PREAMBLE

Recognizing that the self-governing Medical Staff of Huntington Hospital is accountable to the governing body and is responsible to provide oversight of care, treatment and services provided by practitioners with privileges, and that, the Medical Staff provides for a uniform quality of patient care, and ensures that the best interests of the patient are protected in a concerted effort, the physicians, surgeons, dentists and podiatrists practicing in Huntington Hospital thereby organize themselves in conformity with the Bylaws, Rules and Regulations hereinafter stated.

Recognizing that the hospital is part of a larger integrated delivery system within the North Shore-LIJ Health System (“Health System”) and its member hospitals (“System Hospitals”), and that it may be appropriate or desirable for the hospital, and the Medical Staff, to establish certain relationships with other System Hospitals and their medical staffs, the Medical Board is authorized to establish joint relationships with the medical staff of other System Hospitals in order to identify best practices and thereby improve the care rendered at the hospital.

For the purpose of these Bylaws, the words “Medical Staff” and “practitioner” shall be interpreted to include all physicians, surgeons, dentists and podiatrists who are privileged to attend patients in Huntington Hospital.

ARTICLE I - NAME

The name of this organization shall be The Medical Staff of Huntington Hospital, hereinafter sometimes referred to as the “Medical Staff” or as the “staff”. Members of the Medical Staff shall be considered part of an organized health care arrangement with the Hospital (as that term is defined in 42 CFR 160.103) when exercising their clinical privileges in the Hospital. The Medical Staff is the Organized Medical Staff as such term is defined in the Joint Commission’s Comprehensive Accreditation Manual for Hospitals.

ARTICLE II - PURPOSE

The purposes of this organization shall be:

1. To ensure that all patients admitted to the hospital or treated as outpatients in any of the facilities, departments or services of the hospital shall receive the best possible care regardless of their race, color, creed, religion, sex, national origin, sexual orientation, veteran’s status, marital status, age, disability or their ability to pay;

2. To promote the highest professional and ethical standards of medical and surgical practice: and render the highest quality professional care fully consistent with prevailing standards of medical practice and conduct;
3. To provide appropriate mechanisms and processes whereby administrative issues may be discussed by authorized representatives of the Medical Staff with appropriate liaison with the Board of Directors and the Administration;

4. To provide education and to maintain educational standards. To initiate and maintain rules and regulations for the benefit of all patients. To ensure optimal professional performance by all members of the Medical staff through appropriate delineation of privileges to practice in the Hospital, and periodic review and evaluation of all practitioners granted clinical privileges by the Board of Directors.

5. To ensure that the Medical Staff has a leadership role and participates in performance improvement activities to improve the quality of care, treatment and services and patient safety;

6. To ensure that there is Medical Staff representation and participation in any hospital deliberations affecting the discharge of medical staff responsibilities;

7. To ensure that the organized Medical Staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the graduate education program in carrying out his or her patient care responsibilities.

ARTICLE III – MEMBERSHIP

Section 1. Membership and Qualifications

Membership on the Medical Staff of Huntington Hospital is a privilege which shall be extended only to those individuals who are professionally competent and who continuously meet the standards and requirements set forth in these Bylaws, the Medical Staff Rules and Regulations and departmental policies. Only physicians, dentists and podiatrists permitted by law to practice in the State of New York who can provide information attesting to their good character, background, experience, training, judgment, demonstrated competence, physical and mental capabilities, and ability to work with others as to assure, in the judgment of the Medical Board and the governing body, that any patient treated by them in the hospital will be given high quality medical care, shall be qualified for membership on the Medical Staff. Applicants for membership shall be considered regardless of race, color, creed, age, sexual orientation, gender, national origin, marital status, veteran’s status, or disability provided such person’s physical and mental health status does not interfere with their ability to perform the clinical privileges requested.

No physician, dentist or podiatrist shall be entitled to membership on the Medical Staff, or be granted particular clinical privileges merely by virtue of the fact that he/she is duly licensed to practice medicine, dentistry, or podiatry in this or in any other State, or that he/she is a member of some professional organization, or that he/she has in the past, or presently has, such privileges at another hospital.

Applicants shall have achieved Board certification in their principal field of clinical practice, or have met the requirements for such certification as set forth by the relevant Board. In the latter case, the applicant shall achieve Board certification within a period of five years from the time of Board eligibility.
Exceptions to this requirement may be considered on an individual basis at the recommendation of the Department Chair and subject to review by the Medical Board.

All applicants for appointment to the Medical Staff and all existing staff members with clinical privileges shall submit evidence satisfactory to the Board of Directors that there is in full force and effect with a company acceptable to the Board of Directors, a policy of professional liability insurance satisfactory to the Board of Directors in the amount of coverage and all its terms and conditions and such coverage shall be maintained in full force and effect while the appointment to the staff shall be effective. It shall be the responsibility of the staff member to advise the Chief Executive Officer of the hospital, or his/her designee, promptly in writing, of any discontinuance or cancellation of such liability coverage or reduction in the amount of such coverage.

In the event that the professional liability insurance required to be obtained by each member of the Medical Staff and each other practitioner holding any clinical privilege(s) shall not be maintained by the practitioner or shall otherwise lapse, be revoked, be reduced below the applicable minimum mandated coverage, or not be in effect with respect to any clinical privilege to which such practitioner shall have been privileged by the Board of Directors to perform at the hospital pursuant to these Bylaws, any such (or, as the case may be, all) privilege(s) of such practitioner shall be automatically suspended and such practitioner shall not be permitted to exercise any privilege with respect to which he/she does not carry the requisite professional liability insurance. The automatic suspension of any practitioner’s privilege(s) pursuant to the preceding sentence shall not provide the practitioner with any procedural rights pursuant to Articles VI of these Bylaws, and such suspension shall continue until the practitioner obtains the requisite professional liability insurance, and shall apply only to those privilege(s) for which he/she lacks appropriate professional liability insurance.

All members of the Medical Staff who have privileges to treat hospitalized patients must comply with the requirements of the Department of Health relating to periodic physical and mental fitness. This shall include, but not necessarily limited to, physical examination, recorded medical history and any testing or immunization as may be required by law.

Section 2. Ethics and Ethical Relationship

Members of the Medical Staff shall conduct themselves in the highest ethical tradition and shall pledge to provide for the continuous care for their patients. By accepting membership on the Medical Staff, a physician member specifically agree to abide by the Principles of Medical Ethics adopted by the American Medical Association and a dentist member specifically agrees to abide by the Code of Ethics of the American Dental Association and a podiatrist member specifically agrees to abide by the Code of Ethics of the American Podiatric Medical Association. For those who have practiced elsewhere prior to application to this hospital, antecedent adherence to these professional ethics shall be an express condition precedent to staff membership.

Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

Medical Staff members with administrative responsibilities shall exercise the utmost good faith in all transactions touching upon their duties to the hospital and its property. In their dealings with and on behalf of the hospital, they shall be held to a strict rule of honest and fair dealings between themselves and the hospital. They shall not use their positions or knowledge gained there from, in such a way that a conflict might arise between the interest of the hospital and the individual.
Section 3. Terms of Appointment

Subsection 1. For the purpose of these Bylaws, the hospital year shall commence on the first day of July and end on the thirtieth day of June. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors in accordance with the procedures set forth in Article III of these Bylaws. Initial appointments shall be for a period of one year, and the maximum term of such appointment or reappointment shall be two (2) years and shall in no event extend beyond the last calendar day of the next succeeding hospital year. The governing body reserves the right to set the term of an individual practitioner’s reappointment for a more limited period of time.

Subsection 2. The Medical Board shall consider the reappointment of the members of the Medical Staff whose appointment is expiring at the end of the year and submit its recommendations to the Board of Directors no later than the June meeting of the Board of Directors. The recommendations of the Medical Board shall be transmitted directly to the Board of Directors.

Subsection 3. In no case shall the Board of Directors take action on an application, refuse to renew an appointment or cancel an appointment previously made without conference with the Medical Board.

Subsection 4. An appointment to the Medical Staff shall confer on the appointee only such privileges as may hereinafter be provided.

Subsection 5. The Board of Directors shall have the power to dismiss or suspend any member of the staff after conference with the Medical Board.

Subsection 6. Emergency changes in Medical Staff appointments may be made at any time by the Medical Board, to be effective until the next meeting of the Board of Directors when same shall be acted upon.

Subsection 7. A physician, dentist or podiatrist who is dissatisfied with his/her appointment or who has been suspended or dismissed, or who has been refused initial appointment, shall be entitled to an appeal as provided in Article V of these Bylaws.

Section 4. Procedure of Appointment

Subsection 1. Application for membership on the Medical Staff shall be presented in writing on a form prescribed by the Board of Directors which shall state the qualifications and references of the applicant and shall also signify his/her agreement to abide by these Bylaws and the Rules and Regulations of the Medical Staff. The completed application for membership shall be presented to the Office of Medical Affairs who shall transmit it to the Chairman of the Credentials Committee in a period of time not to exceed 90 days. The application form shall include a requirement that the physician, dentist or podiatrist applying for appointment provide the following documentation and information which the hospital is mandated by law to obtain:

(a) The current license status, training, experience, competence and ability to perform the requested privileges;
(b) The names of any facilities with which the physician, dentist or podiatrist was associated, employed, privileged or practiced;

(c) In situations where there has been voluntary or involuntary termination of medical staff membership or limitation, reduction, or loss of clinical privileges at another hospital, the reason for such a change must be indicated;

(d) Any information available concerning any pending professional medical and dental misconduct proceedings, previous or currently pending challenges to any licensure or registration (i.e. DEA) or voluntary relinquishment of such licensure or registration, any malpractice actions in any State;

(e) The findings of any such proceedings or actions;

(f) A waiver by the physician, dentist or podiatrist of any confidentiality provisions concerning the information to be provided to hospital pursuant to this requirement of the legislation; and

(g) A verification by the physician, dentist or podiatrist that the information provided is true and accurate.

