical Staff after authorization by a Department Chair or the Chief Medical Officer and the Medical Staff Credentialing Committee. Prior to granting such privileges the Department Chair must have received: (1) the most recent application for a license to practice medicine, dentistry, podiatry, chiropractics or psychology, as applicable in Massachusetts; (2) Drug Enforcement Administration number; (3) evidence of malpractice insurance; (4) any information required pursuant to the Hospital's health screening policy of subsection I above; (5) appropriate references; and (6) results of the query to the National Practitioner Data Bank, and has found them satisfactory. Additionally the query for the Criminal Offender Record Information must be submitted. Such privileges shall be for a limited period of time not to exceed that which is allowed by the Board of Registration in Medicine. In the exercise

of such privileges, the physician, dentist, psychologist, chiropractor or podiatrist shall be under the supervision of the Chair of the Department or his/her designee in which the temporary appointment is made.

- (c) Temporary privileges shall be immediately terminated by the Chief Medical Officer (or designee) at his/her discretion or upon the request of the Department Chair or the Medical Staff Credentialing Committee.
- (d) The granting of temporary privileges is a courtesy on the part of the Hospital and the granting, denial, restriction or termination of such temporary privileges shall not entitle the individual concerned to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearings and Board review.
- (e) Disaster privileges may be granted by the President or the Chief Medical Officer of the Hospital or their designees which include, but are not limited to, the Chair of the Medical Staff Credentialing Committee, an Associate Chief Medical Officer, and the President of the BWPO and are subject to Hospital policy. The granting of disaster privileges is a courtesy on the part of the Hospital, and the granting, denial, restriction or termination of such disaster privileges shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearing and Board review.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

SECTION 1: THE MEDICAL STAFF

The Medical Staff shall consist of the following categories:

Active Staff	Honorary Staff
Affiliate Staff	House Staff, Clinical
Adjunct Staff	Fellows and Research
Courtesy Staff	Fellows
Senior Consulting Staff	Graduate Assistant Staff
Research Staff	Consultative Staff
Visiting Staff	Clinical Consulting Staff

SECTION 2: ACTIVE STAFF

The Active Staff shall consist of selected physicians, dentists, psychologists, chiropractors and podiatrists who contribute substantially to the Hospital by virtue of:

- (a) An active participation in caring for patients in the Hospital or in ambulatory care settings; and/or
- (b) Conducting research; and/or
- (c) An active participation in the teaching program, to be defined by the relevant Department Chair; and/or
- (d) An active participation in the Hospital's Global Health Equity Program.

Those members of the Active Staff who have been granted clinical and/or admitting privileges must either: (1) care for a majority of their patients at the Hospital or (2) care for a majority of their patients at the Hospital in the particular subspecialty and/or for the particular procedure(s) for which they have been granted privileges.

Members of the Active Staff:

- (a) Shall be eligible to hold office, vote and serve on committees.
- (b) Shall be expected to serve on Hospital committees if so appointed.

SECTION 3: AFFILIATE STAFF

The Affiliate Staff shall consist of selected physicians, dentists, psychologists, chiropractors and podiatrists who have been granted clinical and/or admitting privileges upon the recommendation of the relevant Department Chair at the time of the appointment or reappointment, and who are either: (1) members of a practice association that has contracted with the Hospital for the provision of care for its patients by its own staff; (2) employed by or affiliated with Mass General Brigham Community HealthCare, Inc.; (3) members of the medical staff of BWFH or other Mass General Brigham HealthCare System, Inc. hospitals; or (4) members of the Harvard Medical School faculty whose principal base is at another institution affiliated with Harvard Medical School or at a medical research organization.

Any appointment to the Affiliate Staff will terminate automatically upon the termination of the basis for the staff member's appointment at the Hospital, namely:

(1) upon the termination of the staff member's affiliation with the practice association or upon the termination of the practice association's contract with the Hospital; (2) upon the termination of the staff member's employment by or affiliation with Mass General Brigham Community HealthCare, Inc.; (3) upon the termination of the staff member's relevant medical staff membership or (4) upon the termination of the staff member's appointment at Harvard Medical School or of his or her appointment at an institution other than the Hospital which is affiliated with Harvard Medical School, or at a medical research organization.

Members of the Affiliate Staff must demonstrate:

- (a) An active participation in caring for patients in the Hospital or its ambulatory care settings, and
- (b) An active participation in the teaching program, to be defined by the relevant Department Chair.

Members of the Affiliate Staff:

- (a) Shall be eligible to hold office, vote, and serve on committees.
- (b) Shall be expected to serve on Hospital committees if so appointed.

Telehealth Affiliate Staff

Affiliate Staff shall include members of the Medical Staff that are exclusively providing Telehealth Services to BWH from distant sites ("Telehealth Affiliate Staff"). Telehealth Affiliate Staff may be Credentialed by Proxy pursuant to M.G.L c. 112, Section 50, and all other applicable regulatory and accreditation requirements, or may undergo full credentialing if deemed necessary by BWH. Telehealth Affiliate Staff are subject to these Brigham and Women's Hospital Medical Staff Bylaws, and the BWH Medical Staff retains the ultimate authority over whether to grant, deny, renew, or terminate the Telehealth Affiliate Staff appointment to the Medical Staff. Such providers shall be limited to the provision of telehealth services only and to the extent permitted by their privileges. Telehealth Affiliate Staff shall not pay dues, shall not be eligible to attend meetings, vote, or hold office, and shall not be entitled to the procedures set forth in Article XI of these Bylaws upon termination of appointment.

SECTION 4: ADJUNCT STAFF

The Adjunct Staff shall consist of selected physicians, dentists, psychologists, chiropractors and podiatrists who are given privileges to admit or care for an occasional patient in the Hospital. Each Department Chair shall establish the minimum number of patients that must be and the maximum number of patients that may be admitted or cared for by a member of the Adjunct Staff in that Department during a two year period. Admission or care of more than this designated maximum number of patients shall require the individual to seek membership on the Active or Affiliate Staff. Admission or care of less than this designated minimum number of patients shall require the individual to seek membership on the Courtesy Staff.

Adjunct Staff Members may neither vote nor hold office nor serve on committees.

SECTION 5: SENIOR CONSULTING STAFF

The Senior Consulting Staff shall consist of selected physicians, dentists, psychologists, chiropractors and podiatrists of outstanding reputation in their respective fields who have various skills and areas of competence to provide consultation services upon request of any member of the Medical Staff.

Members of the Senior Consulting Staff:

- (a) Shall not be granted clinical or admitting privileges.
- (b) Need not be credentialed pursuant to these bylaws, but may be credentialed as deemed appropriate by the relevant Department Chair.
- (c) May neither vote nor hold office.
- (d) May serve on committees as requested by the Hospital.
- (e) The length of an appointment to the Senior Consulting Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Senior Consulting Staff does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review.
- (f) No new or additional appointments shall be made to the Senior Consulting Staff after December 31, 2010.

SECTION 6: HONORARY STAFF

The Honorary Staff shall consist of:

- (a) Former members of the Medical Staff who, by their long and meritorious service to the Hospital, warrant such recognition; and
- (b) Other distinguished professionals of outstanding reputation in medicine and the allied health sciences.
- (c) Members of the Honorary Staff shall have no privileges. They may neither vote, nor hold office, nor serve on committees. They need not be credentialed pursuant to these Bylaws, but may be credentialed as deemed appropriate by the relevant Department Chair. The length of an appointment to the Honorary Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Honorary Staff does not constitute a disciplinary action as defined in Article V of these bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review.

