COMMONWEALTH OF MASSACHUSETTS

BERKSHIRE, ss. SUPERIOR COURT
CIVIL ACTION NO._____

KATHLEEN M. SHERIDAN, M.D.,

Complainant

v.

BERKSHIRE HEALTH SYSTEMS, INC., BERKSHIRE FACULTY SERVICES, INC., and BERKSHIRE MEDICAL CENTER, INC.

Respondents

COMPLAINT AND DEMAND FOR JURY TRIAL

INTRODUCTION

This action arises from Dr. Kathleen Sheridan's ("Dr. Sheridan") employment with and separation from Berkshire Faculty Services, Inc. ("BFS"). Dr. Sheridan is a skilled and experienced obstetrician-gynecologist ("OB-GYN") who was assigned to work in the Maternal and Child Health department at Berkshire Medical Center ("BMC"). Dr. Sheridan performed an emergency C-section on a patient, whose newborn tragically died several days later (hereinafter referred to as the "Fatality Incident"), through no fault of Dr. Sheridan's. The Fatality Incident was a result of, *inter alia*, the negligent understaffing of the BMC (where no anesthesiologist was in house and where a quick C-section was impaired by lack of preparedness within the facility); a labor nurse's erroneous report to Dr. Sheridan of a patient's fetal monitoring status; and BFS's failure to properly train labor nurses in patient monitoring, despite Dr. Sheridan's urging. To cover up its gross negligence, BFS inappropriately, misleadingly, and disingenuously

MD

capitalized on the Fatality Incident to summarily suspend Dr. Sheridan's clinical privileges, to subject her to a number of bad-faith investigations, and ultimately to terminate her employment. This negligence not only resulted in the tragic death of the newborn, but had the potential to negatively impact the entire community that BFS serves.

BFS's failure to follow appropriate protocols was not limited to its care of pregnant women and their babies, but also extended to ignoring the U.S. Center for Disease Control's ("CDC") guidelines related to COVID-19. Dr. Sheridan reported BMC's failure to follow CDC COVID-19 guidelines, and shortly thereafter her employment was terminated on the pretext of the Fatality Incident, without even a meaningful investigation. As will be further detailed below, the suspension of Dr. Sheridan's clinical privileges, the ensuing external peer review, her subsequent termination, the internal peer reviews, the investigation by the *ad hoc* committee, and the ultimate reversal of her suspension of privileges by the Medical Executive Committee ("MEC") after nine months of internal and external peer reviews, were fraught with irregularities and bad faith. The facts illustrate that BFS, BMC and Berkshire Health Systems ("BHS"), through their agents, intentionally put Dr. Sheridan through a flawed review process to cover up their own disregard for patient safety and to retaliate against Dr. Sheridan for reporting that BMC and other BFS facilities were not in compliance with CDC COVID-19 guidelines. The flawed review process, the retaliatory termination of Dr. Sheridan's employment, and the undue scrutiny levied on Dr. Sheridan as a result of Defendants' conduct have impaired Dr. Sheridan's career and livelihood.

PARTIES

1. Plaintiff, Kathleen Sheridan, M.D., is an individual who resides in Cummington, Massachusetts.

2. Defendant, Berkshire Health Systems, Inc. is a tax-exempt charitable organization with a principal place of business at 725 North Street, Pittsfield, MA 01201. Berkshire Health Systems ("BHS") controls affiliated hospitals, including Berkshire Medical Center and Fairview Hospital, and is also the parent organization of Berkshire Faculty Services.

3. Defendant, Berkshire Faculty Services, Inc., is a Massachusetts corporation with a principal place of business at 725 North Street, Pittsfield, MA 01201. Defendant Berkshire Faculty Services ("BFS") is a faculty practice organization, supporting the medical education and medical service activities of Berkshire Medical Center Inc.

4. Defendant, Berkshire Medical Center, Inc. ("BMC") is a Massachusetts corporation with a principal place of business at 725 North Street, Pittsfield, MA 01201.

JURISDICTION AND VENUE

5. Pursuant to M.G.L. c. 212, § 3, this Court has jurisdiction over this action, as damages are expected to exceed $50,000.

6. Venue is appropriate in Berkshire County pursuant M.G.L. c. 223, § 1 because (a) the actions and omissions underlying Plaintiff's claims took place in Berkshire County and (b) the parties have acknowledged by prior written agreement that Berkshire County is the appropriate venue for claims arising out of Dr. Sheridan's claims.

FACTS

7. Dr. Sheridan is an accomplished obstetrician-gynecologist with more than twenty (20) years of professional experience. To highlight only a few of Dr. Sheridan's many professional accomplishments; she was appointed to the board of the Berkshire Fallon Health Collaborative in 2021 as the representative of the OB-GYN service line. Dr. Sheridan has also been actively involved in advocating for the treatment of pregnant women with opioid use

disorders, and was the Medical Director of a $300,000 grant approved by the Massachusetts Health Policy Commission to Berkshire Medical Center for the Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns investment program.

8. In February of 2017, Dr. Sheridan was hired by Berkshire Faculty Services, Inc. as a physician specializing in obstetrics and gynecology, to work in the Maternal and Child Health department of Berkshire Medical Center.

9. Accordingly, on February 18, 2017, Dr. Sheridan executed a Physician Employment Agreement with BFS (the "Agreement"), attached hereto as **Exhibit A**.

10. In pertinent part, the Agreement required that 180 days' notice be given in the event BFS chose to terminate Dr. Sheridan without cause.

11. During her employment with BFS, Dr. Sheridan was never subjected to a formal practice evaluation, which is a typical step taken when the hospital has concerns about a clinician.

12. Dr. Sheridan is highly skilled and educated in interpreting fetal tracing, and had previously received advanced training in the interpretation of fetal monitoring during continuing education courses taught by pre-eminent experts on this topic.

13. As such, shortly after being hired by BFS, Dr. Sheridan spoke with the nursing director of the Mother Baby Unit at BMC, Melissa Canata, R.N., and offered to provide the nurses with training on fetal heart monitoring.

14. In response, the nursing director informed Dr. Sheridan that the nurses were well trained, and explained that they did not offer any didactic training on-site to nurses.

15. As Dr. Sheridan was recognized as a skilled and experienced physician, on or about January 21, 2021 she was appointed by Dr. Lauren Slater, the department chair, as Vice Chair of BMC's OB-GYN department.

The Fatality Incident

16. On July 26, 2021, Dr. Sheridan performed an unplanned, medically necessary, emergency C-section on a patient that resulted in the birth of an anoxic newborn, resuscitation, and ultimately the death of the newborn five days after birth.

17. The Fatality Incident triggered a series of events as described in further detail infra, including the summary suspension of Dr. Sheridan's clinical privileges, an outside review of the Fatality Incident, the termination of her employment by BFS, an internal peer review, an investigation by an ad hoc committee, and corrective action by the MEC.

18. The Fatality Incident commenced on July 26, 2021, when a pregnant patient presented to BMC, as she was experiencing contractions. This patient had previously been scheduled for induction of labor on July 27, 2021. Upon presentation, the patient was placed on an external fetal monitor at approximately 6:00 p.m.

19. The patient was evaluated by the Certified Nurse Midwife ("CNM") on duty. The CNM evaluated the patient and identified the patient's fetal heart tracing ("FHT") as a category 2. At approximately 7:30 p.m., Dr. Sheridan was called by the CNM to review the tracing.

20. Dr. Sheridan and the CNM then made the plan to admit the patient and take initial measures to resolve the category 2 FHT, and at approximately 8 p.m., the FHT was documented as a category 1 for the first time; being the expected result of the treatment planned and provided by Dr. Sheridan and the CNM. The decision was made to continue with the previously

established plan to induce labor the following morning, on July 27, 2021. Around 8 p.m. on July 26, 2021, the CNM's work shift ended, and care of the patient was transferred to Dr. Sheridan.

21. Upon knowledge and belief, as well as Dr. Sheridan's expertise on this topic, FHT's are statistically likely to improve; however, a persistent category 2 FHT tracing could require that a cesarean delivery be performed. As such, a plan was put in place to observe for improvement in the patient's FHT's.

22. During this time, Dr. Sheridan was involved in a variety of tasks including taking patient calls and evaluating new patients.

23. As is common practice in the field, Dr. Sheridan was relying on the labor nurse to observe the patient and to alert her to any observations that could indicate potential issues with the pregnancy. Particularly relevant to the current matter, Dr. Sheridan was relying on the labor nurse to monitor and interpret FHTs and to alert her if the category 2 tracing persisted.

24. During a discussion between Dr. Sheridan and the labor nurse during dinner break, the labor nurse reported that the patient's FHT's were normal. This was consistent with the nurses charting in the patient's medical record.

25. The report by the labor nurse constituted a fundamental error in that she incorrectly reported to Dr. Sheridan that the patient's FHT's were at a category 1 level, instead of a category 2 level; the latter would have resulted in further follow-up by Dr. Sheridan.

26. Accordingly, it was only later discovered that the FHT did indicate problems with the pregnancy such that an unscheduled C-section needed to be performed. The necessity to deliver the baby on an emergency basis was first realized later in the evening, around 9:30 p.m., while Dr. Sheridan was standing at the nursing station and observed that the patient had undergone a terminal bradycardia event.

27. As a result, Dr. Sheridan immediately performed a cervical exam and began to prepare to perform an emergency C-section. At the time, there was no anesthesiologist or emergency operating room team in house at BMC. Thus, Dr. Sheridan had no choice but to prepare to perform an unassisted C-section initially, and to prepare the patient using local anesthesia.

28. Later, at approximately 9:58 p.m., the anesthesiologist arrived and placed the patient under general anesthesia. The C-section was performed at approximately 10:00 p.m., and the baby was delivered and subsequently transferred to Baystate Medical Center. Five days after birth, the newborn tragically passed.

29. Upon information and belief, and counter to standard protocol for BMC and hospitals nationwide, no staff debrief was held in the immediate aftermath of the Fatality Incident. Rather, a meeting was held days later during which the blame for the Fatality Incident was immediately put on Dr. Sheridan, in violation of hospital protocol and before any actual investigation had taken place.

30. Of note, and as will be further highlighted infra, there were a variety of factors that contributed to the Fatality Incident and that are completely independent of Dr. Sheridan's actions, to wit:

(a) There was no emergency operating team on staff during the hours of 5 p.m.-11 p.m. (the period during which the emergency C-Section occurred, and the time frame widely considered to comprise the highest volume of emergency surgeries nationally);

(b) There was no anesthesiologist in the hospital at the time of the incident;

(c) The nurses at BMC were not properly trained to interpret FHT's (despite Dr. Sheridan's urging), and

(d) There was no effective system for alerting emergency operating room staff to report to BMC in the case of a potential emergency.

31. The lack of an effective alert system increased the time frame from "decision to incision," i.e. the critical time between the determination that a C-section is required and the time it is actually performed.

32. Despite these institutional deficiencies, amongst others, Dr. Sheridan has suffered the brunt of the blame for the Fatality Incident.

The Flawed Investigations and Review Process

33. On or about August 3, 2021, Dr. Sheridan received a letter from Michael McInerney ("Dr. McInerney"), the Chief of Staff for BMC, informing her that her clinical privileges at BMC and all associated clinics were being summarily suspended effective immediately, pending the outcome of an investigation into the Fatality Incident. That letter is attached hereto as **Exhibit B**.

34. For contextual purposes, summary suspensions of clinical privileges are normally undertaken only in extreme situations, and rarely in response to a single event.

35. Indeed, summary suspension is a drastic measure taken very rarely a result of a single incident, but is instead usually instituted as a precautionary response that takes into consideration the longitudinal performance of a clinician in determining whether a clinician is an immediate danger to their patients.

36. Yet upon information and belief, Dr. Sheridan's clinical privileges were summarily suspended inappropriately based almost entirely on the Fatality Incident.

37. To further illustrate the inappropriateness of this action, during Dr. Sheridan's long tenure with BMC, she has undergone numerous performance evaluations that generally concluded she was performing adequately, and that otherwise did not indicate that there were any significant issues with her practice as an OB-GYN or in her other roles.

38. As such, there was no indication that Dr. Sheridan was not performing her duties adequately.

39. Indeed, upon information and belief, there is no data to suggest that Dr. Sheridan had overseen a disproportionate number of adverse outcomes compared to her colleagues at BMC.

40. Similarly, there is no data to suggest that Dr. Sheridan was an outlier in respect to the average number of C-Sections she performed compared to her colleagues at the time of the Fatality Incident.

41. The typical industry standard in terms of reviewing disciplinary action such as summary suspension is that such reviews are to be conducted by the peers of the individual being disciplined, as they are best situated to report on that individual's capabilities, strengths, and weaknesses.

42. In early August of 2021, Dr. Sheridan's colleagues met with Dr. Lederer and Dr. McInerney and expressed their disagreement with the decision to summarily suspend Dr. Sheridan's privileges.

43. On or about August 12, 2021, a letter was written to Dr. Lederer and Dr. McInerney by Dr. Benner, on behalf of Dr. Sheridan's colleagues, expressing their concern over the summary suspension of Dr. Sheridan's clinical privileges.

44. On August 13, 2021, as recorded in a voicemail to Dr. Sheridan, Dr. Lederer stated that a report of the incident was first being sent to an external peer review company for evaluation.

45. As such, the first investigative measure taken as a result of the Fatality Incident was in the form of an external review performed by Dr. Erin Huffman, an outside OB-GYN, on or about August 16, 2021.

46. Upon information and belief, Dr. Huffman was only provided with Dr. Sheridan's notes and the fetal tracing data; she was not provided with any nursing documentation related to the Fatality Incident for review. Furthermore, Dr. Huffman did not attempt to speak with Dr. Sheridan about the Fatality Incident.

47. Of note, there is no guidance or standard in the BMC's Medical Staff By-Laws that addresses external reviews in the context of a summary suspension of privileges or otherwise.

48. BMC seized on this unnecessary, insubstantial, and faulty outside review to serve as a basis for the decision made by Dr. McInerney, Dr. Lederer, and Dr. Slater, to continue the summary suspension of Dr. Sheridan's clinical privileges.

49. Shockingly, on or about September 3, 2021, after the external review and before any formal peer review process was conducted into the Fatality Incident, Dr. Sheridan received a letter, from Dr. Lederer, informing her that her employment with BFS was terminated, effective immediately. That letter is attached hereto as **Exhibit C**.

50. Dr. Lederer's termination letter is rife with egregious and unfounded allegations, insinuations, and unwarranted and unprofessional statements. Perhaps most offensively, in the letter Dr. Lederer appears to hold Dr. Sheridan solely responsible for two (2) neonatal deaths that

presumably occurred under her supervision. Without providing any additional foundation for these serious allegations, Dr. Lederer stated that these deaths "raise questions about [Dr. Sheridan's] professional judgment and episodes of concern among [her] clinical colleagues that prompt similar questions."

51. In this termination letter, Dr. Lederer goes on to accuse Dr. Sheridan of failing to work well with her colleagues, failing to adhere to good clinical practices, and generally constituting a serious risk to patient safety and well-being. Astoundingly, although Dr. Sheridan's termination was being categorized as not-for-cause, Dr. Lederer informed Dr. Sheridan that BFS was not adhering to Section 2.1 of the Agreement, which would require BFS to give 180 days' notice of its intent to terminate the relationship on a not-for-cause basis; instead, he stated, "BFS has concluded, however, that patient safety and clinical team collaboration require that your employment by BFS **end immediately**" (emphasis added).

52. Upon information and belief, Dr. Lederer terminated Dr. Sheridan prior to conducting an internal peer process and without following applicable procedures pertaining to corrective actions as set forth in Article VII of the Medical Staff By-Laws. Berkshire Medical Center's Medical Staff By-Laws are attached hereto as **Exhibit D.**

53. Upon information and belief, there is no documentation to substantiate any of the reasons cited for terminating Dr. Sheridan: that her clinical colleagues had concerns about her professional judgment; that she was failing to work well with her colleagues; that she was failing to adhere to good clinical practice; and that she otherwise constituted a serious risk to patient safety and well-being.

54. Rather, as is discussed throughout this Complaint, the available evidence appears to contradict every stated reason for BMC's decision.

55. Dr. Sheridan was both respected and trusted by her colleagues, as evidenced by their support following both her promotion to vice chair of the OB-GYN department and the subsequent summary suspension of her privileges. She was never subject to a formal practice evaluation as a result of her "failing to adhere to good clinical privileges," and in fact, all of her standard clinical reviews indicated she was performing adequately. She was not a risk to patient safety and well-being; objectively, the number of adverse outcomes under her supervision was statistically in-line with those of her colleagues, and in some instances, lower than those of the individuals tasked with reviewing her.

56. After issuance of the outside review of the incident and after Dr. Sheridan's employment with BHS had been formally terminated, peer review meetings were conducted to review the incident. As will be further detailed infra, Dr. Lederer was allowed to participate in the internal review process despite Dr. Sheridan's realistic concerns, as noted to Attorney Rogers, that Dr. Lederer may have a negative bias towards her that would contaminate the peer review process.

57. Upon information and belief, no obstetricians participated in BMC's peer review committee considering the Fatality Incident.

58. Additionally, Dr. Sheridan was not provided an opportunity to speak with the internal peer review committee to discuss the Fatality Incident until on or about October 28, 2021.

59. On or about November 2, 2021, a meeting of the MEC was held to hear Dr. Sheridan's appeal of her initial summary suspension. After that meeting, the MEC voted to proceed with considering Dr. Sheridan's continued medical staff privileges and the possibility of

corrective action, thereby rejecting Dr. Sheridan's request to revoke the summary suspension of her privileges.

60. As a result of the MEC's decision to proceed with consideration of corrective action, an *ad hoc* committee was formed on or about December 8, 2021, to generally further investigate the incident and to make recommendations as to any necessary corrective action.

61. In a letter from John Loiodice, M.D., Chief of Staff for BMC, Dr. Sheridan was informed that the *ad hoc* committee had concluded their investigation and that the MEC voted on May 2, 2022, to end the summary suspension of her clinical privileges, effective that same day.

62. However, the ending of the suspension of Dr. Sheridan's clinical privileges came with a caveat put in place by the MEC should she choose to renew her hospital privileges at BMC. The decision outlined a "Plan for the Future" that Dr. Sheridan must commit to should she elect to exercise her clinical privileges at BMC. A copy of the letter received from John Loiodice that includes the details of the Committee's decision and the "Plan for the Future" is attached hereto as **Exhibit E**.

63. The "Plan for the Future" was to include, at a minimum and at Dr. Sheridan's expense, the oversight by a board-certified OB-GYN of: (a) all OB-GYN cases for which patients select her for their care and (b) the completion, to the satisfaction of the Medical Executive Committee, of a course of training by the Association of Women's Health, Obstetric and Neonatal Nurses ("AWHONN") alliance related to management of women in labor.

64. Upon information and belief, the recommendation that Dr. Sheridan participate in a "Plan for the Future" resulted largely from remarks made by Dr. Slater and Dr. Kantor regarding her skills and decision-making, which she was provided no opportunity to refute.

Whistleblowing

65. In March of 2021, BHS received over $5 million in federal funds in response to the COVID-19 pandemic. Upon information and belief, parts of these federal funds were to be allocated to operate a COVID-19 call center to serve all of Berkshire County, where BMC is located.

66. Of note, BFS is the only health system organization in Berkshire County and therefore plays a significant public health role for all of Berkshire County.

67. In July of 2021, the director of the CDC held a press conference that highlighted the new CDC guidelines with respect to COVID-19. In particular, the CDC updated their guidelines to state that those who had received a COVID-19 vaccine should be tested if they had been exposed to someone with COVID; whereas previously the CDC had recommended that vaccinated individuals should get tested only if they developed symptoms.

68. Upon information and belief, Dr. Lederer was in part tasked with implementing the new CDC guidelines as they pertained to the COVID call center/hotline, and otherwise for Berkshire County.

69. On or about August 26, 2021, while investigations into the Fatality Incident were ongoing and her clinical privileges remained suspended, Dr. Sheridan sent an email to Dr. Lederer, in which she, accurately and in good faith, reported that the COVID hotline that covered all of Berkshire County was not in compliance with the new CDC guidelines.

70. Indeed, Dr. Sheridan had been exposed to COVID-19 on or about August 24, 2021, but was refused when she contacted Berkshire County's COVID hotline in order to arrange to be tested.

71. Upon information and belief, BHS failed to implement CDC guidelines until approximately four (4) weeks after they had been issued, and only after Dr. Sheridan reported the issue to Dr. Lederer.

72. By the time the new recommendations were implemented, Berkshire County had gone from having among the lowest rates of COVID cases in the state, to having one of the highest rates of COVID infections in Massachusetts.

73. Dr. Sheridan was aware that Dr. Lederer had made appearances in front of members of the United States Congress to discuss the COVID pandemic, and that upon information and belief, these appearances had played a role in the federal grant being awarded to BHS. Truly. Dr. Lederer was both the hospital spokesperson for and considered to be a local community expert on the COVID-19 pandemic.

74. As such, Dr. Sheridan had concerns that BHS's non-compliance with current COVID-19 CDC guidelines as reported by her to Dr. Lederer would be a source of personal humiliation for him, and could result in other backlash against him. Dr. Sheridan chose to report the error to Dr. Lederer personally and confidentially as she believed that doing so was the best way to ensure the hotline's compliance error, and the potential resulting harm to the community, would be promptly addressed.

75. On September 3, 2021, approximately one week after Dr. Sheridan contacted Dr. Lederer to report the COVID-19 hotline's noncompliance with CDC guidelines, she received a letter from Dr. Lederer terminating the Agreement and her employment with BFS.

76. Upon information and belief, Dr. Lederer terminated Dr. Sheridan as a result of her reporting to him that BHS was not in compliance with CDC guidelines, and the termination

was unrelated to the unfounded reasons that were set forth in the termination letter as described supra.

77. Given these concerns, Dr. Sheridan reached out to BMC's attorney, John Rogers, to request that Dr. Lederer not be part of the peer review process as she feared he would be unable to serve as an unbiased evaluator. Not only were her concerns ignored, but she was accused by Attorney Rogers of making defamatory statements concerning Dr. Lederer.

Aftermath and Continued Impact

78. As a result of the Fatality Incident, members of the Quality and Patient Safety Committee for the Board of Registration in Medicine ("BORIM") met with BMC on or about April 7, 2022, to learn more about BMC's Patient Care Assessment program.

79. Further illustrating BMC's inadequacies, BORIM concluded that there had been a decrease in the reporting of Safety and Quality Review reports submitted by BMC to the Quality and Patient Safety Division.

80. Additionally, in the wake of the Fatality Incident, BMC required all labor nurses, CNMs and MDs to take a course with AWHONN on interpreting fetal monitoring.

81. That BMC required this training following the Fatality Incident further indicated that BMC realized that their nurses had not been properly trained to interpret FHTs.

Impact on Dr. Sheridan

82. Understandably, given the unfair treatment and invasive investigative process Dr. Sheridan was put through following the Fatality Incident, Dr. Sheridan did not have an interest in returning to work for BMC.

83. Furthermore, that Dr. Sheridan would have to comply with BMC's "Plan for the Future" if she wanted to return to work at BMC only added insult to injury, as it became clear

that the Fatality Incident was not a result of her own professional errors, but rather representative of numerous deficiencies in BMC's protocols, staffing, and overall operation.

84. Desiring to move on from BMC and continue her career in a new position, Dr. Sheridan began looking for new employment.