Subsection 2. The Credentials Committee shall investigate the character, qualifications and standing of the applicant including his/her background, experience, training, judgment, competence and physical and mental capabilities. This investigation shall include a personal interview, the obtaining of at least two (2) references, and requesting from any hospital which has granted the physician, dentist or podiatrist privileges or with which he/she had employed or associated the following information:

(a) Any information regarding any pending professional misconduct proceedings or pending malpractice actions;

(b) Any judgments or settlements of malpractice actions and any findings of professional misconduct; and

(c) Any information required to be reported by hospitals concerning disciplinary actions against professional licensees and possible physician professional misconduct; and

(d) The Hospital shall solicit information from the National Practitioner Data Bank and other agencies as may be required by federal, state or local law; and

(e) The investigation shall be completed as soon as possible and a report submitted to the Medical Board recommending that the application be accepted, deferred or rejected. In no case shall this report be delayed more than three months; and

(f) The Medical Board and Board of Directors shall act upon the recommendations of the

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1 References shall be in the format required by the Hospital from at least two practitioners who practice within the same specialty as the applicant, who have current knowledge of the applicant’s patient care and technical skills, medical knowledge, participation in practice-based learning, interpersonal and communication skills, professionalism and support of systems-based practice.
Credentials Committee at their next regularly scheduled meeting following such a report; and

(g) The burden of producing necessary and required information for proper evaluation is the entire responsibility of the applicant. In the event that the applicant fails to furnish all of the necessary information within a reasonable period of time, he/she be informed by letter advising him/her that his/her application is incomplete, if he/she does not submit the missing information within ten (10) days of the date of the letter. Failure to comply with such a request will be deemed to have withdrawn said application, provided that the Department Chairman may extend such a application processing time in the event of extenuating circumstances. Such withdrawal of the application shall not provide the applicant with any procedural rights under Article V; and

(h) If during the pendency of practitioner’s application for appointment the information submitted by the applicant as part of his/her application shall undergo any change, the applicant shall promptly advise the Medical Staff Office of the Hospital of such change. in the event that he/she fails to do so, and such failure is discovered during the pendency of his/her application, the application will be deemed automatically withdrawn, and with respect to such withdrawal, the applicant will not be entitled to any of the procedural rights described in Articles VI with respect thereto. In the event that any such failure is discovered after the practitioner is appointed to the Medical Staff, such failure shall constitute cause for the suspension, limitation or termination of any or all of the practitioner’s clinical privileges in accordance with the procedures described in Articles V and VI hereof.

Subsection 3. Clinical privileges for each member of the Medical Staff shall be delineated in writing at the time of appointment, each reappointment and when a revision of privileges between reappointment periods is recommended by the Chair. The Medical Board shall determine the privileges to be assigned to the applicant and recommended to the Board of Directors that the applicant be accepted, deferred or rejected and, if accepted, the privileges to be granted and, if deferred or rejected, the reasons for such deferment or rejection. An applicant has the right to appear before the Medical Board to discuss the requested privileges.

Subsection 4. The recommendation of the Medical Board shall be transmitted to the Board of Directors.

Subsection 5. Whenever the Board of Directors does not concur with a Medical Board recommendation relative to appointment of clinical privileges, the recommendation shall be reviewed by a joint committee of the Medical Board and the Board of Directors before a final decision is made by the Board of Directors.

Subsection 6. When final action has been taken by the Board of Directors, the Chief Executive Officer or his/her designee of the hospital shall be authorized to transmit this decision to the candidate for membership and, if he/she is accepted, to advise him/her of the specific rights, privileges and limitations assigned to his/her appointment and to secure his/her signed acceptance of the appointment and his/her agreement to be governed by these Bylaws and the Rules and Regulations.

Subsection 7. A period of focused professional practice evaluation shall apply to all initially granted privileges in accordance with Hospital policy.
Section 5. The Reappointment Process

Subsection 1. All recommendations concerning the reappointment of a Medical Staff member and the clinical privileges to be granted shall be based upon the following: (i) professional competence; (ii) demonstrated clinical judgment in the treatment of patients and documentation thereof; (iii) physical and mental ability to perform the privileges requested; (iv) ethics and conduct; (v) attendance and participation in Medical Staff and departmental meetings and performance improvement activities; (vi) participation in continuing medical education programs; and (vii) compliance with hospital and Medical Staff Bylaws, Medical Staff Rules and Regulations, and requirements established by the Chair of the Department and the Medical Board; and (viii) malpractice history and insurance coverage; (ix) review of morbidity and mortality data other benchmarked quality assurance and performance improvement data and committee findings, (x) for all members appointed to Medical Staff on or after July 1, 2010, maintenance of Board certification as required by the specialty Board for the practitioner’s principal field of practice; and (xi) the physician has the right to review all of the above material.

Subsection 2. The Medical Board in consultation with the Department Chairman shall establish a procedure for reviewing the performance and patterns of practice within the hospital which shall include the results of quality management/performance improvement activities, and such review data shall be the basis for the Chair of the Department’s recommendations concerning the reappointment of the Medical Staff member and the clinical privileges to be granted for such reappointment. The Chair of the Department will, upon request, review any such information with a Medical Staff member which has been the basis for a critique of his/her clinical performance, or the basis of any corrective action. The Department Chair shall consider ongoing professional practice evaluation information regarding the maintenance of existing privileges, the revision of existing privileges, or the revocation of existing privileges prior to or at the time of renewal.

Subsection 3. Decision on reappointments or on revocation, revision, or renewal of clinical privileges must consider criteria that are directly related to the quality of care, and such decisions are subject to a fair hearing and appeal process as provided under Article V of these bylaw.

Subsection 4. It is the obligation of all Medical Staff members to maintain current information regarding the items described in Section 5 subsection 1. hereof on file with the Medical Staff Office of the hospital, at all times. If any such information changes, either during the reappointment process or at any other time, the member, must within thirty (30) days, of such change so advise his/her Chair of Department and the Medical Staff Office in writing. If the Medical Staff member does not so notify the Medical Staff Office and his/her Department Chair, the member’s Department Chairman may suspend any or all of the practitioner’s clinical privileges or Medical Staff membership until such information is provided, and such suspension shall not be subject to the procedural rights described in Article V of these Bylaws.

Subsection 5. Focused Professional Practice Review for all initially requested privileges the Hospital shall continuously monitor and evaluate a practitioner’s professional performance. Focused professional practice evaluation will be consistently implemented in accordance with the criteria and requirements defined by Hospital policy. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege. The measures employed to resolve performance issues are defined and consistently implemented by the Hospital.
Section 6. Privileges in Emergency Situations and Temporary Privileges

Subsection 1. In case of emergency, the physician, dentist or podiatrist attending the patient shall be expected to do all in his/her power to save the life and to protect the welfare of the patient, including the calling of such consultation as may be available. For the purposes of this section, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

Subsection 2. The Chief Executive Office of the hospital or his designee, after conference with the Chief of the clinical department concerned shall have the authority to grant temporary privileges to a licensed physician, dentist or podiatrist who is not a member of the Medical Staff. The Chair of the applicable clinical department shall give an authoritative opinion as to the competence and ethical standing of the physician, dentist or podiatrist who desires such temporary privileges, and in the exercise of such privileges, the clinician shall be under direct supervision of the Chair. The temporary privileges shall be granted for a period no longer than 60 days.

Subsection 3. Physician, dentists or podiatrists who have filed application for membership on the Medical Staff may, in unusual circumstances, be granted temporary privileges for specific cases until their application has been acted upon. These privileges shall be granted by the Chief Executive Officer after conference with the Chief of Staff and the physician, dentist or podiatrist to whom these privileges are granted. He/she shall be under the direct supervision of the chief of the particular department involved or a duly delegated member of the Active Medical Staff. The Chair of the department or his/her delegate shall be in charge of the case and shall determine the extent of privileges to be accorded to the physician, dentist or podiatrist. The temporary privileges shall be granted for a period no longer than sixty (60) days.

Temporary privileges shall also be based on verification of the following: 1) current New York State license; 2) relevant training or experience; 3) current competence; 4) ability to perform requested privileges; 5) a query and evaluation of information obtained from the National Practitioner data bank; and 6) no current or previously successful challenge to be the applicant’s license or registration. The granting of such privileges shall be upon the conditions such conditions as the Chief Executive Officer of the Hospital (or designee) at any time may in his or her discretion wish to impose, and shall be exercised only under the supervision of the Department Chair concerned or his or her designee.

Section 7. Disaster Privileges

Disaster privileges may be granted when the Hospital’s emergency management plan has been activated and the Hospital is unable to meet immediate patient care needs due to a national, State or local disaster or emergency. Such disasters and emergencies include, but are not limited to, unexpected events (whether human-made or natural or a combination of both) that result in a sudden, significantly changed or increased demand for the Hospital’s services. Disaster privileges may be granted to a non-affiliated practitioner by the Chief Executive Officer or his/her authorized designee, which shall include the Senior Vice President of Medical Affairs and/or the Chairman of the Medical Board, upon presentation of a valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following:

- A current photo identification card from a health care organization that clearly identifies professional designation; or
- A current license to practice; or
• primary source verification of licensure; or
• identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals, (ESAR-VHP), or other recognized state or federal response organization or group; or
• Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or
• Presentation by current administration or Medical Staff member(s) with personal knowledge regarding practitioner’s identity and such individual’s ability to act as a licensed independent practitioner.

A practitioner who is denied disaster privileges, or whose disaster privileges are subsequently revoked or restricted, shall not be entitled to the procedural rights set forth in Article V of these Bylaws.

The Hospital will ensure oversight of the professional performance of practitioners who are granted disaster privileges by any of the following: direct observation, mentoring or clinical review, as appropriate under the circumstances. Reassessment to determine whether such privileges should continue will occur within seventy-two (72) hours of granting disaster privileges.

The Hospital will provide appropriate identification badges for all practitioners who are granted disaster privileges.

Primary source verification of licensure of practitioners who receive disaster privileges begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours of granting disaster privileges. In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible thereafter. In this extraordinary circumstance, there must be documentation of each of the following:

• Why primary source verification could not be performed in the required time frame;
• Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
• Attempts to perform primary source verification as soon as possible.

Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.

These privileges will be in effect until the Chief Executive Officer or designee has deemed that the services of those practitioners granted disaster privileges are no longer needed for any reason. Upon termination of disaster privileges, the practitioner shall not be entitled to the procedural rights set forth in Article V of these Bylaws and the Medical Staff Rules and Regulations.
Section 8.  Leave of Absence

   Subsection 1.  A leave of absence may be granted to a member of the staff for up a maximum of one (1) year.  Reinstatement to the Medical Staff is based on continued and current compliance with all requirements as set forth under Article III of these Bylaws. The Medical Board in acting upon a reinstatement request by a member will request any relevant information to ascertain the practitioner’s ability to perform the privileges requested.

   Subsection 2.  An absence of more than one year, whether or not such an extension was approved, shall require the practitioner to reapply for staff membership.

   Subsection 3.  A request for a leave of absence must be in writing and submitted to the Office of Medical Affairs who will transmit the request to the respective department Chair for submission to the Medical Board at its next regular meeting.  The Medical Board’s recommendation shall be forwarded to the Board of Directors for final action and notification.  The Chief Executive Officer shall inform the applicant of the Board of Director’s action.

   Subsection 4.  Members of the staff on approved leave for the purpose of active duty with the Armed Forces of the United States shall be awarded all rights and privileges guaranteed by law provided they give notice of their intent to return as an active member of the staff within ninety (90) days of release from active duty.

Section 9.  Resignation from the Medical Staff

   Subsection 1.  In order for a Medical Staff member to resign from the Medical Staff, he/she must send a written notice thereof to resign to the Chairman of each clinical department in which he/she is privileged to practice.  The notice shall be in the form of a letter to the relevant Chairman/Chairmen, shall include the reason(s) for his/her resignation, and shall include a statement to the effect that he/she has on or prior to the date of the letter fulfilled all of the obligations of his/her medical staff membership, including, but not limited to, the completion of all of his outstanding charts and records.