SECTION 7: RESEARCH STAFF

Membership on the Research Staff may be conferred on those whose sole activity is to conduct medical research. As Research Staff are not granted clinical privileges, they need not be licensed to practice medicine in the Commonwealth of Massachusetts. Research Staff need not be credentialed pursuant to these Bylaws, but may be credentialed as deemed appropriate by the relevant Department Chair. The length of an appointment to the Research Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Research Staff does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review. Research Staff members may neither vote nor hold office. They may serve on committees as requested by the Hospital.

SECTION 8: VISITING STAFF

Membership on the Visiting Staff may be conferred on faculty visiting from other institutions to conduct medical education. Visiting Staff are not granted clinical privileges. They may neither vote nor hold office. They need not be credentialed pursuant to these Bylaws, but may be credentialed as deemed appropriate by the

relevant Department Chair. The length of an appointment to the Visiting Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Visiting Staff does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review.

SECTION 9: HOUSE STAFF, CLINICAL FELLOWS AND RESEARCH FELLOWS

- (a) The House Staff shall consist of residents. Each member of the House Staff is considered to be in training and shall provide professional services only at the Hospital under the supervision of members of the Medical Staff or at other hospitals or locations under a resident training program which has been approved by the Hospital, unless otherwise authorized by the Chair of the Department in which he or she serves.
- (b) Clinical Fellows are professionals in postdoctoral training who carry on study and research in clinical subjects and who have patient care responsibility. A Clinical Fellow who occupies a training status shall provide professional services only at the Hospital under appropriate supervision or at other hospitals or locations under a training program approved by the Hospital, unless otherwise authorized by the Chair of the Department in which he or she serves or under policies adopted by the Department of which he or she is appointed.
- (c) Research Fellows are professionals in postdoctoral training with primary activity in research. Clinical privileges may or may not be conferred depending upon the interest, education, and training of the applicant. Research Fellows who are not granted clinical privileges need not be licensed to practice in the Commonwealth of Massachusetts.
- (d) House Staff, Clinical Fellows and Research Fellows shall be appointed to the Medical Staff pursuant to Article III, Section 8. However, Research Fellows who do not seek clinical privileges need not be credentialed pursuant to these Bylaws, but may be credentialed as deemed appropriate by the relevant Department Chair. House Staff and Clinical Fellows may be granted clinical and admitting privileges.
- (e) The disciplinary action process in Article V shall not apply to House Staff, Clinical Fellows and Clinical and Research Fellows enrolled in any clinical or clinical and research training program sponsored by the Hospital (whether or not such a program is nationally accredited) except as specifically provided in

these Bylaws. Disciplinary or adverse actions involving such individuals shall ordinarily be governed by the Mass General Brigham Graduate Trainee Adverse Action Process.

- (f) House Staff, Clinical Fellows and Research Fellows may serve as members of various Medical Staff and Hospital committees. They may not vote nor hold office on the Medical Staff.
- (g) Any appointment to the Medical Staff as a member of the House Staff or as a Clinical or Research Fellow will terminate automatically at the end of the member's residency program or fellowship, if the member's term of appointment has not expired prior to this date; provided however, if the staff category of such individual is changed to another staff category in accordance with Section 14 below, the appointment shall continue until its expiration date (said appointment not to exceed a total of two years) .

SECTION 10: CONSULTATIVE STAFF

The Consultative Staff shall consist of selected audiologists, physicists, geneticists, engineers, and biochemists who provide consultation, assistance and/or advice in their areas of expertise to other members of the medical staff. Each member of the Consultative Staff shall have a primary Department affiliation.

- (a) Consultative Staff may engage in direct clinical activities in accordance with their education, training, experience and current competence, but shall not have clinical or admitting privileges under these bylaws.
- (b) The provisions of Article III, Section 8 shall not apply to the Consultative Staff. The procedure for their appointment and reappointment shall be established by the relevant Departments.
- (c) The length of an appointment to the Consultative Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Consultative Staff does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws, including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review.
- (d) Members of the Consultative Staff may serve as members of the various Medical Staff and Hospital committees as requested.

- (e) Members of the Consultative Staff may neither vote nor hold office.

SECTION 11: COURTESY STAFF

The Courtesy Staff shall consist of selected physicians, dentists and podiatrists who have demonstrated a commitment to the goals and purposes of the Hospital, but who at present have no active role in patient care, teaching or research at the Hospital.

Members of the Courtesy Staff:

- (a) Shall not be granted clinical or admitting privileges.
- (b) May neither vote, nor hold office, nor serve on committees.
- (c) Need not be credentialed pursuant to these Bylaws, but may be credentialed as deemed appropriate by the relevant Department Chair.
- (d) May attend various medical staff events and educational programs.
- (e) The length of an appointment to the Courtesy Staff, and the termination of such appointment shall be as determined by the relevant Department Chair. The denial or the termination of membership to the Courtesy Staff does not constitute a disciplinary action as defined in Article V of these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article V of these Bylaws including but not limited to these procedures with respect to preliminary inquiry, hearings and Board review.

SECTION 12: GRADUATE ASSISTANT STAFF

An appointment to the Graduate Assistant Staff may be requested as a secondary appointment by members of the House Staff (PGY-3 and above), Clinical Fellows, and Research Fellows. Appointment to the Graduate Assistant Staff is temporary and limited by the Department Chair according to the need of the Department and/or Hospital.

Members of the Graduate Assistant Staff:

- (a) Must have a full a full license issued by the Commonwealth of Massachusetts Board of Registration of Medicine.

- (b) May be granted clinical and admitting privileges to the extent specified in his/her delineation of privileges form or equivalent document(s).
- (c) Must comply with all applicable Department, Hospital, BWHC and Mass General Brigham policies including but not limited to the Mass General Brigham Graduate Trainee Moonlighting Policy.
- (d) The denial, restriction or termination of an appointment to the Graduate Assistant Staff shall not be considered a “disciplinary action” under Article V of these Bylaws and shall not entitle the individual concerned to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearings and Board review.

SECTION 13: CLINICAL CONSULTING STAFF

The Clinical Consulting Staff Category shall consist of selected physicians, dentists, psychologists, chiropractors and podiatrists who maintain a clinical practice in the community and wish to follow the course of their patients when admitted to the Hospital, and/or to participate in the teaching of House Staff and Clinical Fellows under the supervision of a Member of the Active or Affiliate Staff.

Members of the Clinical Consulting Staff:

- (a) May perform outpatient preadmission medical history and physical examinations, order noninvasive outpatient diagnostic tests and services, visit patients admitted to the Hospital, review medical records, consult with the attending of record, and observe diagnostic or surgical procedures with the approval of the attending of record.
- (b) May participate in teaching activities, under the supervision of a Member of the Active or Affiliate Staff as part of a teaching session organized by the respective Hospital Department. Any examination conducted as part of the teaching session shall be for teaching purposes only, and shall not be recorded in the patient chart or used to make treatment decisions.
- (c) Shall be appointed to the Medical Staff pursuant to Article III, Section 8 provided that at the request of the Department Chair, and with the approval of the Chief Medical Officer, a community physician with knowledge of the character, qualifications and standing of the Clinical Consulting Staff Member or applicant, may perform the duties and responsibilities of the Department Chair as set forth in Article III, Section 8.

- (d) Shall not be granted clinical or admitting privileges to independently manage the care of patients in the Hospital.
- (e) May attend various medical staff events and educational programs
- (f) May neither vote nor hold office.
- (g) Must fulfill or comply with any applicable Medical Staff or Hospital policies and procedures.

