THE MEDICAL STAFF

BYLAWS

OF

PLAINVIEW HOSPITAL
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PREAMBLE

Plainview Hospital ("Hospital") is a voluntary hospital established as a New York not-for-profit corporation licensed under the laws of the State of New York. The Hospital is part of the North Shore-Long Island Jewish Health System ("Health System") whose mission is to improve the health of the communities its healthcare institutions serve with a commitment to providing the highest quality clinical care; educating the current and future generations of healthcare professionals; searching for new advances in medicine through the conduct of bio-medical research; promoting health education; and caring for the entire community regardless of ability to pay.

In accordance with the Hospital’s mission, the Hospital is committed to accomplishing the following objectives:

- To ensure that all patients admitted to or treated in any of the facilities, campuses, departments or services of the Hospital shall receive the best possible care, irrespective of their race, color, creed, religion, gender, national origin, sexual orientation, veteran’s status, marital status, age, disability, or their ability to pay for such care.

- To provide reliable and valid measures for the continuous evaluation of the overall quality of care provided to all patients of the Hospital and to make recommendations thereon to the Board of Trustees so that all patients admitted or treated at any of the facilities, departments or services of the Hospital receive a safe and high quality of care.

- To ensure a high level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges to practice in the Hospital and the regular review and evaluation of the activities of all individuals granted clinical privileges in the Hospital.

- To provide education and maintain the highest scientific and educational standards in cooperation with the Hospital’s affiliated medical schools and to ensure an optimum atmosphere for continuous progress in professional knowledge and skill of all members of the Medical Staff and those allied health practitioners affiliated with the Medical Staff.

- To initiate and maintain rules and regulations for the governance of the Medical Staff.

- To discuss issues concerning the patients, Medical Staff and the Hospital with the Board of Trustees, the Chief Executive Officer and the Executive Director, through authorized representatives and structures of the Medical Staff, such as the Medical Board and the Joint Conference/Professional Affairs Committees.

- To stimulate and foster approved clinical and laboratory research by members of the Medical Staff and to assist in providing funds therefor.

- To support programs associated with community public health needs.
• To conduct all of the above activities with an overriding concern for the patient and the recognition of his or her dignity as a human being.

• To render other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.

It is recognized that the Medical Staff of the Hospital shares responsibility for the quality of patient care and performance improvement at the Hospital and must accept and discharge that responsibility, subject to the ultimate authority of the Board of Trustees of the Hospital Corporation ("Corporation"), and that the cooperative efforts of the Board of Trustees, the CEO, the Executive Director, the Chief Medical Officer, the Medical Director/Vice President for Medical Affairs and the Medical Staff are necessary to fulfill the Hospital's obligations to its patients.

In order to further the aims and purposes of the Hospital, therefore, the practitioners practicing at the Hospital have organized themselves into a Medical Staff in conformity with these By-Laws, and the Rules and Regulations, which are subject to and shall not conflict with the By-Laws of the Hospital Corporation.
DEFINITIONS

ACADEMIC YEAR – as used in these Bylaws shall mean the period from July 1st to June 30th, inclusive.

BOARD OF TRUSTEES – shall mean the governing body of the Hospital Corporation.

CAMPUS – shall mean the current campus of the Hospital located at 888 Old Country Road, Plainview, NY 11803.

CEO – shall mean the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of the Hospital. The CEO is the CEO of the North Shore-Long Island Jewish Health System and of the Hospital.

CLINICAL PRIVILEGES – shall mean the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services to patients of the Hospital.

CREDENTIALING OFFICE – the Credentialing Office, among other things, receives applications for Medical Staff membership and clinical privileges by practitioners wishing to be members of the Hospital’s Medical Staff. The Credentialing Office processes the application along with making all appropriate inquiries, and forwards completed applications to the Directors of the Clinical Departments, the Credentials Committee and Medical Board for their review and approval.

DEAN AND CHIEF ACADEMIC OFFICER – shall mean the individual appointed by the CEO who is responsible for the activities related to the affiliated medical schools and for educational programs of the Hospital, including its graduate staff, medical students and the continuing medical education of the Medical Staff.

EXECUTIVE DIRECTOR – shall mean the individual appointed by the CEO who is responsible for the administration of the day-to-day operations of the Hospital.

MEDICAL DIRECTOR/VICE PRESIDENT FOR MEDICAL AFFAIRS – shall mean a physician qualified for membership on the Medical Staff, and appointed by and accountable to the Board of Trustees, upon the recommendation of the Executive Director, who shall be responsible for the day-to-day medical activities of the Hospital and directing the Medical Staff organization in accordance with these Bylaws and applicable state and Federal laws and regulations on each of its campuses.

MEDICAL BOARD – shall mean the Executive Committee of the Medical Staff as further defined in Article VI of these Bylaws.
MEDICAL STAFF – shall mean that organized body of physicians, dentists and podiatrists duly licensed and registered by the State of New York, and appointed by the Board of Trustees in accordance with these Bylaws and the Hospital’s Corporate Bylaws, who have clinical privileges at the Hospital’s inpatient and/or ambulatory care facilities. 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 shall also mean the Organized Medical Staff as such term is defined in the Joint Commission’s Comprehensive Accreditation Manual for Hospitals.

SYSTEM CHIEF MEDICAL OFFICER – shall mean the person appointed by the CEO of the Health System who has administrative oversight over all the clinical programs and related activities (not day-to-day medical activities) of each of the System Hospitals, as defined below.

SYSTEM CHIEF OPERATING OFFICER – shall mean the person appointed by the CEO of the Health System who is responsible for the overall operational and administrative issues of the System Hospitals, as defined below. In addition, at its discretion, the Board of Trustees may elect the Chief Operating Officer as an officer of the Corporation.