85. However, as a result of the numerous investigations into Dr. Sheridan's involvement in the Fatality Incident, Dr. Sheridan has been unfairly hampered in her attempts to find gainful employment.

86. Dr. Sheridan has experienced significant delays in board licensure and has otherwise been passed over as a candidate for roles she is well qualified to perform. Truly, had BHS opted to retract the "Plan for the Future" language unjustifiably included in the letter terminating Dr. Sheridan's summary suspension, her licensure and employment options would have improved dramatically.

87. Furthermore, should Dr. Sheridan apply for a license to practice in another state, she will have not only have to disclose to the relevant medical board that she had her clinical privileges unjustly summarily suspended, but also that the MEC baselessly decided that she would be required to participate in a "Plan for the Future" should she want to renew her clinical privileges at BMC. The chilling effect this has had on Dr. Sheridan's ability to get licensed in other states should she choose to cannot be understated, and has effectually limited her to practicing in states where she is already licensed; Massachusetts and Pennsylvania.

88. Upon information and belief, Dr. Sheridan has otherwise passed the interview processes for nine (9) different positions since leaving BMC, but was withdrawn from consideration after hiring manager's followed up with BMC regarding Dr. Sheridan, or after

credentialing leaders at their respective institutions informally advised against presenting her for credentialing.

89. By way of example, Dr. Sheridan was offered a highly desirable position as Medical Director of Women's Health at Davis Medical Center in Elkins, West Virginia. On February 3, 2022, Dr. Sheridan signed a contract for the position, which included a base salary of $364,440, a medical director fee of $50,000, and a recruitment incentive of $50,000.

90. Dr. Sheridan was scheduled to begin her new position at Davis Medical Center on April 24, 2022. To prepare, she completed all of the insurance and hospital credential applications, and applied for a license in West Virginia.

91. However, during a meeting held on March 14, 2022, the West Virginia Board of Medicine decided to defer Dr. Sheridan's application until they were able to receive and review the *ad hoc* committee report concerning the Fatality Incident.

92. Although the ad hoc committee had completed their investigation, Dr. Sheridan had not yet been provided with the report, as the BFS bylaws state that she would receive it after the MEC vote, such that she was not able to provide the report immediately to the West Virginia Board of Medicine.

93. Due to the delay in acquiring the ad hoc committee report, and as the West Virginia Board of Medicine considers applications on a bi-monthly basis, the next such meeting was on May 14, 2022. In the interim, on or about April 25, 2022, Davis Medical Center made the decision to withdraw their offer of employment. Upon information and belief, the Davis Medical Center has since filled that position.

94. Additionally, Dr. Sheridan was planning to apply for a $100,000 student loan forgiveness program related to providing opioid treatment for pregnant women if offered the position at Davis Medical Center.

95. Ultimately Dr. Sheridan decided to withdraw her application for a license with the West Virginia Board of Medicine given the delays in receiving the required documentation from BMC.

96. Dr. Sheridan also interviewed with Cooley Dickinson Hospital, located in Northampton MA, and was transparent during the interview process about what had transpired at BMC and her summary suspension.

97. As part of the hiring process, Dr. Sheridan was required to list Dr. Slater as a reference, as she was the chair of the department Dr. Sheridan worked under up until her termination.

98. Upon information and belief, Dr. Slater provided a negative reference to Cooley Dickinson Hospital, and as a result, Dr. Sheridan was not offered a position.

99. On or about April 4, 2022, Dr. Sheridan signed a contract to work as a Laborist at Geisinger Wyoming Valley Medical Center ("Geisinger") in Wilkes-Barre, PA. However, this position represents a substantial change in circumstances that negatively impacts Dr. Sheridan's livelihood. The position requires that Dr. Sheridan travel to the Geisinger hospital in Pennsylvania from her home in Cummington, MA.

100. Dr. Sheridan's contract with Geisinger does not stipulate any number of shifts per month, leaving Dr. Sheridan with no certainty as to her income. Furthermore, her employment start date was pushed back from the originally planned date of May 9, 2022, as a result of the

delay in resolving her summary suspension. Dr. Sheridan began work at Geisinger on the newly assigned date of June 20, 2022, after being unemployed for 291 days.

101. The disingenuous, unwarranted, and deceitful blame that BHS, BFS, and BMC have subjected Dr. Sheridan to has not only had a significant negative impact on her career, employment opportunities, and financial situation, but has taken a significant toll on her mental health.

102. The additional stress resulting from her termination has also negatively impacted Dr. Sheridan's physical health. By way of example, Dr. Sheridan was diagnosed with bruxism, a condition in which an individual unconsciously grinds their teeth and clenches their jaw, and for which her dentist has since fitted her with a bite guard. Dr. Sheridan was diagnosed with bruxism following her termination, and had never experienced bruxism prior to the trauma of being terminated.

103. Furthermore, Dr. Sheridan is the primary earner in her family, and the resulting loss of income has had a devastating effect not just on her but on her family, including her husband, who suffers from significant medical conditions.

104. Currently, Dr. Sheridan remains employed by Geisinger Wyoming Valley Hospital, where she has worked since June of 2022. However, given that she must travel from Massachusetts to Pennsylvania to work, she only averages six shifts per month at Geisinger Hospital. Taking into consideration her husband's medical condition and other variables, it was not realistic for her to move to Pennsylvania in the hope of receiving more shifts at Geisinger at the time she began working there. However, due to mounting financial concerns, Dr. Sheridan is now in the process of selling the home that her and her husband have shared and had planned to live in for the rest of their lives, in order to move to Pennsylvania for work.

COUNT I – VIOLATION OF M.G.L. c. 149 § 187

(Against all Defendants)

105. Dr. Sheridan incorporates by reference in their entirety all previous and subsequent paragraphs of this Complaint.

106. At all relevant times, Dr. Sheridan was a health care provider as defined in Mass. General Laws c. 149 § 187.

107. At all relevant times, Defendants BFS, BHS, and BMC were healthcare facilities as defined in Mass. General Laws c. 149 § 187.

108. At all relevant times, Defendants, acting through Dr. Lederer, had the authority to take corrective action regarding COVID-19 protocols set forth by the CDC that were applicable to Berkshire County hospitals, including BMC.

109. Dr. Sheridan had reported to Dr. Lederer that BMC was not in compliance with certain CDC guidelines regarding COVID, which led to BMC having to take corrective action.

110. For the reasons stated in this Complaint, Dr. Sheridan asserts that she was terminated in retaliation for reporting this matter to Dr. Lederer.

111. The actions of Defendants were unlawful and in violation of G.L. c. 149 § 187. Defendants are responsible for the actions of Dr. Lederer in violation of this statute.

112. As a direct result of the violation of G.L. c. 149 § 187, Dr. Sheridan suffered damages in an amount to be proven at trial.

113. Defendants are liable for the damages they have caused and continue to cause.

COUNT II - BREACH OF CONTRACT

(Against Berkshire Faculty Services)

114. Dr. Sheridan incorporates by reference in their entirety all previous and subsequent paragraphs of this Complaint.

115. On or about February 18, 2017, Dr. Sheridan and BFS entered into a valid and legally binding Employment Agreement.

116. Under section 2.1 of the Employment Agreement, either party to the Agreement may terminate the relation on a not-for-cause basis on 180 days' notice.

117. On or about September 3, 2021, Dr. Sheridan received a letter from Dr. Lederer informing her that she was being terminated, effective immediately, based on a variety of unsubstantiated and patently false allegations as discussed supra.

118. BFS did not provide any advance notice to Dr. Sheridan of her termination, but rather sought to circumvent the 180-day notice requirement by relying on falsities and in the absence of a reasonable, thorough investigation.

119. In doing so, BFS breached its Agreement with Dr. Sheridan.

120. BFS' breach of the Agreement caused Dr. Sheridan to suffer substantial economic losses, including, but not limited to, lost pay and benefits, and substantial non-economic losses as well.

COUNT III - BREACH OF IMPLIED COVENANT
OF GOOD FAITH & FAIR DEALING

(Against all Defendants)

121. Dr. Sheridan incorporates by reference in their entirety all previous and subsequent paragraphs of this Complaint.

122. Implied in every contract in the Commonwealth of Massachusetts is the covenant that all parties will deal with one another fairly and in good faith and that neither party will do anything to materially interfere with the performances of the other party so as to have the effect

of destroying or injuring the right(s) of that party to receive the benefit(s) to which she is entitled under the contract.

123. BHS, BFS, and BMC willfully and materially breached the implied covenant of good faith and fair dealing when they disregarded, without any substantial and requisite justification, the Agreement's provision requiring that 180 days' notice be provided to terminate the Agreement.

124. Defendants also willfully and materially breached the implied covenant of good faith and fair dealing when they terminated Dr. Sheridan prior to conducting any internal peer review process, and truly, without following any of the policies pertaining to corrective action as stated in the Medical Staff By-Laws.

125. Additionally, contrary to the reasons stated in the termination later, Defendants terminated Dr. Sheridan in bad faith for reporting that BMC was not in compliance with current CDC guidelines.

126. As evidence therefore, Dr. Sheridan was terminated prior to any internal peer review investigations into the Fatality Incident. Indeed, Dr. Sheridan was terminated approximately a week after reporting to Dr. Lederer that Defendants were not in compliance with certain CDC COVID guidelines.

127. Defendants' breach of the implied covenant of good faith and fair dealing caused Dr. Sheridan to experience substantial losses, including, but not limited to, loss of pay and benefits.

COUNT IV - NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

(Against all Defendants)

128. Dr. Sheridan incorporates by reference in their entirety all previous and subsequent paragraphs of this Complaint.

129. The negligent acts set forth above are directly attributable to the Defendants.

130. Those negligent acts by the Defendants that occurred after her termination, including but not limited to: the internal peer reviews; the investigation by the *ad hoc* committee; the ultimate reversal of her suspension of privileges by the Medical Executive Committee; and the requirement that she participate in the "Plan for the Future" should she choose to renew her clinical privileges, have caused Dr. Sheridan emotional distress.

131. As a result of Defendants' conduct that occurred after having terminated her, Dr. Sheridan suffered physical symptoms of her emotional distress which any reasonable person would have suffered under the same circumstances.

132. The Defendants are liable for the damages they have caused and continues to cause.

COUNT V - TORTIOUS INTERFERENCE WITH PROSPECTIVE ECONOMIC ADVANTAGE

(Against all Defendants)

133. Dr. Sheridan incorporates by reference in their entirety all previous and subsequent paragraphs of this Complaint.

134. Defendants have interfered with the prospective contractual and advantageous relationship between Dr. Sheridan and numerous potential employers, including but not limited to Davis Medical Center.

135. Defendants had knowledge of the prospective contractual and advantageous relationships between Dr. Sheridan and various prospective employers.

136. With improper purpose and means, these Defendants acted in bad faith and knowingly and intentionally interfered with, and prevented Dr. Sheridan from proceeding with and benefitting from, relationships with potential employers.

137. Dr. Sheridan has been damaged by this interference as described above, as she has lost income, lost goodwill, and has suffered a negative impact to her reputation.

138. Defendants are liable for the damages they have caused and continue to cause.

PRAYER FOR RELIEF

Plaintiff Kathleen Sheridan respectfully requests that this Honorable Court award judgment in her favor and against the Defendants, jointly and severally, for the following relief:

1. Compensatory damages;
2. Punitive damages;
3. Attorneys' fees;
4. Costs of this action;
5. Pre-judgment and post-judgment interest, and
6. Such further relief as this Court deems just and proper.

JURY DEMAND

Plaintiff Kathleen Sheridan hereby demands a trial by jury on every claim so triable.

Respectfully submitted,

PLAINTIFF KATHLEEN SHERIDAN, M.D.,
Plaintiff,

By Her Attorneys,

Dated: May 9, 2023

/s/ Eric R. LeBlanc

Eric R. LeBlanc (BBO# 666786)
eleblanc@bennettandbelfort.com
Eric R. Lassar (BBO# 710036)
elassar@bennetandbelfort.com
Bennett & Belfort, P.C.
24 Thorndike Street, Suite 300
Cambridge, MA 02141
(617) 577-8800

EXHIBIT A

PHYSICIAN EMPLOYMENT AGREEMENT

AGREEMENT (this "Agreement") dated as of February 18, 2017 between BERKSHIRE FACULTY SERVICES, INC., a Massachusetts charitable corporation having a principal place of business in Pittsfield, Massachusetts ("BFS"), and KATHLEEN M. SHERIDAN, M.D. of Durham, Maine ("Physician").

PRELIMINARY STATEMENT

BFS is a faculty practice organization, supporting the medical education and medical service activities of Berkshire Medical Center, Inc., a teaching hospital with facilities in Pittsfield and North Adams, Massachusetts ("BMC"), and Fairview Hospital in Great Barrington, Massachusetts ("Fairview"; BMC and Fairview are sometimes collectively referred to herein as the "Hospitals"), each of which is a tax-exempt charitable organization. The Hospitals are controlled affiliates of Berkshire Health Systems, Inc. ("BHS"), a tax-exempt charitable organization, which is also the parent organization of BFS. Each of the Hospitals maintains Departments of Surgery and Medicine (collectively, the "Departments") that include a variety of specialties, the availability and effectiveness of which are essential to the quality of patient care services rendered by the Hospitals and their staffs. The Hospitals provide for some or all of the physician staffing and administration of the Departments through an arrangement with BFS.

Physician (a) holds or as of the Commencement Date (as defined in Section 2) shall hold, a full and unrestricted license to practice medicine in the Commonwealth of Massachusetts with a specialty in obstetrics and gynecology ("Physician's Specialty"), and (b) is skilled in the delivery of direct patient care, assistance in the administration and management of services Physician's Specialty, and the education of physicians, other health care professionals, and the community in matters related thereto.

BFS desires to employ Physician to provide the Physician's Specialty services described herein, and Physician desires to accept such employment. This Agreement sets forth the terms and conditions on which Physician shall be so employed by BFS.

AGREEMENT

IT IS THEREFORE AGREED AS FOLLOWS:

1. Scope; Duties.

1.1 BFS hereby employs Physician to provide services and Physician hereby agrees to be employed to provide those services as more specifically set forth herein and in Exhibit A attached hereto ("Physician Services") and upon the terms and conditions set forth in this Agreement.

1.2 During the Term (as defined in Section 2), Physician shall devote Physician's professional attention and skills and best professional efforts to Physician's

employment with BFS on a full-time basis (or, if otherwise set forth in Exhibit A, a part-time basis). Physician shall actively and industriously pursue Physician's profession in BFS's interest and shall carefully avoid any and all personal acts, habits and usages that might injure in any significant way, directly or indirectly, Physician's professional reputation, the professional reputation of BFS, the Hospitals or any affiliate or any employee of BFS or the Hospitals.

1.3 Physician (a) shall abide by all conflict of interest policies of BFS and entities affiliated with BFS and (b) shall not, without the prior written consent of the Chief Executive Officer of BHS or his or her designee (the "BHS President"), (i) engage (1) in professional activities other than those contemplated herein or (2) as an owner or investor in any entity that competes with the operations of BFS or the Hospitals or any affiliate of BFS or the Hospitals, (ii) render services to or receive payment from patients other than patients of BFS, or (iii) engage in any other activities that may interfere with Physician's obligations hereunder. Nothing contained in this Section 1.3 shall restrict or prohibit Physician from (a) personally and on Physician's own account investing in stock, bonds, securities, commodities, real estate and/or other forms of investment; (b) subject to applicable laws and regulations, providing medical services to (i) members of Physician's family or (ii) members or clients of charitable organizations; and (c) with prior notice to the BHS President, writing medical articles or appearing on medical-related radio or television programs or engaging in other professional activities such as teaching, research, consulting, and developing patents, practices and procedures for treatment of patients (collectively, the activities referred to in clause (c) are referred to as "Outside Activities"), provided that such Outside Activities shall not conflict with Physician's duties under this Agreement, as determined by the BHS President. Physician has indicated a desire to perform occasional locum tenens work for third parties during periods of time that she is not obligated to perform Physician Services under this Agreement ("Occasional Locums Work"). BFS shall entertain permitting such Occasional Locums Work provided that (a) Physician make her request for permission to perform Occasional Locums Work at least ten (10) days in advance of the proposed date of such Occasional Locums Work, (b) that such request identify the nature and location of the proposed Occasional Locums Work, (c) that such Occasional Locums Work occur on no more than 14 days during a calendar year and (d) that Physician is deemed to authorize BFS to deduct from any monies owed to Physician (including Base Salary and Incentive Compensation) the incremental cost, if any, of Physician's liability coverage resulting from such Occasional Locums Work. Physician shall only engage in Occasional Locums Work that the BFS Leader and the Division Chief have, in their sole discretion, expressly authorized in writing, after taking into consideration the then current patient care needs and the then current requirements for orderly management of the Division.

1.4 Physician's schedule to evaluate and treat patients at the practice site(s) designated by BFS (the "Clinical Site(s)") shall be established and modified by BFS based on the needs of patients, future changes in health care reimbursement and business strategies.

1.5 Physician shall evaluate and, if appropriate, treat all patients assigned to Physician by BFS. During the Term, all patients treated or examined by Physician (including those patients who wish to engage Physician personally) in connection with Physician's duties

and responsibilities hereunder shall be considered patients of BFS. In providing Physician Services hereunder, Physician agrees to serve all patients regardless of insurance status, ability to pay or other financial circumstances.

2. Term. The term (the "Term") of employment hereunder shall commence on May 1, 2017 or such other date as the parties shall agree in writing (the "Commencement Date") and thereafter shall automatically renew for successive terms of one year, unless sooner terminated as follows:

2.1 Except as otherwise set forth on Exhibit A, 180 days after written notice by either party to the other, with or without cause.

2.2 15 days after written notice by either party that the other shall have committed a substantial breach of this Agreement (except as to any breach that provides grounds for immediate termination as provided in Section 2.3 below), unless such breach shall have been cured to the terminating party's satisfaction within such 15-day period.

2.3 Immediately upon written notice by BFS upon the happening of any one of the following:

2.3.1 Suspension, revocation, limitation, withdrawal or surrender of Physician's (a) license to practice medicine in the Commonwealth of Massachusetts or any other jurisdiction, or (b) controlled substances registration issued by the Massachusetts Department of Public Health, the United States Drug Enforcement Administration or any other governmental agency ("License Suspension").

2.3.2 Physician shall have engaged in any gross misconduct or illegal activity as determined by (a) the Peer Review Committee of one of the Hospitals, (b) the Board of Registration in Medicine, or (c) a court of law.

2.3.3 Resignation or removal of Physician from the medical staff of one of the Hospitals ("Medical Staff") or other termination of Physician's Medical Staff membership.

2.3.4 Summary suspension (a "Summary Suspension Termination") of all or any portion of Physician's clinical privileges pursuant to the Medical Staff By-Laws of one of the Hospitals (as amended from time to time, the "Medical Staff By-Laws").

2.3.5 An Adverse Recommendation by the Medical Executive Committee or an Adverse Action by the Board of Trustees with respect to all or any portion of Physician's clinical privileges pursuant to the Medical Staff By-Laws (as such terms are defined by such Medical Staff By-Laws).

2.3.6 Physician shall die or become Permanently Disabled (as defined in Section 7.2).

2.3.7 Suspension, revocation, limitation, withdrawal or surrender of any of the Necessary Work Permits (as defined in Section 4.7).

Upon expiration or termination of this Agreement, for whatever reason, neither party shall have any further obligation hereunder except for (a) obligations accruing prior to the date of expiration or termination, and (b) obligations and covenants contained herein that are expressly stated to or reasonably intended to survive beyond the expiration or termination of this Agreement, including without limitation, those set forth in Sections 6, 10 and 11 hereof.

3. Compensation; Benefits.

3.1 Subject to Physician's performance of his or her duties and obligations under this Agreement, beginning as of the Commencement Date through the end of the Term, BFS shall (a) pay Physician as set forth in Exhibit B attached hereto, (b) provide benefits to Physician as set forth in Exhibit B-1, and (c) reimburse Physician for work-related expenses. Such compensation, benefits and reimbursements shall be paid in accordance with BFS's standard policies, which policies are subject to change from time to time at the sole discretion of BFS upon written notice to Physician. BFS shall use best efforts to notify Physician at least 60 days prior to any such modification.

3.2 BFS shall withhold amounts from Physician's compensation in accordance with the requirements of applicable federal and state law.

4. Qualifications. As a condition of Physician's providing services and receiving compensation under this Agreement, Physician represents and covenants to BFS that, at all times during the Term, Physician shall:

4.1 Be certified or eligible for certification by a board recognized by the American Boards of Medical Specialties, Inc. in Physician's Specialty. If Physician shall only be board eligible on the Commencement Date, Physician shall, during the Term, make such progress toward board certification as shall be required by the BMC Medical Staff By-Laws.

4.2 Be, and remain, a participating provider in the Medicare and Medicaid programs, other federal and state reimbursement programs, Blue Cross/Blue Shield, and the payment plan of any commercial insurer, health maintenance organization, preferred provider organization or other health benefit program with which BFS may contract, affiliate or otherwise agree to provide services (each a "Health Plan" and collectively, the "Health Plans").

4.3 Possess a valid and unlimited license to practice Physician's Specialty under the laws of the Commonwealth of Massachusetts, which license shall have not been suspended, revoked or restricted in any manner.

4.4 Possess valid controlled substances registrations issued by the appropriate federal and state governmental agencies, which registrations shall have not been surrendered, suspended, revoked or restricted in any manner.

4.5 Maintain in good standing membership on the Medical Staff of those of the Hospitals that BFS shall require Physician to obtain membership, as dictated by the category of appointment required of Physician, and comply with the Medical Staff By-Laws. The

application, appointment and reappointment to the Medical Staff and the granting of privileges shall be determined solely as provided by the Medical Staff By-Laws and applicable federal and state laws and regulations. Except to the extent that the terms of the Medical Staff By-Laws are expressly incorporated into this Agreement by reference, the Medical Staff By-Laws shall not govern the construction, performance or enforcement of the terms of this Agreement. Nothing in this Agreement shall constitute any assurance by BFS that Physician shall receive or retain Medical Staff membership or clinical privileges at either of the Hospitals.

4.6 Disclose in writing to BFS the existence, as of the Commencement Date, of all ownership interests in, or compensation arrangements with, any health care entity or enterprise (collectively, "Outside Interests") of Physician and members of Physician's family, including Physician's spouse, domestic partner, minor/dependent children and other persons living in Physician's household. Following the Commencement Date, Physician shall disclose Outside Interests (a) when they shall arise and (b) upon the request of BFS.

4.7 To the extent applicable, have full and complete authorization under the immigration laws of the United States to perform the duties set forth in this Agreement and maintain all necessary visas, permits and approvals (collectively, the "Necessary Work Permits") from the United States Citizenship and Immigration Services Bureau of the Department of Homeland Security. Except for those costs that Physician may be legally required to pay (if any), BFS shall pay or reimburse Physician for the costs associated with securing the Necessary Work Permits.

5. Standards of Practice.

5.1 Physician shall provide professional services to patients in a competent and professional manner, consistent with the quality assurance standards of BFS and the Hospitals and the currently accepted and approved practices and standards applicable to Physician's Specialty.