   Subsection 2.  Upon receipt of a Staff member’s notice to resign, the Chair of the Department shall confirm that the staff member has fulfilled all of the obligations of his/her medical staff membership, including, but not limited to, the completion of all of his/her outstanding charts and records and any quality management obligations.  The Chief of Department shall only recommend acceptance of the staff member’s notice to resign, and Board of Directors shall only accept such recommendation if the staff member has fulfilled all of the obligations of his/her medical staff membership; provided that the Board may waive such obligations if the staff member resigns due to health or other emergent concerns. In the event that the staff member shall not have completed all of the obligations of his/her medical staff membership, he/she will not be considered to have resigned in good standing from the hospital and any appropriate facility or credentialing body contacting the hospital to inquire as to the status of the staff member may be so notified.

   Subsection 3.  A staff member who shall have resigned in good standing may reapply for membership to the medical staff at any time in accordance with the procedures contained in these Bylaws and the Medical Staff Rules and Regulations.
ARTICLE IV – CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into the Active, Honorary, Emeritus, Consulting, Courtesy, Visiting Pro-tem, Adjunct, and Health Center Staffs.

Section 2. The Active Medical Staff

Subsection 1. The Active Medical Staff shall consist of physicians, dentists and podiatrists who have been selected because of their qualifications and demonstrated competence, together with their active interest in the work of the hospital, to provide the majority of professional service to patients and to perform most of the Medical Staff administrative duties within the hospital. These shall include a constructive role in the development of policies and standards of patient care by means of active participation in staff committee work, staff and departmental meetings, clinical performance improvement activities and medical education programs.

Only members of the Active Medical Staff, except those whose medical staff dues are in arrears, shall be eligible to vote, hold office and serve on committees, provided however that the Assistant Attending Medical Staff shall not be eligible to serve on the Medical Board.

Subsection 2. The Active Medical Staff shall include the following grades of rank: Attending, Associate Attending and Assistant Attending. The Attending Medical Staff shall be considered the senior of the three and insofar as it is possible, appointment to the Attending Medical Staff shall be made by promotion from the Associate Attending Medical Staff. The Active Medical Staff shall also include the Adjunct Staff, whose members are active in Hospital affairs, but have no inpatient clinical activity.

Subsection 3. Members of the Active Medical Staff shall be required to attend Medical Staff meetings as provided in Article X of these Bylaws.

Section 3. The Honorary Medical Staff

The Honorary Medical Staff shall consist of physicians, dentists and podiatrists who have distinguished themselves in such a manner as to make their appointment to Honorary Staff appropriate. The members of the Honorary Staff shall have no duties and no privileges with respect to the admission of patients to the hospital. They shall not be eligible to vote or hold office on the Medical Staff or the Medical Board.

Section 4. The Emeritus Medical Staff

The Emeritus Medical Staff shall consist of physicians, dentists and podiatrists who have served the hospital in an active capacity as members of the active Medical Staff and who shall have retired from the active Medical Staff. Members of the Emeritus Medical Staff shall have no assigned duties. They shall have no clinical privileges, and shall not be eligible to vote or hold office on the Medical Staff or the Medical Board.
Section 5.  **The Consulting Medical Staff**

Subsection 1. The Consulting Medical Staff shall consist of physicians, dentists and podiatrists of recognized professional ability who are accessible to the Hospital and who have signified their willingness to accept appointment as consultants in their respective fields, and shall be appointed by invitation of the Medical Board with approval of the Board of Directors. They shall not be eligible to vote or hold office on the Medical Staff or the Medical Board and shall have no privileges with respect to the admission of patients to the hospital.

Subsection 2. The members of the Consulting Medical Staff may be called upon as consultants, as the occasion may arise.

Section 6.  **The Courtesy Medical Staff**

The Courtesy Medical Staff shall consist of those practitioners who have privilege of admitting an occasional patient to the hospital and make infrequent use of its inpatient facilities. A member of the Courtesy Staff may not admit more than five (5) patients per year. Practitioners requesting Courtesy Staff appointment must meet the same requirement as members of the Active Staff. They shall not be required to attend meetings, nor be eligible to vote or hold office, nor be required to serve on committees, but may do so by appointment. Their assignment to the Emergency Room Call coverage is at the sole discretion of the Chairman of their department. Admissions resulting from such Emergency Room coverage should not be considered within the limitation of admissions for this category. Courtesy Staff dues will be 50% of the Active Staff dues.

Section 7.  **Visiting Pro Tem**

Under special circumstances, practitioners who are needed to meet an important patient care or education need, including but not limited to those who are requested by a patient or another person authorized to consent on behalf of the patient to provide clinical care, may be granted temporary privileges. All such practitioners shall be designated as visiting pro tem. Visiting pro tem appointments shall require the following documents: a delineation of privileges, health assessment form, proof of malpractice insurance coverage, current Curriculum Vitae, a DEA certificate if applicable to the privileges requested, evidence of infection control training, a proof of clinical competence evidenced by a minimum of one letter of reference and a copy of the current registration of the New York State license or, in such absence, the New York State Education Law regarding exemptions of such license shall apply. The visiting pro tem appointee shall be under the appropriate level of supervision of the Chair of the Clinical Department or designee. A visiting pro tem appointee shall not have the right to admit patients, or to vote, hold office, serve on committees or attend Medical Board or Medical Staff meetings. These visiting pro tem privileges shall not be granted for a period exceeding three (3) months. Privileges may be terminated when, in the opinion of the Department Chair, such need no longer exists. No practitioner whose request for temporary privileges is denied shall be entitled to the procedural rights afforded by Article V of these Bylaws.

Section 8.  **Adjunct Staff**

The Adjunct Staff shall consist of those members of the Medical Staff who do not admit patients, but perform significant other services to the Hospital. Such members of the Adjunct Staff may not admit patients, but they may visit and review the medical records of their patients. They may not render consultations or write notes or orders concerning Hospital patients. Members of the Adjunct Staff shall have
Section 9. Huntington Hospital Dolan Family Health Center Staff

Subsection 1. The Huntington Hospital Dolan Family Health Center Medical Staff shall consist of licensed physicians whose sole function shall be to serve in the Huntington Hospital Dolan Family Health Care, either full or part-time. Huntington Hospital Dolan Family Health Center staff physicians shall have admitting privileges.

Subsection 2. Members of the Huntington Hospital Dolan Family Health Center staff shall be appointed upon proper application in the same manner as provided for other categories of Medical Staff membership.

Subsection 3. If members of the Huntington Hospital Dolan Family Health Center staff wish to change their category to another type of Medical Staff appointment, they must reapply in the same manner as provided for new applicants to the Medical Staff.

Subsection 4. Members of the Huntington Hospital Dolan Family Health Center staff shall be subject to the Bylaws of the Medical Staff and modifications thereof and to such other Rules and Regulations and modifications thereto as may be promulgated by the Medical Board.

ARTICLE V – CORRECTIVE ACTION FOR MEDICAL STAFF MEMBERS

Section 5.1 Corrective Action Process Defined

These Bylaws set forth the bases for taking corrective action against a practitioner and the basic hearing and appeal procedures available to a practitioner who is subject to corrective action. The details relating to such procedures are set forth in the Medical Staff Rules and Regulations.

Subsection 5.1.1 A request for corrective action may be made with regard to any practitioner who is a member of the Medical Staff whenever the conduct or condition, professional or otherwise, of such Medical Staff member is considered to be inconsistent with the Hospital’s standards of patient care, patient welfare or the objectives of the Hospital; if such conduct or condition reflects adversely on the Hospital or the practitioner; or results in disruption of Hospital operations. A request for corrective action also may be made with regard to any Medical Staff member who fails to comply with any of these Bylaws; the Medical Staff Rules and Regulations; the Corporate Bylaws, rules, regulations or policies; or the policies of his or her Clinical Department.

(a) Such request for corrective action shall be made to the Chairman of the Medical Board by any Director or Officer of the Corporation, the Chief Executive Officer, the Department Chair, or any member of the Medical Board or of the Medical Staff,
provided that a request for corrective action regarding the Chairman of the Medical Board shall be made to the Senior Vice President of Medical Affairs. Such request for corrective action shall be in writing and shall set forth the facts upon which it is based. Subject to the provisions for summary suspension set forth in these Bylaws and in the Medical Staff Rules and Regulations, any request for corrective action by the Chair of the Department in which the practitioner holds clinical privileges shall be based upon a prior investigation.

(b) If a request for corrective action is made by any person other than the practitioner’s Department Chair, upon receipt of the request for corrective action, the Chairman of the Medical Board shall refer the matter back to the practitioner’s Department Chair for him or her to conduct a departmental investigation of the issues that gave rise to the request for corrective action, unless such an investigation has already been conducted. In the event that a request for corrective action is made regarding a Department Chair, the investigation of the matter shall be conducted by the Senior Vice President of Medical Affairs.

(c) No person filing a request for corrective action in an individual capacity shall sit on any committee reviewing the request under this Article V.

(d) The Chairman of the Medical Board shall ensure that a copy of such request for corrective action shall be sent to the practitioner about whom it is filed as soon as may be practicable under the circumstances. The copy of the request for corrective action sent to the affected practitioner shall be accompanied by a copy of this Article V.

(e) Whenever any provision of this Article V requires that notice or any other communication be sent to the affected practitioner or to the parties to a hearing held pursuant to this Section 5.1, or to their legal counsel, such notice or communication shall be sent by overnight delivery service or personal delivery, and/or by such other prompt and reliable means as may be specified in the Medical Staff Rules and Regulations.

Subsection 5.1.2 Corrective Action: General Rules

(a) A request for corrective action may include, without limitation, one or more of the following actions:

(i) A written warning or reprimand, or letter of admonition;

(ii) Time-limited terms of probation requiring monitoring of the practitioner, which may be extended or modified, or result in different corrective action, based on events during the period of probation;

(iii) A requirement of remedial activity, such as further clinical training, study or education;

(iv) Referral to the Medical Staff Health Committee;

(v) Suspension pending medical or psychiatric consultation/evaluation by a physician or other health care provider acceptable to the Department Chair;
(vi) Reduction, suspension, restriction or termination of some or all clinical privileges pending investigation;

(vii) Reduction, suspension, restriction or revocation of some or all clinical privileges;

(viii) Continuation, modification or expansion of a previously imposed corrective action;

(ix) A requirement for clinical supervision or consultation with respect to care or categories of care, or co-privileges with another practitioner;

(x) Suspension or termination of Medical Staff membership; and/or

(xi) Other specific sanctions as appropriate in the circumstances.