SYSTEM HOSPITAL – shall mean a hospital in the Health System whose sole voting member is either North Shore Health System or North Shore-Long Island Jewish Health System and which is an acute care hospital licensed under Article 28 of the New York State Public Health Law.

SYSTEM SENIOR VICE PRESIDENT, QUALITY MANAGEMENT – System Senior Vice President Quality Management shall mean the person appointed by the CEO who has administrative oversight over all of the aspects of the Hospital’s Quality Management Program, as defined below.
ARTICLE I
NAME

The name of this organization shall be the “Medical Staff of Plainview Hospital” (hereinafter the "Medical Staff").

ARTICLE II
PURPOSES

The purposes of these By-Laws and of the Medical Staff shall be:

To ensure that all patients admitted to or treated in any of the facilities, Departments or Services of the Hospital shall receive the best possible care, regardless of their race, color, creed, religion, gender, national origin, sexual orientation, veteran’s status, marital status, age, disability, or their ability to pay for such care.

To provide reliable and valid measures for the continuous evaluation and improvement of the overall quality of care provided to all patients of the Hospital and to make recommendations thereon to the Board of Trustees so that all patients admitted or treated at any of the facilities, Departments or Services of the Hospital receive a safe and high quality of care.

To ensure a high level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges to practice in the Hospital and the regular review and evaluation of the activities of all practitioners granted clinical privileges in the Hospital.

To provide education and maintain the highest scientific and educational standards in cooperation with the Hospital’s affiliated medical schools and to ensure an optimum atmosphere for continuous progress in professional knowledge and skill of all members of the Medical Staff and those allied health practitioners affiliated with the Medical Staff.

To initiate and maintain Rules and Regulations for the governance of the Medical Staff.

To discuss issues concerning the patients, Medical Staff and the Hospital with the Board of Trustees, the Chief Executive Officer and Executive Director, through authorized representatives and structures of the Medical Staff, such as the Medical Board, and the Joint Conference/Professional Affairs Committees.

To stimulate and foster approved clinical and laboratory research by members of the Medical Staff.

To support programs associated with community public health needs.

To conduct all of the above activities with an overriding concern for the patient and the recognition of his or her dignity as a human being.
To render such other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.

ARTICLE III
MEMBERSHIP ON THE MEDICAL STAFF

Section 3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege that shall be extended only to practitioners who upon application can demonstrate practical and academic competence and good character, and who continuously meet the qualifications, standards and requirements of the Hospital's Corporate By-Laws and of these By-Laws and the Rules and Regulations. Gender, race, creed, age, sexual orientation, disability, national origin or any other legally impermissible basis shall not be used in making decisions regarding the granting or denying of privileges or appointment to the Medical Staff. Appointments and reappointments to the Medical Staff shall be made by the Board of Trustees following recommendation by the Medical Board as provided in these By-Laws and the Rules and Regulations. In addition, in the absence of a conflict, members of the Medical Staff who are eligible for a faculty appointment to the affiliated medical school shall accept such appointment if offered.

Section 3.2 QUALIFICATIONS FOR MEMBERSHIP

Applicants to the Medical Staff must satisfy the following initial requirements. They must:

A. Be practitioners who can demonstrate acceptable levels and quality of education and who have graduated from educational institutions approved by nationally and internationally recognized accrediting agencies, such as the Liaison Committee on Medical Education and the American Osteopathic Association;

B. Unless, with the knowledge of the Medical Director/Vice President for Medical Affairs, granted a specific waiver by the Department Director and the Medical Board for a limited license, as allowed by law, or unless applying only for Honorary or Emeritus status, possess unrestricted and duly registered licenses to practice their professions in the State of New York;

C. Unless granted a specific waiver by the Department Director and approval by the Medical Board, not be involuntarily excluded as a participant in good standing in the Medicaid and Medicare programs; and

D. Be board certified or board eligible (ABMS, AOA), subject to the following:

1. For physicians who are foreign trained and not eligible to take specialty boards, equivalent certification as determined by the Department Chair is an acceptable alternative;
2. For physicians who are board eligible at the time of initial appointment, board certification is required within 5 years. If board certification is not achieved within the five year period, then, at the time of the next reappointment, the Department Chair shall review the
application and recommend to the Credentials Committee whether to approve continuing Medical Staff membership; and

3. The Department Chair may request that the Credentials Committee approve an exception to the requirement of board certification or board eligibility.

As set forth more specifically in Section 3.4, applicants for Medical Staff membership have the burden to document their background, experience, training and demonstrated competence, adherence to the ethics of their profession, their good reputations, and their ability to work with and be supervised by others, with sufficient adequacy to assure the Medical Board and the Board of Trustees that all patients treated by them in the Hospital will be given consistently high quality professional care fully consistent with prevailing standards of medical practice and conduct in their specialty, sub-specialty or area of practice; that they will cooperate fully and with sustained interest in the overall functions, activities and responsibilities of the Hospital; and that they will afford all patients all rights guaranteed by applicable statute or regulation and these By-Laws and the Rules and Regulations. These qualifications, criteria, and performance standards are designed to assure the Board of Trustees and the Medical Staff that Hospital patients will receive one level of quality patient care. The process of appointment will be the same for applicants holding or proposed for administrative positions. Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing process of the Hospital. No practitioners shall be entitled to membership on the Medical Staff or to clinical privileges at the Hospital merely by virtue of the fact that they are licensed to practice their profession, or that they are members of or certified by any professional organization, or that they have or have had professional privileges at other hospitals.

All members of the Medical Staff shall participate in relevant programs of continuing education as required by the appropriate Department Director. Such participation must be documented in the practitioner's Medical Staff credentials file.