5.2 Physician shall perform Physician's duties under this Agreement in accordance with the standards of professional ethics of the American Medical Association, as amended; applicable local, state and federal laws, rules and regulations; applicable standards of The Joint Commission; and applicable bylaws, policies, rules and guidelines of BFS, the Hospitals and the Medical Staff, including, without limitation, those rules that pertain to the timely completion of medical records and other required reports.

5.3 Physician shall participate in quality improvement/quality assurance activities of the Medical Staff, BFS, the Hospitals or pursuant to any third-party payer contracts as well as other activities related to monitoring and improving the delivery of patient care (e.g., electronic medical records initiatives) as directed by BFS. As a condition of Medical Staff membership and employment under this Agreement, Physician shall fulfill all responsibilities required of members of the Medical Staff.

5.4 BFS shall be entitled to exercise direction and control over (a) the financial operation of Physician Services hereunder and (b) the development, amendment and implementation of standards, policies and record-keeping protocols, which shall be developed

in consultation with Physician and other physicians employed by in the Division, but BFS shall not unreasonably or unlawfully restrict the medical judgment of Physician or the customary physician-patient relationship with respect to patients attended by Physician.

6. Payments for Professional Services; Billing.

6.1 All payments due on account of professional services rendered by Physician under this Agreement during the Term shall belong and be remitted to BFS. Physician (a) hereby irrevocably assigns and grants to BFS all of Physician's rights, if any, to all such payments and (b) shall (i) execute such forms of assignment as BFS may request from time to time and (ii) promptly pay over to BFS any such payments received by Physician. Any violation of this Section 6.1 by Physician shall constitute a substantial breach of this Agreement. The provisions of this Section 6.1 shall survive the termination (for whatever reason) of this Agreement.

6.2 All fees for professional services rendered by Physician shall be set by BFS. Physician shall not make any adjustment in any such fees except with the prior written consent of the BHS President.

6.3 Physician shall keep and maintain (or cause to be kept and maintained) appropriate records relating to all professional services rendered by Physician under this Agreement, including such records as shall be, in the judgment of the BHS President, necessary to comply with federal, state or Health Plan requirements for reimbursement for Physician's professional services hereunder. Physician shall prepare and complete all documentation related to billings, records, reports, claims, and correspondence, in the form and manner required by BFS, all of which documentation shall belong to BFS and shall be used by BFS, without limitation, to collect the fees attributable to the services rendered by Physician.

6.4 BFS shall perform on behalf of Physician all of the billing, collection, accounting and management functions necessary to collect the fees attributable to the services rendered by Physician. All such bills, fees and payments from any source shall be payable directly to BFS. Physician shall cooperate fully with BFS in collecting such amounts, including endorsement and delivery of all checks received from patients or third-party payers on behalf of Physician and completion of all such collections.

6.5 Physician shall comply in all material respects with BFS's and the Hospitals' policies and requirements regarding billing, collection, accounting and management functions for services provided by Physician, including but not limited to attendance at educational sessions, timely completion of documentation in the appropriate form and content, and timely adherence to third-party billing rules. Physician's failure to properly discharge in any material respect these billing, collection, accounting and management functions shall constitute a substantial breach of this Agreement.

6.6 Physician shall execute such agreements or other documents as shall be, in the judgment of the BHS President, necessary to comply with federal, state or Health Plan requirements for reimbursement for Physician's professional services hereunder. Physician

hereby acknowledges that some Health Plans may require that Physician be personally bound by the terms and conditions of the agreements between Health Plan and BFS, and Physician hereby grants BFS the authority to bind Physician thereunder. Under no circumstances shall Physician, without the express written consent of the BHS President, (a) independently enter into contracts or affiliations with any Health Plan for any medical or surgical services or (b) bill any Health Plan for such services provided to patients.

6.7 Upon termination of this Agreement for any reason, all accounts receivable for services rendered by Physician hereunder through the effective date of such termination shall be the sole and exclusive property of BFS and shall not be subject to any claim by Physician.

7. Disability.

7.1 Physician shall be deemed "Temporarily Disabled" if Physician shall be unable, as a result of physical or mental illness, accident or, at the election of BFS, License Suspension or Summary Suspension Termination, to perform Physician's duties hereunder in accordance with Physician's work commitment as set forth on Exhibit A.

7.2 Physician shall be deemed "Permanently Disabled" or to have suffered "Permanent Disability" if (a) Physician and BFS shall agree that Physician is permanently disabled, (b) Physician shall be Temporarily Disabled for six consecutive months or non-consecutive periods aggregating 40 weeks in any 60 consecutive weeks, or (c) Physician shall qualify for payments for total and permanent disability under any applicable disability income insurance policy covering Physician or from the U.S. Social Security Administration.

7.3 All successive periods of disability (whether Physician shall be Temporarily Disabled or Permanently Disabled during such period) shall be deemed a single period of disability unless separated by at least six months of service in accordance with Physician's work commitment as set forth on Exhibit A.

8. Professional Liability Coverage. BFS shall provide professional liability coverage at no cost to Physician for all activities directly related to services provided under this Agreement. BFS shall have the right to elect to provide such coverage either through a commercial carrier authorized to do business in Massachusetts or through a BHS program of indemnification and self-insurance. In either event, coverage provided shall have the features of a professional liability policy written on an occurrence-like professional liability insurance policy, (a) providing coverage for claims arising during the term of Physician's employment and including a built-in reporting tail feature that shall provide coverage for such claims not asserted until after termination of Physician's employment, but (b) shall be subject to Physician's reasonable cooperation in the litigation and defense of matters relating to Physician and such coverage. The limits of such coverage shall be not less than $1,000,000 per each covered event and $3,000,000 in the aggregate for any coverage year.

9. Facilities; Practice Activity Reports.

9.1 Facilities. BFS shall, at its sole expense, provide to Physician such practice space, equipment, computer services, supplies and personnel (including technicians, nurses and office staff) as shall be reasonably necessary for Physician to provide Physician Services under this Agreement. Physician shall use Physician's professionally reasonable efforts to render Physician Services in a cost-effective and efficient manner and in accordance with BFS's annual expense budget.

9.2 Practice Activity Reports. At Physician's request, BFS shall make available to Physician monthly and annual practice activity reports (including billing and receipts and wRVU information) and shall do so, to the extent reasonably practicable, by the 15th day following the close of each month and by the 45th day following the close of each fiscal year.

10. Confidentiality; Medical Records; HIPAA. After the Term and in accordance with, and solely to the extent allowed by, applicable federal and state law and regulations, including but not limited to the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), BFS shall make available to Physician (or to Physician's executors, administrators, heirs) copies of any medical records relating to patients whom the Physician has treated during the term of this Agreement if (a) BFS shall have received an acceptable medical records release signed by the patient (or patient representative) authorizing such disclosure; (b) Physician shall have a bona fide need for such records to satisfy an audit or other inquiry conducted by any third-party payer, governmental agency, quasi-governmental agency or accrediting agency; or (c) Physician or Physician's professional liability or other coverage carrier shall request such records relative to litigation or threatened litigation involving Physician.

11. Proprietary Information.

11.1 In the course of Physician's employment by BFS, Physician will have access to certain lists, files, records, correspondence and notes, in written, audio, or machine-readable form, relating to patient care and other business activities of BFS or the Hospitals, certain of which materials may be confidential and/or otherwise proprietary ("Proprietary Information").

11.2 BFS shall have the complete right to possession, use and title to all Proprietary Information which Physician may originate during the Term within Physician's scope of employment under this Agreement, and Physician agrees to promptly disclose and deliver such Proprietary Information to BFS. Except as otherwise provided herein, Physician shall not, during the Term, or thereafter, disclose, directly or indirectly, any confidential Proprietary Information to any person, other than to (a) BFS, the Hospitals or their authorized agents or employees, (b) such other persons to whom Physician has been specifically instructed to make disclosure by an officer of BFS, (c) Physician or Physician's professional liability insurance or other coverage carrier that shall request such records relative to litigation or

threatened litigation or pursuant to an order or other proper request from a regulatory or other government agency with authority over Physician or a payment source with respect to Physician's practice, and (d) in all such cases only to the extent required or permitted by law; provided, however, that such obligation not to disclose shall not extend to any records, data or information that are in the public domain before or during the period of Physician's employment, provided that the same are not in the public domain as a consequence of disclosure directly or indirectly by Physician in violation of this Agreement. At the expiration or termination of the Term, Physician shall deliver to BFS all Proprietary Information which is then in the possession or control of Physician. Physician shall not retain or use any copies of summaries of such information; provided, however, Physician shall have the right of access to such Proprietary Information as set forth in Section 10 hereof.

11.3 Physician acknowledges that any breach of the provisions of this Section 11 is likely to result in serious and irreparable injury to BFS and the Hospitals and that the remedy at law alone will be wholly inadequate for such breach. Therefore, in addition to any other remedy available, BFS and the Hospitals shall be entitled to specific performance of this Agreement by Physician and to seek both temporary and permanent injunctive relief (to the extent permitted by law) without the necessity of proving actual damages.

11.4 Nothing in this Section 11 shall be construed to prevent appropriate patient access to the patient's own medical record.

12. No Conflicts; Compliance with Law. Neither Physician nor BFS intends that any payments made under this Agreement shall be in return for the referral of ongoing business, if any, or in return for the purchasing, leasing, or ordering of any services other than the specific services described in this Agreement. All payments specified in this Agreement are consistent with what the parties reasonably believe to be a fair market value for the services provided.

13. Notices. Any notice, approval, consent or other communication under this Agreement shall be in writing and shall be considered given when (1) delivered personally, or (2) mailed by registered or certified mail, return receipt requested, or (3) transmitted by facsimile with a confirming copy sent by overnight mail or courier service to the parties at the addresses indicated below (or at such other address as a party may specify by notice to the others pursuant hereto). Notice given by a party's counsel shall be considered notice given by that party.

If to BFS, to it at:

Berkshire Faculty Services, Inc.
725 North Street
Pittsfield, MA 01201
Attention: Ruth Blodgett, Interim Vice President for Physician Services

If to Physician, to Physician at:

152 Grant Road
Durham, ME 04222

In each case, with a copy to:

John F. Rogers, Vice President and General Counsel
Berkshire Health Systems, Inc.
725 North Street
Pittsfield, MA 01201

and

Bruce D. Armon, Esq.
Saul Ewing LLP
1500 Market Street, 38th Floor
Centre Square West
Philadelphia, PA 19102

14. No Waiver. No delay or omission by either party in exercising any right under this Agreement shall operate as a waiver of that or any other right. Any waiver by either party of any right or remedy under this Agreement shall be limited to the specific instance and shall not constitute a waiver of such right or remedy in the future.

15. Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof. This Agreement specifically revokes and supersedes any and all other agreements, whether oral, written, or otherwise, between Physician and BFS, relating to the subject matter covered herein, that are not expressly incorporated herein by reference.

16. Binding Effect; Assignment. This Agreement shall be binding upon and inure to the benefit of the parties, their heirs, legal representatives, successors and legal assigns and shall not be assignable by either party, except that BFS may assign this Agreement and its rights hereunder to its parent, or an affiliate or subsidiary thereof.

17. Amendment / Modification. This Agreement may be amended or modified only upon written agreement, signed by the parties hereto.

18. Severability. If any provision of this Agreement shall be deemed invalid or unenforceable by any court having jurisdiction thereon, the balance of this Agreement shall remain in full force and effect. If any provision of this Agreement shall be deemed by any such court to be unenforceable because such provision shall be too broad in scope, such provision shall be construed to be limited in scope to the extent such court shall deem

necessary to make it enforceable. If any provision of this Agreement shall be deemed inapplicable to any person or circumstance by any such court, it shall nevertheless be construed to apply to all other persons and circumstances.

19. Governing Law; Venue. This Agreement shall be governed by and construed in accordance with the substantive law of the Commonwealth of Massachusetts, without giving effect to the conflicts or choice of law provisions of Massachusetts or any other jurisdiction, and shall have the effect of a sealed instrument. The parties agree that any and all actions hereunder shall be brought exclusively in the federal or state courts located within the Commonwealth of Massachusetts.

20. Headings; Exhibits; Conflicts. The section captions used in this Agreement are included solely for convenience and shall not affect nor be used in conjunction with the interpretation of this Agreement. All exhibits attached to this Agreement are made a part hereof and are expressly incorporated herein by reference. In the event of a conflict between the provisions of this Agreement and any exhibit attached hereto, the provisions of the exhibit shall control.

21. Further Action. Each of the parties shall hereafter execute and deliver such further instruments and do such further acts and things as may be required or useful to carry out the intent and purpose of this Agreement and as are consistent with the terms hereof.

22. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall constitute an original and together shall constitute one instrument.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement under seal as of the day and year first above written.

BERKSHIRE FACULTY SERVICES, INC.

By _____
Darlene Rodowicz, Chief Financial Officer

PHYSICIAN:

_____ MD
KATHLEEN M. SHERIDAN, M.D.

EXHIBIT A TO PHYSICIAN EMPLOYMENT AGREEMENT DATED AS OF FEBRUARY 1, 2017 (the "Agreement") BETWEEN BERKSHIRE FACULTY SERVICES, INC. ("BFS") and KATHLEEN M. SHERIDAN, M.D. ("Physician")

PROFESSIONAL SERVICES TO BE RENDERED BY PHYSICIAN ("Physician Services")

Position Title (if any):	N/A
Physician's Specialty:	Obstetrics / Gynecology
BMC Department:	Maternal / Child Health
BFS Division:	Obstetrics / Gynecology
Reports To:	Department Chairperson/Division Chief or designee (for clinical practice oversight) and the BFS senior administrative executive ("BFS Leader") (for contractual, administrative and operational matters)
Initial Clinical Site(s):	Existing Division practice locations (collectively, the "Practice Site")

1. WORK COMMITMENT; PRACTICE SCHEDULE

1.1. Physician shall provide Physician Services, consisting of direct patient care services (including documentation and other administrative work associated with such services ("Clinical Services") on a full-time basis. Unless and until otherwise agreed in writing, Physician shall, on an annualized basis, provide Clinical Services approximately 40 hours per week (approximately 36 hours of which shall consist of direct patient care and approximately 4 hours of which shall consist of charting and payment for such care) during usual practice hours, as determined by the BFS Leader and the Division Chief, in consultation with Physician ("Customary Practice Hours"). Physician shall provide on-call coverage for Clinical Services for patients of the Division after Customary Practice Hours pursuant to an on-call schedule for the Division (the "On-Call Schedule") which shall (a) be determined by the BFS Leader and Division Chief, in consultation with Physician and other physicians in the Division and (b) provide for coverage for services within the Division seven days a week and twenty-four hours a day.

1.2. Physician shall participate equitably with the other physicians in the Division in an On-Call Schedule in Physician's Specialty at BMC that will provide for on-call coverage year round, seven days a week. The On-Call Schedule shall not require Physician, however, to be on-call more frequently than one night in four and one weekend in four during more than six months of any year or more frequently than one night in five and one weekend in five over the entire course of any year. In the event that, in order to provide on-call coverage in Physician's Specialty year round, seven days a week, BFS would require a one night and one weekend in four for more than six months in any year, BFS shall supplement the

On-Call Schedule with locum tenens physicians, offer Physician a fair market value stipend for excess call responsibility or both.

1.3. Unless and until agreed to in writing otherwise by the BFS Leader and the Division Chief on behalf of the physicians in the Division, weekday call shall begin at 7:30 a.m. and end the following morning at 7:30 a.m.; non-weekend holiday call shall begin at 7:30 a.m. on the holiday and end at 7:30 a.m. the following day and weekend call shall begin at 7:30 a.m. Saturday and end at 7:30 a.m. on Monday.

1.4. Subject to the limitations set forth in this paragraph, Physician shall accept, at any time during the Term, the transfer of her employment to Community Health Programs, Inc., Great Barrington, Massachusetts, a federally qualified health center, providing a range of community health services throughout Berkshire County ("CHP"). Physician's obligation to accept transfer of her employment to CHP shall be subject to (a) the provision of 90-days advance written notice from BFS of its election to effectuate the transfer to CHP and (b) execution of an employment agreement with CHP on substantially the same terms and conditions as set forth in this Agreement, with the economic value of the compensation and benefits being the same as set forth in this Agreement (the "CHP Transfer").

2. LEAVE TIME REQUESTS

2.1. In order to assure sufficient and appropriate coverage for Physician's Specialty services in the Division, prior to the beginning of each calendar year of the Term, Physician shall submit a proposed schedule of anticipated leave for such calendar year to the Division Chief and the BFS Leader for written approval. Subject to the staffing requirements of the Division, and provided that Physician shall be entitled to such leave time, the requested leave shall be approved.

3. TERMINATION

3.1 Except as provided in this section, in no event shall BFS or Physician be entitled to give notice of termination of Physician's employment pursuant to Section 2.1 of the Agreement prior to 180 days following the Commencement Date.

3.2 Physician shall have the right to give notice of Early Termination as described in this Exhibit B in the event of a CHP Transfer.

3.3 In the event that, during the Term, Physician desires to adjust her work commitment (a) to less than full-time (a "Time Adjustment") or (b) to include only gynecological services (or otherwise limit the services she has historically provided (a "Service Adjustment"), Physician shall give BFS written notice of that desire and her proposed adjusted work commitment 180 days in advance in the case of a Time Adjustment and 365-days in advance in the case of a Service Adjustment. After consultation with Physician, the Chairman of the Department and the Division Chief, the BFS Leader shall propose the terms and conditions, if any, upon which BFS shall agree to such an adjusted work commitment. In responding to a request for an adjusted work commitment, the BFS Leader shall take into

consideration, among other things, (a) the needs of the patient population served by the Division, (b) the length and quality of service that Physician has provided to the community and will be able to continue to provide with an adjusted work commitment; (c) the additional burden (e.g., patient volume and call responsibilities), if any, that the adjusted work commitment would place on the other physicians assigned to the Division; (d) the impact that the adjusted work commitment would have on any physician recruiting plans for the Division; and (e) the amount of fixed costs that would be associated with the adjusted work commitment (e.g., space and staff support).

4. DUTIES AND RESPONSIBILITIES

4.1. Clinical Duties

To provide all clinical duties within the scope of Physician's Specialty, the Medical Staff By-laws and BFS's reasonable expectations, including, but not limited to, the following:

4.1.1. Coordination and delivery of professional care to patients presenting for Physician's Specialty evaluation or treatment.

4.1.2. Keeping and maintaining (or causing to be kept and maintained) appropriate records relating to all direct patient care services rendered by Physician ("Direct Patient Care Services") and preparing all necessary reports and correspondence relating thereto, all of which shall remain the property of BFS.

4.1.3. In connection with all Direct Patient Care Services rendered by Physician, timely completing all required medical records, chart entries, registration information, transcription and documentation necessary to assure appropriate continuity and quality of care.

4.1.4. Completing and submitting in a timely manner such Medicare time audit reports and other time audit reports as BFS shall reasonably determine.

4.1.5. Supervision of evaluation and treatment in the Division provided by nurse practitioners, physician assistants and medical residents assigned to, or otherwise serving in the Division.

4.1.6. Performing such other clinical duties as may be assigned by BFS from time to time.

4.2. General Duties

4.2.1. Working collaboratively and respectfully with all staff, peers and departments to maintain a high level of care for all patients.

4.2.2. Serving on such departmental or hospital committees or other committees of BFS as requested by BFS or, at the discretion of BFS.

4.2.3. Actively participating in and cooperating with (a) quality assurance, quality improvement, utilization review and risk management activities; (b) peer review activities; (c) pay-for-performance initiatives; (d) electronic medical records initiatives, and (e) other similar initiatives of BFS or the Hospitals.

4.2.4. Performing such other general duties as may be reasonably assigned by BFS from time to time.

4.3. **Education-Related Duties**

To the extent and in the manner reasonably determined by BFS, Physician shall provide education services, which may include the following:

4.3.1. Assisting in the development of Department/Divisional or program curriculum for medical students.

4.3.2. Participating in the teaching of medical students and residents, including attending rounds, noon conferences and morning report (or similar programs).

4.3.3. Developing and assisting in the implementation of educational programs for medical staff, nursing staff and the community.

4.3.4. Participating in research programs, including joint research initiatives with tertiary care centers approved by the Hospitals.

4.3.5. Providing such other education services as may be assigned by BFS from time to time.

EXHIBIT B TO PHYSICIAN EMPLOYMENT AGREEMENT DATED AS OF FEBRUARY 18, 2017 (the "Agreement") BETWEEN BERKSHIRE FACULTY SERVICES, INC. ("BFS") and KATHLEEN M. SHERIDAN, M.D. ("Physician")

COMPENSATION

During the Term, BFS shall provide Physician with compensation as set forth in this Exhibit B.

1. Base Salary.

1.1. Base Salary Amount. During the first three years of the Term, Physician shall be paid an annual base salary ("Base Salary") of $300,000, provided, however, that Physician maintain the productivity level described in Section 1.2 hereof.

1.2. Productivity Threshold. The Base Salary amount during the first year of the Term is based upon an expectation that Physician shall generate wRVUs (as defined in Section 2.2 of this Exhibit B) at least equal to 95% of the median productivity of physicians in the Physician's Specialty as reported in the most recently available national productivity index published by a nationally recognized, independent reporting firm (such as the Medical Group Management Association ("MGMA") or SullivanCotter & Associates) then generally used by BFS in establishing physician compensation and productivity measures (the "3rd Party Index") (the "Base wRVU Threshold"). (The Base wRVU Threshold shall be established and subject to adjustment as described in Section 2.3 hereof. In addition to Base Salary, Physician shall be eligible for Incentive Compensation as described in Section 2 of this Exhibit B.) In the event that, for any year of the Term, Physician's productivity falls below 95% of the median productivity reported on the 3rd Party Index (the "Productivity Floor"), his Base Salary for the subsequent year of the Term shall be reduced by a percentage equal to the percentage by which his productivity falls below the Productivity Floor (a "Reduction Event"). In the event that, in any year following a Reduction Event, Physician restores his productivity to an amount at least equal to the Productivity Floor, his Base Salary shall be restored to the full Base Salary for that year.

1.3. Annual Review. Beginning at least 90-days prior to the end of the third year of the Term and at least 90-days prior to the end of each subsequent year of the Term, Base Salary shall be reviewed by BFS in consultation with Physician and the Division Chief, and in conducting such review, BFS shall consider (a) physician compensation information from the 3rd Party Index, (b) such qualitative measures as BFS shall deem appropriate, such as the financial and patient satisfaction performance of the Division, and (c) the performance of Physician under the Agreement. Except as otherwise agreed in writing by Physician and BFS, any adjustment in Physician's Base Salary from such review shall be effective as of the beginning of the next succeeding year of the Term. Prior to making any downward adjustments in Base Salary, BFS shall cause the BFS Leader to meet with the Division Chief

and Physician to discuss, in good faith, (and, when appropriate, implement) adjustments in Physician's practice, including staffing levels and other practice support, practice hours and accessibility, marketing strategies and billing and collection practices.

2. Incentive Compensation. BFS desires to properly and lawfully make available appropriate incentives to its physicians to provide accessible, quality services in a cost-effective manner ("Incentive Compensation"). To the extent that Physician is eligible for Incentive Compensation, BFS shall supplement the Base Salary paid to Physician with Incentive Compensation based upon measures of productivity and, beginning in the second year of the Term, quality of care, patient access and satisfaction and administrative participation and compliance developed by BFS in consultation with, the Division Chief, Physician and any other physicians in the Division.