(b) Whenever corrective action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations, any two of the following: the Department Chair, the Chairman of the Medical Board, the Senior Vice President of Medical Affairs, and the Chief Executive Officer, jointly shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges granted by the Hospital to a member of the Medical Staff (hereinafter referred to as “summary action”). Such summary action also may be imposed pending an investigation to determine whether grounds exist for immediate action; such an investigation shall not exceed a period of fourteen (14) days without the practitioner’s consent. The practitioner shall be given notice of such summary action in accordance with Subsection 5.1.1(E) above. Such summary action shall become effective immediately upon imposition.

(c) Except as specifically provided otherwise elsewhere in these Bylaws and the Medical Staff Rules and Regulations, any corrective action recommended pursuant to Subsection 5.1.2(A)(vii) through (xi) above shall entitle the Medical Staff member to the procedural rights, including but not limited to a hearing before a Hearing Committee and review by an Appellate Review Committee of the Board of Directors, as set forth this Article V and in the Medical Staff Rules and Regulations. In the event of a summary suspension of a practitioner’s clinical privileges and/or Medical Staff membership pursuant to Subsection 5.1.2(B) above, the procedures set forth in Section 5.2 below and in the Medical Staff Rules and Regulations shall apply. If a corrective action is upheld by final action by the Board of Directors, it may be reportable to the Office of Professional Medical Conduct in the New York State Department of Health, as set forth in the Public Health Law, to the Office of Professional Discipline in the New York State Education Department, and to the National Practitioner Data Bank.

**Subsection 5.1.3 Right to Hearing.** Any practitioner who has received notice of a request for corrective action as set forth in Subsection 5.1.2(A)(vii) through (xi) above is entitled to a hearing before a Hearing Committee pursuant to the procedures set forth in this Article V and in the Medical Staff Rules and Regulations. The notice, provided to the practitioner by the Chairman of the Medical Board, shall state: the particular action taken or proposed to be taken against the practitioner; the reasons for the action; that the practitioner has the right to request a hearing on the action; the time limit within which the practitioner may request the hearing; and a summary of the practitioner’s rights at the...
hearing under this Section. In addition, any practitioner who has received notice in accordance with Article V of these Bylaws of an adverse recommendation with respect to appointment or reappointment to the Medical Staff or to a restriction and/or reduction of the practitioner’s clinical privileges (hereafter referred to as an adverse appointment recommendation), is entitled to a hearing in accordance with the procedures set forth in this Article V. In the event the practitioner elects not to have a hearing or does not respond to the notice, the Medical Board shall act on the request for corrective action or the adverse appointment recommendation at its next regular meeting.

Subsection 5.1.4 Scheduling and Notice of Hearing. The Chairman of the Medical Board (or designee) shall schedule the hearing and shall notify the practitioner of the time, date and place of the hearing and the names of the Hearing Committee members and any witnesses expected to testify. Except as set forth below, the date of the hearing shall be no less than thirty (30) and no more than sixty (60) days from the date of receipt by the practitioner of the notice of the scheduling of the hearing, unless the practitioner makes a written request to the Chairman of the Medical Board to schedule the Hearing for a later date.

If a request for a hearing is received from a practitioner whose clinical privileges have been summarily restricted or suspended in accordance with these Bylaws, the hearing may, upon the written request by the practitioner to the Chairman of the Medical Board, be scheduled for a date earlier than 30 days from the date of receipt by the practitioner of such notice. However, the hearing shall not be scheduled for a date earlier than fifteen (15) days from the receipt by the Chairman of the Medical Board of the practitioner’s request for an expedited hearing. Postponement of the hearing beyond the hearing date shall be granted only with the approval of the Chair of the Hearing Committee.

Subsection 5.1.5 Composition and Selection of the Hearing Committee. The hearing shall be conducted by a Hearing Committee, consisting of at least five (5) voting members; three (3) members shall be members of the Medical Board including the Medical Staff President, and at least two (2) Active Staff members who do not serve on the Medical Board all selected by the Chairman of the Medical Board. One member of the Hearing Committee shall be designated as its Chair by the Chairman of the Medical Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Hearing Committee so long as that person did not take part in any process leading to the request for corrective action or adverse appointment recommendation. Members of the Medical Board or Active Staff who are direct economic competitors of the practitioner shall not sit on the Hearing Committee. If for any reason the Chairman of the Medical Board is unable to select a Hearing Committee satisfying the above requirements, then the Chairman may, with the consent of and in consultation with the President of the Medical Staff and the Senior Vice President of Medical Affairs, select one or more individuals from outside the Hospital to serve on the Hearing Committee.

Subsection 5.1.6 Conduct of the Hearing. The practitioner must be present at the hearing, and both parties shall have the right to be represented by counsel, to present relevant evidence, to cross-examine witnesses, to receive a written basis for the Hearing Committee’s recommendation, to receive a copy of the record of the proceedings, and such other rights and obligations as more fully set forth in the Medical Staff Rules and Regulations. It shall be the obligation of counsel for the party who requested the corrective action or made the adverse appointment recommendation to first present the reasons supporting the request or adverse appointment recommendation. In order to reverse the recommendation, the affected practitioner or counsel shall have the obligation to persuade the Hearing Committee, by clear and convincing evidence, that the reasons supporting the request for corrective action or adverse appointment recommendation lack any factual basis or that such basis, or any action based thereon, is either arbitrary, unreasonable or not in compliance with applicable law. Failure without good cause of the
practitioner to appear at the hearing shall constitute a waiver of his or her rights under these Bylaws. The Hearing Committee shall determine if the reason a practitioner fails to appear at the Hearing is good cause.

Subsection 5.1.7 Recommendation of Hearing Committee; Ratification by Medical Board. Within fourteen (14) days of the completion of the hearing, the Hearing Committee shall issue a recommendation, by majority vote of the Hearing Committee, either upholding the request for corrective action or the adverse appointment recommendation, or terminating or modifying such request or adverse appointment recommendation. The Hearing Committee’s recommendation shall then be submitted to the Medical Board for its ratification. Members of the Medical Board who also served on the Hearing Committee may vote on the Hearing Committee’s recommendation. Neither the affected practitioner, nor his or her representative, may attend the Medical Board meeting at which the Hearing Committee’s recommendation is being presented for ratification. Upon its ratification by majority vote of those present at the meeting, the Chair of the Medical Board (or designee) shall forward copies of its decision to the Secretary of the Board of Directors and to the parties or their counsel. In the event the Medical Board does not ratify the Hearing Committee’s recommendation, the Medical Board may, by majority vote of those present, issue its own decision or request that the Hearing Committee either clarify its recommendation or re-review the Hearing record in light of Medical Board’s concerns.

Subsection 5.1.8 Right of Appeal. If the Medical Board ratifies an adverse recommendation of the Hearing Committee or renders its own decision restricting, suspending or terminating the practitioner’s clinical privileges or Medical Staff membership, then the affected practitioner may request an appellate review before an Appellate Review Committee of the Board of Directors. The party that requested the corrective action or made the adverse appointment recommendation shall also have the right to request an appellate review of a decision of the Medical Board that is adverse to it. A request for appellate review shall be made by written notice to the Board of Directors, with a copy to the other party, and must be received within ten (10) days after receipt of the adverse decision of the Medical Board. The request shall identify the grounds for the appeal and include a clear and concise statement of the reasons in support of the appeal. If a request for appellate review is not made within such period, the action of the Medical Board shall be final, with no further notice or proceeding required, except that the Medical Board’s decision shall be forwarded to the Board of Directors for final action. Upon final action, the Board of Directors shall forward copies of its decision to the Medical Board and to the parties or their counsel.

Subsection 5.1.9 Appeal Process. The party appealing shall submit a written statement setting forth in full the grounds for appeal and the reasons in support of the appeal, and thereafter the opposing party shall submit a responsive statement. Such statements shall be submitted in accordance with the procedures set forth in the Medical Staff Rules and Regulations. The decision of the Medical Board shall not be set aside unless it could not reasonably have been made considering the burden of proof of the practitioner as set forth in Subsection 5.1.6 above and the facts and circumstances of the case.

Subsection 5.1.10 Decision of Appellate Review Committee; Ratification by the Board of Directors. Within thirty (30) days after the conclusion of the appellate review, the Appellate Review Committee, through majority vote, shall render its decision in the matter, in writing. The Appellate Review Committee may affirm, modify, or reverse the decision of the Medical Board or remand the matter to the Medical Board for reconsideration. The Appellate Review Committee shall then submit its decision to the Board of Directors for final action, and the members shall recuse themselves from any
consideration of the matter by the Board of Directors. Upon final action, the Board of Directors shall forward copies of its decision to the Medical Board and to the parties or their counsel.

No practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter that has been the subject of adverse action or recommendation. All proceedings under this Article V shall be considered confidential to the maximum extent permitted by law and subject to the reasonable needs of the Board of Directors and other persons who may be authorized from time to time by the Board of Directors to review the proceedings.

Section 5.2 Summary Action Proceedings

Medical Board Review of Summary Action. Except when imposed pending an investigation as described in Subsection 5.1.2(B) above, within ten (10) days of the imposition of summary action the Medical Board shall meet to review and uphold, modify or void such action. If the summary action is imposed pending an investigation, the Medical Board shall be convened as described above only after the investigation has been completed and a determination has been made that there is a need for immediate action.

All further proceedings with respect to the summary action, including the hearing procedures to be afforded the affected practitioner, shall be in accordance with the provisions of Section 5.1 of these Bylaws and the Medical Staff Rules and Regulations.

Section 5.3 Automatic Termination of Medical Staff Membership

(a) Notwithstanding any other provisions of these Bylaws, the Medical Staff membership of a practitioner shall be terminated automatically, without any of the procedural rights set forth in this Article V, upon the termination of the practitioner’s professional license. It shall be the duty of a practitioner who becomes subject to such a sanction or whose license has lapsed to report that fact in writing to his or her Department Chair, the Senior Vice President of Medical Affairs and to the Chief Executive Officer immediately. Upon removal of the sanction, the practitioner may reapply for Medical Staff membership and clinical privileges in accordance with these Bylaws.

(b) Notwithstanding any other provisions of these Bylaws, where a practitioner has been appointed to the Medical Staff and granted clinical privileges at the Hospital pursuant to a contract between the Hospital and any other facility, organization or vendor, the Medical Staff membership and privileges of such practitioner shall automatically terminate, without the procedural rights set forth in this Article V, upon the termination of such contract; or if the practitioner ceases to be employed by such other facility, organization or vendor; or if such other facility, organization or vendor ceases to assign the practitioner to provide services to the Hospital. Such Medical Staff member may at that time re-apply for Medical Staff membership and clinical privileges. Upon recommendation of the Department Chair, the Medical Board may waive the foregoing automatic termination requirement.