SECTION 14: CHANGE IN STAFF CATEGORY

Except as otherwise provided in these Bylaws, in the event that a Department Chair concludes during the term of a Medical Staff member's appointment that the Medical Staff member no longer satisfies the requirements for membership in the staff category to which she/he was appointed, and the Department Chair determines that the member satisfies the requirement for membership in another staff category, the Department Chair may elect to change the Medical Staff member's staff category to the appropriate one. Such a change in staff category shall not be considered a "disciplinary action" and shall not entitle the individual concerned to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearing and Board review.

SECTION 15: ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals, who shall include licensed physician assistants and nurses practicing in an expanded role, are not members of the Medical Staff. An Advanced Practice Professional may engage in direct clinical activities and be granted clinical and/or admitting privileges only to the extent defined in written protocols or guidelines that have been reviewed and approved by the appropriate committees of the Medical Staff and Hospital and in accordance with any applicable laws or regulations. The protocols or guidelines shall specify the activities or situations requiring referral to or consultation with a member of the Medical Staff and shall limit the Advanced Practice Professional to activities in which he or she has documented appropriate professional education, training and experience, and current competence. Each Advanced Practice Professional must meet at a minimum all requirements for professional education, clinical training and experience established by the appropriate state board or agency. If there is no such board or agency, the minimum professional requirements for the Advanced Practice Professional shall be those recommended by the Medical Staff Credentialing Committee, and approved by the Medical Staff Executive Committee.

ARTICLE V: DISCIPLINARY ACTION

SECTION 1: DEFINITIONS

- (a) “Disciplinary action” includes any of the following actions by the Hospital: revocation of a right or privilege; suspension; censure; written reprimand; fine; required performance of public service; or a course of education, counseling or monitoring arising out of the filing of a complaint or a formal charge reflecting on professional competence. The following actions are also included, only if related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw: restriction, non-renewal or denial of a right of privilege; resignation; leave of absence; withdrawal of an application; or termination or non-renewal of a contract.

Such disciplinary actions shall be taken in accordance with this Article V, except as otherwise provided in these Bylaws.

However, the following actions, among others shall not be considered to be a “disciplinary action”, and the taking of any such action shall not entitle the applicant or Staff member to any of the procedural rights provided in Article V of these Bylaws, including but not limited to those procedures with respect to preliminary inquiry, hearing, and Board review: (i) an action based upon failure

to complete medical records or perform minor administrative functions in a timely fashion that does not relate to professional competence or to a complaint or allegation regarding any violation of law or regulation, and which the Hospital takes pursuant to a process independent of these Bylaws; (ii) denial of a Staff member's request to change staff category or add new privileges; (iii) supervision and proctorship provided they are for evaluative purposes and for a limited period of time; (iv) probation; (v) issuance of a verbal reprimand or admonition; (vi) termination from a medical administrative position; (vii) automatic termination of appointment to the Affiliate Staff upon the termination of the basis for the professional's appointment with the Hospital; and (viii) denial of appointment or reappointment which is not related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw. This list is not intended to be exhaustive.

- (b) "Disciplinary Action Process" is a medical peer review committee process intended to review, evaluate and determine certain recommended actions with respect to a Staff member's privileges or appointment.

SECTION 2: GROUND FOR DISCIPLINARY ACTION

Disciplinary action may be taken for due cause, including but not limited to any of the following reasons:

- (a) professional incompetence, or conduct that might be inconsistent with or harmful to good patient care or safety, lower than the standards of the Medical Staff, or disruptive to Hospital operations;
- (b) conduct that (i) calls into question the Staff member's integrity, ethics, character (including personal conduct and behavior), professionalism or judgment, or (ii) could prove detrimental to the Hospital's employees, operations or reputation;
- (c) violation of the bylaws or policies and procedures of the Medical Staff, the Hospital, Mass General Brigham, or Harvard Medical School;
- (d) research misconduct;
- (e) failure to perform duties.

SECTION 3: INITIATION OF DISCIPLINARY ACTION PROCESS

Except as otherwise provided, the process leading to potential disciplinary action may be initiated by the relevant Department Chair, the Chief Medical Officer, the Medical Staff Executive Committee, or the Board of Trustees, upon any allegation of due cause for disciplinary action. The process shall be initiated by the prompt submission to the relevant Department Chair of notice of the allegation, supported by reference to the specific activity or conduct that constitutes the grounds for the allegation. The Department Chair shall apprise the Chief Medical Officer forthwith of such submission.

Any allegation of research misconduct by any member of the Medical Staff, including a member of the House Staff, a Clinical or Research Fellow, or a member of the Consultative Staff shall be addressed and resolved pursuant to the process initiated in accordance with Section 6.

An allegation of non-compliance in human subjects research (which is not required to be referred to the Hospital's Research Integrity Officer pursuant to Section 6) against any member of the Medical Staff, including a member of the House Staff, a Clinical Fellow or Research Fellow shall be addressed and resolved as described in Section 7.

The denial or recommendation of denial of appointment or reappointment to the medical staff, if such denial is related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw, shall be addressed and reviewed pursuant to the process initiated in accordance with Article III, Section 8.

SECTION 4: SUMMARY ACTION

- (a) The Chief Medical Officer or designee may make an immediate summary suspension of any member of the Medical Staff, or take other summary disciplinary action, whenever such action is deemed necessary to maintain acceptable standards of care, safety, operation, integrity, or ethics at the Hospital.
- (b) The Chief Medical Officer or designee shall send forthwith a written report of such action and the reason(s) therefore to the Staff member involved, and the relevant Department Chair.
- (c) The Medical Staff Executive Committee or ad hoc committee thereof shall review the summary suspension or other summary disciplinary action. Within

fourteen (14) days of the time the summary suspension or other summary disciplinary action was initiated, the Medical Staff Executive Committee or ad hoc committee thereof shall decide whether it appears substantiated by fact and reasonable and should be continued in force, or whether it should be lifted. The Medical Staff Executive Committee or ad hoc committee thereof shall send prompt written notice of the decision to the Staff member involved, the Chief Medical Officer, the relevant Department Chair, and the Board of Trustees.

SECTION 5: AUTOMATIC REVOCATION, RESTRICTION OR SUSPENSION

(a) Lack of Minimum Malpractice Insurance

Whenever it is discovered that a Medical Staff member with clinical privileges does not carry the minimum malpractice insurance coverage required by Article III, Section 1, the Medical Staff member shall be given immediate written notice thereof, and the Chief Medical Officer or his/her designee may impose summary disciplinary action pursuant to Section 4. If the Staff member does not give the Hospital satisfactory proof he or she has obtained the requisite coverage within thirty (30) days of receipt of the notice, his or her Medical Staff appointment and privileges shall be immediately and automatically revoked.

(b) License Revocation, Non-Renewal, Restriction, or Suspension

Whenever a Medical Staff member's license, certificate or other legal credential authorizing practice in the Commonwealth of Massachusetts is revoked or not renewed, his or her Medical Staff appointment and privileges shall be immediately and automatically revoked.

Whenever a Medical Staff member's license, certificate or other legal credential is suspended, his or her Medical Staff appointment and privileges shall be immediately and automatically suspended.

Whenever a Medical Staff member's license, certificate or other legal credential is limited or restricted by the applicable licensing or certifying authority, those privileges granted which have been so limited or restricted shall be immediately and automatically limited or restricted in the same manner.

When a licensing or certifying authority ends a suspension, limitation or restriction, or reinstates a license, certificate or other legal credential, the individual may apply for Medical Staff appointment, or appointment without such limitation or restriction, and shall be evaluated as an applicant for initial appointment.