Section 3.3 PROCEDURE FOR APPOINTMENT

Subsection 3.3.1 APPLICATION FOR APPOINTMENT. Each application for membership on the Medical Staff will follow the procedure for appointments as set forth by the Hospital. A period of focused professional practice evaluation shall apply to all initially requested privileges and maintenance of privileges in accordance with Hospital policy. The Department Director will determine clinical privileges at each Hospital Campus. Each application shall be presented in a form satisfactory to the Board of Trustees and shall state and include not less than the following information, which the practitioner shall verify to be complete, true and correct:

A. Full information concerning the applicant's education, training, license and practice; previous, concurrent, and pending hospital clinical privileges and medical staff memberships; past, present, and pending academic affiliations and titles; membership in professional societies; and an agreement to provide any and all additional information requested on a timely basis;
B. Evidence of current health status including, but not limited to, a recorded medical history and physical examination attesting to the applicant's physical and mental competence to exercise the clinical privileges requested and any additional health-related information requested by the Medical Board and/or the Hospital;

C. Documentation in the format required by the Hospital from at least three practitioners, at least two practitioners who practice within the same discipline as the applicant, who have knowledge of the applicant's technical and clinical skills, clinical judgment, interpersonal and communication skills, medical/clinical knowledge, ethical character, competence, physical and mental capabilities and ability to work cooperatively with others, and ability to accept supervision. The named individuals must have acquired the knowledge through recent observation of the applicant's professional practice over a reasonable period of time and must be able to attest to the applicant’s professionalism. The practitioners should also be able to comment on the applicant’s utilization of cost effective, best practice guidelines and demonstrated knowledge of systems-based practice. None of the references should be related to the applicant by family, and no more than one by current or impending professional association.

D. The statement and acknowledgment that, by applying for appointment to the Medical Staff, the applicant: (1) waives confidentiality as to all information requested in the application; (2) authorizes the Hospital and the Medical Board to consult with persons, whether or not listed as references, who, in the opinion of the Hospital, may have relevant information concerning the applicant, including, but not limited to, his or her license, specific training, experience, current competence and health status as such relates to the ability to perform the clinical privileges requested; (3) authorizes all persons consulted to provide such information; (4) consents to the Hospital's and Medical Board’s inspection of all records and documents that the Hospital and/or Medical Board deem to be material to the application; (5) provides a reassessment of his or her health status as frequently as necessary, but no less than annually; (6) agrees to take no action against the Hospital, its Board of Trustees or any Trustee thereof, members of the Medical Staff or Hospital employees or agents, and any institution or person supplying information or evidence thereto, for acts performed or statements made, in good faith and without malice, in connection with evaluating the applicant or the applicant's credentials, performance or character; and agrees to release them to the fullest extent permitted by law in connection with all activities pertaining to the Hospital's consideration of the application for appointment;

E. The applicant's acknowledgment that he or she will maintain professional liability insurance covering the applicant's practice, and clinical duties at the Hospital, and that he or she will use such insurance coverage in the event of a litigation that also names the Hospital and/or its employees as Co-defendants with the practitioner, such insurance shall name the Hospital as a certificate holder, with minimum limits not less than those set by the Board of Trustees from time to time, with the name of the insurance carrier and the policy number. This information shall be provided by the Applicant in the form of an insurance certificate. The applicant's verification that he or she will notify the Hospital in writing ten (10) days in advance of any change in his or her insurance coverage or classification of insurance coverage, (or if the practitioner receives less than ten (10) days' notice, within one day in advance of any change), and that upon appointment to the Medical Staff, the applicant will provide a certificate from his or her insurance carrier(s) stating that the practitioner will be given such notice as is provided by
the standard form of insurance contract and shall request that the insurance carrier provide such notice to the Hospital;

F. The requirement that the applicant identify the nature and extent of clinical privileges for which application is being made in accordance with the approved method of delineation adopted by the Clinical Department concerned;

G. In addition to the interview that shall take place with the Department Director at his or her discretion, a statement that, if requested, the applicant will appear for an interview, in connection with the application or as requested by the Medical Board or its Credentials Committee;

H. A statement identifying the status of and basis for: (1) any pending legal action commenced or claim made against the applicant in connection with his or her professional activities in this or any other state or any other country, and any final judgments or settlements in any professional liability action in which he or she is or was a party; (2) any challenge to, investigation of, official action regarding a voluntary or involuntary relinquishing of the applicant's license or registration or status as a Medicaid or Medicare provider; (3) any action taken as a result of a complaint or report about the applicant made to or by any federal, state or local government or professional licensing or disciplinary agency, foreign or domestic, including, but not limited to, the New York State Office of Professional Medical Conduct, Office of Health Systems Management, Department of Health, Bureau of Controlled Substances, Department of Education, Department of Mental Hygiene, and any predecessor or successor of any of these agencies and any investigation relating thereto; (4) any previous or pending voluntary or involuntary termination, limitation, suspension, resignation or other discontinuation of the applicant's Medical Staff membership, clinical privileges or employment of any kind at any hospital or health care facility or denial of any application therefor; (5) any criminal conviction in any jurisdiction; (6) any and all information relating to findings pertinent to violations of patients' rights as set forth in any applicable statute or regulation; and (7) an acknowledgment that the applicant will inform the Credentialing Office on a timely basis of facts germane to these areas of inquiry that arise during the application process and any term of appointment;

I. The applicant's D.E.A. number, if applicable, and information as to whether the applicant's narcotic license has ever been or is in the process of being investigated, suspended or revoked;

J. The applicant's agreement and acknowledgement of his or her responsibility to notify the Hospital in writing within five (5) days of any change in the information submitted in connection with the application or additional information which becomes known to the applicant after submission of the application;