Section 5.4 Automatic Suspension of Medical Staff Membership

A practitioner’s Medical Staff membership shall automatically be suspended without any of the procedural rights set forth in Article V, upon (i) an action by New York State suspending a practitioner’s license to practice his or her profession or the failure of the practitioner to re-register for his or her
license, (ii) upon the practitioner’s failure to maintain adequate and satisfactory professional liability insurance, or upon his or her failure to provide documentation of adequate and satisfactory professional liability insurance, as required by these Bylaws and the Rules and Regulations, (iii) upon failure to provide the Medical Staff Services Central Office with any and all documentation required by law, such as proof of infection control training or health status, or (iv) upon exclusion from the Medicare or Medicaid programs. The suspension may terminate upon the determination by the Senior Vice President of Medical Affairs or Chairman of the Medical Board that the practitioner is in compliance with the requirements of the Hospital and these Bylaws and the Rules and Regulations regarding maintenance of a professional license in full force and effect, or adequate and satisfactory professional liability insurance, or upon reinstatement as a Medicare and/or Medicaid provider, as applicable.

In addition, a temporary suspension, in the form of a withdrawal of a Medical Staff member’s clinical privileges, shall be imposed automatically for failure to complete medical records as specified in these Bylaws or the Rules and Regulations or other Medical Board or Hospital policies or procedures. Such temporary suspension shall be effective until the medical records are completed.

Section 5.5 Duty of Cooperation

It shall be the duty of each practitioner to cooperate fully with all proceedings in which he or she is involved. Failure or refusal of a practitioner at any time to do so shall be cause for suspension, summary or otherwise, termination, or limitation of all or part of his or her clinical privileges and Medical Staff membership. Furthermore, by accepting membership on the Medical Staff each practitioner thereby agrees that he or she will take no action against the Hospital or any representatives of the Hospital or its Medical, Graduate or Nursing Staff, or against any person supplying information or evidence thereto, for acts performed or statements made in good faith and without malice in connection with any proceedings provided for in these Medical Staff Bylaws.

ARTICLE VI – CLINICAL DEPARTMENTS AND CHAIRS

Section 1. Departments

Subsection 1. Departments of the Medical Staff shall be as follows: Anesthesiology; Cardiology; Emergency Medicine; Family Practice; Medicine; Obstetrics & Gynecology; Orthopaedics; Pathology; Pediatrics; Psychiatry; Radiology; and Surgery.

Subsection 2. Sections within the various Departments may be established from time to time upon the approval of the Medical Board. Sections so established shall be under the supervision of the Chair of the particular Department involved and shall have such duties as he shall assign subject to the approval of the Medical Board.

Subsection 3. Specialists in the various subspecialties of Medicine and Surgery will be appointed to the particular Department concerned (either Medicine or Surgery). This appointment shall indicate the appropriate specialty whether or not a Section has been established for the specialty.

Section 2. Family Practice Department

Subsection 1. There shall be a Department of Family Practice to which all physicians engaging in Family Practice shall be appointed. It shall be a Clinical Department and shall participate in the review of clinical performance of its members, but the final responsibility to recommend clinical
privileges and the final authority to review clinical performance shall reside in the applicable specialty
departments. All patients admitted by members of the Department of Family Practice will be admitted
to the appropriate specialty department.

Subsection 2. The members of the Department of Family Practice shall be assigned clinical privileges in the specialty departments in accordance with their qualifications.

Section 3. Assignment to Departments

Assignment to Departments shall be made at the time of appointment or reappointment to the Medical Staff. Specific privileges will also be assigned at that time. Recommendations for assignment to Departments and privileges to be accorded will be originated by the Chair of the Clinical Departments, recommended by the Medical Board and approved by the Board of Directors in accordance with Article III.

Section 4. Organization of Departments

Subsection 1. Each Department shall be organized as a division of the Staff as a whole and shall have a Chair appointed by the Board of Directors as provided in Section 6 of this article.

Subsection 2. Each of the Clinical Departments of Family Practice, Medicine, Cardiology, Obstetrics/Gynecology, Orthopaedics, Pediatrics, Psychiatry, and Surgery shall hold departmental meetings as provided in Article X of these Bylaws. Attendance at departmental meetings shall be in accordance with the requirements of Article X of these Bylaws.

Section 5. Medical Officers

Subsection 1. There shall be a Chief of Staff appointed annually by the Board of Directors from the Active Staff. He/she in cooperation with the Senior Vice President of Medical Affairs shall be responsible for the functioning of the clinical organization of the Hospital and shall keep or cause to be kept, a careful supervision over all the clinical work done in the Hospital. He/she shall coordinate the work of the Chair of Departments and shall serve as Chairman of the Medical Board. Although the appointment of the Chief of Staff is the sole responsibility of the Board of Directors, the Board shall request the advice of the Medical Board concerning this appointment.

Subsection 2. The Senior Vice President of Medical Affairs is appointed by the Chief Executive Officer and is responsible for establishing and implementing standards and policies, consistent with state, federal, and other regulatory and accrediting bodies, to ensure the quality of medical care provided to patients, as well as the ethical conduct and professional practice of the Medical Staff.

Senior Vice President of Medical Affairs will provide oversight to the educational needs of the Medical Staff and post graduate training staff and act as a liaison between the Medical Staff, the Board of Directors and the Health System.

Section 6. Organization and Selection of Chairs

Subsection 1. Departmentalization - In order to accomplish its required functions, the Medical Staff shall establish an organizational structure that consists of at least the following departments: Anesthesia, Cardiology, Emergency Medicine, Medicine, Family Practice, Obstetrics/Gynecology,
Orthopaedics, Pathology, Pediatrics, Psychiatry, Radiology and Surgery. Each department shall be organized and shall have a Chair who shall be responsible for the overall supervision of the clinical and administrative activities. The Chair of a department shall be accountable to the Chief of Staff through the Medical Board with specific duties as described herein and as specified in the departmental Rules and Regulations.

Subsection 2. Qualifications – The Chairs of the aforementioned departments shall be members of the Active Medical Staff qualified by training, experience, demonstrated leadership skills and meeting the following requirements:

(a) Attending member in good standing of the active staff of the department or sections of the department, as applicable, and remain in good standing throughout his/her term; and

(b) Certification by the appropriate ABMS or AOA specialty board;

(c) Have demonstrated administrative and leadership abilities;

(d) Agree to and, when in office, willingly and faithfully discharge the functions and exercise the authority of his/her office and work with the other Chairs, Officers of the Staff, the Chief Executive Officer, Senior Vice President of Medical Affairs, the Medical Board and the Committees of the Medical Staff.

Subsection 3. Selection – Except for the Departments of Anesthesiology, Emergency Medicine, Pathology, Psychiatry and Radiology, the Chairs of the major clinical departments shall be appointed by the Board of Directors, upon the recommendation of an ad hoc Search Committee that shall be established as set forth below. Incumbent Chairs shall be allowed to serve out their terms of office under the current bylaw provisions.

(a) In the event that the position of any Chair of a Medical Staff department shall become vacant for any reason, a successor shall be selected pursuant to the provisions of this subsection.

(b) When practicable, the incumbent department Chair shall inform the members of his/her department at a regularly scheduled departmental meeting, and in writing, at least three (3) months prior to his/her intention to resign. Within two (2) weeks of such notice, any qualified physician interested in the position of department Chair shall so advise the Chief of Staff in writing.

(c) The Chief of Staff will appoint an Ad Hoc Search Committee and serve as Chair of this Ad Hoc Search Committee or designate such Committee’s Chairman.

(d) The Ad Hoc Search Committee shall consist of at least the following individuals: Chief of Staff, Chief Executive Officer, Senior Vice President of Medical Affairs, Medical Staff President, the Department Chairs of two (2) other departments, and at least one member of the Department concerned. The members of the Department shall be consulted as part of the process.
(e) The Ad Hoc Search Committee shall canvass the field for qualified candidates, including self-identified candidates pursuant to Subsection 3(b), above, and present to the Board of Directors or its designated committee the name of one candidate. The members of the department shall be consulted as part of the process. The Board of Directors (or its designated committee) shall review the qualifications of the Candidate and, if approved, the candidate’s application will be processed pursuant to the credentialing process. If the Board of Directors does not approve the Ad Hoc Search Committee’s candidate, or if the candidate does not successfully complete the application (credentialing) process, the Search Committee shall commence its search again until another qualified candidate is found who does successfully complete the process.

Subsection 4. Confidentiality – Any information reviewed by members of the department and Medical Board as part of this process of recommending a candidate for the position of Chair shall be held in the strictest confidence by members of these committees.

Subsection 5. Duties and Responsibilities

(a) The Chair of a Department shall be responsible to the Chief of Staff and the Board of Directors for the functioning of his/her Department and shall have general supervision over all clinically related activities of the Department including assessing and recommending off-site sources for needed patient care services not provided by the Department. He/she shall enforce adherence to the Bylaws, Rules and Regulations, subject to the approval of the Medical Board. He/she may promulgate Rules and Regulations his/her deems necessary for the proper functioning and supervision of his/her department as provided in Article X of these Bylaws. The Department Chair is responsible for all administratively related activities of the Department, unless otherwise provided for by the hospital, for the coordination and integration of inter and intra department services; for the development and implementation of policies and procedures that guide and support the provision of care, treatment and services; the recommendations for sufficient number of qualified and competent persons to provide care, treatment, and service; the continuous assessment and improvement of the quality of care, treatment, and services, the orientation and continuing education of all persons in the department of service; and recommendations for space and other resources needed by the department or service.

(b) The Chair of a department shall make appropriate recommendations to the Medical Board concerning the appointment, reappointment, and clinical privileges for each member of his/her department as required under Article III, Sections 4, 5, and 6. He/she is responsible for the continuing surveillance of the professional performance of all credentialed members of the department. He/she shall recommend to the Medical Board the criteria for clinical privileges that are relevant to the care provided in the department and for recommending clinical privileges for each member of the department.

(c) The Chair of a department shall develop a schedule for coverage of services in the Emergency Department and, may at his/her discretion, grant exemptions to members of the department for age, service and extenuating circumstances
provided that such Exemptions are consistent with the policies of the Medical Board and needs of the hospital.

(d) The Chair of a department shall conduct departmental meetings as part of the continuous assessment, evaluation and improvement of the quality of care, treatment and services.

(e) The Chair of a department shall be responsible for determining the qualifications and competence of personnel in the department who are not licensed independent practitioners and who provide patient care, treatment and services.

Subsection 6. Interim Appointment - In the event a vacancy in the position of Department Chair occurs, until a new Chair is selected, an interim Chair, who is a member of the Active Staff, shall be appointed by the Chief of Staff in consultation with the Medical Board. The interim Chair shall fulfill the responsibilities of the position in an acting capacity, including those related to the election process, until a Chair is formally appointed by the Board of Directors.