(c) Drug Enforcement Agency (“DEA”) Registration Revocation, Non-Renewal, Restriction or Suspension

Whenever a Medical Staff member’s DEA registration number is revoked or not renewed, he or she shall immediately and automatically be divested of his or her right to prescribe or dispense controlled substances authorized by the registration. Whenever a Medical Staff member’s DEA registration is suspended, he or she shall be automatically divested of his or her right to prescribe or dispense controlled substances authorized by the registration effective upon and for at least the term of the suspension.

Whenever a Medical Staff member’s DEA registration is restricted, his or her right to prescribe or dispense controlled substances shall be immediately and automatically limited in accordance with the terms of the restriction.

(d) Federal Excluded Provider

Whenever a Medical Staff member is (i) excluded, debarred or otherwise ineligible to participate in the Federal health care programs (including but not limited to Medicare, Medicaid, Champus or Veterans Administration) or in Federal procurement or non-procurement programs or (ii) has been convicted of a criminal offense related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible, his or her Medical Staff appointment and privileges shall be immediately and automatically revoked.

When a Medical Staff member’s exclusion, debarment or ineligibility to participate in Federal health care programs or in Federal procurement or non-procurement programs has ended, such Medical Staff member may apply for appointment, and shall be evaluated as an applicant for initial appointment.

(e) Duty to Notify

The Medical Staff member involved shall immediately notify the relevant Department Chair, who will immediately notify the Chief Medical Officer:

- (i) Whenever the Medical Staff member has knowledge that he or she is being investigated by a licensing, certifying or regulatory authority for possible revocation, non-renewal, restriction, suspension or probation of his or her license to practice or DEA registration, or for any other possible disciplinary or adverse action

or as a result of a complaint or an allegation regarding any violation of law, regulation or bylaw; or

- (ii) whenever the Medical Staff member has knowledge that his or her license or DEA registration has been revoked, not renewed, or suspended, or that he or she has been placed on probation with respect to either his or her license or DEA registration, or that he or she has been the subject of any other disciplinary or adverse action by a licensing, certifying or regulatory authority; or
- (iii) whenever the Medical Staff member has knowledge that another health care facility, employer or professional medical association has taken disciplinary or other adverse action against the Staff member or that proceedings for disciplinary or other adverse action have been initiated; or
- (iv) whenever the Medical Staff member has knowledge that he or she is (a) excluded, debarred or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs or that proceedings for such exclusion, debarment or ineligibility have been initiated or (b) has been convicted of a criminal offense related to the provision of health care services or items, but has not yet been excluded, debarred or otherwise declared ineligible.

(f) Applicability to House Staff, Clinical Fellows and Research Fellows

This Section 5 shall apply to all members of the Medical Staff, including House Staff, Clinical Fellows and Research Fellows.

SECTION 6: REFERRAL OF RESEARCH MISCONDUCT ALLEGATIONS

The Chief Medical Officer shall promptly refer to the Hospital's Research Integrity Officer any allegation of research misconduct by any member of the Medical Staff, including a member of the House Staff or a Clinical or Research Fellow. The Research Integrity Officer shall conduct the review of the allegations pursuant to the Mass General Brigham Policy and Procedure for Handling Allegations of Research Misconduct.

Any disciplinary action (as defined in Section 1 of this Article V) imposed by the review pursuant to the Mass General Brigham Policy and Procedures for Handling

Allegations of Research Misconduct shall be considered final action by the Hospital and the Medical Staff Member shall not be entitled to any of the procedural rights provided for in this Article V including but not limited to those procedures with respect to preliminary inquiry, hearing and Board review unless the disciplinary action is one or more of the disciplinary actions specified in Section 10 (c). If the disciplinary action imposed is one or more of the disciplinary actions specified in Section 10 (c), the Medical Staff member shall be entitled to a hearing under Section 11 to appeal the imposition of the sanction, and the Medical Staff member shall be so notified. In accordance with Section 8 of this Article V, a Medical Staff member may not retry a finding of misconduct in such hearing.

SECTION 7: REFERRAL OF CERTAIN MATTERS TO MASS GENERAL BRIGHAM
INSTITUTIONAL REVIEW BOARDS AND HUMAN RESEARCH AFFAIRS

The Chief Medical Officer, after consultation with the Hospital's Senior Vice President for Research, may refer any allegation described in Section 2, pertaining to non-compliance in human subjects research (which is not required to be referred to the Hospital's Research Integrity Officer pursuant to Section 6) to the Mass General Brigham Institutional Review Boards (IRBs) and/or Human Research Affairs (HRA) for review and appropriate action, if any. Alternatively, the Chief Medical Officer, after consultation with the Hospital's Senior Vice President for Research, may elect for the Hospital to jointly review the alleged non-compliance in human subject's research with the Mass General Brigham IRB and/or HRA in accordance with policies and procedures duly adopted by the Hospital and its IRBs. Upon receipt of the report and recommendation from the referral or joint review, the Chief Medical Officer shall make a recommendation pursuant to Section 10 with respect to appropriate disciplinary or other adverse action, if any, by the Hospital.

SECTION 8: HOSPITAL ACCEPTANCE OF FACT FINDINGS

In any action taken pursuant to this Article, a Staff member may not retry, and the Hospital may rely on and accept as true, any finding of fact contained in a final decision by the applicable licensing, certifying or regulatory authority, by the process described in Section 6, or by the referral or joint process described in Section 7 provided the affected Medical Staff member was a party to the proceeding in which the finding of fact was made.

SECTION 9: PRELIMINARY INQUIRY

With respect to any allegation raised pursuant to Section 3 other than one which is (a) referred to the Hospital's Research Integrity Officer pursuant to Section 6, (b) reviewed pursuant to Section 7 or (c) the denial or recommendation of denial of appointment or reappointment in accordance with the procedures set forth in Article III, Section 8 for reasons related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw, the relevant Department Chair or the Chief Medical Officer shall conduct or cause to be conducted a prompt informal inquiry to ascertain whether there is a reasonable basis for the allegation. This inquiry shall not be in the form of a hearing. The procedures provided in Section 11 with respect to hearings need not apply.

The inquiry shall include consultation with the Staff member involved. Failure of the Staff member to cooperate with such inquiry or with any other inquiry or investigation described in these Bylaws shall be grounds for disciplinary action.

SECTION 10: RECOMMENDATION CONCERNING APPROPRIATE DISCIPLINARY ACTION, IF ANY

At the conclusion of the preliminary inquiry, the relevant Department Chair or Chief Medical Officer shall issue or cause to be issued a written report of findings of fact and recommendation(s). Copies shall be sent to the affected Medical Staff member and the Chief Medical Officer or Department Chair, as appropriate.

- (a) If the preliminary inquiry report (or the Chief Medical Officer based upon the report concerning alleged non-compliance in human subjects research pursuant to Section 7) concludes there was no reasonable basis for the allegation(s) at issue, or that no disciplinary action by the Hospital is warranted, no further action under these Bylaws shall be taken, but the Department Chair or Chief Medical Officer may take remedial or other corrective action as he/she deems appropriate.
- (b) If the preliminary inquiry report (or the Chief Medical Officer based upon the report concerning alleged non-compliance in human subjects research pursuant to Section 7) recommends that disciplinary action other than one referred to in Section 10 (c) is warranted, the Board of Trustees shall review this recommendation. The Board may provide for such review by a committee of the Board especially appointed for the purpose.

The review of the Board of Trustees or committee thereof shall be based on the preliminary inquiry report and recommendations (or the report concerning

alleged non-compliance with human subjects research pursuant to Section 7) and any written response which the affected Medical Staff member and the initiator of the disciplinary action process wish to make. They shall be apprised of their right to make such a response. At its sole discretion, the Board of Trustees or committee thereof may also consider new or additional information. If it does so, it shall share this information with the affected Medical Staff member, the initiator of the disciplinary action process, and the relevant Department Chair or Chief Medical Officer and give them the opportunity to respond.