K. A sworn statement by the applicant that all information provided by him or her is complete, true and accurate; and
L. The applicant's signed acknowledgment of his or her obligation to (i) comply with applicable federal, state and local statutes, rules and regulations, (ii) obtain, read and abide by these Medical Staff By-Laws and the Rules and Regulations, and comply with the Hospital's Corporate By-Laws, and all other relevant Hospital and Department policies including, but not limited to, those set forth in the Hospital Administrative Policies and Procedures Manual, the Patients' Bill of Rights, the Hospital’s Notice of Privacy Practices and the Hospital’s policies on the privacy and security of patient information as set forth in any amendments thereto, (iii) cooperate with and participate in the Hospital's quality assurance and performance improvement program, risk management, legal compliance and malpractice prevention programs and (iv) abide by generally accepted principles of professional ethics. The applicant pledges to provide for continuous care for his or her patients.

Subsection 3.3.2 REVIEW OF APPLICATION AND RECOMMENDATION.

A. Upon the written request of a practitioner to the Executive Director, the Credentialing Office shall provide to the practitioner, after review by the Medical Director/Vice President for Medical Affairs, an application for Medical Staff membership and clinical privileges. An application shall be deemed completed by the applicant when it includes all required supporting data and documentation, as set forth in Section 3.3.1 to these By-Laws. Completed applications shall be submitted by the applicant to the Credentialing Office.

B. Upon receipt of a completed application, the Credentialing Office shall request information from all hospitals and other health care facilities with which the applicant states he or she has been associated to confirm the accuracy and completeness of information provided in the application. In addition, the National Practitioner Data Bank shall be queried and primary source verification sought of the applicant’s medical education, including residency and fellowship training, license, malpractice history and specialty board certification, as applicable.

C. The Credentialing Office shall forward completed applications, as well as all information and primary source verification materials received to the Director of the Clinical Department(s) in which clinical privileges have been requested for further review.

D. The Department Director or the person designated by the Director to act in his or her absence shall review the completed application and other information received from the Credentialing Office, may interview the applicant, and conduct such other investigations or inquiries as deemed appropriate in the particular case. In performing an evaluation of an application, the Department Director also shall consider whether the Hospital is able to provide adequate facilities and support services to the applicant. On the basis of this review, the Department Director shall render a recommendation to grant or deny Medical Staff membership and the exercise of the clinical privileges applied for. The Department Director may reject any applicant not meeting the requirements and/or standards of the Director’s Clinical Department.

In the event that an application for Medical Staff membership is rejected for such reasons the applicant may be entitled to a hearing in accordance with Article VIII of these By-Laws.
E. The recommendation of the Department Director, along with the completed application and all other collected materials shall be processed and reviewed by the Credentials Committee and the Medical Board.

F. Absent unanticipated delays that are unavoidable, each completed application for appointment to the Medical Staff should be processed and forwarded to the Medical Board within a one hundred twenty (120) day period from the date that the completed application was received by the Credentialing Office.

Subsection 3.3.3 CREDENTIALS COMMITTEE. Upon receipt of the completed and verified application and the Department Director’s recommendation as to Medical Staff appointment and clinical privileges, the Credentials Committee shall (i) review and evaluate the qualifications of the applicant, (ii) ensure that all essential information has been obtained and validated, and that the recommendations regarding appointment are soundly based, and (iii) submit a written recommendation to the Medical Board.

Subsection 3.3.4 MEDICAL BOARD REVIEW AND RECOMMENDATION.

A. At its next regularly scheduled meeting after receipt of the reports and recommendations described in Subsections 3.3.2 and 3.3.3 or as soon thereafter as is practicable, the Medical Board shall consider the prior recommendations and any other relevant information. After consideration of all the prior recommendations and such supporting information and evidence as the Medical Board in its judgment shall deem sufficient, the Medical Board, by majority vote of those present, shall make a written recommendation as to Medical Staff membership and clinical privileges, which shall be transmitted through the Committee on Quality, to the Board of Trustees for final action in accordance with the Hospital's Corporate By-Laws. Prior to making its recommendation final, if the Medical Board's decision is adverse to the applicant as to Medical Staff membership or the extent of clinical privileges, the applicant shall be notified in writing, by overnight delivery service or personal delivery, of the recommendation and of the reasons therefor. A practitioner who receives such notice of an adverse recommendation with respect to Medical Staff membership or the extent of clinical privileges shall be entitled to a hearing in accordance with Article VIII of these By-Laws.

B. When the final recommendation of the Medical Board is adverse to the applicant as to either Medical Staff membership or the extent of clinical privileges recommended, the recommendation as transmitted to the Board of Trustees shall reflect the reasons for the adverse action. These reasons must relate to patient welfare, standards of patient care, the objectives of the Hospital or the character or competence of the applicant.

Subsection 3.3.5 BOARD OF TRUSTEES ACTION

A. The Board of Trustees may accept, reject or modify the recommendation of the Medical Board, or may refer the matter back to the Medical Board with a direction for further consideration.
B. The Executive Director of the Hospital shall give written notice of the final decision of the Board of Trustees to the practitioner, the Director of the Clinical Department and the Chairman of the Medical Board. If the final decision of the Board of Trustees shall be to not grant a practitioner Medical Staff membership or clinical privileges to the extent applied for, the Executive Director of the Hospital shall inform the practitioner in writing of the reasons for the decision, which must relate to patient welfare, standards of patient care, the objectives of the Hospital or the character or competence of the applicant. The applicant shall be afforded an opportunity to appear before a committee of the Board of Trustees as provided in Article VIII of these By-Laws.