Subsection 7. Hospital-Based Department Chiefs - The appointment of the Chairs of the Departments of Anesthesiology, Psychiatry, Radiology, Pathology, and Emergency Medicine shall be recommended by the Hospital's Chief Executive Officer and the Chief of Staff, to the Board of Directors. The members of these departments shall be consulted as part of the process. Any unexpected vacancy of these aforesaid department Chiefs may be filled on an interim basis by an active member of the Medical Staff selected by the hospital’s Chief Executive Officer in consultation with the Chief of Staff. He/she would fulfill the responsibilities of the Chair in an acting capacity until a new Chair is selected and approved by the Board of Directors. Removal of the Chairs of these aforesaid departments may be made upon the recommendations of the Chief Executive Officer, with notification to the Medical Board provided that not such removal shall be effective unless it has been ratified by the Board of Directors.

Subsection 8. The Chair of the Department shall be responsible for assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization.

ARTICLE VII

DETERMINATION OF QUALIFICATIONS AND PRIVILEGES

Section 1. Classification of Privileges

Privileges granted to physicians and dentists who have been appointed to the Medical Staff shall be recommended by the Chair of the Clinical Departments involved, further recommended and approved by the Medical Board and assigned by the Board of Directors. The applicant has the right to appear before the Medical Board to discuss the requested privileges.

Section 2. Determination of Privileges

Subsection 1. Determination of initial privileges shall be based upon an applicant’s training, experience, ability to perform the requested privilege, and upon monitoring by the Chair during the period of initial Focused Professional Practice Evaluation.
**Subsection 2.** Determination of further privileges shall be based upon an applicant’s training, experience, and ability to perform the requested privilege which shall be evaluated by review of the applicant’s credentials, direct observation and review of reports of the Medical Records, Performance Improvement Committee and Peer Review Committee findings as provided in Article IX of these Bylaws.

**Section 3. Relationships of Medical Staff to Resident Staff**

Rules relating to supervision of residents are set forth in the Rules and Regulations of the Medical Staff as well as the policies of the department to which they are assigned. In all instances, such rules must provide that the attending Medical Staff member shall remain in charge of the care, retains the right to issue orders for patient care, and that all orders given by the resident staff pertaining to his/her patient are subject to the Attending physician’s approval and may be revised by him/her as he considers necessary.

**Section 4. Continuing Medical Education**

Continuing education for all Medical Staff members is required as continuing education is an adjunct to maintaining clinical skills and current competence. Each department shall provide a program of relevant continuing education, which is consonant with the hospital’s mission, the population served and the patient care services provided, as a part of its departmental meetings. Practitioners shall also be encouraged to participate in outside continuing education programs.

The Chair of each department is responsible for the continuing education program in his/her department. Overall coordination of continuing education programs shall be the responsibility of the Medical Board who may utilize the appointment of a Director of Continuing Medical Education to assist in carrying out this function.

It is recommended that each Medical Staff member participate in a minimum of twenty-five (25) hours of continuing medical education per year. Both in-hospital and outside continuing education programs may be included to meet this recommendation. Documentation of each Medical Staff member’s continuing medical education credits will be maintained and will be considered at reappointment time.

**ARTICLE VIII – OFFICERS AND COMMITTEES**

**Section 1. Officers**

The officers of the Medical Staff shall be the President, the Vice-President and the Secretary-Treasurer. These officers shall be elected at an Annual Meeting of the Active Staff and shall hold office for a period of two years.

**Section 2. Qualifications of Officers**

Officers shall have been members of the Active Medical Staff for at least 1 year at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
Section 3.  Election of Officers

Officers shall be elected at an Annual Meeting of the Medical Staff. All members of the Attending, Associate Attending, and Assistant Attending Staffs shall also be eligible to vote. Election of the Secretary/Treasurer shall be by ballot and a majority vote will be necessary for election. In the event there are three (3) or more candidates and no candidate receives a majority of the votes, the candidate with the fewest votes shall be eliminated and a new ballot taken. This procedure shall be followed until a majority vote is obtained by one candidate. The President may appoint a Nominating Committee of members of the Active Staff to offer one or more nominees and nominations may also be made from the floor at the time of the Annual Meeting. With the approval of the Medical Staff, the sitting Vice President shall assume the office of President and the sitting Secretary/Treasurer shall assume the office of Vice President.

Section 4.  Duties of the Officers

The duties of the officers of the Medical Staff shall be as follows:

1. The President shall call and preside at all meetings of the Medical Staff and shall be a member ex-officio of all committees. He/she shall appoint all committees except the Medical Board and the Joint Conference Committee.

2. The Vice President, in the absence of the President, shall assume all of his duties and have all his/her authority. He/she shall have such other duties as may be assigned to him by the President. In the absence of both the President and Vice-President, a temporary chairman will be chosen by the members of the staff attending a specific meeting.

3. The Secretary-Treasurer shall keep or cause to be kept complete and accurate minutes of all staff meetings, these minutes to include the attendance. He/she shall notify members of staff meetings and attend to all correspondence. He/she shall collect all dues and shall be accountable for all funds entrusted to him/her. He/she shall disburse funds in accordance with authorization from the staff and shall submit an annual financial report to the staff at the Annual Meeting.

Section 5.  Recall of Officers

Failure of an officer of the Medical Staff to carry out a substantial degree of the duties and responsibilities of his/her office, for a reason which does not result in such officer’s ceasing to remain a member in good standing of the active Medical Staff, shall subject such officers to recall from office by action of the members of the Medical Staff by a two-thirds vote at a regular or special meeting called and held in accordance with the provisions of these Bylaws as set forth under Article X. In the event of recall, the vacancy created thereby shall be filled in the manner provided under Article VIII, Section 3.

Section 6.  Committees

Committees shall be standing and special. All committees other than the Medical Board, the Joint Conference Committee, the Performance Improvement Coordinating Group, and the Ethics Committee shall be appointed by the President and he shall designate the Chairman.
Standing Committees shall be:

**Subsection 1. The Joint Conference Committee** shall consist of the Chairs of each clinical department of the hospital, and an equal number of lay members of the Board of Directors to be appointed by the Chairman of the Board of Directors. The hospital’s Chief Executive Officer (CEO), the Chief Operating Officer (COO), and the Senior Vice President of Medical Affairs will also be invited to attend as non-voting members. The members of the committee shall be appointed to one-year terms which may be renewed. The Chairman of the Committee shall be selected by the Chairman of the Board from among one of the director members. The Committee shall meet at such times and places as may be designated by either the Chairman of the Board, the hospital’s Chief Executive Officer or by any member of the committee requesting a meeting through its Chairman. Notices of meetings shall be given by mail sent not less than ten (10) days prior to a meeting or by phone no less than three (3) days prior to the meeting. The Committee shall act as a liaison between the Board of Directors and the Medical Staff and Administration on matters of mutual interest to directors, physicians and administrators. It shall receive recommendations from the Medical Staff and recommend changes to the Board of Directors on matters relating to Rules and Regulations, Bylaws, credentialing requirements and patient care standards. In addition, the Joint Conference Committee may be utilized in physician disciplinary matters in accordance with the Bylaws. The Committee shall also provide additional oversight of the quality management functions to assure that the Board’s responsibility with respect to the quality of patient care is fulfilled. As liaison for directors, physicians, and administrators, the Joint Conference Committee shall provide a vehicle for educating and providing insight to its members on issues that are topical and relevant in an effort to continuously seek opportunities to improve quality in all areas of hospital-clinical administrative and financial. The Committee shall maintain a permanent record of its proceedings and actions, including attendance records.

The Joint Conference Committee may, in the interests of enhancing the patient care rendered at the hospital and to its community, establish relationships with the joint committees with other system hospitals in order to better address the quality issues which arise in the hospital.

**Subsection 2. The Medical Board** The Medical Board shall consist of: the Chief of Staff who shall be the Chairman; the Chairs of the Departments of Cardiology, Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Family Practice, Anesthesiology, Emergency Medicine, Pathology, Radiology, and Orthopaedics; the President, Vice-President and Secretary-Treasurer of the Medical Staff; the Senior Vice President of Medical Affairs; and three (3) members of the Active Medical Staff, who are actively practicing in the hospital elected by the staff by plurality, for a term of three years. In the event that the President or Vice-President of the Medical Staff is also a Department Chair, a fourth member of the Medical Board shall be elected by the staff. In the event that both the President and Vice President are department Chairs, two (2) additional members shall be elected by the Active Staff. No member of the Active Staff is ineligible for membership on the Medical Board solely because of his or her professional discipline or medical specialty.

The duties of the Medical Board shall be: to provide for effective communication among the Medical Staff, hospital Administration and governing body (ref MS.2.3.6); to coordinate the activities and general policies of the various departments; to receive, review, and act upon the reports of Medical Staff committees, clinical departments and assigned activity groups designated by the Medical Staff to fulfill the Medical Staff’s accountability to the Board of Directors for

(i) The medical care rendered to patients in the hospital;
(ii) The Medical Staff’s structure;

(iii) The mechanism used to review credentials and to delineate individual privileges;

(iv) Recommendations for medical staff membership and delineation of clinical privileges for each eligible member;

(v) The Medical Staff’s participation in an organized performance improvement program;

(vi) The mechanism by which Medical Staff membership may be terminated and;

(vii) The mechanism for a fair-hearing procedure; to ensure that the Medical Staff is kept abreast of the accreditation status of the hospital; to recommend action to the Chief Executive Officer on matters of a medical-administrative nature; to review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations to the Board of Directors concerning matters of medical policy and appointments to the Medical Staff as hereinbefore provided; to meet with representatives of the Board of Directors as provided in this section when necessary, such changes to be effective until the next meeting of the Board of Directors when same shall be acted upon; the Medical Board shall also be responsible for the program at all regular Medical Staff meetings. The Medical Staff Bylaws empower the Medical Board to act for the organized Medical Staff between meetings of the organized Medical Staff. Such actions are delegated to the Medical Board for purposes of adopting Policies but specifically exclude the delegation of authority to change these Bylaws, and are subject to review at meetings of the organized Medical Staff.

To the extent permitted by applicable law and The Joint Commission’s standards, the Medical Board is authorized to adopt, on behalf of the Medical Staff and subject to approval by the Board of Trustees, details concerning the foregoing matters, and to place such details in the Medical Staff Rules and Regulations or in Medical Staff policies.

The Medical Board plays a vital role in the relationship between the medical staff and the governing body. Medical staffs and governing bodies often rely on the Medical Board to act expeditiously on urgent and other delegated matters that arise within the organization. The Medical Board serves as a voice for the medical staff to communicate to the governing body, and is, therefore, accountable to the organized medical staff, regardless of how the Medical Board members are selected. Because it plays this vital role, it is incumbent upon the Medical Board to convey accurately to the governing body the views of the medical staff on all issues, including those relating to quality and safety. In order to fulfill this role, the Medical Board seeks out the medical staff’s views on all appropriate issues.

The Medical Board shall meet at least once each month and maintain a permanent record of its proceedings and actions and shall report to the Board of Directors. The Chief of Staff shall make a report at each general staff meeting on behalf of the Medical Board. A quorum shall consist of five (5) members. The Chief of Staff shall be the Chairman of the Medical Board and shall call all
meetings of the committee. In the absence of the Chairman, a special meeting of the Medical Board may be called upon the request of three (3) of its members.