2.1. The Incentive Compensation plan currently in effect for physicians in the Specialty provides for BFS to fund a pool out of which Physician shall be paid Incentive Compensation, provided that, beginning in the second year of the Term, performance targets, more fully described in this Section 2.1, are met. The pool out of which Incentive Compensation shall be paid shall be funded semi-annually to an amount equal to that amount by which (a) Physician exceeds the Base wRVU Threshold *times* the (b) the Conversion Factor (as defined in Section 2.4) (the "Gross Eligible Amount"). During the first year of the Term, the Gross Eligible Amount shall be fully distributed as Incentive Compensation to Physician. Beginning in the second year of the Term, the portion of the Gross Eligible Amount that is distributable as Incentive Compensation to Physician shall be dependent upon Physician's scores in the following performance areas: (i) patient access and satisfaction targets (the "Patient Access and Satisfaction Component"), (ii) clinical quality targets (the "Clinical Quality Component") (iii) teaching quality targets (the Teaching Quality Component") and (iv) administrative efficiency and improvement targets (the "Administrative Improvement Component") (collectively, the "Performance Targets"). The Performance Targets (or any agreed-upon substitutes for any of these four targets) shall be determined annually by the Division Chief and the BFS Leader, in consultation with Physician and the other physicians assigned to the Division, and shall be measured annually by them, in consultation with Physician on behalf of herself and the other physicians in the Division, on the basis of the year ending September 30.

2.2. As used herein, the term "wRVU" shall mean the relative value units, as published by the Centers for Medicare and Medicaid Services ("CMS") and utilized in the most recently available MGMA Index, (a) associated with medical services (i) personally provided or supervised by Physician and not independently billable by the provider and (ii) defined in accordance with the Current Procedural Terminology codes most recently published by the American Medical Association, and (b) including only the "Work RVU" factors. Unless and until otherwise agreed in writing by BFS and Physician, the Base wRVU Threshold shall be equal to the 50th percentile of the 3rd Party Index.

2.3. Unless and until otherwise agreed in writing by BFS, Physician and the Division Chief (on behalf of himself and all other physicians in the Division), the "Individual wRVU Threshold" shall be equal to the 50th percentile of physician productivity for physicians

providing Physician's Specialty services, as reported in the then most currently available 3rd Party Index as of the Reset Date or Subsequent Reset Date (as those terms are defined in this Section 2.3). As of the Commencement Date, Physician's Individual wRVU Threshold shall be the Individual wRVU Threshold then in effect for the other physicians assigned to the Division (currently 6683 wRVUs) (the "Initial Threshold"). The Initial Threshold shall remain in effect until the next date as of which the Individual wRVU Threshold for the physicians assigned to the Division is scheduled to be reset (the "Reset Date"). Physician's Individual wRVU Threshold shall be reset as of the Initial Reset Date and every other year thereafter as of October 1 (the "Subsequent Reset Date").

2.4. As used herein, the term "Conversion Factor" shall mean the dollar amount by which the wRVUs generated by Physician in excess of the Base wRVU Threshold, as described in Section 2.1 hereof, shall be multiplied to determine the Gross Eligible Amount. During the first three years of the Full Term (and each year thereafter unless the parties have agreed in writing to an alternate method of calculating the Conversion Factor), the Conversion Factor shall be $42.00 and shall, be adjusted every other year thereafter to 110% of the amount determined by multiplying the "Medicare Conversion Factor" by the "Geographic Practice Cost Index", in each case as most recently published by CMS in the Federal Register.

2.5. Physician's Incentive Compensation shall be calculated and distributed semi-annually as described in this Section 2.5.

2.5.1. During each year of the Term, BFS shall, in consultation with Physician and the Division Chief, determine the number of wRVUs generated by Physician during the first six months of that year (in each case, a "Provisional Calculation Period"). To the extent that, during a Provisional Calculation Period, Physician shall have generated wRVUs in excess of one-half of the annual wRVU Threshold, he shall be eligible for payment of a provisional amount of Incentive Compensation (in each case, a "Provisional Eligible Amount"), calculated with the Conversion Factor then in effect.

2.5.2. Beginning in the second year of the Term, the Provisional Eligible Amount shall be subject to adjustment by the Physician's scores on the Performance Targets, in each case measured (or estimated, in good faith, if actual measurement is not feasible on a semi-annual basis) for the Provisional Calculation Period. Within 45 days following the end of the Provisional Calculation Period, BFS shall pay to Physician, as part of his regular payroll, an amount equal to 65 percent of the Provisional Eligible Amount to which he is entitled.

2.5.3. Within 45 days of the end of each year of the Term, BFS shall, in consultation with Physician and the Division Chief, calculate the Gross Eligible Amount that is distributable to Physician with respect to that entire year (the "Annual Calculation Date").

2.5.3.1. To the extent that the distributable Gross Eligible Amount is greater than the Provisional Eligible Amount, BFS shall include the difference in Physician's regular compensation no later than the second payroll period after the Annual Calculation Date.

2.5.3.2. To the extent that the distributable Gross Eligible Amount is less than the Provisional Eligible Amount, BFS shall have the right, after consultation with Physician, to deduct the difference from amounts otherwise payable by BFS to Physician, including Base Salary, Incentive Compensation or other compensation, for that year or any subsequent year.

2.5.3.3. For any Provisional Calculation Period, BFS shall, in consultation with Physician, determine the amount of reasonably expected collections (a) associated with medical services (i) personally provided or supervised by Physician during such Provisional Calculation Period (but in the case of supervised medical services, only those services which are not independently billable by the supervised provider) and (b) after adjustments for such items as third-party contractual allowances, charity care, provision for bad debts and prior period adjustments.

2.5.3.4. Upon termination of Physician's employment for any reason, BFS shall, within 45 days of the termination date, calculate that portion of the Gross Eligible Amount to which Physician would, as of the termination, be entitled to be paid and shall promptly pay over that amount to Physician, net of any amount that Physician may be obligated to BFS for any purpose.

3. Other Compensation / Recruitment Incentive and Relocation Support.

1.1. As a further inducement to Physician to relocate to the BFS service area, BFS shall make a recruitment incentive commitment to Physician ("Recruitment Incentive"), payable in three installments. Each installment shall be in the form of a taxable grant made to Physician. The first installment of $10,000 shall be payable to Physician upon her written request at any time after Physician shall have returned a signed copy of this Agreement to BFS. The second and third installments, in the amount of $10,000 each, shall be payable to Physician on the second and third anniversary of the Commencement Date, provided Physician continues to be employed by BFS, by another BHS entity or by CHP at that time and that neither Physician nor BFS has delivered a notice of intent to terminate this Agreement. All Recruitment Incentive payments shall be subject to any required federal and state withholding and any payroll withholding otherwise agreed by Physician, and any Recruitment Incentive payments made to Physician after 45 days of employment shall also be subject to withholdings required under the terms of the BFS Section 403(b) retirement plan.

3.2 Upon submission of appropriate invoices, BFS shall reimburse Physician (a) for actual travel expenses (hotel and meals) incurred in connection with one house-hunting trip from Durham, Maine to the BMC service area and (b) the cost of relocating Physician's residence by a commercial moving service in an amount not to exceed $10,000, (the "Relocation Support"). The Relocation Support shall be subject to such payroll tax and other withholding amounts as may be required by federal and state law.

4. Benefits.

4.1. Physician shall be entitled to such benefits, including vacation and leave benefits, health insurance, life insurance, disability income insurance and participation in the Retirement Plan (as defined in Section 4.2) on the same basis as other physician employees of BFS, which benefits shall, on the Commencement Date, include those benefits set forth on Exhibit B-1 attached hereto.

4.2. If, during the Term, Physician shall qualify for, and elect participation in a Retirement Plan, any contributions payable by Physician shall be deducted from Base Salary and Incentive Compensation in accordance with the limitations of the Internal Revenue Code; matching contributions or other employer contributions made directly by BFS, if any, shall not be deducted from Base Salary or Incentive Compensation. As used herein, "Retirement Plan" shall mean any qualified retirement plan of BFS currently in effect and any other qualified retirement plan which may be adopted by BFS from time to time.

4.3. The benefits described in this Section 4 shall be subject to (a) the provisions of those contracts, policies and plans under which such benefits are provided and (b) the right of BFS to amend, modify or terminate any such benefit (each a "Benefits Change"), provided that any Benefits Change shall be made with respect to the entire class of BFS's employees entitled to such benefit.

5. Total Compensation. Notwithstanding any other provision of the Agreement or this Exhibit B, Physician's total compensation, including Base Salary, Incentive Compensation and benefits, shall not, under any circumstances, exceed the reasonable value for Physician Services, as determined by BFS in accordance with the 3rd Party Index, by generally aligning Physician's productivity level with Physician's compensation level (after taking into account Physician's teaching and administrative services commitment).

EXHIBIT B-1 TO PHYSICIAN EMPLOYMENT AGREEMENT DATED AS OF FEBRUARY 16, 2017 (the "Agreement") BETWEEN BERKSHIRE FACULTY SERVICES, INC. ("BFS") and KATHLEEN M. SHERIDAN, M.D. ("Physician")

BENEFITS

Except as otherwise specified in the Agreement:

Medflex: The MEDFLEX flexible benefits program allows credits to be applied toward the purchase of employee benefits on a tax-preferred basis. Benefits available under the program include Health Insurance, Dental Insurance and Long Term Disability. Additional voluntary benefits under the plan include supplemental life insurance, enhanced disability insurance, and dependent life insurance.

Health & Dental Insurance: BFS assumes a substantial portion of the premium cost for individual and family health insurance coverage. The employer contribution is equal to the employer contribution to health insurance and dental plans for senior administrative employees of BFS-affiliated entities. Physician will be charged, by way of payroll deduction, the employee's contribution to the health and/or dental insurance coverage.

Short Term Disability Salary Continuation Benefit: In the event that, after six months of continuous employment with BFS or an affiliate thereof, Physician shall be Temporarily Disabled (as defined in Section 7.1 of the Agreement), BFS shall continue to pay Physician during the period of Temporary Disability (the "Temporary Disability Period") at the rate of (a) 100% of Base Salary for the first 30 days of such Temporary Disability Period, and (b) 60% of Base Salary thereafter. The Temporary Disability Period shall not extend beyond the lesser of (a) four calendar months (if Physician has less than two years of service as an employee of BFS or any affiliate), (b) six calendar months (if Physician has two years or more of service as an employee of BFS or any affiliate) or (c) cessation of the Temporary Disability (including by conversion to "Permanently Disabled" as defined in Section 7.2 of the Agreement).

Long Term Disability Insurance: After three months of continuous employment with BFS or an affiliate thereof, Long Term Disability Insurance is provided after a six-month elimination period and at a wage replacement equaling 60% of Base Salary, up to a maximum of $10,000 per month.

Group Life Insurance: BFS provides term group life insurance in an amount equal to two (2) times Base Salary to a maximum of $500,000 following ninety (90) days of continuous employment. The entire premium is paid by BFS. In addition, in the event of accidental death/dismemberment, there is a benefit sum equal to the life insurance benefit.

Professional Liability Coverage: See Section 8 of the Agreement.

Continuing Medical Education (CME) and Dues Funding: Physician shall be eligible for up to ten days of leave during each fiscal year of the Term for the purpose of attending courses,

seminars and medical conferences, subject to the approval of the BFS Leader. Upon submission by Physician of such supporting documentation as BFS shall require, BFS shall reimburse Physician (or otherwise pay) up to $4,500 of the costs (including travel) during any fiscal year of the Term (prorated for fiscal years of less than 12 calendar months) for business expenses allowable under the federal tax code and associated with CME activities, society and medical organization dues (including physician dues and assessments for membership in any BHS-sponsored physician-hospital organization), license renewal and basic subscriptions, approved in accordance with BFS's policies (the "Core Reimbursable Amount"). For so long as BFS agrees that the BMC gynecology surgery program benefits from certification of that program and the surgeons in the Division by the AAGL Center of Excellence in Minimally Invasive Gynecology program, BFS shall pay, in addition to the Core Reimbursable Amount, the costs reasonably associated with such certification. BFS shall have the right to condition Physician's reimbursement for CME activities offered outside of the BMC service area upon Physician's attendance, after the first fiscal year of the Term, at the entirety of at least 50% of the designated patient satisfaction, quality improvement or risk management educational programs offered by BFS during the preceding 12 months of the Term. At Physician's election and upon submission by Physician of such supporting documentation as BFS shall require, BFS shall, within 30 days of the Commencement Date, reimburse to her from the Core Reimbursable Amount available to her during the first year of the Term the amounts paid by her to the Commonwealth of Massachusetts associated with her securing a license to practice medicine in the Commonwealth.

Vacation Time: Physician shall be entitled to six weeks of vacation in each calendar year of the Term, prorated for any year of the Term that is less than 12 calendar months. Physician shall use permitted vacation time in the calendar year in which it is earned and vacation time may not be carried over to subsequent years or converted to cash at any time.

Holiday and Weekend Time: BFS shall cause the Division Chief to assign work and call coverage for holidays and weekends in an equitable manner among the physicians employed within the Division.

Retirement Program: BHS sponsors a retirement plan for the benefit of all qualifying full-time and part-time employees. In order to be eligible for employer contributions, the employee (a) must be at least twenty-one (21) years of age, satisfy one year of service eligibility requirement, and (b) have worked 1000 hours or more during the eligibility period (the "Qualifying Criteria"). For those employees who meet the Qualifying Criteria, BFS shall contribute a core contribution equal to two and one-half percent (2.5%) of the employee's annual salary and shall make an additional matching contribution equal to fifty percent (50%) of any voluntary contributions that the employee may make to the retirement plan, provided that such additional contributions by BFS shall not exceed two percent (2.0%) of the employee's annual salary. The core and matching contributions are subject to compensation limits as set forth annually by the Internal Revenue Service.

Non-Qualified Tax Deferred Section 457(b) Plan: BFS sponsors a non-qualified tax deferred plan established under section 457(b) of the Internal Revenue Code (the "457(b) Plan").

Physician shall be eligible to defer Base Salary into the 457(b) Plan up to the maximum amount allowed by law.

All benefits referred to in this Exhibit B-1 are calculated on the basis of a full-time equivalency commitment and some shall be prorated in the event of lesser commitments or have minimum commitment requirements for eligibility.

EXHIBIT B

Michael R. McInerney MD
Chief of Staff, Berkshire Medical Center
725 North St., Pittsfield MA 01201
Tuesday, August 3, 2021

to: Dr. Kathleen Sheridan

Dr. Sheridan:

It is my duty to inform you that your clinical privileges at Berkshire Medical Center (and all associated clinics) are hereby summarily suspended pending the outcome of an investigation into a recent incident that involved you. The summary suspension is a precautionary action only and not a judgment about the incident or your involvement in it.

Until instructed otherwise by myself or your department chair (Dr. Slater), you are to refrain from any and all clinical activities in the hospital or any associated clinics. I have provided you with a copy of the Berkshire Medical Center Medical Staff Bylaws. Article VII, subsection 2 is the section outlining summary suspension, including your rights to appeal the summary nature of the suspension to the executive committee of the medical staff.

MD

Michael R. McInerney, MD
Chief of Staff, Berkshire Medical Center

MD

Kathleen Sheridan, MD
(aknowledging receipt of notification)

EXHIBIT C

Berkshire
Health Systems, Inc.

725 North Street
Pittsfield, MA 01201
(413) 447-2000

VIA hand, e-Mail and
First Class Mail
September 3, 2021

Kathleen M. Sheridan, M.D.
127 Mount Road
Cummington, MA 01026

Re: Employment Agreement with Berkshire Faculty Services, Inc. dated as of February 18, 2017, as amended by Letter Amendments dated May 3, 2017, October 30, 2018, and December 13, 2018 (the "Agreement")

Dear Dr. Sheridan:

This letter will serve as notice to you under Section 2.1 of the Agreement that Berkshire Faculty Services, Inc. ("BFS") elects to terminate the Agreement and your employment by BFS.

During the course of your employment by BFS, there have been two neonatal deaths that raise questions about your professional judgment and episodes of concern among your clinical colleagues that prompt similar questions. As you know, failure to work well with your colleagues, like failure to adhere to good clinical practice, constitutes a serious risk to patient safety and well-being.

Notwithstanding the serious concerns that BFS and medical staff leadership have about your performance to date, BFS is willing, at this time, to proceed with this termination as a not-for-cause termination under Section 2.1 of the Agreement.

As you know, Section 2.1 provides that either party to the Agreement may terminate the relationship on a not-for-cause basis on 180 days' notice. BFS has concluded, however, that patient safety and clinical team collaboration require that your employment by BFS end immediately. Accordingly, you are relieved of all responsibility under the Agreement, except as specified below, effective at the close of business on Friday, September 3, 2021. BFS shall, however, continue your compensation and benefits through March 2, 2022.

You shall continue to be obligated to BFS under Sections 5.2 and 6.3 of the Agreement (and the Massachusetts Board of Registration in Medicine regulations) to complete and sign all outstanding patient records and other documents concerning care that you have provided to patients.

Notwithstanding termination of the Agreement, BFS and you shall each continue to be obligated to the other under Sections 8 of the Agreement with respect to professional liability coverage, including (a) tail coverage and (b) your obligation to cooperate in the defense of any action.

Both BFS and you shall continue to be obligated to the other with respect to all other provisions of the Agreement that, by their terms, survive termination of the Agreement.

As of March 2, 2022, your participation in the Berkshire Health Systems group health insurance plan shall cease, but you shall be eligible to receive extended health coverage under the Consolidated Omnibus Reconciliation Act of 1985, as amended ("COBRA"). If you elect to take advantage of your COBRA rights, please contact the Berkshire Health Systems Human Resources Department about the process to make that election.

Sincerely,

James W. Lederer, Jr., M.D.
Chief Medical Officer
Berkshire Health Systems, Inc

EXHIBIT D

BERKSHIRE MEDICAL CENTER

MEDICAL STAFF BY-LAWS

April 13, 2021

TABLE OF CONTENTS

BERKSHIRE MEDICAL CENTER

BYLAWS OF THE MEDICAL STAFF

PART I

BERKSHIRE MEDICAL CENTER, INC.

BYLAWS OF THE MEDICAL STAFF

PREAMBLE

WHEREAS, the Berkshire Medical Center, Inc. is a non-profit corporation organized under the laws of the Commonwealth of Massachusetts; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, medical education and research; and preventive and community health services; and

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital governing body;

THEREFORE, the physicians and dentists practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

DEFINITIONS

1. The term "Medical Staff" means collectively all "Licensed Independent Practitioners", who have been approved by the Governing Body for membership.

2. The term "Licensed Independent Practitioners" means any individual permitted by law and the organization to provide care, treatment and services without direction or supervision.

3. The term "Advanced Practice Providers" means a licensed practitioner who may be granted privileges, but whose services are required by law or the organization to be under the direction or supervision of a "Licensed Independent Practitioner". Advanced Practice Providers and Licensed Independent Practitioners may be granted privileges independent of membership.

4. The term "Governing Body" means the Board of Trustees of the hospital.

5. The term "Executive Committee" means the executive committee of the medical staff, unless specific reference is made to the executive committee of the Governing Body.

6. The term "Chief Operating Officer" means the individual appointed by the Governing Body to act in its behalf in the overall management of the hospital.

7. The head of the medical staff shall be referred to as the "Chief of Staff" in these bylaws.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of the Berkshire Medical Center, Inc.

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To provide that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive high quality care;

2. To assure a high level of professional performance by all Practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each Practitioner may exercise, and through an ongoing review and evaluation of each Practitioner's performance;

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

4. To initiate and maintain rules and regulations for the Medical Staff;

5. To provide a means whereby medical staff issues may be discussed (with the intention of achieving resolution) with the Medical Staff, the Governing Body, the Chief Medical Officer and the Chief Operating Officer;

6. To assure that each Practitioner shall observe all ethical standards as guided by his/her profession.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of Berkshire Medical Center, Inc. is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws. No applicant shall be denied membership on the basis of sex, race, creed, color, national origin, or on the basis of any criterion lacking professional justification.

Section 2. Qualifications for Membership

Only Practitioners who can document the personal and professional qualifications listed below with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the hospital will receive high quality medical care shall be qualified for membership on the Medical Staff.

No practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice a profession in this or in any other state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.

a. License to practice in the Commonwealth of Massachusetts; Education, training, experience, and demonstrated competence in their profession;
b. New applicants for Medical Staff membership and privileges must be Board certified and recertified (if time limited) by a specialty Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Podiatric Medical Association, or the American Dental Association, except as described in Section 2b of Article V and with the exception of general dentistry, which does not have a certifying board.
c. Applicants who have recently completed residency or Fellowship training are obligated to obtain board certification within the time frame designated by the appropriate ABMS or AOA member board in their specialty.
d. Good moral character;
e. Good reputation;
f. Ability to work with others;
g. Ability and willingness to work within recognized standard of care;
h. Ability to perform the privileges requested; and
i. All other criteria established by federal, state, or local statutes, rules, or regulations.

Section 3. Conditions of Appointment and Reappointment

Applicants for Medical Staff membership and reappointment shall, by making application, be deemed to have agreed to accept and abide by the conditions listed herein for appointment and maintenance of Medical Staff membership:

a. Accept the ethical standards of the AMA, AOA, ADA, or the APMA whichever is applicable;
b. Show evidence of malpractice insurance with policy limits and underwritten by an insurance carrier acceptable to the Executive

Committee and as required by federal, state, or local statutes, rules, or regulations;

c. Limit professional activity to those privileges granted;
d. Provide continuous care and supervision for his/her patients;
e. Agree to provide his/her patients with care at the generally recognized professional level of quality and with due regard to economic efficiency;
f. Adhere to Medical Records requirements as outlined in Article III, Section 4.
g. Participate in Medical Staff affairs by acceptance of committee assignments and peer review activities;
h. Participate in the quality improvement program (patient care assessment program) when requested by the department chair or the Chief of Staff;
i. Accept assignment to a call roster for the provision of emergency care when requested by the department chair or the Chief of Staff; see Rules & Regulations, Section A., Items 6 through 9;
j. Accept other such reasonable duties as requested by the department chair or Chief of Staff;
k. Maintain as confidential all individual and aggregate patient information as provided for in hospital policy and by Federal regulations;
l. Accept responsibility for Medical Staff dues as described in Section 6;
m. Meet the Massachusetts Board of Registration in Medicine or other applicable licensing Board requirements for Continuing Professional Education; and
n. All other conditions for staff membership established by federal, state, or local statutes, rules or regulations.

Section 4. Medical Records

1. Within twenty-four (24) hours of admission and prior to surgery, a complete history and physical exam will be entered into the chart or dictated. If dictated, a brief written entry must be made which reflects the attending licensed independent practitioner's assessment, essential findings, and planned course of action.

   The history and physical should contain data pertinent, relevant, and sufficient to provide the care required. The information necessary may vary by setting, level of care, procedure and developmental stage. Each department will determine the appropriate content of the history and physical examination for the setting(s) in which the departmental members provide services or treatment.

   At a minimum, the history and physical examination will include the following:

- Chief complaint/reason for admission
- Details of the present illness
- Relevant medications and allergies, past history, social and family history and review of systems
- All pertinent physical findings resulting from a current assessment of body systems, unless deferred in the attending licensed independent practitioner's judgment
- Diagnosis or diagnostic impression
- Reason for admission and treatment plan

2. The history and physical will be completed no more than 30 days prior to admission or surgery, or, as noted in Item 1, within 24 hours after admission. When a history and physical is done in the 30 days prior to admission or surgery, an update by the attending licensed independent practitioner documenting any clinical changes is required within 24 hours after admission or immediately prior to surgery.