Section 3.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

Every member of the Medical Staff has responsibilities to the patient, to the Hospital and to the Department granting clinical privileges. Each member also has a responsibility to the Medical Staff to pay its mandatory dues.

Regarding the Patient, Medical Staff Members Shall:

1. Render the highest quality professional care fully consistent with prevailing standards of medical practice and conduct in his or her specialty, sub-specialty, or area of practice. The attending physician of record will coordinate the care, treatment and services among the different practitioners involved in a patient’s care, treatment and services.

2. Care for patients at the Hospital regardless of their race, color, creed, religion, sex, sexual orientation, age, marital status, national origin, veteran’s status, disability, or other category of legally impermissible discrimination, or the ability to pay for such care. Medical Staff members may not refuse to provide necessary medical care for patients in the Hospital based on the patient’s type of or lack of health insurance.

3. Afford patients all rights guaranteed by applicable statute or regulation, in the Hospital Patients' Bill of Rights and those set forth in these By-Laws and the Rules and Regulations and to cooperate fully with patients' legally authorized representatives who may inquire as to the enforcement of these rights in a particular case.

4. Provide for continuous care for his or her patients, provided that a physician may inform a patient that he or she refuses to give advice with respect to or participate in any induced termination of pregnancy.

5. Protect the privacy, confidentiality and security of patient information in accordance with the Hospital’s Notice of Privacy Practices.

6. Where the appropriate diagnosis, treatment or therapy of a patient is subject to reasonable doubt, seek appropriate consultations in accordance with sound medical practice in his or her specialty, sub-specialty, or area of practice.
7. Not rebate a portion of a fee, or receive other inducements in exchange for patient referrals.

8. Complete and document a medical history and physical examination 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 within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Such updated examination must be completed and documented by a physician, an oromaxillofacial surgeon or other qualified licensed individual in accordance with law and hospital policy. The admission history and physical examination, if recorded by a member of the graduate staff, physician’s assistant, or nurse practitioner shall be reviewed with and countersigned by the attending physician within twenty-four (24) hours of admission and prior to any major diagnostic or therapeutic intervention, but no later than twenty-four (24) hours of admission. Other details associated with the recording of the history and physical examination are set forth in the Rules and Regulations of the Medical Staff.

Regarding the Hospital, Medical Staff Members Shall:

9. Cooperate fully and with sustained interest in the overall functions and activities of the Hospital.

10. Abide by all federal, state and local laws, rules and regulations; these Medical Staff By-Laws, the Rules and Regulations and the Hospital's Corporate By-Laws; and all Hospital and Department policies, rules and regulations, including, without limitation, those set forth in the Hospital’s Notice of Privacy Practices, as they are amended from time to time.

11. Maintain ongoing evidence of his or her physical and mental competence and provide any additional health-related information requested by the Medical Board and/or the Hospital upon initial affiliation with the Hospital; he or she shall also provide a reassessment of his or her health status as frequently as necessary, but no less than annually, to ensure that he or she is free from health impairments which could pose potential risk to patients or personnel or which may interfere with the performance of duties. In the event of a health or other impairment, immediately notify the Hospital if any health or other impairment might interfere with performance of the Medical Staff member's duties or might pose a potential health risk to patients.

12. Cooperate with and participate in the Hospital's quality assurance and performance improvement program, risk management and malpractice prevention programs, legal compliance program and carry out committee activities as may be assigned.
13. Maintain professional liability insurance covering his or her practice and duties at the Hospital with minimum limits not less than those set by the Board of Trustees. The Medical Staff member shall immediately notify the Hospital and Department Director of any change in the ability to maintain the necessary malpractice insurance.

14. Prepare and complete in a timely manner the medical record and other required records for all patients he or she admits or for whom he or she in any way provides care in the Hospital, as provided in these Medical Staff By-Laws and the Rules and Regulations and other applicable Hospital policies, rules and regulations.

15. Participate in the education and appropriate supervision of the Graduate Staff.

Regarding the Department, Medical Staff Members Shall:

16. Continuously meet all performance standards promulgated by the Department Director.

17. Attend Department meetings and participate in continuing education activities according to Department guidelines.

18. Participate in Department and Medical Staff review and evaluation functions.

Section 3.5 ETHICS

The professional conduct of members of the Medical Staff shall conform to accepted principles of professional and medical ethics.

Section 3.6 TERMS OF APPOINTMENTS

All initial appointments to the Medical Staff shall be for a period of up to two years, and shall be provisional for at least the first year. The Medical Staff appointment and clinical privileges of full-time employed practitioners in Clinical Departments that are comprised solely of full-time salaried physicians shall terminate immediately upon the termination of such practitioner’s employment at the Hospital. Provisional status shall be reviewed by the Department Director at the end of the first year of the initial appointment, and may be extended to the second year of the initial appointment at the discretion of the Department Director, with notification to the Medical Board and the Board of Trustees. At the recommendation of the Department Director, and upon approval of the Medical Board and the Board of Trustees, provisional status may be waived for practitioners who have appointments at other System hospitals.

Section 3.7 CLINICAL PRIVILEGES

Subsection 3.7.1 LIMITATIONS ON CLINICAL PRIVILEGES. Appointment or reappointment to the Medical Staff shall entitle a practitioner to exercise only those clinical
privileges granted to him or her by the Board of Trustees, except to the extent that a practitioner is granted temporary or emergency privileges as hereinafter provided.

Subsection 3.7.2  Delineation. 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 in-between reappointment periods is recommended by the Department Director in accordance with the method recommended by the Medical Board and approved by the Board of Trustees for the clinical Department concerned, and shall be based on consideration of the practitioner's education, training, experience, demonstrated current competence, references, the objectives, plans and programs of the Hospital and such other relevant information as may be obtained.