The Chief Executive Officer of the hospital, or his representative, and the Vice President of Nursing shall be privileged to attend all meetings of the Medical Board. They shall not have a vote.

In addition, the Medical Board and/or the Chairman thereof is empowered to invite such guests to the proceedings of the Medical Board as is or he/she deems appropriate, including, but not limited to, the Chairmen of all other system hospitals.

Subsection 3. The Performance Improvement Coordinating Group (PICG). The responsibilities and duties of the PICG shall be to coordinate and promote an effective hospital-wide quality improvement program in fulfillment of the Medical Staffs’ accountability to the Board of Directors for the medical care rendered to patients in the hospital and to make such recommendations on medico-administrative matters, as they relate to patient care, through hospital management. This may include, but not necessarily be limited to, the systematic collection of relevant data, performance measurement, outcomes analysis, making recommendations about changes in organizational functions, and subsequent assessment of the effectiveness of such changes in processes. The Committee may use internal and external data base sources in the conduct of its duties.

The Committee shall meet at least ten (10) times per year and report regularly to the Board of Directors through the Medical Board.

Subsection 4. The Credentials Committee shall consist of at least three (3) members of the Active Staff. Its duties shall be to investigate the credentials of all applicants to the Medical Staff; this investigation to include a personal interview; to make appropriate recommendations to the Medical Board in conformity with Article III, Section 4, Subsections 1 and 2 of these Bylaws; to investigate at the request of the Medical Board any suspected breach of ethics; to review, at the request of the Medical Board, any other matters concerned with the credentials of any applicant or staff member. This committee shall meet as required.

Subsection 5. The Bioethics Committee serves as an advisory body on ethical issues related to the care and treatment of the hospital’s patients. The Committee will provide a forum in the hospital for the discussion of ethical issues and concerns. The Committee will encourage and assist in the development of bioethical educational programs in the hospital and in the community.

The Bioethics Committee serves as an advisory body on ethical issues for the administrative and professional staffs of the hospital. It will assist in the formulation or assessment of policies, procedures, or guidelines concerning patient care and treatment. The Committee will be available to consult on any matter presented to it by any person involved in a patient’s care about any bioethical issues arising from the patient’s care and treatment.

The Chair of the Bioethics Committee will be appointed by the Chief Executive Officer of the hospital in consultation with the Chairman of the Medical Board. The Chair will serve a renewable two (2) year term. The Committee will consist of at least twenty (20) members to include physicians from the following departments: Anesthesiology; Critical Care; Emergency Medicine; Family Practice; General Internal Medicine; Nephrology; Neurology; Obstetrics/Gynecology; Pediatrics; Psychiatry; and Surgery, members of the Nursing Staff, including Critical Care; ethicist(s); representative of the clergy; social worker; lawyer; hospital administrator; community representative(s) who are not affiliated with the
hospital; and a representative from home health care agencies/hospices. The members of the Bioethics committee will be appointed by the Chair with the approval of the Chief Executive Officer of the Hospital in consultation with the Chairman of the Medical Board. Each member will serve a renewable three (3) year term. The members of the committee will be chosen for their individual expertise and collective breadth of perspectives. Members will not serve as representatives of particular constituencies. The Ethics Committee will meet monthly at least ten (10) times a year.

Minutes and records of the Bioethics Committee will be kept confidential and will not be released by members of the committee or by any other person. The Committee will have access to medical information, medical and clinical records of patients necessary to perform its functions. Any such information or records will be kept confidential. The Chair will prepare an annual report to the Hospital Administration setting forth the Committee’s activities.

Subsection 6. The Health Information Management Committee shall consist of at least four (4) members of the Active Medical Staff representing the Departments of Medicine, Surgery, Obstetrics and Gynecology, and Pediatrics; the Chief Executive Officer, the Vice President-Nursing, and the Director of Medical Records or their designated representatives. The duties of the Committee shall be to supervise and appraise medical records, and to ensure the maintenance at the required standard. In the Performance of their duties the members of this committee may call upon other members of the Medical Staff to assist them but the responsibility for this function shall rest solely upon the committee members.

The Committee shall meet monthly at least ten (10) times per year and submit to the Medical Board a report in writing, which will be made a part of the permanent record.

Subsection 7. The Surgical Performance Improvement Committee shall consist of representatives of the Department of Surgery, Obstetrics and Gynecology and Medicine. The Chairs of Pathology and Radiology shall be members ex-officio. The duties of the committee shall be to review all surgical cases in which there is a significant or unexpected adverse outcome, an identified or suspected error in diagnosis or management, or where there is a discrepancy between the clinical preoperative diagnosis and the pathological findings. The committee shall meet at least ten (10) times per year and submit to the Medical Board a report, in writing that will be made a part of the permanent record.

Subsection 8. The Library Committee shall be in charge of the Medical Library. It shall make such rules as are necessary and shall make recommendations to the Medical Staff concerning the purchase of publications. The Committee shall meet no less than two (2) times per year.

Subsection 9. The Bylaws Committee shall consist of at least three (3) members of the staff. The duties of this committee shall be to study revisions to the Bylaws which may from time to time become indicated and to report its recommendations to the Medical Staff. The Committee shall meet at least once every two years.

Subsection 10. The Case Management Committee shall consist of at least four (4) members of the Active Medical Staff. Each clinical department shall be represented on the committee. The duties of the Committee shall be to study and evaluate the effectiveness of hospitalization and to promote the most efficient use of available health facilities and services. It is the duty of the Utilization Committee to affect a plan to review the services furnished by the hospital to inpatients. Such a plan should include the organization and composition of the committee, the frequency of meetings, the type of records to be kept, the methods to be used in selecting cases on a sample or other basis, the definition
of what constitutes the period or periods of extended duration, the relationship of the utilization review plan to third party payors, arrangement for committee reports and dissemination of information. Reviews are made of admissions, duration of stay, and professional services furnished, with respect to the medical necessities of the services and for the purpose of promoting the most efficient use of available health facilities and services. The Committee shall report to the Medical Board. The Committee shall meet monthly at least six (6) times per year.

Subsection 11. The Infection Committee shall consist of at least four (4) members of the staff representing the clinical departments, nursing representation, and other departments on an ad hoc basis. The duties of this committee shall be to meet with representatives of Administration and to discuss matters pertaining to hospital infections. The Committee shall review surveillance data and make such recommendations as they deem appropriate to the Medical Board. The Committee shall meet monthly at least ten (10) times per year.

Subsection 12. The Pharmacy and Therapeutic Committee shall consist of at least four (4) members of the Medical Staff. The duties of this committee shall be to meet with the Director of Pharmacy and the Chief Executive Officer or his authorized representative to discuss all matters pertinent to the use of drugs in the hospital. The Committee shall make recommendations to the Medical Board concerning the evaluation, selection, procurement, distribution, use, safety procedures and other matters relating to drugs in the hospital. The Committee shall develop and maintain a formulary of accepted drugs for use in the hospital. The Committee shall meet monthly at least ten (10) times per year.

Subsection 13. The Perinatal Morbidity and Mortality Committee shall consist of at least four (4) members of the Medical Staff. Representation shall include but not be limited to at least one physician from each of the following departments: Obstetrics and Gynecology, Pediatrics and Anesthesiology. A representative of the Pathology Department will serve ex-officio. The Duties of this committee shall be to review and study all matters affecting perinatal morbidity and mortality and to report to the Medical Board the results of their study. The Committee shall meet at least two (2) times per year.

Subsection 14. The Cancer Committee shall be multidisciplinary and must include at least one of each of the following board certified clinical practitioners: surgeon, medical oncologist, radiation oncologist, diagnostic radiologist, cancer liaison physician, and the Chief of the Section of Oncology. Non-physician members must include, but are not necessarily limited to, administration, nursing, social services, pharmacy cancer registry, and quality management. Other disciplines may be appointed, as appropriate, to help plan, initiate, stimulate and monitor all clinical and educational cancer related activities in the hospital. The Committee shall meet quarterly with recorded minutes and report to the Medical Board directly or through the HSQ Committee.

The Cancer Committee responsibilities include the following: to develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer; to promote a coordinated, multidisciplinary approach to patient management; to ensure that educational and consultative cancer conferences cover all major sites and related issues; to ensure that an active supportive care system is in place for patients, families, and staff; to monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes; to promote clinical research; to supervise the Cancer Registry and ensure accurate and timely abstracting, staging, and follow-up reporting; to perform quality control of registry data; to encourage data usage and regular reporting; to ensure that the content of the Annual Report meets requirements and to publish the Annual Report by November 1 of the following year.
Subsection 15. **Institutional Review Board:** An Institutional Review Board (IRB) is a committee authorized by the Health System’s Human Research Protection Program and charged with the responsibility for reviewing and approving all research activities involving human subjects. An authorized IRB may be one that is established by the Health System, one that is established by a System Hospital, or one that is established by an external organization. The IRB review includes investigator-initiated research, projects that are interdepartmental in nature and cooperative research projects with other institutions or organizations. In addition, the IRB may serve as the Privacy Board for research activities with regard to HIPAA and will determine the need for obtaining authorization from subjects and/or issuing a waiver of authorization for research projects involving human subjects. These requirements are in place regardless of the source of funding for the project. Prior to undertaking such research, members of the Medical Staff must obtain appropriate administrative and IRB approval in accordance with Human Research Protection Program policies. If such approval is obtained, it shall be the responsibility of the Medical Staff member, together with his/her department Chairman, to inform the Medical Board of the research project so that it may exercise appropriate oversight.

Subsection 16. **Special Committees** shall be appointed from time to time as may be required to carry out properly the duties of the Medical Staff. Such committees shall be appointed by the President and shall confine their work to the purpose for which they were appointed and shall report to the full Medical Staff. They shall not have power of action unless such is specifically granted by the motion which created the committee.

**ARTICLE IX – MEETINGS**

Section 1. **The Annual Meeting**

An Annual meeting of the Medical Staff shall be held within thirty (30) days following the close of the calendar year. The agenda of this meeting shall include the election of Officers and Medical Board representatives for the year; reports from officers and committees as may be desirable; and reports of review and evaluation of the work done in the clinical departments and the performance of the required Medical Staff functions.

Section 2. **Regular Meetings**

Subsection 1. In addition to the Annual Meeting, the Medical Board may schedule additional regular meetings of the Medical Staff for the purpose of transacting such business as may come before the meeting.

Subsection 2. All regular meetings including the Annual Meeting shall be scheduled as to date, time, and place by the President of the Medical Staff and sufficient notice of any regular meeting shall be given by posting on the bulletin board in the staff room and by mail to each member of the active staff at least five (5) days before the time set for the meeting.