If the Board of Trustees affirms the preliminary inquiry report and recommendations (or the report concerning alleged non-compliance with human subjects research pursuant to Section 7) or determines that another disciplinary action (other than one referred to in Section 10(c)) is warranted, or determines that no disciplinary action is warranted, the decision of the Board of Trustees shall be the final decision of the Hospital in this matter.

If the Board of Trustees or committee thereof recommends a disciplinary action referred to in Section 10(c), the Medical Staff member shall be given an opportunity to a hearing under Section 11. Prompt written notice of the decision of the Board of Trustees or the Board review committee shall be sent to the affected Medical Staff member, the Chief Medical Officer and the relevant Department Chair.

- (c) If the preliminary inquiry report (or the Chief Medical Officer based upon the report concerning alleged non-compliance in human subjects research pursuant to Section 7) recommends one or more of the following disciplinary actions, the Medical Staff member involved shall be given an opportunity for a hearing under Section 11:
- revocation or suspension of membership privileges;
 - restriction of privileges, provided that such recommended action is related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw.
- (d) Notwithstanding any provision in these Bylaws to the contrary, an applicant or staff member shall not be entitled to those procedures set forth in Sections 11 and 12 below with respect to a hearing or Board review except in such matters where (1) the preliminary inquiry report, the review pursuant to the Mass General Brigham Policy and Procedures for Handling Allegations of Research Misconduct as specified in Section 6, the Chief Medical Officer based upon the

report concerning alleged non-compliance in human subjects research pursuant to Section 7. or the Board of Trustees or committee thereof pursuant to Section 10 (b) has recommended one or more of the disciplinary actions specified in Section 10 (c) or (2) the denial or recommendation for denial of an application for appointment or reappointment has been made pursuant to Article III, Section 8, for reasons related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw.

SECTION 11: RIGHT TO HEARING

- (a) In any case where a disciplinary action referred to in Section 10 (c) is recommended or in the case of a denial or recommendation for denial of appointment or reappointment pursuant to Article III, Section 8, if the denial or recommendation for denial is related to professional competence or to a complaint or allegation regarding any violation of law, regulation or bylaw, the applicant or member shall be entitled to a hearing as described below.

The Chief Medical Officer shall give notice of the adverse recommendation or action to the applicant or member. This shall include a statement of the reason(s) for the recommendation or action, and a statement of the applicant or member's right to a hearing. The Chief Medical Officer shall also advise the applicant or member of his or her right to appear with legal counsel and right to introduce witnesses or evidence, subject to the limitations imposed pursuant to Section 8. The applicant or member shall have thirty (30) days from the date of said notification to request a hearing in writing.

- (b) If the applicant or member does not so request a hearing, the Board of Trustees shall review the adverse recommendation or action in accordance with the procedure set forth in Section 10 (b). The Board may provide for such review by a committee of the Board especially appointed for the purpose.

If the Board of Trustees or committee thereof wishes to propose a stricter disciplinary action, the applicant or member shall be given another opportunity to request a hearing pursuant to paragraph (a).

If no such stricter disciplinary action is proposed, the decision of the Board of Trustees or the Board review committee shall be final decision of the Hospital in the matter.

Within seven (7) days after the conclusion of the Board of Trustees or the Board review committee, it shall issue its decision in writing. A copy shall be sent to

the affected applicant or member, the Chief Medical Officer, and the relevant Department Chair.

- (c) If the applicant or member requests a hearing pursuant to paragraph (a), the committee before which the hearing shall be held shall consist of not fewer than three (3) persons, the majority of whom are peers of the affected applicant or member, appointed by the Chief Medical Officer, one of whom shall be the chair of the credentialing committee or his/her designee. One of the hearing committee members shall be designated Chair. No person who has actively participated in the initiation of the adverse recommendation or action shall be appointed to the hearing committee.
- (d) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The hearing committee shall consider such evidence as reasonable persons are accustomed to rely on in the conduct of serious affairs. The hearing committee may take notice of any general, technical, or scientific fact within the specialized knowledge of the committee, and shall decide all other procedural matters not specified herein.
- (e) The relevant Department Chair, committee or person whose adverse recommendation or action occasioned the hearing, or their designee, shall have the initial obligation to present evidence in support of the adverse recommendation or action. Thereafter, the applicant or member requesting the hearing shall have the burden of proving that adverse recommendation or action is unsupported by substantial evidence.
- (f) Within thirty (30) days after adjournment of the hearing, the hearing committee shall issue a written report of its findings of fact and recommendations to what disciplinary action, if any, should be taken by the Hospital. A copy shall be sent to the affected applicant or member, the Chief Medical Officer, the relevant Department Chair, and any other committee or person whose adverse recommendation or action occasioned the hearing.

SECTION 12: BOARD OF TRUSTEES REVIEW

The Board of Trustees shall review the matter. It may provide for such review by a committee of the Board especially appointed for the purpose. The Board of Trustees or committee thereof shall have available for its review the initial allegation of due cause for disciplinary action, the preliminary inquiry report and recommendations (or the report and recommendations prepared pursuant to Section 6 or Section 7 of this Article V as applicable) or in the case of denial of appointment

or reappointment, the application and other pertinent materials, the record of the hearing and the report of the hearing committee, as well as any written response which the affected applicant or member, the initiator of the disciplinary action process, and the relevant Department Chair or designee wish to make. These persons shall be notified of their right to make such a response. At its sole discretion, the Board of Trustees or Board review committee may also consider new or additional information. If it does so, it shall share this information with the affected applicant or member, the initiator of the disciplinary action process, and the relevant Department Chair or designee, and give them the opportunity to respond.

The Board of Trustees or Board review committee shall issue its decision in writing. A copy shall be sent to the affected applicant or member, the Chief Medical Officer, the relevant Department Chair, and any other committee or person whose adverse recommendation or action initiated the disciplinary process. It shall be the final decision of the Hospital in the matter.

SECTION 13: REPORTING OF DISCIPLINARY ACTIONS

The Hospital will comply with all statutory and regulatory requirements with respect to the reporting of disciplinary actions.

ARTICLE VI: MEDICAL STAFF HEALTH PROGRAM

SECTION 1: OBJECTIVES

The objectives of the Medical Staff Health Program (“Program”) are to (a) safeguard patients (b) to assist Medical Staff members in recovering from illness with the least interference with their ability to practice their profession consistent with patient safety; and (c) to satisfy the requirements of federal and state law.

SECTION 2: DEFINITION OF “AFFECTED MEDICAL STAFF MEMBER”

“Affected Medical Staff Member” is a Medical Staff member who has been deemed by a duly convened Health Status Committee on the basis of credible information or an admission, to be affected by a physical, mental or emotional illness, condition or disability and/or by drugs and/or alcohol which has or may potentially impair his or her ability to practice medicine, dentistry, chiropractic, psychology or podiatry as applicable, or to otherwise exercise his or her privileges or Medical Staff membership.

SECTION 3: THE PROGRAM

(a) Initiation.

Credible evidence or admission that a Medical Staff member is an Affected Medical Staff Member as defined in Section 2 should be brought to the Chief Medical Officer who will appoint and convene the Health Status Committee.

(b) Health Status Committee (“HSC”).

The HSC is a medical peer review committee and shall be composed of three or more members appointed by the Chief Medical Officer.