3. Progress notes must be written at least daily to adequately document a patient's hospital course. This requirement may be met by countersigning a progress note written by a medical student, house officer, or allied health professional; with wording such as "I have read and agree with the above". Documentation for patients admitted to the trauma services must meet the standards as defined by the American College of Surgeons.

4. Operative notes shall be dictated immediately following surgery and must include a detailed account of the findings at surgery, details of the surgical technique, tissue removed or altered, complications, the condition of patient at termination of procedure and a post-operative diagnosis.

5. A discharge summary shall be available within 24 hours of discharge, or prior to the time of contact with the subsequent provider of care. For patients discharged to the care of another to acute care or subacute care facility, a dictated discharge summary is required prior to transfer.

   A final discharge summary must be dictated for all medical and surgical inpatient discharges and observation patients regardless of their length of stay. The final discharge summary shall include the reason for admission, appropriate medical histories, pertinent physical findings, relevant laboratory and imaging findings, treatments provided and the results of treatment, the patient's condition on discharge, and suggested plan for follow-up care. Copies of the final discharge summary should, at a minimum, be provided to the attending and primary care physician.

A short stay discharge summary may be used for elective outpatient surgeries or any other outpatient procedure during which the patient retains an outpatient status, excluding observation status

Section 5. Appointment

Appointments to the Medical Staff shall confer on the appointee only such clinical privileges, as have been recommended by the Credentials Committee and the Medical Staff, and approved by the governing body in accordance with these bylaws. Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation as described in Article III Section 3. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall ordinarily act upon appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these bylaws; however, in the event of a delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of appropriate evidence of the applicant's or staff member's professional and personal qualifications. When acting without recommendation of the Medical Staff, the Governing Body must base its decision upon the same kind of information as is usually considered by the Medical Staff. For the purpose of this section, delay generally means one hundred and twenty days from the date that a fully completed application has been received by the Medical Staff.

Section 6. Duration

Each first appointment shall be conditional during the first twenty-four months of Medical Staff membership, except as otherwise provided for in these bylaws. Reappointment shall be for a period of not more than two years.

Section 7. Assessment of Medical Staff Dues

The Executive Committee shall annually determine the amount of dues necessary to meet the contribution of the Medical Staff to the compensation of the Chief of Staff as described in Article IX and such other expenses of the medical staff may be approved by a simple majority vote. Each year, each member of the Medical Staff shall be sent a notice of assessment of his or her prorated share of such dues. The requirement to pay dues shall be waived for any member of the Medical Staff on authorized leave of absence, as defined in Section 7 of this Article III. Dues for visiting and advance practice provider staff shall be those approved by the Executive Committee.

Section 8. Authorized Leave of Absence

Upon the request of a member of the Medical Staff, and with the approval of the Executive Committee and the Chair of the department to which the member belongs, the Governing Body may authorize the member to take a leave of absence from the Medical Staff for an initial period not to exceed one year, renewable by the Governing Body for up to one additional year. An authorized leave of absence may not be granted until such time as the member has fulfilled all of his/her hospital obligations, including but not limited to transfer of patients and completion of medical records. During the term of any authorized leave of absence, the member shall have no right to vote on Medical Staff or other hospital matters, may not serve on committees and will have none of the rights secured to members of the Medical Staff by the bylaws. A member granted an authorized leave of absence must remain licensed to practice medicine in the Commonwealth and remain otherwise eligible for membership on the Medical Staff. Members wishing to return must request a review by the Chair of the department in which they hold privileges. Upon receipt of such a request, the Chair of the department the member holds privileges in will review the privileges held with the Credentials Committee. Following favorable recommendation of the Department Chair, the Credentials Committee and the Medical Executive Committee, the practitioner will have his/her privileges reinstated. In the case of an adverse recommendation by the Department Chair, Credentials Committee and/or Medical Executive Committee, the practitioner will have the right of appeal as outlined in Article V, Section 2 of these bylaws.

Section 9. Medical or Mental Health Conditions

A medical staff member who experiences a medical or mental health condition which has the reasonable potential to impair the ongoing performance of their duties is required to report that condition to the Chair of their department as soon after such an occurrence as is possible. Once so informed, the Chair of the department will determine whether a medical or psychological evaluation is prudent to ensure that the staff member can safely continue to exercise their privileges. If such an evaluation is needed, the Chief of Staff will be notified.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

The categories of the Medical Staff shall be Provisional, Associate, Active, Visiting, and Emeritus. Each first appointment shall be to the Provisional staff, except for the chairsof the clinical departments of the Hospital (Anesthesiology, Emergency Medicine, Maternal-Child Health, Medicine, Pathology, Psychiatry, Radiology and Surgery) who shall be appointed to the Active Staff once they have been accepted for Medical Staff membership. Active Staff status may also be granted to newly appointed physicians when requested by the Chief of Staff. Each first appointment shall be provisional during the first 24 months of Medical Staff membership regardless of staff status. Advancement in staff from provisional status is based upon an evaluation of

professional competence, technical skill, clinical judgment, commitment to the conditions of appointment, maintenance of the qualifications for membership and the recommendation of the Chair of the department(s) in which privileges have been granted. If, at the end of the two-year period the physician has not satisfied the requirements for staff eligibility, his/her provisional status shall automatically terminate and the member shall be given written notice of such termination and of his/her entitlement of the procedural rights as specified in these bylaws. If, at the end of the two year provisional period there is insufficient clinical activity at Berkshire Medical Center to adequately evaluate performance, an extension of provisional status for up to one year may be recommended by the Credentials Committee.

Any Medical Staff member who wishes to change his/her staff category or relinquish his/her Medical Staff membership must make a request in writing to the Chair of the department in which privileges are held one hundred and twenty days before such contemplated change would take effect. The chair of the appropriate department shall report to the Credentials Committee his/her recommendations regarding a change in staff category or privileges. The Credentials Committee shall forward its recommendations on the requested change to the Executive Committee which will make formal recommendation to the Governing Body.

Section 1. The Provisional Staff

a. The provisional staff shall consist of licensed independent practitioners holding first appointments and extensions thereof. Provisional status may also be imposed by the executive committee as a result of a disciplinary administrative action.

b. A provisional member may provide care within the scope of his/her delineated clinical privileges. If a practitioner wishes to advance to Active staff status, he/she must have attended at least 50% of department, committee, and quarterly medical staff meetings, during the entire period that he/she held provisional status. A provisional member is ineligible to vote at any regular or special meeting of the entire medical staff or to hold office. He/she may, from time to time, be required to carry out the duties assigned by the Chief of Staff or chair of any department in which he/she has privileges. A provisional member shall indicate in writing to the Credentials Committee, no later than the first day of the month immediately preceding the second anniversary of the member's appointment, whether he/she desires to be advanced to Visiting, Associate, or Active staff membership.

c. During such time as a member is appointed on a provisional basis, active staff members, under the direction of the appropriate department chair, shall have the responsibility of observing such member in the performance of his/her professional responsibilities. In the month immediately preceding the first anniversary of the member's appointment and a second time in the month immediately preceding the second anniversary of the member's appointment, the chair of the department to which the

provisional staff member is assigned or in which he/she has privileges, shall report upon such member to the Credentials Committee. The second such report shall include a recommendation regarding advancement in staff status to Visiting, Associate, or Active staff. The Credentials Committee shall report its recommendation to the Executive Committee.

Section 2. Active Staff

The active staff shall consist of Practitioners advanced from Provisional or other staff level, except as provided for in the introduction to this article. Advancement is based upon an evaluation of professional performance and commitment to the hospital during the provisional period. Members holding active staff status will have demonstrated their interest and commitment by regular attendance of patients in the hospital, participation in medical education activities, performance of assigned duties, compliance with the bylaws, rules, regulation and procedures, moral, legal and ethical practice, compliance with continuing medication education requirements of the Board of Registration in Medicine, or other applicable licensing Board, and be recommended for membership and privileges at initial appointment and on reappointment by the Department Chair in which privileges are held. Active staff members shall conduct all the business of the Medical Staff and are the only members who may vote on Medical Staff membership, staff advancement, clinical privileges, and bylaws, rules, and regulations. Only active staff members may be elected officers and serve as chair of committees. Active staff members must attend at least 50% of regular staff, committee, and department meetings each year.

Section 3. The Associate Staff

The Associate Staff shall consist of practitioners advanced from Provisional or other staff level. Advancement from provisional status or reappointment is based upon an evaluation of professional performance as described for Active Staff in Section 2 of this Article IV. Associate Staff members will be extended the privilege of providing care to a limited number of patients, approved by the Chair of the Department in which the member holds privileges. The obligations of an Associate Staff member are also limited. Committee assignment is not required. In the event that an Associate member wishes to participate in a medical staff committee, 50% attendance at meetings is required. The Associate member is eligible to vote at the department and committee level, but is ineligible to vote for medical staff membership, clinical privileges, Bylaws, Rules and Regulations, and election of the officers of the medical staff. The Associate Staff member shall be ineligible to serve as Chair of a committee or department. An Associate Staff member shall be required to pay dues as described in Article III, Section VI.

Section 4. Visiting Staff

Visiting Staff shall consist of practitioners who, in the judgment of the Chair of the department in which they seek membership, (a) will provide to the hospital and to the medical staff a special expertise, not generally available among the current members of the Active medical staff or (b) will participate actively as a presenter or as an instructor in the professional education programs offered by the hospital. Visiting Staff members may be directly appointed or advanced from Provisional or other staff level. Advancement from provisional status or reappointment is based upon (a) the continued recommendation of the Chair of the relevant department and (b) an evaluation of professional performance as described for Active Staff in Section 2 of this Article IV. In order to accomplish a meaningful evaluation of professional performance, Visiting Staff members shall either (a) maintain a level of clinical activity in the hospital sufficient to permit such evaluation or (b) provide the Chair of the relevant clinical department a sufficient means, in the judgment of such Chair, of assessing professional performance by producing performance information from another accredited facility or society. The Chair of the relevant department shall forward the applicant's request for original staff membership or renewal of staff membership, along with his/her favorable or unfavorable recommendation(s) to the Credentials Committee for its consideration. Except in unusual circumstances, privileges for members of the Visiting Staff will be limited to those provided in an ambulatory setting or as a consultant. Although not required to attend Department or Staff meetings, a Visiting Staff member may attend such meetings in a non-voting capacity if invited by the relevant Department Chair or the Chief of Staff in the case of meetings of the medical staff. A Visiting Staff member is not required to accept assignment to the emergency call roster. The level of dues obligation for this category of staff will be approved by the Executive Committee on an annual basis. The Visiting Staff member must maintain the requirements and qualifications for membership and reappointment at all times.

Section 5. Emeritus Staff

Emeritus staff shall consist of Practitioners who have retired from active practice, but wish to continue their association with the Medical Staff of the Hospital. Such member shall have completed five years of active staff membership in good standing. Such member shall have no obligation to the Medical Staff, including payment of dues, no clinical privileges, and no vote at staff or department meetings. Such member is welcome at Medical Staff social functions and medical education programs. An active license and maintenance of malpractice insurance is not required.

Section 6: Telemedicine Staff

Telemedicine Staff are those members of the Medical Staff who provide specified telemedicine consulting services as agreed upon by contract with the hospital or credentialed members of the Medical Staff. Members of the Medical Staff or Departments of the Medical Staff shall not sponsor providers of telemedicine services for credentialing without the prior approval of the Medical Executive Committee and the

Chief Operating Officer of the hospital and no such provider shall be credentialed if the services offered conflict with services provided at or for the hospital by a practitioner or practice group holding an exclusive contract for such services.

In order to obtain credentialing, telemedicine providers shall provide the hospital with the same documentation and information as required of all other medical staff applicants and candidates for appointment and reappointment and shall be held to the same requirements as are other members of the Medical Staff, except as provided herein. Telemedicine Staff members are not required to attend meetings of the Department to which they are assigned, are not expected to serve on medical staff committees and will not hold voting privileges. A Telemedicine Staff member is not required to accept assignment to the emergency call roster. Telemedicine Staff members are required to pay medical staff dues as described in Article III, Section IV. Telemedicine Staff Members must provide timely service and abide by the Medical Staff Bylaws, Rules and Regulations and applicable policies. Telemedicine Staff members must agree to participate in performance improvement activities as requested by the Chair of the Department to which they are assigned or by the Chair of the Medical Staff Quality Council or by the Chief of Staff.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment

a. By submitting an application, the applicant shall be deemed to have agreed to be bound by the terms of these By-Laws and medical staff rules and regulations.

b. All applications for appointment to the Medical Staff shall be submitted in writing on a form approved by the Credentials Committee and signed by the applicant. The application shall require information as to the applicant's qualifications for membership as described in Article III Section 2. It shall also require the names of three persons who, from personal experience and direct observation, can provide adequate reference pertaining to the applicant's current professional competence and ethical character. The application shall state whether any of the following have ever been revoked, suspended, reduced, voluntarily or involuntarily relinquished, not renewed, or whether there is any action pending which would do the same:
    (1) License to practice any profession in any state;
    (2) Membership in any local, state, or national professional society;
    (3) Membership status or clinical privileges at any hospital or other health care institution.

c. The applicant shall have the entire burden of providing adequate evidence for proper evaluation of his/her qualifications and for resolving any doubts about such qualifications.

d. The applicant shall provide authorization for release of all information from any and all malpractice insurance carriers for the previous ten (10) years.

e. The applicant shall state whether his/her mental or physical health may affect the ability to perform the privileges requested.

f. The applicant shall agree to be evaluated by the Committee on Practitioner Health if requested by the Credentials Committee. If the applicant has a mental or physical impairment, the applicant shall provide evidence that the impairment does not interfere with the licensee's competence to exercise the privileges requested.

g. The application shall be submitted to the Chief of Staff via the Medical Staff Office. The Chief Operating Officer, Chief Medical Officer and the Chief of Staff shall supervise the operations of the Medical Staff Office and the application process. Primary source verification will be obtained for license, education and training, current competence, and ability to perform the privileges requested. After collecting and verifying the references and other materials the Chief of Staff deems pertinent, he/she shall transmit the application and all supporting materials to the relevant Department Chair and then to the Credentials Committee for evaluation and recommendation.

h. The application shall be accompanied by a non-refundable fee, the amount of which shall be determined by the Medical Staff Officers and the Chief Operating Officer.

i. The applicant shall also provide such other information and meet such other requirements as may be required from time to time by federal, state, or local statutes, rules, or regulations. By applying for appointment to the Medical Staff, each applicant:

    (1) agrees to appear for a personal interview in regard to his/her application;

    (2) authorizes the Chief Medical Officer or designee to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character, and ethical qualifications;

    (3) consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as of his/her moral and ethical qualifications for staff membership;

    (4) releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, and;

    (5) releases from any liability all individuals and organizations who provide information in good faith concerning the applicant's competence, ethics, character, and other

qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

j. The application form shall include a statement that the applicant has received and read the bylaws of the Hospital and the bylaws, rules, and regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

Section 2. Appointment Process

a. Each applicant has the responsibility to submit a completed application and all supporting documents (a fully completed application) to the Medical Staff Office. Once the Medical Staff Office verifies that the office has received a fully completed application, the Medical Staff Office will accomplish all primary source verification and verification of required information within 120 days. The applicant is responsible for assisting the Medical Staff Office in obtaining professional references. If the Medical Staff Office does not submit a fully completed application to the Credentials Committee within 120 days, the applicant may request a hearing with the Medical Executive Committee.

b. Within sixty (60) days after receipt of a fully completed and fully verified application for membership, the Credentials Committee shall make a written report of its investigation to the Executive Committee. The application shall be considered completed and the sixty (60) day period will commence only upon receipt and verification of all information and requirements supporting the application for membership, including a referral to the Committee on Practitioner Health and all subsequent follow-up recommendations, if requested, payment of the required fee, and completion of the required interview. Prior to making its final report, the Credentials Committee shall examine the evidence of character, professional competence, qualifications and ethical standing of the practitioner and shall determine through the information contained in references and other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the Practitioner has established and meets all the necessary qualifications for Medical Staff membership and clinical privileges requested. In extraordinary circumstances, a specific qualification may be met by an appropriate alternative or a substantially equivalent qualification as determined by a 75% vote of the Credentials Committee. The Chair of the department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the Practitioner's clinical privileges and these recommendations shall be made part of this report. Together with this report, the Credentials Committee shall transmit to the Executive

Committee the completed application and a recommendation that the practitioner be either appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

c. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend that the practitioner be appointed to the Medical Staff, that he/she be rejected for medical staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, including any that may be qualified by probationary conditions.

d. When the recommendation is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for Medical Staff membership.

e. When the recommendation of the Executive Committee is favorable to the practitioner, the Chief of Staff shall promptly forward it, together with all supporting documentation, to the Governing Body. The active staff shall then vote on the appointment at its next regular meeting.

f. When the recommendation of the Executive Committee is adverse to the Practitioner, either in respect to appointment, reappointment, return from an approved leave of absence or clinical privileges, either the Chief of Staff or Chief Medical Officer shall promptly so notify the Practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these bylaws.

g. If, after the Executive Committee has considered the report and recommendation of the ad hoc hearing committee, as provided in Article VIII, Section 5, the Executive Committee's reconsidered recommendation is favorable to the Practitioner, it shall be processed in accordance with Section 2d. If such recommendation continues to be adverse, either the Chief of Staff or the Chief Medical Officer shall promptly notify the Practitioner by certified mail, return receipt requested. The Chief of Staff shall also forward such recommendation and the application documents to the Governing Body, but the Governing Body shall take action thereon only in a manner consistent with the provisions of Article VIII of these bylaws.

h. At its next regular meeting after receipt of a favorable recommendation on an application, the Governing Body shall act in the matter. If the Governing Body's decision is adverse to the Practitioner in respect to either appointment or clinical privileges, either the Chief of Staff or the Chief Medical Officer shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the Practitioner has exercised or

has been deemed to have waived his/her rights under Article VIII of these bylaws and until there has been compliance with sub-paragraph i of this Section 2. The fact that an adverse decision is held in abeyance shall not be deemed to confer privileges upon the practitioner which he/she did not previously have.

i. The Governing Body's decision shall be conclusive and subject to only such review or appellate rights as are provided in Article VIII. The Governing Body shall render its final decision no later than its next regular meeting after the Practitioner has exhausted or waived all of his/her rights under Article VIII, except that the Governing Body may defer final determination and, if it elects, refer the matter back to the Executive Committee or Credentials Committee for further consideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and any new evidence in the matter, the Governing Body shall render its final decision on the application. All appointments to the Medical Staff shall include a delineation of the clinical privileges which the practitioner may exercise.

j. When the Governing Body has rendered its final decision, it shall send notice of such decision through the Chief Medical Officer to:

(1) the secretary of the Medical Staff;
(2) the chair of the Executive Committee;
(3) the chair of the department concerned; and
(4) by certified mail, return receipt requested, to the practitioner
(5) the Chief Operating Officer.

Section 3. Reappointment Process

a. The first reappointment shall occur at the conclusion of the provisional period as provided for in these bylaws. Each subsequent reappointment shall occur within three months after each Massachusetts license renewal. In no case shall a reappointment extend beyond twenty-four (24) months or a lesser time as may be prescribed by federal, state, or local statutes, rules, or regulations.

b. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence, clinical judgment, health status, compliance with the appropriate Massachusetts professional licensing Board requirements , including the requirements for Continuing Professional Education, compliance with the hospital Bylaws and Medical Staff Bylaws, Rules, and Regulations, and maintenance of all of the qualifications for and conditions of membership as described in Article III, Sections 2 and 3. Maintenance of Board certification in the member's

area of practice is expected, and failure to do so shall result in a review of the practitioner's performance by the Credentials Committee and the Chair of the Department in which the practitioner holds privileges. If a medical staff member has allowed their board certification to lapse, conditional reappointment to the medical staff will be permitted. Transition of this conditional reappointment to full reappointment is contingent on the practitioner reinstating her/his board-certified status within one (1) year. The credentials committee will report to the medical executive committee and the medical executive committee will report to the governing body the status of such conditional reappointments one (1) year after they were allowed. Members of the medical staff with "Refer, Follow and Resume Care" and/or "Ambulatory Care" Privileges will not be required to maintain further Board Certification after 25 years of professional practice with Board Certification.

c. At least 30 days prior to the expiration date of the member's Massachusetts license issued by the appropriate Board of Registration, a reappointment package will be provided by regular mail or in person. The application will have the same requirements as described in Article V, Section 1a, except that only one peer reference pertaining to the applicant's current professional competence is required. The application and required supporting documents must be returned to the Medical Staff Office no later than 30 days after the Massachusetts license expiration date. Failure to meet this deadline may result in lapse of the right to exercise clinical privileges and loss of membership. It may also serve as grounds for Corrective Action.

d. First, the relevant Department Chair and then the Credentials Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal, for the purpose of determining recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period and shall transmit their recommendations , in writing, to the Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

e. The Executive Committee shall make written recommendations to the Governing Body, through the Chief of Staff, concerning the reappointment and clinical privileges of each Practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented. When an ad hoc committee has recommended any corrective action which has subsequently been approved by the Medical Executive Committee during the prior credentialing cycle, the subsequent reappointment shall be for not more than one year.

f. Thereafter, the procedures provided in Section 2 of this Article V relating to recommendations on applications for initial appointment shall be followed.

ARTICLE VI. CLINICAL PRIVILEGES

Section 1. Clinical Privileges Restricted

a. Every practitioner practicing at this hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the governing body, except as provided in Section 2 and 3 of this Article VI.

b. Every application for staff appointment or reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including an appraisal by the department chair in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. Regardless of the mechanisms used to grant, renew, or revise clinical privileges, the privileges granted are hospital specific, based not only on the applicant's qualifications, but also on a consideration of the procedures and types of care or services that can be performed or provided within Berkshire Medical Center. If an applicant's training or experience is in a specific area(s), corresponding privileges can be granted only if the hospital has adequate facilities, equipment, number and types of qualified support personnel, and any necessary support services.

c. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon some or all of the following:
   (1) direct observation of care provided;
   (2) review of the records of patients treated in this or other hospitals; and
   (3) review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

Section 2. Temporary Privileges

a. When appropriate, the Chief Medical Officer or designee, or his or her designee, may grant Temporary clinical privileges for a limited time period on the recommendation of the Chair of the relevant clinical department, when available, or the Chief of Staff in all other circumstances. Appropriate circumstances are:
   (1) When an important patient care need is served and the following conditions are met:
      A. Primary source verification of licensure, current competence, and malpractice liability insurance coverage is obtained;

B. Specific clinical privileges are recommended by the Department Chair or the Chief of Staff;
C. The time period does not exceed 120 days;
D. The practitioner agrees in writing to be bound by the Bylaws, Rules and Regulations and hospital policy;

(2) When an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and/or the Governing Body, temporary privileges may be granted for a time period of up to 120 days.

b. Special requirements of supervision and reporting may be imposed by the relevant departmental chair with respect to any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Medical Officer or designee upon notice of any failure by the Practitioner to comply with such special conditions.

c. The Chief Medical Officer may, at any time upon the recommendation of the Department Chair or the Chief of Staff, terminate a Practitioner's temporary privileges. Termination may also be imposed by any person entitled to impose a summary suspension pursuant to Section 2a of Article VII of these bylaws, and the same shall be immediately effective. The appropriate department chair, or his or her designee, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until discharged from the Hospital. The wishes of the patient shall be considered where feasible in selection of such substitute Practitioner.