Subsection 3. In addition to the regular tri-annual meetings of the Medical Staff, the Department of Medicine, Surgery, Obstetrics & Gynecology, Pediatrics, Family Practice, Orthopaedics and Emergency Medicine shall hold monthly conferences, not less than ten (10) in each calendar year, by each department. The program of these conferences shall include, but need not be limited to, monitoring and evaluating the quality and appropriateness of patient care provided within the department. Such conferences may also include relevant educational programs by outside speakers.
The monthly departmental conferences should also include a review of current cases and the clinical work of the members of the department. The requirement for attendance, as provided under Article X, Section 4 of these Bylaws, shall apply to these meetings.

**Subsection 4.** Clinical conferences and scientific meetings of the Medical Staff shall be held from time to time. These meetings shall be educational in purpose and the program may include guest lectures, demonstrations and other educational techniques. Attendance at these meetings shall not be compulsory.

**Subsection 5.** Adequate minutes of all of the Medical Staff meetings, except the scientific meetings, shall be kept and shall become a part of the permanent record.

**Section 3. Special Meetings**

Special meetings of the Medical Staff may be called at any time by the President and shall be called at the request of the Board of Directors, the Medical Board, or any five (5) members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be posted on the bulletin board in the staff room and by mail or telephone at least 48 hours before the time set for the meeting.

**Section 4. Attendance at Meetings**

**Subsection 1.** Active Staff members shall be encouraged to attend at least 50% of the scheduled annual and regular meetings unless excused by the Medical Board. Information regarding attendance at meetings will be considered at reappointment time.

**Subsection 2.** Reinstatement of members of the Active Staff to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

**Subsection 3.** Members of the Emeritus, Consulting, and Courtesy categories of the Medical Staff shall not be required to attend meetings, but they shall be invited to attend and participate in these meetings.

**Subsection 4.** A member of any category of the staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present. Failure to attend on receipt of such notice shall be subject to disciplinary action by the Medical Board. Should any member of the staff be absent from any meeting at which a case that he/she has attended is to be discussed, it shall be presented, nevertheless, unless the member is unavoidably absent and has requested that discussion be postponed. In no case, shall postponement be granted for a period longer than that until the next regular meeting.

**Section 5. Quorum**

Fifty members of the voting Medical Staff shall constitute a quorum. Absent a quorum, ballots shall be mailed to Medical Staff members for voting.

**Section 6. Agenda**
The agenda at any regular meeting of the Medical Staff shall be:
1. Call to order.
2. Approval of minutes.
3. Treasurer’s Report.
5. Report of Chief of Staff.
7. Old Business.
9. Adjournment

Section 7. Chief Executive Officer

The Chief Executive Officer of the Hospital or his authorized representative shall be privileged to attend all annual, regular and special meetings of the Medical Staff. He shall also be privileged to attend departmental meetings, clinicopathologic meeting and scientific meetings. He shall not be entitled to vote.

ARTICLE X – RULES AND REGULATIONS & ASSOCIATED POLICIES

Section 1. Rules and Regulations

The Medical Board shall adopt such Rules and Regulations and amendments thereto as may be necessary for the proper conduct of the work of the Medical Staff. The Bylaws Committee shall review such Rules and Regulations not less frequently than every two years, and shall make recommendations to the Medical Board for such new or amended Rules and Regulations as it may deem appropriate. The Rules and Regulations may be amended at any regular meeting of the Medical Board at which there is a quorum, without prior notice, by majority vote of those present, or in accordance with the procedure for the adoption of Policies as set forth in Section 2 of this Article. Such amendments shall become effective when approved by the Board of Directors of the Hospital and shall replace any previous Rules and Regulations. They shall, when adopted and approved, be equally binding on the governing body and the Medical Staff.

When the Medical Board proposes to adopt or amend the Rules and Regulations, it shall notify the Medical Staff of such a proposal and shall provide twenty-one (21) days for the Medical Staff to submit comments. However, if it becomes necessary for the hospital to urgently amend the Rules and Regulations in order to comply with any statutory, regulatory or accreditation requirement, the Board of Directors may provisionally approve such amendment as may be required to comply with the law or regulation without prior communication to the members of the Medical Staff. In such circumstances, the Board of Directors shall immediately notify the members of the Medical Staff in writing of such amendment and the reason that it is necessary. The Medical Staff shall have the opportunity to retrospectively review and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Board of Directors, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the conflict management process set forth in Article XII of these Bylaws shall be implemented.

When the Medical Board adopts or amends the Rules and Regulations, it shall communicate such fact to the members of the Medical Staff.
Section 2. Medical Board Policies

The Medical Board shall adopt such policies as may be necessary to implement the Bylaws and the Medical Staff Rules and Regulations and to guide the Medical Staff in its work. Such policies shall be reviewed not less frequently than every two years and revised as necessary. These policies may be amended at any regular meeting of the Medical Board without previous notice by majority vote of those present, at which there is a quorum. Such amendments, when adopted and approved, shall replace any previous Medical Board policies and shall be binding on the Medical Staff.

When the Medical Board proposes to amend or adopt a policy, it shall notify the Medical Staff of such a proposal and shall provide twenty-one (21) days for the Medical Staff to submit comments. When the Medical Board adopts or amends a policy, it shall communicate such fact to the members of the Medical Staff.

In the event it becomes necessary for the Medical Board to urgently amend one of its policies in order to comply with any law or regulation, the Medical Board shall have the authority to provisionally adopt such amendment or modification as may be required to comply with the law or regulation without prior communication to the members of the Medical Staff. In such circumstances, the Medical Board shall immediately notify the members of the Medical Staff in writing of such amendment and the reason that it is necessary. The Medical Staff shall have the opportunity to comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Board, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the conflict management process set forth in Article XII of these Bylaws shall be implemented.

ARTICLE XI - BYLAW AMENDMENTS

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend amendments to these Bylaws, which shall be reviewed not less frequently than every two years and revised as necessary.

Amendments to these Bylaws proposed by the Medical Staff shall be submitted to the Bylaws Committee for review and recommendation. Upon favorable recommendation by the Bylaws Committee, the proposed amendment shall be submitted, together with the notice of intention to take such action, in writing to the Medical Staff members eligible to vote not less than ten (10) days prior to the meeting at which time action on the amendment(s) is to be taken. Following this 10-day period, the proposed amendment shall be adopted at any regular meeting or at a special meeting properly called of the Active Medical Staff at which a quorum is present, by the affirmative vote of a two-thirds majority of those present. Such amendments shall become effective when approved by the Board of Directors of the Hospital and shall replace any previous Bylaws. They shall, when adopted and approved, be equally binding on the governing body and the Medical Staff.

The Bylaws Committee may recommend Bylaw amendments to the Medical Staff. The proposed amendment shall be submitted to the Medical Staff members eligible to vote in the same manner as described above.

Neither the Medical Staff nor the Board of Directors may unilaterally amend these Bylaws, except that in the event that the staff shall fail to exercise its responsibility and authority with respect to statutory, regulatory or accreditation requirements, and after notice from the Board of
Directors to such effect, the Board may amend these Bylaws, Rules and Regulations to bring them into compliance with federal, state or local law, regulations, or standards of accreditation.

**ARTICLE XI – CONFLICT MANAGEMENT**

The following conflict management process shall be followed in the event of conflict between the Medical Board and the Medical Staff regarding a proposed or adopted medical staff Bylaw, medical staff Rule and Regulation, or an associated policy of the Medical Board, or other significant matter under the purview of the Medical Staff or the Medical Board. The conflict management process may be triggered either by a written petition signed by at least twenty-five (25) members of the Medical Staff and submitted to the President of the Medical Staff, or by a letter from the Chair of Medical Board to the President of the Medical Staff. The petition or letter, as the case may be, shall include (a) a clear statement of the reason for the conflict and the terms of any alternative Bylaw, Rule and Regulation or associated policy, and (b) the designation of 3 representatives of the Medical Staff or the Medical Board, as the case may be. The 3 representatives of the Medical Board shall be selected by the Chair of the Medical Board. The 3 representatives of the Medical Staff shall be selected by the petitioning members of the Medical Staff.

Within one week after receipt of the petition or letter, the President of the Medical Staff shall convene a meeting between the 3 representatives designated in the petition or letter, and the 3 representatives designated by the other party.

The representatives of the Medical Board and of the Medical Staff shall exchange information relevant to the conflict and shall work in good faith to resolve differences within thirty (30) days of their first meeting, in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Board and the safety and quality of patient care at the Hospital. Resolution of the matter shall require a majority vote of the 3 representatives of the Medical Board and a majority vote of the 3 representatives of the Medical Staff. If such a resolution proposes a medical staff Bylaw, medical staff Rule and Regulation, or associated policy that has not been previously submitted to the Medical Staff, such resolution shall follow the process outlined in Article X or XI above, as applicable.

If the parties’ representatives are unable to reach a resolution, they may, by mutual agreement, utilize persons skilled in conflict management to assist in resolving their conflict. Differences that remain unresolved after the expiration of the above thirty-day period shall be submitted to the Hospital’s Board of Directors for its consideration in making a final decision with respect to the proposed medical staff Bylaw, medical staff Rule and Regulation, or associated policy, or other matter. The Board of Directors shall determine the method by which unresolved conflicts are submitted to the Board. Revised amendments to the policy, regulation or bylaw as applicable shall be submitted to the Board of Directors for its consideration.

At all times the participants in the conflict management process shall observe the following principles:

- Resolution of all conflicts shall be undertaken in a manner that promotes productive, collaborative, and effective teamwork, and in an atmosphere of mutual respect and understanding.
Resolution of the conflict shall be consistent with the organization’s mission, values, strategic objectives, policies and organizational ethics; shall protect patient safety and quality of care; and shall best serve the interests of the patient.

All discussions regarding the issues that are the subject of the conflict shall be confined to internal communications, and the highest level of confidentiality shall be maintained with respect to such discussions and issues. Communication to the public with respect to the issues is not appropriate.

ARTICLE XIII – HISTORIES & PHYSICAL EXAMINATIONS

A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or the performance of any procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon or other qualified licensed individual in accordance with law and hospital policy. If a complete history and physical examination has been obtained within thirty (30) days before admission or registration, then a durable, legible copy of this history and physical examination must be placed in the patient’s hospital medical record at the time of, or prior to, any anticipated procedure, and an updated examination including any changes in the patient’s condition or the absence thereof must be completed and documented twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Other details associated with the recording of the history and physical examination are set forth in the Rules and Regulations of the Medical Staff.

Adopted by the Active Medical Staff of Huntington Hospital:

___________________________________
Christopher Anselmi, M.D., President, Medical Staff

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Kevin Lawlor, President & CEO

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William Frazier, Chairman of the Board

Approved – Medical Staff Meeting 5/19/05, Medical Staff 2/13/08, Medical Staff Meeting 09/24/09, 6/15/10, 3/15/11, 11/25/13, 6/2/14, 9/21/14
Approved – Board of Directors 7/26/05, 3/25/08, 12/15/09, 6/29/10, 3/29/11, 12/17/13, 7/29/14, 9/30/14