(c) The HSC will meet promptly to review the evidence and interview the Medical Staff member in question to determine whether evidence supports the conclusion that the practitioner is an Affected Medical Staff Member. The HSC shall have the authority to require an independent physical and/or psychiatric evaluation by an evaluator acceptable to both parties. Failure of the Medical Staff member to cooperate with the evaluation process shall be grounds for disciplinary action pursuant to Article V of these Bylaws. The evaluator’s findings shall be reported to the HSC.

(d) If the HSC finds no reasonable basis to conclude that the Medical Staff member is “affected”, the HSC shall report such findings to the Chief Medical Officer and the Medical Staff Member’s Department Chair who shall have the option of initiating the Disciplinary Action process pursuant to Article V, if appropriate. No further action or reporting will be undertaken by the HSC.

(e) If the HSC finds a reasonable basis to conclude that the Medical Staff member is “affected”, the HSC shall recommend that the Medical Staff member participate in the Program, and may recommend that the Medical Staff member take a leave of absence for the purpose of evaluation, treatment and counseling.

(f) Participation Recommendation Accepted.

If the Medical Staff member agrees to participate in the Program, the HSC will develop and recommend a remedial plan in consultation with the Medical Staff member as provided below. The findings, recommendations and actions of the HSC will not be used in a Disciplinary Action Process under Article V, so long as the Medical Staff member remains compliant with his or her remedial plan. Provided, however, the Hospital may be required to report certain aspects of the remedial plan to regulatory agencies and/or other entities. The Medical Staff

member shall be apprised of any potential reporting obligations prior to making a decision as to whether to participate in the Program.

(g) Participation Recommendation Rejected.

If the Medical Staff member refuses to participate in the Program, the HSC shall so notify the Chief Medical Officer and the Medical Staff Member's Department Chair, who, if appropriate, shall initiate the Disciplinary Action Process pursuant to Article V of these Bylaws. Failure of the Medical Staff member to respond within a reasonable time to a recommendation by the HSC for participation in the Program shall be construed as refusal to participate in the Program.

(h) Upon acceptance of the recommendation by the Medical Staff member to participate in the Program, the HSC shall develop a remedial plan in consultation with the Medical Staff member, and may revise the plan from time to time after consultation with the Medical Staff member. A remedial plan and any modifications to a remedial plan must be approved by the Chief Medical Officer and the Medical Staff Member's Department Chair.

(i) In addition to a leave of absence, a remedial plan may include, but is not limited to, counseling and treatment, urine screening or other surveillance for drug or alcohol use, voluntary curtailment or other change in clinical privileges, and the use of monitors, proctors, chaperones, or supervised practice.

(j) The HSC shall monitor the compliance of a Medical Staff member with the terms of the Staff member's remedial plan. The HSC may require, as part of its monitoring, that the Medical Staff member agree to communication between the HSC and the Medical Staff member's physician, therapist, or others as determined by the HSC. The HSC may condition the Medical Staff member's return from a leave of absence or other changes or modifications in the remedial plan upon an independent physical and/or psychiatric evaluation by an evaluator acceptable to both parties.

(k) The HSC may initiate a request for Disciplinary Action under Article V when a Medical Staff member fails or refuses to comply with the recommendation of leave or any provision of a remedial plan adopted by the HSC.

(l) The HSC will approve the termination of the Medical Staff member's participation in the Program once the Medical Staff member has demonstrated successful completion of the terms and conditions of his or her remedial plan

and current capacity to meet the qualifications, standards and requirements established in these Bylaws.

ARTICLE VII: PHYSICIANS' COUNCIL

SECTION 1: MEMBERSHIP

The Physicians' Council (the "Council"), a joint committee of the BWPO and the Medical Staff, shall include eighteen appointed representatives of the Medical Staff. The President of the BWPO or his/her designee and the Chief Medical Officer of the Hospital or his/her designee also shall serve, *ex officio*, as members of the Council.

SECTION 2: MEDICAL STAFF REPRESENTATION ON PHYSICIANS' COUNCIL; CO-CHAIRS; CO-CHAIR ELECT

- (a) The President of the BWPO and the Chief Medical Officer of the Hospital shall appoint (after consultation with the Department Chairs) one representative from the Active Staff of each Department of the Hospital (with the exception of the Department of Medicine which shall have three appointed representatives) to serve on the Council. In addition, the President of the BWPO and the Chief Medical Officer of the Hospital shall appoint one representative from the Affiliate Staff and one representative from the Brigham and Women's Private Staff Association to serve on the Council. (The Brigham and Women's Private Staff Association is an unincorporated association of physicians who are in private practice and hold appointments to the Hospital's Medical Staff). The President of the BWPO and the Chief Medical Officer of the Hospital shall review the membership on an annual basis, and make any changes that may be appropriate.
- (b) The President of the BWPO or his/her designee shall serve as Co-Chair of the Council on a permanent basis. The appointed representatives of the Medical Staff serving on the Council shall elect a Co-Chair and a Co-Chair Elect from among the Council's appointed membership. Both the Co-Chair and the Co-Chair Elect shall serve in such capacity for a term of two years. At the end of each two-year term, the Co-Chair Elect shall become Co-Chair and the appointed representatives of the Council shall elect a new Co-Chair Elect from among the Council's appointed membership.
- (c) In the event the elected Co-Chair is unable to complete his/her term, the Co-Chair Elect shall assume the position of Co-Chair, and shall serve for the balance of his/her predecessor's term, and then continue to serve as Co-Chair for the two-years for which he/she was elected. If such event should occur, the appointed

representatives of the Council will elect a new Co-Chair Elect from among the Council's appointed membership.

- (d) After the expiration of his/her term as Co-Chair, the Council member may seek election as Co-Chair Elect provided he or she remains as an appointed representative on the Council. The Co-Chair and Co-Chair Elect shall serve as the representative of his/her constituency while serving on the Council in these positions, and no additional representative from their constituencies shall be appointed during these terms.

SECTION 3: FUNCTIONS OF PHYSICIANS' COUNCIL

- (a) The elected Co-Chair of the Council and the Co-Chair Elect shall serve on the Medical Staff Executive Committee of the Hospital. The appointed representatives on the Council shall elect, by simple majority, one additional representative on the Council to serve on the Medical Staff Executive Committee. With the exception of the Co-Chair and Co-Chair Elect, appointed representatives to the Council shall serve for no more than two consecutive years on the Medical Staff Executive Committee.
- (b) The Council shall be responsible for developing programs and activities in support of the Medical Staff and the Hospital in such areas as leadership development, training, mentorship, staff recognition, community outreach and volunteerism, workplace standards, and work life issues.
- (c) The elected representative Co-Chair of the Council (or the Co-Chair Elect in the absence of the Co-Chair) shall call and preside at all meetings of the Medical Staff, including the Annual Meeting.

ARTICLE VIII: MEETINGS

SECTION 1: GENERAL MEETING OF THE MEDICAL STAFF

- (a) There shall be at least one general meeting of the Medical Staff each year, which shall be the Annual Meeting of the Medical Staff. It shall generally be in the fall. The elected Co-Chair of the Physicians' Council or the President of the BWPO shall preside.
- (b) Active and Affiliate Medical Staff members shall be notified of the time, place, and agenda at least three (3) weeks in advance.

- (c) Accurate and complete minutes including attendance of members shall be kept. Copies of minutes shall be filed with the Co-Chairs of the Physicians' Council.

SECTION 2: QUORUM AND VOTING

A quorum for purposes of a Regular or Special Meeting shall consist of a minimum of ten (10) percent of the Active and Affiliate Staff attending the meeting in person or by proxy or by casting a vote by electronic means. If there is a quorum, action may be taken by a majority of the Active and Affiliate Staff present in person or by proxy or who vote on the action by electronic means.