Section 3. Emergency and Disaster Privileges

In the case of emergency, any Practitioner, or member of the resident house staff, to the degree permitted by his/her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of a patient. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

In addition to the foregoing, disaster privileges may be granted to a licensed independent practitioner for a specific period of time when the Hospital Emergency Operations Plan has been activated and the organization is unable, or anticipates it will be unable, to handle the immediate patient needs.

a. The determination that the organization is unable to handle the immediate patient care needs will be made jointly by a medical staff leader and a hospital senior administrator. Medical staff leader means the Chief Medical Officer, a member of the Medical Executive Committee, Department Vice-Chair, or Division Chair. Senior administrator means hospital Chief Operating Officer, Vice-President of Acute Care Services, or House Nursing Director.

b. The Chief Medical Officer, Chief Operating Officer or Chief of Staff, or their designee(s) may grant disaster privileges upon the practitioner's presentation of:
   (1) A valid government issued photo identification and
   (2) A current license to practice in Massachusetts unless:
      a. A licensing waiver has been issued by the Massachusetts Department of Public Health or
      b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) issued by the US Department of Health and Human Services that has been activated in response to the disaster.

c. The titles of individuals who may act as designees of the Chief Medical Officer, Chief Operating Officer or Chief of Staff and their responsibilities are described in a separate policy approved by the Medical Executive Committee. The management of the activities of the individuals granted disaster privileges and the mechanism to identify these individuals will also be described in the same policy.

d. As soon as the immediate situation is under control, the verification process described for Temporary Privileges will be addressed as high priority.

Section 4. Privileges for Advanced Practice Providers

Providers who are licensed, certified or registered under the law to render or assist in rendering health care related services independently and/or under the supervision of a Practitioner, shall have their privileges delineated in the same manner as the Medical Staff. Privileges will be granted based on documented competence, training, and experience in their professional field and confirmation of the same by adequate references. Each advanced practice provider so credentialed will be assigned to a specific clinical department and will be responsible to the chair of that department for their professional performance, including monitoring and evaluation. These individuals will, in all respects, be governed by the bylaws of the Hospital and of the Medical Staff. The Executive Committee, with the approval of the Governing Body, will determine which professional services are needed for benefit of patients at the Hospital. The specific types of advanced practice provider identified by the Executive Committee and the restrictions or requirements applicable to each shall be described in the rules and regulations of the Medical Staff.

ARTICLE VII. CORRECTIVE ACTION

Section 1. Procedure

a. Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered to be lower than the standards generally required of members of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Practitioner may be requested by an officer of the Medical Staff, by the Credentials Committee, by the chair of any clinical department, by the Chief Medical Officer, by the Chief Operating Officer, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the

Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Medical Executive Committee will have up to thirty (30) days to consider the request for corrective action, gather more information and make a final decision as to whether to proceed with correction action.

b. Whenever the Medical Executive Committee votes to proceed with a corrective action, within twenty-four (24) hours, the Executive Committee shall notify in writing by mail (with return receipt requested) the practitioner(s) for whom corrective action is proceeding. The Medical Executive Committee shall forward such a request to the chair of the department wherein the Practitioner has such privileges. Upon receipt of such request, the chair of the department and the Chief of Staff shall immediately appoint an ad hoc committee to investigate the matter.

c. The ad hoc committee shall make a report of its investigation to the Executive Committee within sixty (60) days of the initiation of the corrective action proceeding. The ad hoc committee chair may request a one-time extension of time of up to an additional sixty (60) days to complete the committee's investigation and conclusions. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, he/she shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply hereto. A record of such interview shall be made by the ad hoc committee and included with its report to the Executive Committee. The ad hoc committee shall also interview other individuals who have direct knowledge of the issues, circumstances, or events important to a full and fair evaluation of the request for Corrective Action. These interviews shall also be recorded, electronically or in writing, and reported to the Executive Committee.

d. Within thirty (30) days following the receipt of a report from an ad hoc committee investigating a request for corrective action involving possible reduction or suspension of clinical privileges, or report to the appropriate Board of Registration, the Executive Committee shall take action upon the request. The affected Practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made to the Executive Committee.

e. The action of the Executive Committee on a request for corrective action may be to reject or modify the request, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension, or

revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the Practitioner's Medical Staff membership be suspended or revoked.

f. Any adverse recommendation by the Executive Committee shall entitle the Practitioner to the procedural rights provided in Article VIII of these bylaws.

g. The Chair of the Executive Committee shall promptly notify the Chief Medical Officer or designee, in writing, of all requests for corrective action received by the Executive Committee and shall continue to keep the Chief Medical Officer fully informed of all action taken in connection therewith. The Chief Operating Officer shall forward any recommendation of the Medical Executive Committee for restriction, reduction or limitation of privileges, or for suspension or expulsion from the medical staff, to the Governing Body for action.

h. Any Practitioner whose employment or other engagement by the Hospital requires membership on the Medical Staff shall not have his/her medical privileges terminated without the same due process provisions herein for any other member of the Medical Staff, unless otherwise contractually agreed.

Section 2. Summary Suspension

a. Any one of the following - the chair of the Executive Committee, the Chief of Staff, the chair of the clinical department, the Chief Medical Officer, in accordance with the Berkshire Medical Center bylaws, or the Executive Committee of the Medical Staff shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner, and such summary suspension shall become effective immediately upon imposition. (It should be noted that this does not remove the Practitioner from the staff, but just suspends specified clinical privileges.)

b. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Executive Committee may be convened in accordance with Article VIII of these bylaws.

c. The Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the affected Practitioner shall, also in accordance with Article VIII, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision thereon by the Governing Body.

d. Immediately upon the imposition of a summary suspension, the chair of the Executive Committee or responsible departmental chair shall have authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner. If the patient requests the care of a non-staff practitioner, he/she may request transfer to another facility.

Section 3. Automatic Suspension

a. Clear, current and complete medical records are an essential part of safe and effective patient care and all practitioners are strongly encouraged to complete and sign their patients' medical records either during hospitalization or as soon after discharge as is reasonably practical. The licensed independent practitioner responsible for a patient's record entry is responsible for the timeliness of the completion and signature of those records and shall be notified weekly of all incomplete records, including those that have progressed to overdue and delinquent status.

If a record of a patient discharged from the hospital is incomplete or unsigned at the time of discharge, it shall be deemed "incomplete". Records of patients discharged from the hospital not completed within twenty two (22) days of discharge shall be considered "overdue". Any records not completed within thirty (30) days of discharge will be considered "delinquent" and a warning of suspension of the practitioner's hospital privileges will be given. Delinquent records are required to be completed immediately following notification of warning of suspension, and for each additional week that passes, any records remaining delinquent or new records aging to delinquent will result in the next step in the process; a second warning, progressing to an automatic suspension if and when warranted. Should a practitioner's recurring delinquency in records result in warnings of suspension 2 times in one year, then the next occurrence (3rd) of delinquency will result in automatic suspension of the practitioner's medical staff membership and privileges. This first automatic suspension will be for a minimum of 3 days or until all delinquent records are completed. A second or any subsequent automatic suspension will be for a minimum of 5 days or until all delinquent records are completed.

When the Chief of Staff or the Chair of the Department in which the practitioner holds membership determines that immediate imposition of an automatic suspension may result in significant disruption in patient care, they may delay the imposition of the suspension for up to 2 weeks. The

Chief of Staff will not withdraw an automatic suspension until notified by the Medical Record department that the suspended practitioner has completed all delinquent medical records and the practitioner has served the appropriate duration of suspension. This includes all warnings or automatic suspensions occurring in a calendar year.

b. Action by the Board of Registration in Medicine revoking or suspending a Practitioner's license shall automatically suspend his/her Medical Staff membership and all of his/her Hospital privileges.

c. It shall be the duty of the Chief of Staff to cooperate with the Chief Medical Officer in enforcing all automatic suspensions.

Section 4. Suspension for Failure to Pay Dues

In the event that a member of the Medical Staff shall fail to pay the dues assessed under Article III, Section 6 within thirty (30) days of the date of assessment, a summary suspension of the member's admitting privileges shall be imposed until such time as the dues assessed are paid in full. The procedures set forth in Section 2 of this Article governing summary suspensions shall apply to summary suspension for failure to pay dues. Continued failure to pay the dues assessed for a period of ninety (90) days after the date of assessment shall be deemed a resignation by the member from the Medical Staff.

ARTICLE VIII. HEARING AND SPECIAL REVIEW PROCEDURE

Section 1. Right to Hearing

Except as limited elsewhere in these bylaws, or by separate agreement, a Practitioner, whether an applicant or a person holding a Medical Staff appointment or privileges, shall be entitled to a hearing whenever a decision of the Governing Body or a recommendation of the Executive Committee has been made against him/her which would result in one of the following actions (hereinafter referred to as "Adverse Actions" in the case of Governing Body decisions, and "Adverse Recommendations" in the case of Executive Committee recommendations): a. denial of initial medical staff appointment; b. denial of requested advancement in medical staff category; c. denial of medical staff reappointment; d. revocation of medical staff appointment; e. denial of requested initial clinical privileges; f. denial of requested increased clinical privileges; g. decrease of clinical privileges; h. suspension of total clinical privileges for a term of thirty (30) days or more; or i. any action other than that consented to by the Practitioner, that requires a report to the Board of Registration in Medicine. Neither voluntary or automatic relinquishment of clinical privileges, as provided for elsewhere in these bylaws, nor the imposition of any requirement for consultation, the imposition of a requirement for retraining, additional training, or continuing education, whether imposed by the Executive Committee or the Governing Body, shall constitute grounds for a hearing or appeal unless such action requires a report to the Board of Registration in Medicine.

Section 2. Procedure to Claim Hearing; Waiver

a. Within five (5) days of the Adverse Action or Adverse Recommendation, the Chief Medical Officer shall deliver written notice to the affected Practitioner by certified mail, return receipt requested.

b. Within thirty (30) days of receipt of the notice described in Section 2a of this Article VIII, the affected Practitioner may request a hearing by delivery to the Chief Medical Officer, by certified mail, return receipt requested, a written request for hearing stating briefly the Adverse Action or Adverse Recommendation about which a hearing is sought and the claim of error or other basis which prompts the request for hearing.

c. Failure of the affected Practitioner to request a hearing, as provided in Section 2b of this Article VIII, shall constitute a waiver of his/her right to a hearing or any right to request special review as provided in this Article VIII.

d. If the affected Practitioner waives his/her right to a hearing following an Adverse Recommendation of the Executive Committee, the Adverse Recommendation shall become effective against the affected Practitioner pending the decision of the Governing Body. If the affected Practitioner waives his/her right to a hearing following an Adverse Action of the Governing Body, the Adverse Action shall become effective as a final decision of the Governing Body as described in Section 2 of this Article VIII. Upon the waiver of the affected Practitioner's right to a hearing, the Chief Medical Officer shall promptly notify the affected Practitioner, by certified mail, return receipt requested, of the waiver and its effect.

e. Notwithstanding any other provision of these bylaws, no affected Practitioner shall be entitled as a right to more than one hearing and one special review, pursuant to this Article VIII, with respect to any matter which shall have been the subject of an Adverse Recommendation by the Executive Committee of the Medical Staff, or by an Adverse Action by the Governing Body.

Section 3. Notice of Hearing

a. Within ten (10) days of receipt by the Chief Medical Officer of a request for hearing, the Executive Committee in the case of a challenged Adverse Recommendation or the Governing Body, in the case of a challenged Adverse Action, shall schedule a hearing and shall, through the Chief Medical Officer, notify the affected Practitioner, by certified mail, return receipt requested, of the time, place and date of the hearing. The hearing shall be scheduled not less than five (5) nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that if the challenged Adverse Action or Adverse Recommendation is a

suspension of total clinical privileges or revocation of Medical Staff membership, the hearing shall be scheduled as soon as practical, but in no event later than thirty (30) days after receipt of the request for hearing.

b. The notice of hearing shall state briefly the nature and basis of the Adverse Action or Adverse Recommendation and, if appropriate, shall also list specific or representative patient charts under question. If, upon receipt of the notice, the Practitioner desires a more particular statement or clarification of the Adverse Action or Adverse Recommendation than provided in the hearing notice, he/she shall make a written request of the Chief Medical Officer within 72 hours of receipt of the hearing notice.

Section 4. Composition of Hearing Committee

a. In the event that the requested hearing relates to an Adverse Recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc committee of not less than five members of the Medical Staff appointed by the Chief of Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated by the Chief of Staff as committee chair. No staff member who has actively participated in the consideration of the Adverse Recommendation shall be appointed a member of the ad hoc hearing committee unless the Chief of Staff determines that the requisite number of hearing committee members cannot practicably be assembled, within the time permitted by these bylaws, from those members of the Medical Staff who have not actively participated in the Adverse Recommendation.

b. In the event that the requested hearing relates to an Adverse Action of the Governing Body, such hearing shall be conducted by an ad hoc committee of not less than five individuals appointed by the Chief of Staff. At least one representative from the Medical Staff shall be included on the committee, and no member of the Governing Body shall be disqualified from membership on the ad hoc committee solely on the grounds of having actively participated in the consideration of Adverse Action.

c. The ad hoc committee shall designate one of its members as chair.

Section 5. Conduct of the Hearing

a. There shall be at least a simple majority of the members of the ad hoc committee present during the hearing and deliberations. No member may vote by proxy.

b. An accurate record of the hearing shall be made. The ad hoc committee may choose to make its record by use of a stenographic reporter, electronic recording unit, or by the taking of minutes.

c. The affected Practitioner shall attend the hearing. An affected Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided

in Section 2 of this Article VIII and to have accepted the Adverse Recommendation or Adverse Action involved, and the same shall thereupon become and remain in effect as provided in Section 2 of this Article VIII.

d. Postponement of hearing beyond the time set forth in these bylaws shall be made only with the approval of the ad hoc committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the ad hoc committee.

e. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society.

f. The chair of the ad hoc committee, or his or her designee, shall preside over the hearing and, subject to the provisions of these bylaws, shall determine the order of procedure during the hearing, maintain decorum, and provide a reasonable opportunity to persons with an actual interest in the matter to present relevant oral and documentary evidence.

g. The hearing need not be conducted strictly according to rules of judicial or administrative law or procedure relating to the examination of witnesses or presentation of evidence. Any relevant matter may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible over objection in civil or criminal action or administrative proceeding. The affected Practitioner and, in the case of an Adverse Recommendation, the Executive Committee, or, in the case of an Adverse Action, the Governing Body, as the case may be, shall, prior to or during the hearing, be entitled to submit to the ad hoc committee memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

h. In the case of a challenged Adverse Recommendation, the Chief of Staff shall appoint a member of the Executive Committee or some other member of the Medical Staff to represent the Executive Committee at the ad hoc committee hearing, to present the facts in support of the Executive Committee's Adverse Recommendation and to examine witnesses. In the case of a challenged Adverse Action, the Chief of Staff shall appoint one of the members of the Governing Body at the ad hoc committee hearing to present the facts in support of the Governing Body's Adverse Action and to examine witnesses.

i. The burden of initially going forward with evidence in support of the Adverse Recommendation or Adverse Action shall rest with the Executive Committee or the Governing Body respectively. The affected Practitioner, however, shall thereafter have the burden of introducing contrary evidence and shall, in any event, have the burden of persuading the ad hoc committee that the Adverse Recommendation or Adverse Action was arbitrary, capricious, or lacked any basis in fact.

j. The affected Practitioner and the Executive Committee or the Governing Body, as the case may be, shall each have the following procedural rights: (a) to call and examine witnesses; (b) to introduce written evidence; (c) to

cross-examine any witness on any matter relevant to the issue of the hearing; (d) to rebut any evidence. If the affected Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

k. Any ad hoc hearing following an Adverse Recommendation or Adverse Action is intended to resolve, on an intra-professional basis, matters bearing on professional competency and conduct and the quality of medical care generally rendered by or at the Hospital. Accordingly, neither the affected Practitioner, nor the Executive Committee or the Governing Body shall be represented at any phase of the hearing procedure by an attorney-at-law, unless the ad hoc committee, in its sole discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the affected Practitioner, the Executive Committee, or the Governing Body of the right to legal counsel in connection with preparation for the hearing or preparation for a request for special review as provided in Section 7 of this Article VIII.

l. The ad hoc committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing shall be closed upon conclusion of presentation of oral and written evidence or at such other time as the ad hoc committee may announce. The ad hoc committee shall, following closing of the hearing, and at a time convenient to itself, conduct its deliberations outside the presence of the affected Practitioner or the representative of the Executive Committee or Governing Body appointed in Section 5h. Within thirty (30) days after the close of the hearing, the ad hoc committee shall make a written report and recommendation and shall forward same, together with the hearing record and all other documentation, to the Executive committee or to the Governing Body, whichever convened it. The report may recommend confirmation, modification, or reversal of the original Adverse Recommendation or Adverse Action.

Section 6. Action Following Ad Hoc Committee Report and Recommendation

a. At its next regular meeting after receipt of the recommendation of any ad hoc committee covered by it, the Executive Committee shall consider the recommendation and confirm, modify, or reverse its original Adverse Recommendation. The Executive Committee shall immediately thereafter, through the Chief of Staff, deliver to the Governing Body its original Adverse Recommendation, its final recommendation, and the entire record of any proceedings before the ad hoc committee with a copy of the same document delivered by certified mail to the affected Practitioner. If the record of the ad hoc committee proceedings is, in the judgment of the Chief of Staff, too voluminous to reproduce, the

Executive Committee shall deliver to the affected Practitioner a copy of the original Adverse Recommendation, the final recommendation, and a notice of where the record may be reviewed.

b. At its next regular meeting, after receipt of the recommendation of any ad hoc committee convened by it, or at such other time as it may determine, the Governing Body shall consider the recommendation and vote to confirm, modify or reverse its original Adverse Action. The Governing Body, acting through the Chief Medical Officer, shall immediately thereafter deliver by certified mail, return receipt requested, a copy of the original Adverse Action decision, the proposed final decision, and the record of proceedings before the hearing committee to the affected Practitioner. The final decision of the Governing Body shall become effective as a final decision ten (10) days after notice is sent to the affected Practitioner pursuant to this section, unless the Governing Body specifies a greater or lesser time in its notice.

c. At its next regular meeting after receipt of the recommendation of the Executive Committee pursuant to Section 6a of this Article VIII, or at such other time as it may determine, the Governing Body shall vote to adopt, modify, or reject the recommendation or take action it deems appropriate. The Governing Body, acting through the Chief Medical Officer, shall immediately thereafter deliver by certified mail, return receipt requested, notice of the decision of the Governing Body. The decision of the Governing Body shall become effective as a final decision ten (10) days after notice is sent to the affected Practitioner pursuant to this section, unless the Governing Body specifies a greater or lesser time in its notice.

Section 7. Special Review

a. Within ten (10) days after notice of the final decision of the Governing Body has been sent pursuant to Section 6b or c, the affected Practitioner may request a special review by the Governing Body limited to the issue of whether the ad hoc committee substantially failed to adhere to these bylaws or otherwise reached its recommendation in a manner which lacked fundamental fairness. The granting or denial of such a special review shall rest within the sole discretion of the Governing Body and any such request shall be granted only upon a showing by the affected Practitioner of a likelihood of success on the special review issues. Any request for special review shall be in writing, delivered to the Chief Medical Officer by certified mail, return receipt requested, and shall state the basis upon which the review is sought in sufficient detail to assist the Governing Body in determining whether to grant or deny the request. Unless the Governing Body notifies the affected Practitioner to the contrary, the submission of a request for special review shall not stay the effectiveness of any final decision of the Governing Body. Within thirty (30) days of receipt of a request for special review, the Governing Body

shall notify the affected Practitioner by certified mail, return receipt requested, of its decision to grant or deny such review.

b. If the Governing Body grants the requested special review, the date of the special review shall not be less than fifteen (15) days, nor more than thirty (30) days, from the date of granting of the request for special review, except that when the affected Practitioner requesting the review is under suspension for more than thirty (30) days, which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than thirty (30) days from the date of receipt of such notice.

c. The special review shall be conducted by the Governing Body as a whole or by a duly appointed special review panel of the Governing Body consisting of not less than five members.

d. The affected Practitioner shall have ten (10) days from receipt of the notice granting special review to submit a written statement in his/her own behalf in which he/she specifies his/her allegations and the factual basis for them. Such written statement shall be submitted to the Governing Body through the Chief Medical Officer by certified mail, return receipt requested, at least seven (7) days prior to the scheduled date for the special review session. A similar statement may be submitted by the Chief of Staff on behalf of the Executive Committee or by the chair of the ad hoc committee appointed by the Governing Body, as the case may be, and if submitted, the Chief Medical Officer shall provide a copy thereof to the affected Practitioner at least three (3) days prior to the date of such special review session by certified mail, return receipt requested.

e. The Governing Body, or its appointed special review committee, shall review the ad hoc committee's report and recommendations, the record otherwise created in the proceedings, and the written statements submitted pursuant to Section 5h, for the purpose of determining whether the ad hoc committee substantially failed to adhere to these bylaws or otherwise reached its recommendations in a manner which lacked fundamental fairness. If oral argument is requested by either party as part of the special review procedure, the affected Practitioner shall be present at such special review, shall be permitted to speak in support of his/her position, and shall answer questions put to him/her by any member of the Governing Body special review panel. The Executive Committee or the Governing Body, as the case may be, shall be represented by a duly appointed individual who shall speak hospital in support of its position and shall answer questions put to him/her by any member of the Governing Body or special review panel.

f. New or additional matters not raised during the original hearing or in the ad hoc committee report and recommendations, nor otherwise reflected in the record, shall only be introduced at the special review under unusual circumstances, and the Governing Body or special review panel shall in its sole discretion determine whether such new matters shall be accepted.

g. If the special review is conducted by the Governing Body as a whole, the Governing Body may take whatever action it deems appropriate, including affirming, modifying, or reversing its prior decision.

Section 8. Final Decision by Governing Body

Within ten (10) days after the conclusion of the special review and its consideration of the recommendation of the special review panel, the Governing Body shall make its decision with respect to the matters raised in the special review and shall send notice thereof to the Executive Committee and, through the Chief Medical Officer, to the affected Practitioner by certified mail, return receipt requested. Such decision shall be immediately effective and final and shall not be subject to further hearing or special review.

Section 9. Voluntary Withdrawal of Application

If an interested Practitioner withdraws his/her application and reapplies within one year after the withdrawal date, his/her reapplication will be taken up again at the point in the procedure wherein the original application had been withdrawn, provided that the entire application process be reviewed by the Credentials Committee and further that the Credentials Committee approve such resumption of the application process.