Subsection 3.7.3  Emergency Privileges. In the case of an emergency when a practitioner qualified by these By-Laws and the Rules and Regulations is not available, any licensed practitioner at the Hospital, regardless of his or her Department or extent of clinical privileges approved, shall be permitted and expected to do everything reasonably possible to save a patient from imminent serious harm or death. Such practitioner shall use every available resource of the Hospital, including calling for assistance as may be available.

Subsection 3.7.4  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 Executive Director or his/her authorized designee, which shall include the Medical Director 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.

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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 VIII 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 Executive Director 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 VIII of these Bylaws and the Medical Staff Rules and Regulations.

Subsection 3.7.5 CONTINUOUS PRACTICE REVIEW. The Hospital shall continuously monitor and evaluate a practitioner’s professional performance. The performance monitoring process shall be in accordance with Hospital policy and will include (i) criteria for conducting performance monitoring; (ii) a method for establishing a monitoring plan specific to the requested privilege; (iii) a method for determining the duration of performance monitoring; and (iv) the circumstances under which monitoring by an external source is required. Focused professional practice evaluation will be consistently implemented in accordance with the criteria and requirement 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 Hospital.

Section 3.8 TEMPORARY PRIVILEGES

Subsection 3.8.1 FOLLOWING A COMPLETED APPLICATION. Pending the recommendation of the Medical Board and final action by the Board of Trustees on a completed application for Medical Staff membership, the Executive Director of the Hospital or his or her designee, or the Medical Director/Vice President for Medical Affairs may grant temporary clinical privileges to an applicant upon the request of the Department Director to satisfy an important patient care need or when a new applicant with a completed application which raises no concerns is awaiting review and approval of the medical staff executive committee and the governing body. Temporary privileges shall also be based on verification of the following: (i) a current New York State license; (ii) relevant training or experience; (iii) current competence; (iv) ability to perform the privileges requested; (v) a query and evaluation of information obtained from the National Practitioner Data Bank; and (vi) no current or previously successful challenge to the applicant’s licensure or registration. The grant of such privileges shall be upon such conditions as the Executive Director of the Hospital (or designee) at any time may in his or her discretion wish to impose. Temporary privileges on a completed application to the Medical Staff shall be granted for a period not to exceed one hundred twenty (120) days. Such privileges may be revoked at will at any time by the Department Director in whose Department the temporary privileges were granted, the Chairman of the Medical Board, the Executive Director of the Hospital, or the Medical Director/Vice President for Medical Affairs or his or her designee.

Subsection 3.8.2 VISITING PRO TEM. Under special circumstances, practitioners who are needed to meet an important patient care 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 Director 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 Director, such need no longer exists. No practitioner whose request for temporary privileges is denied shall be entitled to the procedural rights afforded by Article VIII of these Bylaws.

Section 3.9 ORGAN PROCUREMENT ORGANIZATION EXEMPTION

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As required by regulation, practitioners from outside organ procurement organizations designated by the Secretary of the United States Department of Health and Human Services and engaged at the Hospital solely in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to federal and state law shall be exempt from having to obtain a Medical Staff appointment or clinical privileges.

Section 3.10 COMMUNICATION OF BY-LAWS AND REVISIONS TO THESE BY-LAWS

The Hospital shall provide these By-Laws and the Rules and Regulations and other policies of the Medical Staff to individuals who have been appointed to the Medical Staff and/or granted clinical privileges. The Hospital will provide to such individuals significant revisions to these By-Laws, the Rules and Regulations and other policies of the Medical Staff, if any. Members of the Medical Staff shall be responsible for keeping informed of such revisions.

Section 3.11 MEDICAL STAFF CREDENTIALS AND PERFORMANCE IMPROVEMENT FILES

The Hospital shall maintain separate, confidential credentials and performance improvement files for each member of the Medical Staff and each person granted clinical privileges and those files shall contain all documentation relating to the practitioner, including his or her applications for appointment and reappointment, and pertaining to the quality of care rendered by him or her. The performance improvement file shall be kept within the Department of Quality Management.

Section 3.12 PROCEDURE FOR REAPPOINTMENT

Subsection 3.12.1 APPLICATIONS FOR REAPPOINTMENTS. Each applicant for reappointment will follow the procedures set forth in these By-Laws. It shall be the duty of each member of the Medical Staff to submit his or her reappointment application form on a timely basis containing such information as may be required evidencing such member's fitness for reappointment to the Medical Staff and retention of clinical privileges, and his or her compliance with the Hospital's Corporate By-Laws, these Medical Staff By-Laws, the Rules and Regulations and Hospital and Department policies and procedures. The application for reappointment shall contain the Medical Staff member's waiver of confidentiality as to all information requested. The application for reappointment shall also contain an affirmation by the applicant that the information provided is complete, true and accurate. In particular, the Medical Staff member shall ensure that the information provided in response to Subsection 3.3.1 is complete and up-to-date. After receiving reasonable notice of the requirement to do so, failure of any such member of the Medical Staff to submit the required information form in a timely fashion as prescribed shall be deemed to constitute his or her resignation from the Medical Staff. Such resignation shall be effective at the expiration of his or her then current appointment. With respect to the reappointment of a Department Director, the Medical Director/Vice President for Medical Affairs will review the reappointment application with input from an appropriate Attending member of the Clinical Department involved.
Subsection 3.12.2   HOSPITAL INVESTIGATION OF CREDENTIALS. Upon the Credentialing Office’s receipt of the completed information form submitted by the Medical Staff member, the Credentialing Office’s investigation generally following the investigation and verification procedure set forth in Subsection 3.3.2 of these By-Laws on initial appointment shall take place and updated information from all hospitals and other healthcare facilities or organizations with which the practitioner has been associated during at least the last ten (10) years, or longer if indicated, will be requested. When insufficient peer review information is available, it is appropriate to obtain and evaluate peer recommendations.