If vote is by electronic means, the affiliate staff will be given 21 days to review and cast their vote. The meeting will close 21 days from then when voting closes.

SECTION 3: SPECIAL MEETINGS

- (a) Special Meetings of the Medical Staff may be called at any time by the elected Co-Chair of the Physicians' Council at the request of the Board of Trustees, the Medical Staff Executive Committee, or any twenty-five (25) members of the Medical Staff. At any Special Meeting no business shall be transacted except the agenda items slated in the notice calling the meeting.
- (b) Written notice and agenda of such Special Meetings shall be given to all members of the Active and Affiliate Staff at least ten (10) days prior to the date set for the meeting.
- (c) Accurate and complete minutes including attendance of members shall be kept. Copies of minutes shall be filed with the Co-chairs of the Physicians' Council.

ARTICLE IX: COMMITTEES

SECTION 1: COMMITTEES OF THE MEDICAL STAFF

1.1 STANDING COMMITTEES

The Standing Committees of the Medical Staff include but are not limited to the following:

Executive
Quality Assurance/Risk Management

Medical Staff Credentialing
Cancer

1.2 OTHER COMMITTEES

The Medical Staff Executive Committee following consultation with the Chief Medical Officer may establish such other committees of the Medical Staff as it deems appropriate.

1.3 GENERAL PROVISIONS REGARDING MEDICAL STAFF COMMITTEES

Except as otherwise provided in these Bylaws, the following provisions shall apply to all Medical Staff Committees:

- (a) The Chair of each Department is generally expected to designate a Departmental representative for each committee. Other members of the Committee shall be appointed by the Chief Medical Officer. The majority of each Medical Staff Committee shall be composed of Members of the Medical Staff.
- (b) Except as otherwise provided in these Bylaws, a majority of members of any committee shall constitute a quorum thereof and if a quorum is present, a majority of the committee members eligible to vote and voting may take any action on its behalf.
- (c) References in this section to “members,” as to any committee having non-voting members, shall refer only to voting members.
- (d) A member of any Medical Staff Committee who neglects the exercise of their duties, including failure to attend meetings, may be removed by majority vote of that Medical Staff Committee membership. In every such case, the member shall have been given reasonable notice of the grounds for the removal and an opportunity to be heard.

1.4 MEDICAL STAFF EXECUTIVE COMMITTEE

- (a) The Medical Staff Executive Committee, a medical peer review committee, shall serve as the governing body for the Medical Staff and shall act for the Medical Staff in all professional matters pertaining to the Hospital, as further specified in the policies and procedures of the medical staff. The Medical Staff Executive Committee shall assess and implement recommendations from the Care Improvement Council (the

Patient Care Assessment Committee)as appropriate (described in further detail in Article X, below).

- (b) The Medical Staff Executive Committee shall consist of the Chief Medical Officer, one member of the Active or Affiliate Staff of each Department enumerated in Article II, Section 1 who has been selected by the Chair of the applicable Department in consultation with the Chief Medical Officer, the elected Co-chair, Co-Chair Elect and an elected representative from the Physicians' Council as described in Article VII, Section 2 above, the Vice President for Patient Care Services, and such other members as may be appointed by the Chief Medical Officer. The Departmental representatives shall serve for a three (3) year term with such term to be renewable at the discretion of the Department Chair and Chief Medical Officer.
- (c) The Chief Medical Officer shall appoint a physician from the Active Staff as Chair to preside at meetings and he/she shall become a voting member of the Committee. The elected Co-Chair of the Physicians' Council shall serve as Vice Chair of the Committee.
- (d) The Medical Staff Executive Committee shall meet monthly or as required. Minutes of all meetings shall be kept.
- (e) The Medical Staff Executive Committee shall participate in the credentialing procedures for new appointments and reappointments as provided in these Bylaws. The Medical Staff Executive Committee may vote to designate one or more of its members to act on its behalf with respect to credentialing matters in accordance with the provisions of Article III of these Bylaws.
- (f) Any member of the Active or Affiliate Medical Staff may, upon request, attend a meeting of the Medical Staff Executive Committee for the purpose of discussing a concern or any matter germane to the Hospital, or the Medical Staff Executive Committee may require the presence of a member if the agenda includes a topic in his or her area of concern. The Medical Staff shall have a process, set forth in Rules and Regulations to manage conflict between the Medical Staff and the Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in this process is intended to prevent Medical Staff members from communicating with the Board of Directors on a rule, regulation, or

policy adopted by the Medical Staff or the Executive Committee. The Board of Directors shall determine the method of communication.

1.5 MEDICAL STAFF CREDENTIALING COMMITTEE

The Medical Staff Credentialing Committee, a medical peer review committee, shall serve as the Medical Staff Credentialing Committee for both the Hospital and BWFH. It shall consist of at least one physician representative from each of the Hospital Departments appointed by the applicable Chair in consultation with the Chief Medical Officer, as well as appropriate representatives from BWFH and such other voting and non-voting members as may be appointed by the Hospital's Chief Medical Officer. In addition, the Committee shall include one physician assistant from the Hospital selected by the Chief Medical Officer, one nurse practicing in an expanded role from the Hospital selected by the Chief Nursing Officer, and one physician assistant or nurse practicing in an expanded role from BWFH selected by the BWFH Chief Medical Officer. The Chief Medical Officer shall appoint a physician from the Active Staff of the Hospital to serve as Chair to preside at the meetings and he/she shall become a voting member of the Committee. The Hospital's Chief Medical Officer shall also appoint a physician from the Active Staff of BWFH to serve as Vice Chair. This Committee shall review applications and make recommendations for appointments and reappointments, as provided in these Bylaws.

1.6 CANCER COMMITTEE

- (a) The Cancer Committee, a medical staff peer review committee, shall consist of representatives from Surgery, Medical Oncology, Radiology, Pathology, Nursing, Care Coordination, Quality Improvement and the Cancer Registry, and may include representatives from other Departments as appropriate.
- (b) The Cancer Committee shall meet quarterly or as needed. Minutes of all meetings shall be kept.
- (c) The Cancer Committee shall develop and evaluate annual goals and objectives for the clinical, educational and programmatic activities related to cancer; promote a coordinated, multidisciplinary approach to patient management; ensure educational and consultative cancer conferences covering all major sites and related issues; ensure an active, supportive care system is in place for patients, families and staff; perform quality improvement studies with focus on quality, access to care and outcomes; promote clinical research; oversee the Cancer Registry; conduct quality review of annual Cancer Registry data; encourage data usage and regular reporting; and report of its activities.

1.7 QUALITY ASSURANCE/RISK MANAGEMENT COMMITTEE

The Quality Assurance/Risk Management Committee, a medical peer review committee, shall consist of one representative from each Department who has been designated by the applicable Department Chair, a representative from each of Nursing, Pharmacy and the Transfusion Service, and representatives from other Hospital administrative departments, as appropriate. The Chief Medical Officer shall appoint a member of the Active Staff as Chair to preside over the meetings and he or she shall become a voting member of the Committee. The Chief Medical Officer shall also appoint a member of the Active Staff to serve as Vice Chair. The Committee shall review Department and case specific data related to quality assurance and risk management, and shall conduct medical peer review activities as defined in Article X, Section 5 (a).

SECTION 2: DEPARTMENT COMMITTEES

The Departments may appoint such Committees as they deem appropriate in their respective organization plans.

ARTICLE X: PATIENT CARE ASSESSMENT

SECTION 1: PATIENT CARE ASSESSMENT PROGRAM

The programs, policies and procedures existing throughout the Hospital which are designed to foster optimal patient care shall be known collectively as the Patient Care Assessment Program.