ARTICLE IX. OFFICERS OF THE MEDICAL STAFF

Section 1. Chief of Staff:

a. Qualifications and Election of the Chief of Staff. In order to qualify as a candidate for the office of Chief of Staff, a member must meet the qualifications for active staff membership and have experience in both clinical practice and medical administrative matters and must enjoy a general reputation for adhering to the highest standards of personal and professional integrity. Candidates will demonstrate a thorough understanding of the Bylaws, Rules and Regulations and a commitment to providing the leadership and time necessary to achieve the purposes described in Article II. Candidates for the office of Chief of Staff shall be interviewed and evaluated by a Nominating Committee, defined and described in Section 3 of Article XI. The Nominating Committee shall recommend a candidate to the Executive Committee, which may

recommend the candidate to the Medical Staff by simple majority vote. The Medical Staff may approve and recommend the candidate by simple majority vote. Upon approval of the candidate by the Medical Staff, the Nominating Committee shall recommend such candidate to the Governing Body. The Governing Body has final authority to approve and appoint the Chief of Staff by a simple majority. In the event that the candidate recommended by the Nominating Committee does not receive the approval of the Medical Staff and the Governing Body, the Nominating Committee shall recommend an alternate candidate first to the Executive Committee, then to the Medical Staff, and finally to the Governing Body, until a candidate is approved by all three entities and appointed by the Governing Body.

b. Duties of the Chief of Staff. The Chief of Staff shall serve as the leader of the Medical Staff and shall perform the various duties required of the Chief of Staff by these bylaws and the bylaws of the Hospital. In addition to other duties, the Chief of Staff shall preside at all meetings of the active staff and all meetings of the Executive Committee. The Chief of Staff shall be a voting member ex officio of the Governing Body and voting member ex officio of all Medical Staff committees described in Article XI of these bylaws. Except as otherwise provided in these bylaws, the Chief of Staff shall not, however, vote as a member of the Governing Body, the Medical Staff Executive Committee, Nominating Committee, or any other committee on any matter directly concerning the appointment, reappointment, evaluation or compensation of the Chief of Staff. The Chief of Staff shall, in coordination with the Chief Medical Officer, participate in quality and patient care processes, shall meet with administration, medical staff members or their groups to review concerns, investigations, disciplinary actions, disagreements and other items deemed appropriate to medical staff function.

c. Tenure of the Chief of Staff. The Chief of Staff shall be elected, as provided in Section l. of this Article IX for a period of three years.

d. Compensation of Chief of Staff and Contribution by Medical Staff. (1) The annual compensation paid to the Chief of Staff shall be determined by the Executive Committee on recommendation of the Nominating Committee. Compensation paid to the Chief of Staff shall be paid through the Hospital from the proceeds of Medical Staff dues. The Nominating Committee shall inform the Executive Committee of the amount of contribution to be required of the Medical Staff for the ensuing year. Such amount shall be included in the Medical Staff dues budget for approval by the Medical Staff.

Section 2. Vice Chief of Staff

Candidates for the office of Vice Chief of Staff shall demonstrate the same qualifications, commitment, and personal qualities as described for the Chief of Staff in

Section 1a of this Article IX and the intention to succeed the current Chief of Staff. The Nominating Committee, Medical Executive Committee, the medical staff, and the Governing Body will follow the same process for election as described for the Chief of Staff in Article IX, Section 1. The Vice Chief of Staff will serve for a three year term. The duties of the Vice Chief of Staff shall include:

a. Acting for the Chief of Staff in his or her absence;
b. Perform duties as the Chief of Staff or the Executive Committee may reasonably assign;
c. Become an active member of the Credentials Committee and the Medical Staff;
d. Quality Council; and
e. Chair the Credentials Committee.

Section 3. The Secretary-Treasurer

The secretary-treasurer will be qualified for the office by reason of demonstrated leadership ability, a reputation for adherence to the highest standards of personal and professional integrity, and dedication to the Hospital and its Medical Staff. The Nominating Committee shall select a nominee from the active staff for the office of secretary-treasurer to be placed in nomination at the September quarterly Medical Staff meeting and to stand for election at the December annual meeting of the Medical Staff. The secretary-treasurer shall serve for a three year term. The secretary-treasurer shall perform the usual duties of that office, plus any duties assigned by the Chief of Staff or the Executive Committee. He/she shall review the recorded minutes and shall be responsible for Medical Staff financial transactions. In the absence of the Chief of Staff and the Chief of Staff Elect, the secretary-treasurer will be acting chair of the Executive Committee and shall assume the duties and responsibilities of the Chief of Staff.

Section 4. Removal of Officers of the Staff and Medical Executive Committee Members

An individual medical staff officer or committee member may be removed from office by a vote of two-thirds of the Medical Executive Committee, followed by votes of two-thirds of both the Active Staff and the Governing Body. The grounds for removal shall include immoral, unethical or fraudulent conduct or by a loss of Active staff privileges.

ARTICLE X: CLINICAL DEPARTMENTS

Section 1. Organization

The Medical Staff shall be organized into eight distinct departments. Some departments shall have divisions based on clinical criteria. Each department will be headed by a Chair who will hold the responsibilities described in Section 2a of this Article X. The Chair of each department and the Chief of each division must be a member of the Active Staff and Board certified by an appropriate specialty Board or hold a substantially equivalent qualification. Upon recommendation of the department chair and with the approval of the Medical Executive Committee, the requirement that a division chief be on the active staff can be waived, to allow provisional staff members to serve in this capacity. Each department is expected to work towards the highest quality of care attainable through growth and development of programs, self-assessment, integrating services with other departments where needed, education, contributing to the work of Medical Staff committees, and making recommendations to the Executive Committee of the staff. These departments and divisions shall be:

Department	Division
Anesthesiology	Pain Medicine
Emergency Medicine	Urgent Care
Psychiatry	Addiction Medicine
Pathology	
Radiology	
Maternal Child Health	Obstetrics and Gynecology
	Hospital Pediatrics
	Community Pediatrics
Medicine	Cardiology
	Dermatology
	Endocrinology
	Family Practice
	Gastroenterology
	General Internal Medicine
	Geriatrics
	Hematology/Oncology
	Hospital Medicine
	Infectious Disease
	Nephrology
	Neurology
	Occupational Medicine
	Palliative Medicine
	Physical Medicine & Rehab
	Pulmonary/Critical Care
	Radiation Oncology
	Rheumatology

Surgery	General Surgery Ophthalmology Orthopedic Surgery Otorhinolaryngology Plastic Surgery Urological Surgery Dentistry/Oral Surgery Podiatric Surgery

Assignment to Medical Staff departments will be made based on recommendation of the Credentials Committee to the Executive Committee and approved by the Medical Staff. A practitioner with requisite training and experience in multiple disciplines may become a member of more than one department.

Section 2. Department Chair

a. Each department chair is responsible for the following:

(1) All clinically related activities of the department;
(2) All administratively related activities of the department, unless otherwise provided for by the hospital;
(3) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
(4) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
(5) Recommending clinical privileges for each member of the department;
(6) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;
(7) The integration of the department or service into the primary functions of the organization;
(8) The coordination and integration of interdepartmental and intradepartmental services;
(9) The development and implementation of policies and procedures that guide and support the provision of services;
(10) The continuous assessment and improvement of the quality of care and services provided;
(11) The maintenance of quality control programs, as appropriate;
(12) The orientation and continuing education of all persons in the department or service;
(13) Enforcement of the hospital and medical staff Bylaws, policies, rules and regulations within the department;

(14) Performance of other such duties commensurate with this office as may from time to time be reasonably requested of him/her by the Executive Committee or the Governing Body;
(15) Recommending sufficient numbers of qualified and competent persons to provide care or services;
(16) Determination of the qualifications and competence of department or service personnel who are not Licensed Independent Practitioners and who provide care; and
(17) Recommending for space and other resources needed by the department or service.

b. The chairs of the departments of radiology, pathology, anesthesiology, emergency medicine, psychiatry, and maternal child health will be appointed by the Chief Executive Officer, with the approval of the active staff and the Governing Body. The chairs of these departments shall be a member of the active staff and should be qualified by virtue of leadership ability, education, training and experience, and adherence to the highest standards of personal and professional integrity. When a vacancy exists or is anticipated in the near future, an ad hoc committee appointed by the Chief of Staff and approved by the Executive Committee shall work with the administration in obtaining suitable candidates for the chair of these departments. At least one of the members of the ad hoc committee must be from the department concerned, provided that he/she is not an applicant himself/herself. The ad hoc committee will make a recommendation to the Chief Executive Officer through the Executive Committee. The chairs of these departments described in this Section 2b shall serve for a term determined by the contractual agreement with the hospital, but shall terminate automatically upon such chair's loss of active staff privileges. The performance of the chairs of departments described in this Section 2b will be the subject of a periodic review by the Chief Medical Officer, Chief Operating Officer and the officers of the Medical Staff.

c. The Chairmanship of the Department of Medicine, shall be a position appointed by the Chief Executive Officer, subject to the approval of the active staff and the Governing Body. The departmental chair shall be responsible for carrying out the roles and responsibilities outlined in Section2.a. The departmental chair may also be appointed as the program director for the medicine residency program, but need not be appointed to that position. In the event that an individual other than the departmental chair serves as program director for the medicine residency program, that individual shall have a reporting relationship (a) to the departmental chair, (b) to the Designated Institutional Officer (as defined and required by any residency program accrediting body) and (c) as defined in any contractual arrangement with the Hospital or Hospital affiliate. The departmental chair shall be a member of the active staff, board Certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, and have demonstrated leadership ability, appropriate

education, training and experience, and adherence to the highest standards of personal and professional integrity.

Upon the occurrence of an actual or anticipated vacancy in the departmental chairmanship on or after January 1, 2015, an ad hoc search committee appointed by the Chief Executive Officer or their designee, after consultation with the Executive Committee, shall select suitable candidates for the relevant position. The ad hoc search committee shall, in all cases, include (a) a minimum of four members of the department of Medicine (b) the medicine residency program director, if a separate individual serves in that position; (c) two at-large members of the active medical staff; (d) the Chief Medical Officer, (e) the Chief Operating Officer and (f) the Chief of Staff. In the case of a search for a departmental chair who will also serve as medicine residency program director, the ad hoc committee shall also include one representative of the executive faculty council and one representative of any medical school with which the Hospital has a primary affiliation (provided that the affiliation agreement requires participation by such a medical school representative). No member of the ad hoc search committee may be a candidate for the position of chair for which the ad hoc committee is seeking candidates.

The ad hoc search committee shall make its recommendation through the Department of Medicine and the Executive Committee to the Chief Executive Officer, who shall have the power to appoint the departmental chair, subject to the approval of the active staff and Governing Body. If the departmental chair also serves as the medicine residency program director, he/she shall be appointed for a term consistent with the requirements of the ACGME and AOA, but the term shall terminate automatically upon such chair's loss of active staff privileges or other permitted grounds. The departmental chair shall: (1) meet monthly with the department to assure that department and inter-departmental issues are resolved satisfactorily; (2) seek advice from the department with regard to planning, program development and policy and; (3) assume direct leadership of any hospital-based faculty in the department.

The departmental chair shall be the subject of a performance evaluation at six months and at the anniversary date, second anniversary date, and every second anniversary date thereafter by an evaluation committee composed of the department vice-chair, the Chief Medical Officer, Chief of Staff, Hospital Chief Operating Officer, and two at large active staff members of the department elected by the department's active staff.

If the departmental chair does not also serve as the medicine residency program director, he/she shall have the right to nominate, from time to time, an individual to serve in that role, subject to the approval of the

executive faculty council and the Hospital Chief operating officer. The departmental chair, executive faculty council and Hospital chief operating officer shall review the performance of the program director every two years, or more frequently as they determine.

d. The Chairmanship of the Department of Surgery, shall be a position appointed by the Chief Executive Officer, subject to the approval of the active staff and the Governing Body. The departmental chair shall be responsible for carrying out the roles and responsibilities outlined in Section 2.a. The departmental chair may also be appointed as the program director for the surgical residency program, but need not be appointed to that position. In the event that an individual other than the departmental chair serves as program director for the surgical residency program, that individual shall have a reporting relationship (a) to the departmental chair, (b) to the Designated Institutional Officer (as defined and required by any residency program accrediting body) and (c) as defined in any contractual arrangement with the Hospital or Hospital affiliate. The departmental chair shall be a member of the active staff, and active in clinical practice, board Certified by the American Board of Surgery or the American Osteopathic Board of Surgery, and have demonstrated leadership ability, appropriate education, training and experience, and adherence to the highest standards of personal and professional integrity.

Upon the occurrence of an actual or anticipated vacancy in the departmental chairmanship on or after January 1, 2015, an ad hoc search committee appointed by the Chief Executive Officer or their designee, after consultation with the Executive Committee, shall select suitable candidates for the relevant position. The ad hoc search committee shall in all cases, include (a) a minimum of four members of the department of surgery; (b) the surgical residency program director, if a separate individual serves in that position; (c) two at-large members of the active medical staff; (d) the Chief Medical Officer (e) the Chief Operating Officer and (f) the Chief of Staff. In the case of a search for a departmental chair who will also serve as surgical residency program director, the ad hoc committee shall also include one representative of the executive faculty council and one representative of any medical school with which the Hospital has a primary affiliation (provided that the affiliation agreement requires participation by such a medical school representative). No member of the ad hoc search committee may be a candidate for the position for which the ad hoc search committee is seeking candidates.

The ad hoc search committee shall make its recommendation through the Department of Surgery and the Executive Committee to the Chief Executive Officer who shall have the power to appoint the departmental chair, subject to the approval of the acting staff and Governing Body. If

the departmental chair also serves as the surgical residency program director, he/she shall be appointed for a term consistent with the requirements of the ACGME and AOA, but the term shall terminate automatically upon such chair's loss of active staff privileges or other permitted grounds. The departmental chair shall: (l) meet monthly with the department to assure that department and inter-departmental issues are resolved satisfactorily; (2) seek advice from the department with regard to planning, program development and policy, and; (3) assume direct leadership of any hospital-based faculty in the department.

The departmental chair shall be the subject of a performance evaluation at six months and at the anniversary date, second anniversary date, and every second anniversary date thereafter by an evaluation committee composed of the departmental vice-chair, the Chief Medical Officer, Chief of Staff, Hospital Chief Operating Officer, and two at-large active staff members of the department elected by the department's active staff.

If the departmental chair does not also serve as the surgery residency program director, he/she shall have the right to nominate, from time to time, an individual to serve in that role, subject to the approval of the executive faculty council and the Hospital Chief operating officer. The departmental chair, executive faculty council and Hospital chief operating officer shall review the performance of the program director every two years, or more frequently as they determine.

e. Each department shall have a-vice-chair who is to be nominated by the chair of the department, approved by the Medical Executive Committee, the active staff and the Governing Body, who shall perform the prescribed duties of the chair in the latter's absence.

f. Division chiefs will be nominated by the chair of the department, approved by the Medical Executive Committee, the active staff and the governing body.

g. The Chief Medical Officer shall be a member, *ex officio* with vote, of all ad hoc search committees for all departmental chair positions.

ARTICLE XI: COMMITTEES

The committees of the Medical Staff shall be those necessary for the staff to perform the functions required to meet its obligation to: (1) its stated purposes in Article II of these bylaws; (2) the Governing Body and; (3) the various regulatory agencies. Medical Staff committees support and augment departmental functions and the functions of the Medical Staff Executive Committee. In addition, they support and augment

activities of the Hospital administration. Further, the Medical Staff participates in joint committees with the hospital administration. The name and characteristics of each standing and joint committee are described in these bylaws, but may be further characterized in the rules, regulations, and procedures of the Medical Staff. The Chief of Staff may appoint an ad hoc committee for any reasonable purpose, but such a committee must report its findings to any standing or joint committee or the Executive Committee of the Medical Staff. The members and chair of all Medical Staff committees shall be appointed by the Chief of Staff, except as otherwise described in these bylaws (see Executive Committee, Nominating Committee and faculty council). These appointments shall be made annually and approved by the Executive Committee. The chairmanship of the joint committees shall be by agreement of the Chief Medical Officer, the Chief of Staff and the Chief Operating Officer, or their respective designees. The Chief of Staff shall be an ex officio member of all committees with vote, except as described in Article IX. Section 1b of these bylaws. Each committee shall submit an annual report of its activities to the Executive Committee directly or as otherwise described in these bylaws. Each Committee shall maintain minutes of its activities. This shall fulfill the Committees' reporting responsibility to the Executive Committee. A Committee recommendation, which may require a change in hospital policy, departmental policy, or the Medical Staff Bylaws, Rules, and Regulations should be referred to the Medical Executive Committee or the relevant hospital department. The various standing and joint committees are described as follows:

1. The Medical Staff Executive Committee

The Executive Committee shall consist of the chairs of the clinical departments, the officers of the Medical Staff, and three at large members from the department of medicine, one of whom shall be a family practitioner, two at large members from the department of surgery and a member of the Advanced Practice provider Staff. The Executive Committee may include Licensed Independent Practitioners who are voting members of the Medical Staff. At the outset, term length shall be adjusted so that continuity can be achieved through overlapping terms. Subsequently, at large members and the advanced practice provider member would be expected to serve two successive two year terms. The at large position shall be elected by the respective department Active staff members and approved by the Medical Staff and the Governing Body. The advanced practice provider position shall be elected by the advanced practice provider staff members and approved by the Medical Staff and the Governing Body. The Chief Medical Officer and the Chief Operating Officer, or his or her representative, shall serve as members of the Executive Committee, but in each case, without vote. The secretary of the medical staff shall serve as recording secretary. The duties of the Executive Committee shall be to coordinate the activities and general policies of the various departments, to make appropriate disposition of all reports dealing with various staff functions and to make decisions for the Medical Staff. The immediate past Chief of Staff will maintain voting membership on the Executive Committee for a period of one year following his or her term. A voting member of the Medical Staff Executive Committee may authorize a proxy if he or she is unable to attend a meeting. Proxy for the

Chairperson of a clinical department or the at-large member shall be the Vice Chair of that department. Proxy designation shall be in writing, submitted to the Chief of Staff, and in effect for one meeting only. The authority delegated to the medical executive committee to act on behalf of the medical staff may be limited or removed by vote of two-thirds of the active medical staff. This will be in effect only in a prospective manner. Individual decisions by the medical executive committee are subject to a reversal of its decisions by a majority vote of the active staff.

Among the duties of the Executive Committee are the following:

a. to represent and act on behalf of the Medical Staff between meetings of the Medical Staff;
b. to coordinate the activities and general policies of the various departments;
c. to receive and act upon committee reports;
d. to implement policies of the Medical Staff not otherwise the responsibility of the departments;
e. to provide liaison between Medical Staff and hospital administrative leadership and the Governing Body;
f. to recommend action to the Chief Executive Officer on matters of medico-administrative nature;
g. to make recommendations on hospital management matters to the Governing Body through the Chief of Staff;
h. to fulfill the medical staff's accountability to the Governing Body for the medical care rendered to patients in the hospital;
i. to review the credentials of all applicants and to make recommendations for Medical Staff membership, assignment to departments, and delineation of clinical privileges;
j. to review periodically all information available regarding the performance and clinical competence of Medical Staff members and other Practitioners with clinical privileges and as a result of such review to make recommendations for reappointment and renewal or changes in clinical privileges;
k. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
l. to report at each general Medical Staff meeting.

2. The Credentials Committee

The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of at least three members of the Executive Committee, at least four members of the active staff and a member of the Advanced Practice Provider Staff. The

chair and the members shall be selected by the Chief of Staff on a basis that will ensure representation of the major clinical specialties, the hospital based specialties, medical education, and the Medical Staff at large. The Credentials Committee is responsible for oversight of the credentialing of all medical staff. The committee is chaired by the Vice Chief of Staff.

The duties of the Credentials Committee shall be:

a. to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges based upon the interview, telephone validations, and compliance with Articles V and VI of these bylaws;
b. to make a report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the Chair of the department in which the applicant requests privileges;
c. to review periodically all information available regarding the competence of Medical Staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Article V and VI of these bylaws;
d. to investigate any alleged breach of ethics reported to it and make recommendations to the Executive Committee based on the results of such investigation;
e. to investigate any allegations that a Medical Staff member has become physically or mentally impaired and make recommendation to the Executive Committee based on the results of such investigation; and
f. to review, evaluate, and make recommendations on reports that are referred to it by the Executive Committee, quality improvement, utilization review, and patient care assessment committees, by the clinical departments and by the Chief of Staff.

The Credentials Committee shall meet monthly and shall maintain a permanent record of its proceedings and shall make written reports of its activities and recommendations to the Executive Committee.

3. The Nominating Committee

The Nominating Committee shall consist of:

a. the physician members of the Governing Body recommended by the Medical Executive Committee
b. Two at-large members of the active staff nominated by the Medical Executive Committee and elected by a simple majority vote of the Medical Staff; and
c. The Immediate Past Chief of Staff

The Executive Committee shall annually present to the Medical Staff the name of candidate(s) for the positions of at large member. The members at large may serve any number of one year terms, but no more than three years consecutively. The Nominating Committee shall announce at the September meeting of the Medical Staff the candidates for staff officers and nominees for membership on the Governing Body to be voted upon by the Medical Staff at the December annual meeting provided for in Article XIV, Section 2. The Nominating Committee shall also nominate practitioners to fill unexpired terms of Medical Staff offices at any time. Except as may be incidental to its nominating function, the Nominating Committee shall have no obligation or authority to review the performance of any Medical Staff officers.

4. The Bylaws Committee

The Bylaws Committee shall meet at least annually to review the bylaws, rules, regulations, and procedures and shall reports its findings and recommendations to the Executive Committee.

5. The Perioperative Administration Committee

The Perioperative Administration Committee shall review, evaluate and make recommendations on the functioning of all operating room facilities, equipment, support services, and staffing.

6. The Library Committee

The Library Committee shall review, evaluate, and make recommendations on the operation of the medical library. It shall meet on an ad hoc basis as needed and make a written report of its activities and recommendations as appropriate to the Chief Operating Officer.

7. The Critical Care Committee

The Critical Care Committee shall review, evaluate and make recommendations on the operation of the Critical Care Unit, the Critical Care Step-Down Unit and Respiratory Therapy. It shall meet at least quarterly and make a written report of its activities and recommendations.

8. The Nutrition Committee

The Nutrition Committee shall review, evaluate, and make recommendations on all nutritional services provided by the hospital. It shall meet at least quarterly and make a written report of its activities and recommendations.

9. The Endoscopy Committee

The Endoscopy Committee shall review, evaluate, and make recommendations on the operation of the endoscopy unit. The committee shall also ensure that those who perform these procedures are adequately trained and that the equipment and facilities are adequately and properly maintained, and that the utilization and safety of the procedures meets generally accepted standards. The committee shall consist of representatives of medicine and surgery. It shall meet at least quarterly and make a written report of its activities and recommendations.

10. The Trauma Committee

The Trauma Committee will review, evaluate, and make recommendations on the trauma program. It shall meet at least quarterly and make a written report of its activities and recommendations.

11. The Health Information Management Committee

The Health Information Management Committee shall review, evaluate, and make recommendations on the operation of the medical records department as it relates to medical practice and the delivery of patient care. It shall meet quarterly and make a written report of its activities and recommendations.

12. Pharmacy & Therapeutics/IV Therapy Committee

The Pharmacy and Therapeutics Committee shall review, evaluate, and make recommendations on the operation of the pharmacy and other therapeutic services, including IV therapy, as they pertain to medical practice and the provision of patient care. It shall meet at least quarterly and make a written report of its activities and recommendations.