Subsection 3.12.3   DEPARTMENT DIRECTOR REVIEW AND RECOMMENDATIONS. Each Department Director shall make written recommendations concerning the reappointment and clinical privileges of each Medical Staff member of his or her Department, following review of the proposed reappointments by the Department. The Department Director 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. Such recommendations shall be based on:

- consideration of the information form submitted by each practitioner, including evidence of current license, D.E.A. registration and health status;
- review of the Medical Staff member's record, including findings of any quality assurance and performance improvement program committees;
- review of morbidity and mortality data;
- review of medical malpractice history;
- past professional performance and practice;
- demonstrated current clinical competence;
- character, clinical judgment and mental and physical capacity to perform the clinical privileges requested;
- attendance at Department meetings, participation in Department and Medical Staff committee review and evaluation functions, and continuing education;
- use of the Hospital's facilities for his or her patients;
- willingness and availability to consult;
- participation in the education and supervision of the Graduate Staff as requested by the Department; and
- relations with other members of the Medical Staff, personnel and general attitude towards patients, the Hospital, Hospital Administration and the public.

Physicians who were board certified at the time of their most recent appointment or reappointment are required to maintain such certification in at least one primary specialty or subspecialty. Physicians who were board eligible at the time of initial appointment are required to obtain board certification within 5 years thereafter. Failure to maintain or obtain board
certification as aforesaid shall result in rejection of their application for reappointment unless the Credentials Committee approves a request for an exception by the Department Director. Physicians who were not board certified at the time of their most recent appointment or reappointment, and who are no longer board eligible, are urged but not required to obtain board certification.

A Department Director shall reject the application for reappointment of any Medical Staff member who is unable to document (i) that he or she holds a valid registered license issued by the State of New York to practice his or her profession, or (ii) maintains the required professional liability insurance coverage. In the event the application for reappointment is rejected for any of these reasons, the hearing procedure set forth in Article VIII of these By-Laws shall not apply.

The applicant shall be required to submit any additional information requested by the Board of Trustees, the Medical Board, the Credentials Committee or the appropriate Department Director to the body or person requesting it. The recommendations of the Department Director, together with each practitioner's information form and other supporting data, shall be forwarded by the Department Director to the Credentialing Office. The Credentialing Office shall forward the recommendation to the Credentials Committee. The Credentials Committee pursuant to Section 3.3 above, shall review the recommendation of the Department Director and make its own recommendation on the application to the Medical Board.

Subsection 3.12.4 MEDICAL BOARD REVIEW AND RECOMMENDATION.

The Medical Board shall review the materials and recommendation of the Department Director concerned and the Credentials Committee to ensure that all essential information has been obtained and validated and that the recommendation is soundly based. Upon completion of this review, the Medical Board shall submit its own recommendation as to the reappointment of Medical Staff membership and clinical privileges, to the Board of Trustees.

Subsection 3.12.5 BOARD OF TRUSTEES ACTION. Decisions of the Board of Trustees with respect to reappointments and clinical privileges will be implemented generally in accordance with the procedures and requirements prescribed in these By-Laws for initial appointments. The Executive Director shall inform the practitioner in writing of the decision of the Board of Trustees.

Section 3.13 LEAVES OF ABSENCE

Subsection 3.13.1 Requests for leaves of absence shall be made to the Director of the Clinical Department in which a practitioner has privileges and shall state the dates and duration of the requested leave. All leaves of absence for a single period up to and including twelve (12) months may be granted by the Department Director at his or her own discretion, with written notice to the practitioner, the Medical Board and the Executive Director of the Hospital.

Subsection 3.13.2 Subject to Subsections 3.13.3 and 3.13.4 below, any practitioner on leave of absence who desires to resume his/her Medical Staff appointment and clinical privileges
shall submit at least fifteen (15) days’ prior written notice to the Director of his/her Clinical Department. The Director shall forward such notice to the Medical Board and the Executive Director.

Subsection 3.13.3 In addition to the requirements of Subsections 3.13.2 and 3.13.4, any practitioner wishing to return from a leave of absence granted for medical reasons must submit to the Director of his/her Clinical Department at least fifteen (15) days prior to the anticipated date of return a letter [or medical clearance form] signed by his or her treating physician indicating that the practitioner is physically and mentally capable of resuming the activities and obligations of his/her appointment and clinical privileges.

Subsection 3.13.4 If the practitioner’s term of appointment to the Medical Staff is scheduled to expire during the period of the practitioner’s leave of absence, the practitioner must submit a completed application for reappointment in accordance with Section 3.12 of these Bylaws.

Subsection 3.13.5 During a leave of absence, a practitioner who has a claims made policy shall be required to maintain professional liability insurance or tail coverage in the amounts and upon the terms required by the Hospital.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

THE MEDICAL STAFF

The Medical Staff shall consist of the following categories: Active, Emeritus and Honorary. Each practitioner shall at the time of appointment to the Medical Staff be appointed to one of the foregoing categories.

Section 4.1 THE ACTIVE STAFF

The Active Staff shall consist of the Attending Staff, the Affiliated Medical Staff, the Adjunct Staff and the Special Services Staff.