SECTION 2: CARE IMPROVEMENT COUNCIL

The Care Improvement Council a medical peer review committee established at the governing board level, is a joint committee of the Board of Trustees and the Medical Staff. It shall also be known as the Hospital's Patient Care Assessment Committee, and shall carry out the functions required of such a committee by the regulations of the Board of Registration in Medicine. It is responsible for the Patient Care Assessment Program. It shall include at least one trustee. It shall also consist of members of the Medical Staff, and administrators, including a high level nursing administrator, who are essential to the quality of patient care.

In addition to the functions otherwise specified in these Bylaws, the Care Improvement Council or others acting on its behalf shall establish the elements of the Patient Care Assessment Program.

SECTION 3: PATIENT CARE ASSESSMENT COORDINATOR

The Care Improvement Council shall also serve as the Patient Care Assessment Coordinator, as defined in the regulations of the Board of Registration in Medicine.

SECTION 4: PATIENT CARE ASSESSMENT PLAN

There shall be a written Patient Care Assessment Plan, approved by the Board of Trustees and filed with the Board of Registration in Medicine, which describes the policies and procedures constituting the Patient Care Assessment Program.

SECTION 5: MEDICAL PEER REVIEW COMMITTEE

- (a) The “medical peer review committees” of the Hospital include the Medical Staff Executive Committee , The Care improvement Council (the Patient Care Assessment Committee), and all other committees, agents of such committees or individuals charged under these Bylaws, policies and procedures or the Patient Care Assessment Plan with any responsibility for (1) the evaluation or improvement of the quality of health care rendered by providers, (2) the determination whether health care services were performed in compliance with applicable standards of care, (3) the determination whether the cost of health care services rendered was considered reasonable by the providers of health services in the area, (4) the determination whether the actions of a provider call into question his or her fitness to provide health care services, or (5) the evaluation and assistance of providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise. Without limiting the foregoing, the peer review activities conducted by the Department Chairs or their designees, shall be considered the activities of a medical peer review committee. All committees, agents and individuals designated as medical peer review committees hereunder shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act.
- (b) In 2012, the Hospital and BWFH through their respective Boards of Trustees/Directors along with the Board of Trustees of BWHC, agreed to a plan of closer clinical integration between the Hospital and BWFH. The goal of the increased clinical integration was to provide the appropriate level of care in the appropriate location for patients by creating a seamless patient experience across the Hospital and BWFH campuses. At the direction of the Boards of Trustees/Directors and with the approval of the Hospital and BWFH medical staffs, joint credentialing and quality activities were instituted to assist in effectuating the goals of this closer clinical integration. Toward this end, the “medical peer review committees” of the Hospital shall include the Medical

Staff Credentialing Committee, the Care Improvement Council and all other committees, agents of such committees, or individuals charged with any responsibilities for joint peer review activities conducted by the Hospital in concert with BWFH and pertaining to the functions set forth in subsection (a) above.

- (c) The proceedings, reports, records, findings, recommendations, evaluations, opinions, deliberations or other actions by a medical peer review committee in its discharge of the medical peer review functions set forth in subsection (a) above, and the identity of and information provided to such peer review committee by witnesses or any other individuals, shall be treated as confidential to the extent permitted by law and public regulations. This confidentiality shall not prevent or be waived by the transmission of necessary information to the Board of Trustees (or committees thereof) or to other committees or individuals within the Hospital to enable them to fulfill their responsibilities under the Patient Care Assessment Program or otherwise. Nor shall this confidentiality prevent or be waived by the transmission of information required by law or regulation, including responses to requests from other health care providers for information relevant to their credentialing activities.

SECTION 6: PROCEDURE FOR INVESTIGATION AND RESOLUTION OF REPORTS CONCERNING HEALTH CARE PROVIDERS

- (a) Reports made to the Hospital from whatever source, other than those pursuant to Article V, Section 3 or parallel disciplinary rules for other providers, concerning the conduct of any health care provider (“provider”) at the Hospital, including all members of the medical staff, medical students, and all other licensed health care providers, that allege incompetence in the provider’s specialty or conduct which might be inconsistent with or harmful to good patient care and safety, shall be brought to the attention of the Medical Staff Executive Committee, the Quality Assurance/Risk Management Committee, any other medical peer review committee, the respective Department Chair, the Chief Medical Officer, or the Director of Patient and Family Relations.
- (b) All reports, records, findings, recommendations, evaluations, or opinions received by any of the above committees or individuals pursuant to this Section shall be accorded the confidentiality provided by the Bylaws of the Medical Staff and the laws and regulations of Massachusetts for the records of a “medical peer review committee”.
- (c) Reports concerning providers who are not members of the Medical Staff

Reports concerning providers who are not members of the Medical Staff shall be investigated and resolved in accordance with the procedures described in the Patient Care Assessment Plan.

- (d) Reports concerning members of the Medical Staff except in the case of reports which are determined by the Director of Patient and Family Relations to lack sufficient basis to warrant further investigation, the Director of Patient and Family Relations shall promptly forward all written requests concerning any member of the Medical Staff to the Chief Medical Officer for inquiry, investigation if necessary, and resolution. The Director of Patient and Family Relations shall be advised of the resolution of the matter.

ARTICLE XI: POLICIES AND PROCEDURES

SECTION 1: GENERAL

The Medical Staff Executive Committee shall adopt such Policies and Procedures as may be necessary or desirable for the proper conduct of the work of the Medical Staff and are not inconsistent with the Charter and Bylaws of the Hospital and the Bylaws of the Medical Staff.

SECTION 2: MEDICAL HISTORY AND PHYSICAL EXAMINATION

A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days prior to or twenty-four (24) hours after hospital admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first. The medical history and physical examination must be completed and documented by a physician, dentist, oromaxillofacial surgeon, podiatrist, chiropractor or other qualified licensed individual in accordance with Massachusetts law and hospital policy.

SECTION 3: SUPERVISION OF TRAINEES

The Hospital shall have appropriate policies for the supervision of the House Staff, Clinical Fellows and Clinical and Research Fellows.

ARTICLE XII: AMENDMENTS

- (a) Amendments to these Bylaws shall become effective when approved by the Board of Trustees or committee thereof after adoption by the Medical Staff, at a Meeting of the Medical Staff. Adoption of amendments shall require a majority vote of the Active and Affiliate Staff members present in person or by

proxy or by casting a vote by electronic means at a duly called Medical Staff meeting, such meeting to be called no sooner than twenty-one (21) days following the date when notice of the proposed amendment(s) to the Bylaws was issued. Neither the Board of Trustees nor the Medical Staff may amend these Bylaws unilaterally.

- (b) These Bylaws shall be reviewed at least once every five (5) years by the Chief Medical Officer, and a Hospital attorney, who, after such review, shall propose amendments to the Bylaws as are appropriate.
- (c) Ten or more members of the Active and/or Affiliate Staff may together propose (1) an amendment or amendments to these Bylaws or (2) a new or revised policy or procedure to the Medical Staff Executive Committee, the Chief Medical Officer. Proposed amendments shall be considered at the next annual meeting of the Medical Staff. Proposed new or revised policies and procedures shall be considered in accordance with the Hospital's standard practice for review and adoption of such policies and procedures.

ARTICLE XIII: MISCELLANEOUS

SECTION 1: SEVERABILITY

The invalidation of one or more provisions of these Bylaws shall not affect the validity of all remaining provisions hereunder.

Approved by the Medical Staff on 10/2022 and the Board of Trustees on 3/2023.