13. The Institutional Review Board

The Institutional Review Board is a joint medical staff and hospital administration board with additional representatives of the lay community. The board's purpose is to review requests to conduct medical research involving humans with the express purpose of patient advocacy; namely, adequate patient information regarding risks as well as benefits to the participant in the investigation. It is the duty of the board to assure that all medical research conducted at BMC has received approval by this or another Department of Public Health approved IRB. The board shall include a pharmacist, a representative of the hospital administration, members of the Medical Staff, and lay persons not associated with the Hospital. The lay members must comprise at least one third of the total membership. The board shall meet as often as required, but at least annually. The board shall make a written report of its activities and recommendations.

14. The Patient Care Ethics Committee

The Patient Care Ethics Committee is a joint Hospital Administration/Medical Staff committee. It shall consist of one primary care physician, one specialist physician, one psychiatrist or psychologist, one member of the house staff, two nurses, one Hospital administrator, one social worker, one attorney, one member of the clergy, and one member of the Governing Body. Additional members may be appointed as deemed appropriate by agreement of the Hospital Chief Operating Officer, or his or her designee, and the Chief of Staff. The committee's function is to promote education of all members of the BMC community about ethical considerations in Hospital activities, review and clarify Hospital policies which have ethical ramifications, and serve as an advisory resource for physicians, patients, and patients' families who face specific ethical problems in patient care. It shall meet at least quarterly and, with due regard to confidentiality, make a written report of its actions and recommendations.

15. The Radiation Safety Committee

The Radiation Safety Committee is a joint Hospital/Medical Staff committee which shall oversee the use of radioactive materials and radiation emitting devices, so as to assure the safety of their use. It shall meet at least quarterly and make a written report of its activities and recommendations.

16. The Emergency Preparedness Committee

The Emergency Preparedness Committee is a joint Hospital/Medical Staff committee which shall coordinate the planning and execution of disaster medical care. It shall meet at least quarterly and make a written report of its activities and recommendations.

17. The Infant Surgery Review Committee

The Infant Surgery Review Committee shall be responsible for reviewing proposed surgical procedures on infants at this hospital and will determine pre-operatively the adequacy of support facilities for intra-operative and postoperative care. It will be the responsibility of the operating surgeon to call the committee into session for any cases deemed somewhat out of the ordinary. In addition, on review of proposed surgery, the chair of anesthesia or other anesthesiologist acting on his/her behalf may activate the committee. The committee shall be composed of the chair of pediatrics, the chair of surgery, the chair of anesthesia, the medical director of critical care, and the nursing director of maternal/child health. This committee will meet on an as needed basis as deemed necessary by either the operating surgeon or the chief of anesthesiology. Whenever possible, the committee shall meet at least forty-eight hours in advance of the contemplated surgery. In a case of emergencies, every attempt should be made to convene this committee. The recommendation of the committee will govern the subsequent management of the case.

18. The BMC Value Council

The BMC Value Council shall be responsible for coordinating all activities and integrating all information concerned with the quality and appropriateness of patient care provided by all individuals with clinical privileges. This shall include, but not be limited to, review of surgical and other invasive procedures, surgical case review, medical case review, drug use evaluation, medical record audit, blood usage review, risk management, infection control, utilization review, cancer committee (see Art. XI #21) and the review of the professional performance conducted by the Medical Staff Peer Review committee (see Article XI #22) and the clinical departments. The various functions of the value council may be delegated to sub-committees whose members need not be members of the value council itself. The composition of the committee and its various sub-committees should have broad representation among the clinical departments and hospital staff. The value council and its various sub-committees shall be considered a medical peer review committee as defined by MGL c 111, sec1. Additionally, the various clinical departments shall be considered medical peer review committees in performing their quality assurance function. The BMC Value Council will keep a record of its monitoring and evaluation activities and make a report of its recommendations on a regular basis to the Executive Committee.

19. The Multi-Disciplinary Pain Management Committee

The purpose of the committee is to support and guide the efforts of Berkshire Medical Center to make available to our community a well-coordinated and comprehensive program of pain management. The composition of the committee membership will reflect important aspects of diagnosis and care. The committee will maintain a written record of its activities and recommendations.

20. Committee on Practitioner Health

The Committee on Practitioner Health will be responsible for accomplishing the goals established by the Medical Staff policy on Practitioner Health, as approved by the Medical Executive Committee and Governing Body, and as referred to in Article XIII Section 3 of the Bylaws. The Committee will be composed of members of the Active staff appointed by the Chief of Staff, in consultation with the Medical Executive Committee, the Chief Medical Officer or designee and the Chief Operating Officer or designee. The Committee will meet at least semi-annually and report its recommendations to the Executive Committee, the Chief of Staff, or the Chair of a Medical Staff Department, as appropriate. The Committee's activities with regard to any individual are peer review activities as described in Massachusetts state law.

21. Cancer Committee

The Cancer Committee is a multi-disciplinary standing committee whose purpose is the provision of superior care to patients with cancer. The Medical Staff membership shall be appointed by the Chief of Staff and the non-medical staff membership shall be

appointed by the Chief Operating Officer. The composition of membership and responsibilities of the committee shall meet the requirements of the American College of Surgeons Commission on Cancer (see Appendix). The Committee shall meet at least quarterly and reports its activities and recommendations to the Medical Executive Committee through the BHS Value Council.

22. Combined Medical Staff Peer Review Committee

The Combined Medical Staff Peer Review Committee is a standing committee comprised of staff members from both BMC and Fairview Hosptials and whose purpose is to conduct peer review on individual cases and aggregate patient care data reports. The Chair of the committee will be appointed by the Chief of Staff of Berkshire Medical Center. The members of the committee from each hospital will be appointed by their respective Chiefs of Staff. The Committee will conduct all of its activities in accordance with the medical staff policy on peer review approved by the Medical Executive Committee.

23. Continuum of Care Committee

The Continuum of Care Committee (CCC) is a joint Hospital/Medical Staff committee. It serves in conjunction with the Department of Case Management to ensure that health care services are medically necessary, appropriate, efficient and effective. The CCC membership must include at least two doctors of medicine or osteopathy. The committee will meet bi-monthly and make regular written reports to the Berkshire Health System Value Council. The CCC will assist in assuring implementation of the hospital Continuum of Care Plan as outlined in the hospital Department of Case Management Policy.

ARTICLE XII. THE TEACHING FACULTY

The Teaching Faculty of the Medical Staff shall be organized as follows:

Section 1. The Faculty Organization

The Faculty Organization shall include all members of the medical staff holding academic appointments at any medical or dental school, which hold signed affiliation agreements with Berkshire Medical Center. The Faculty Organization will function in a manner consistent with the aims and purposes of such affiliation agreement(s). The Faculty Organization shall meet from time to time on an as needs basis as determined by the Faculty Committee, or promptly upon the written request of twelve staff members holding academic rank.

Section 2. The Executive Faculty Committee (EFC)

a. The Executive Faculty Committee shall be comprised of the following:
   (1) BMC's appointed Director of Medical Education/Designated Institutional Official and any Academic Deans sited at BMC;
   (2) All residency program directors, fellowship directors, student coordinators, and a representative from each medical staff department associated with the educational effort;
   (3) The Hospital Chief Operating Officer (or designee);
   (4) A representative of Berkshire Area Health Education Center;
   (5) A representative of Acute Care Administration; and
   (6) One peer selected resident member from each approved residency program.
   (7) Chief Medical Officer.

b. The Executive Faculty Committee shall meet monthly.

c. All members of the Executive Faculty Committee shall be eligible to vote on matters properly before it. The BMC appointed Director of Medical Education/Designated Institutional Official will chair the Executive Faculty Committee and represent it at the Medical Executive Committee. In the absence of a Director of Medical Education/Designated Institutional Official, the Council will elect, from its membership, a Chair and representation to the Medical Executive Committee.

d. The responsibilities of the Executive Faculty Committee shall include the following:
   (1) Reviewing and evaluating the performance of all medical education programs at Berkshire Medical Center, including undergraduate, graduate, continuing, and other health related educational programs. In this capacity, it shall act as BMC's Graduate Medical Education Committee (GMEC).
   (2) Acting as a forum for discussion and evaluation of all issues with respect to medical education policy and planning.
   (3) Coordinating the educational effort of the Medical Staff and allied health professional staff;
   (4) Administering the educational efforts;
   (5) Defining areas of responsibility within the overall education effort of the Hospital and its affiliates;
   (6) Reviewing and evaluating existing educational policy and, as required, developing new or modified policy;
   (7) Assuring compliance with hospital, state, federal, and other regulating body requirements with respect to undergraduate, graduate, and continuing medical education;

(8) Approving all specialized or individual education programs including, but not limited to, those for refugee physicians, observer physicians, medical students from non-affiliated medical schools and residencies or fellowships not already established at the Hospital;

(9) Reporting through the Director of Medical Education/Designated Institutional Official at least quarterly to the Medical Executive Committee and the Chief Medical Officer concerning the Hospital medical education programs;

(10) Reporting through the Director of Medical Education/Designated Institutional Official at least annually at a quarterly staff meeting or other appropriate meeting format to the Medical Staff concerning the hospital medical education programs;

(11) Reporting through the Director of Medical Education/Designated Institutional Official at least annually to the Board of Trustees concerning the hospital medical education programs.

(12) Reporting to the Medical Executive Committee and the Governing Body shall include information about:

A. Mechanisms for supervision of resident physicians;

B. Roles, responsibilities, the nature, safety and quality of patient care activities of resident physicians;

C. Mechanisms for decisions about each participant's progressive involvement and independence in specific patient care activities; and

D. Educational needs and performance of program participants.

ARTICLE XIII. PATIENT CARE ASSESSMENT PROGRAM

The medical staff shall support and participate in an incident reporting system pursuant to the Massachusetts General Laws based upon an affirmative duty of all healthcare providers to report "injuries and incidents" in writing to a patient care assessment coordinator designated by the Chief Operating Officer of the corporation as delegated by the Governing Body. This Program will include:

a. (1) Receiving written reports of (l) injuries and incidents attributed to health care providers, (2) any conduct by a health care provider that indicates incompetency in his or her specialty or that might be inconsistent with or harmful to good patient care. These shall be reported in accordance with the Medical Staff bylaws if the report pertains to a member of the Medical Staff, or shall be reported to the Chief Operating Officer if the report pertains to an agent or

employee of the hospital who is not a member of the Medical Staff. Reports pertaining to members of the Medical Staff shall be investigated, reviewed, and resolved in accordance with the procedures specified in the Medical Staff bylaws. Reports pertaining to agents or employees of the Hospital who are not members of the Medical Staff shall be investigated, reviewed, and resolved in accordance with such policies and procedures as may be adopted from time to time by the Governing Body. Any disciplinary action which may result will be documented in writing.

(2) Investigating and analyzing the frequency and causes of general categories and specific types of all incident reports.

(3) Developing appropriate measures to minimize the risk of injuries and incidents to patients.

(4) Collecting, investigating, and responding in a timely manner to patient complaints which relate to patient care and the quality of medical services.

(5) Reporting summarily with recommendations to the board semi-annually or more often as the board requires.

(6) Detailing incident reporting procedures in writing and disseminating the procedures to all appropriate employees of the Hospital.

b. Maintenance of all incident reports, summary reports, and reports written to and from the coordinator for a period of time as required by Law. These records will be available to the Board of Registration in Medicine and the Department of Public Health.

c. Establishment of a process by the Medical Executive Committee to identify and manage matters of individual physician or other practitioners' health. This process will be designed to provide education, prevention of illness, confidential diagnosis, treatment and rehabilitation of practitioners who suffers from a potential impairment or condition. The intent of the process is to provide assistance and rehabilitation and is not disciplinary in nature. The Chief of Staff, in consultation with the Executive Committee shall appoint a committee to accomplish this goal.

d. Appointment of a Hospital committee by the Chief Operating Officer of the corporation, as delegated by the Governing Body, to oversee the safety and maintenance of facilities and equipment. The committee shall report periodically to the patient care assessment coordinator.

e. The Chief Operating Officer, acting for the Governing Body, shall ensure that patients' rights as provided by law are protected.

f. Whenever a medical peer review committee or other equivalent body concludes that a health care provider should be subject to disciplinary action, the committee shall forward the recommendation to the appropriate body, in the case of a practitioner to the Executive Committee for action according to the Medical Staff bylaws, and in the case of healthcare

provider other than a practitioner according to policies and procedures established by the Governing Body.

ARTICLE XIV. MEETINGS

Section 1. The Annual Meeting

The annual meeting of the active staff shall be during December. At this meeting, the officers and departmental Chair for the ensuing year shall be elected.

Section 2. Regular Meetings

a. No less than four quarterly meetings of the active staff shall be held in each calendar year. In addition to the annual meeting held in December, there shall be a meeting held during March, June, and September. All meetings shall be held at a date and time assigned by the Chief of Staff. At these stated meetings, the business of the staff shall be conducted.

b. At least 10 department or division meetings shall be held by all departments each year. The Department Chair shall determine which meetings will qualify for fulfilling the attendance requirement. Discussion at these meetings shall include, but not be limited to, administrative matters and the analysis of the quality of care provided by members of the department.

Section 3. Special Meetings

The Chief of Staff or the Executive Committee may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a meeting within fourteen (14) days upon receipt by him/her of a written request for same signed by not less than one-fourth of the active staff and stating the purpose of such meeting. The Executive Committee shall designate the time and place of any special meeting. Written notice or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the active staff not less than seven or more than ten days before the date of such meeting by or at the direction of the Chief of Staff (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to members of other medical staff categories

who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in a notice calling the meeting.

Section 4. Attendance at Meetings

a. Each member of the Active and Provisional Medical Staff shall be required to attend 50% of the regular Medical Staff meetings each year. Unless excused for cause by the Executive Committee, the failure to meet the foregoing annual attendance requirements shall result in a loss of voting capability until attendance at two meetings (50%) within the subsequent calendar year. At a minimum, a warning shall be issued.

b. Each member of the Active and Provisional medical staffs shall be required to attend not less than 50% of all meetings of the committees of which he/she may be a member and 5 department or division meetings. Failure to meet the foregoing annual attendance requirements, unless excused by the chair for good cause shown, shall be grounds for corrective action leading to a change in status. At a minimum, a warning will be issued.

c. Each member of the associate staff shall be required to attend each year not less than 3 meetings of his/her department or division and 50% of the meetings of each committee of which he/she may be a member. The failure to meet the foregoing annual attendance requirements, unless excused by the chair for good cause, shall be grounds for corrective action leading to a change in status. At a minimum, a warning will be issued.

Section 5. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the attendees for approval. Each committee and the department shall maintain a permanent file of the minutes of each meeting.

Section 6. Quorum

A fifty (50) percent quorum of the voting members is required for a special, quarterly, annual, department or committee meeting. No business shall be conducted unless a quorum is present and established by the chair. For those issues which are in the

province of the active staff, the quorum requirement shall only be met by the active staff membership.

Section 7. Agenda

The agenda for any regular business meeting shall be:

a. Call to order;
b. Reading of the minutes of the last regular and of all special meetings;
c. Unfinished business;
d. Communications;
e. Report of standing and special committees;
f. New business; and
g. Adjournment.

Section 8. Procedure Governing Meetings

Robert's Rules of Order, Revised, shall be the parliamentary guide for all meetings of the Medical Staff, except in situations where the specific provision to the contrary are included in these bylaws.

ARTICLE XV. VOTING

Except as otherwise expressly required by these bylaws or other documents, rules or regulations, approval of matters requiring a vote by the Medical Staff, any committee of the Medical Staff, or any department of the Medical Staff shall be by a simple majority.

ARTICLE XVI. RULES, REGULATIONS AND PROCEDURES

The Medical Staff may adopt such rules, regulations and procedures as may be necessary for the proper conduct of its work. Such rules, regulations and procedures shall have the same force as these bylaws. They may be amended at any regular meeting without previous notice by a simple majority vote. Such amendments shall become effective when approved by the Board of Trustees. In cases of a documented need for an urgent amendment to the rules and regulations necessary to comply with law or regulation, the medical executive committee may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff will have the opportunity for retrospective review of and vote on the provisional amendment at the next quarterly staff meeting. If approved at the quarterly staff meeting, the provisional amendment stands. If

there is no approval, the medical executive committee will submit a revised amendment to the medical staff for approval and subsequently to the governing body for action.

ARTICLE XVII. AMENDMENTS

These bylaws may be amended after notice and presentation of the proposed amendments at any meeting of the active staff. Such proposed amendments shall not, however, be voted upon until the following meeting of the active staff, at which time the proposed amendments and any proposed additions or alterations to the proposed amendments submitted to the bylaws committee at least 14 days prior to such meeting may be adopted. Any proposed addition or alteration to the proposed amendments submitted later than 14 days prior to the meeting at which the vote is to take place may only be considered if seventy-five (75) percent vote to consider it in which case it shall be acted upon as if timely submitted to by the bylaws committee. All amendments to the Bylaws, Rules & Regulations will become effective only after approval by the Governing Body.

ARTICLE XVIII. ANNUAL REVIEW

These bylaws will be subject of an annual review by the bylaws committee. An annual report, including any recommendations for amendments be made to the Executive Committee prior to the September meeting of the Medical Staff.

ARTICLE XIX. SEPARATION OF PROVISIONS

Failure of the Medical Staff to approve any provisions of these bylaws, rules, and regulations shall not invalidate the remainder of the bylaws, rules, and regulations.

ARTICLE XX. ADOPTION

These bylaws, together with the appended rules, regulations and procedures, shall be adopted at any regular or special meeting of the active staff and shall replace any previous bylaws, rules, regulations and procedures and shall become effective when approved by the Board of Trustees. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff.

Adopted:	**1969**	
Amended:	**February 11, 2002**	**Article V** **Article VI, Section 2, Section 3** **Article X, Section 2** **Article XI** **Article XII, Section 2**
Amended:	**October 7, 2002**	**Article III, Section 3** **Article XII** **Appendix H1**
Amended:	**February 10, 2003**	**Article VI, Section 3** **Article VII, Section 1**
Amended:	**April 7, 2003**	**Article IV, Section 6**
Amended:	**July 11, 2005**	**Article IV, Section 4**
Amended:	**October 10, 2006**	**Definitions** **Article II** **Article IV** **Article V**
Amended:	**July 9, 2007**	**Article III**
Amended:	**October 9, 2007**	**Article III, Section 6** **Article IV, Section 4** **Article IX, Section 1, Section 2** **Article X, Section 1** **Article XI, Section 1** **Article XIV, Section 4**
Amended:	**January 14, 2008**	**Article XI, Section 1**
Amended:	**April 14, 2008**	**Article V, Section 3** **Article VII, Section 3**
Amended:	**October 14, 2008**	**Definitions 1, 2, 3** **Article III, Section 2** **Article VII, Section 1** **Article IX, Section 1,** **Section 3, Section 4** **Article X, Section 2** **Article XI**

		Article XIV, Section 6
Amended:	April 13, 2009	Article III, Section 2, Section 3 Article IV, Section 1 Article V, Section 2, Section 3 Article VII, Section 1, Section 2 Article XII, Section 2
Amended:	September 14, 2009	Article V, Section 3 Article X, Section 1 Article XI, Section 7, Section 11
Amended:	October 12, 2010	Article XI, Section 5, Section 7, Section 18
Amended:	November 13, 2012	Article III, Section 2 Article XI
Amended:	August 13, 2013	Article VI, Section 3
Amended:	April 8, 2014	Article III, Sections 2-8 Article V, Section 3 Article XI, Section 18
Amended:	October 14, 2014	Article III, Section 3
Amended:	April 14, 2015	Part I, DEFINITIONS, Section 3 Article VI, Section 4 Article X, Section 1 Article X, Sections 2.c and 2.d
Amended:	January 12, 2016	Article III, Section 7 Article XII, Section 2.a (6)
Amended:	April 12, 2016	Article VII, Section 3 (a)
Amended:	October 18, 2016	Article XI, Section 6 and Section 23
Amended:	April 11, 2017	Article V, Section 3 (b) Article IX, Section 4 Article XI, Sections 1, 2 and 2 (a)
Amended:	April 9, 2019	Article II, Section 5 Article III, Section 3(h)(i)(j) and Section 8 Article IV, Section 1(b)(c), Sections 2, 3 Article V, Section 1(g)(i), Section 2(b)(c)(f)(g)(h)(j), Section 3(d)(e)

		Article VI, Section 1(b), Section 2(a)(b)(c), Section 3, (a)(b)(c), Section 4 **Article VII, Section 1(a)(b)(g), Section 2(a)(d), Section 3(c)** **Article VIII, Section 2(a)(b)(d), Section 3(a)(b), Section 4(a)(b)(c), Section 5(f)(h), Section 6(b)(c), Section 7(a)(d), Section 8** **Article IX, Section 1(b), Section 2(e), Section 3** **Article X, Section 1, Section 2(b)(c)(d)(e)(f)** **Article XI, Section 1(e)(f)(g), Section 2, Section 17, Section 20, Section 22, Section 23** **Article XII, Section 2(a)(d)** **Article XiV, Section 1, Section 2(b), Section 4(b)(c)**
Amended:	**October 15, 2019**	**Article IV, Section 6** **Article V, Section 3** **Article VI, Section 2 (1)(C)(D)(E)** **Article X, Section 1** **Article XVI**
Amended:	**July 14, 2020**	**Article III, Section 9**
Amended:	**October 13, 2020**	**Article IV, Section 6** **Article X, Section 1** **Article XI, Section 22**
Amended:	**April 13, 2021**	**Article X, Section 1, Section 2(e)(f)(g)**

Approved by the Medical Staff March 19, 2021

EXHIBIT E

Berkshire
Medical Center, Inc.
BERKSHIRE HEALTH SYSTEMS, INC.

Office of the Chief of Staff
725 North Street
Pittsfield, MA 01201
(413) 447-2866

Kathleen Sheridan, MD
127 Mount Rd
Cummington, MA 01026

Dear Dr. Sheridan,

It is my duty to provide to you this formal notice, under Article VII of the Berkshire Medical Center Medical Staff bylaws, that the Medical Executive Committee (the "Committee"), after consideration of (a) the report of the Ad Hoc Committee appointed by the Committee in this matter and (b) your statements to the Committee, voted on May 2, 2022, as follows:

1. In consideration of the facts of the July 27, 2021, neonatal fatality (the "Fatality Incident") that have become apparent since the imposition of the summary suspension of your clinical privileges immediately following the Fatality Incident, the summary suspension of your privileges is hereby terminated effective May 2, 2022.

2. In the event that you elect to exercise your clinical privileges at Berkshire Medical Center, either between May 2, 2022 and the expiration of your current period of medical staff membership, or, if (a) you elect to seek renewal of your medical staff membership and clinical privileges and (b) your applications for membership and credentials are approved by the Berkshire Medical Center Medical Staff Credentials Committee, Medical Executive Committee and Board of Trustees, you will be required to engage in a period of education, oversight and mentorship until at least February 1, 2023 (collectively, the "Plan for the Future") as described below.

3. The Plan for the Future shall include, at a minimum, the oversight at your cost, of a board-certified obstetrician and gynecologist, of (a) all cases, obstetric and gynecologic, for which patients select you for their care and (b) the completion, to the satisfaction of the Medical Executive Committee, of a course of training by the Association of Women's Health, Obstetric and Neonatal Nurses ("AWHONN") alliance relating to management of women in labor.

4. To the extent that you elect to submit an application for recredentialing by the Berkshire Medical Center Medical Staff, the maximum period that the Medical Staff Medical Executive Committee shall recommend to the Berkshire Medical Center Board of Trustees will be limited to February 1, 2023.

Sincerely,

John A. Loiodice, MD, Chief of Staff