Subsection 4.1.1 THE ATTENDING STAFF. The Attending Staff shall consist of those physicians, dentists and podiatrists who admit patients to the Hospital. The Attending Staff may include those practitioners whose appointments and privileges are contingent upon or otherwise subject to an agreement between the Hospital and any other facility or organization. Attending Staff members shall perform such duties as may appropriately be assigned to them by their respective Department Directors in the patient care, education, research and preventive medicine programs of their respective Departments, whether such duties relate to inpatients, outpatients or Emergency Room patients. Attending Staff members also shall be responsible for managing the medical care of all patients for whom they are the primary attending physician (physician of record). Members of the Attending Staff shall be eligible to serve on the Medical Board and its committees and subcommittees and shall attend all mandatory meetings of the Medical Staff and their respective Departments. Attending Staff members who have admitting
privileges shall admit patients only in accordance with the admitting policies of the Hospital and such members' clinical privileges as delineated and shall comply with all applicable statutes, rules, regulations, and Hospital policies relating to patient admissions and inpatient discharge review procedures.

Subsection 4.1.2 THE AFFILIATED MEDICAL STAFF.

A. The Affiliated Medical Staff shall consist of those physicians, dentists and podiatrists who are in good standing on the Active Staff of another System Hospital and who obtain a secondary appointment to the Medical Staff of the Hospital (in accordance with this Article IV, Section 4.2) in order to provide to their patients care and access to services at the Hospital which cannot be provided at the other System Hospital.

B. Appointment to the Affiliated Medical Staff will be made by the Board of Trustees only upon receiving the favorable recommendations of Joint Conference/Professional Affairs Committee, the Medical Board, the Credentials Committee and the relevant Department Director upon an application by the practitioner in accordance with the credentialing procedures and requirements applicable to all members of the Medical Staff contained in these Bylaws and the Rules and Regulations, and only after a determination (made in consultation with the Department Director or Chairman or Chief of Service of the other System Hospital) that the physician’s, dentist’s, or podiatrist’s primary appointment will be to the other System Hospital. The designation of the physician’s, dentist’s and podiatrist’s primary appointment (as between the Hospital and the other System Hospital) shall be to the hospital where the physician, dentist or podiatrist conducts the majority of his professional activity, as determined by the relevant Department Director in consultation with the Director, Chairman or Chief of Service of the other System Hospital. The physician, dentist or podiatrist who seeks membership on the Affiliated Medical Staff may only apply for and obtain privileges to do at the Hospital those procedures for which he is credentialed at the other System Hospital and his privileges at the Hospital shall not exceed his privileges at the other System Hospital. The Director of the relevant department shall monitor the number of cases treated by the practitioner as a member of the Affiliated Medical Staff to determine if application for appointment to another Staff category is appropriate under the circumstances.

C. The existence of the Affiliated Medical Staff category shall not prevent individuals who wish to participate fully in the work of both hospitals from applying to the Active Staff of both hospitals in accordance with the application and credentialing procedures of both hospitals. Dual Active Staff appointment will be made upon the recommendation of the relevant Department Director (in consultation with the Chairman, Director or Chief of Service of the relevant department of the other System Hospital). Medical Staff members with Active Staff appointment at both hospitals must meet all Staff requirements at both institutions.

D. The Affiliated Medical Staff member will not be required to fulfill all of the responsibilities attendant to membership on the Active Staff of the Hospital. Specifically, the attendance of members of the Affiliated Medical Staff at all Staff and Department meetings of the Hospital is not mandatory, except that they will attend and participate in such meetings which address quality management, performance improvement and utilization activities. In addition,
the members of the Affiliated Medical Staff shall have no mandatory teaching responsibilities at
the Hospital, but may be required by the Medical Board to serve on committees. Members of the
Affiliated Medical Staff shall not be eligible to vote or hold office on the Medical Staff or the
Medical Board, and shall not be required to pay dues at a level set for membership on the Active
Staff.

E. Members of the Affiliated Medical Staff shall be subject to the Hospital Bylaws, the
Medical Staff Bylaws, the Rules and Regulations and all applicable Hospital and Medical Staff
Policies and Procedures, including, but not limited to all credentialing, appointment, quality
management and performance improvement requirements specified herein. Delineated clinical
privileges, including, but not limited to, admitting privileges, at the Hospital will be made upon
the recommendation of the relevant Department Director.

F. Termination, suspension or limitation of the privileges or medical staff membership of a
member of the Affiliated Medical Staff at the other System Hospital shall automatically so
terminate, suspend or limit such practitioners membership in the Affiliated Medical Staff and the
practitioner shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws
because his privileges at the Hospital are so terminated, suspended or limited.

G. Unless otherwise waived by the Hospital, appointment to the Affiliated Medical Staff
shall automatically terminate for a practitioner appointed thereto in the event that North Shore
Health System is no longer the sole voting member of the other System Hospital and the
practitioner shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws
because his privileges are so terminated.

Subsection 4.1.3 THE ADJUNCT STAFF. The Adjunct Staff shall consist of those
members of the Medical Staff of demonstrated competence in their fields of specialty who desire
to maintain a relationship with the Hospital, and who have signified a willingness to accept such
appointment. Members of the Adjunct Staff shall not be granted privileges to admit patients, but
they may visit and review the charts of their patients when hospitalized. They may not render
consultations or write orders concerning Hospital patients. Members of the Adjunct Staff shall
have no other mandatory assigned duties in the Hospital except pursuant to specific provisions of
the Corporate Bylaws of the Hospital, the Bylaws and the Rules and Regulations of the Medical
Staff, and the policies and procedures of their respective Clinical Departments, as amended from
time to time. Appointment to the Adjunct Staff shall be made in accordance with the provisions
of Article III to these Bylaws. Adjunct Staff members shall not be eligible to vote, hold office,
or serve on committees concerning the Medical Staff or Medical Board. The respective
Department Directors may require their attendance at departmental meetings at their discretion
and as necessary in connection with the departmental quality assurance process and other clinical
and administrative matters.

Subsection 4.1.4 THE SPECIAL SERVICES STAFF. A qualified physician may be
appointed to the Special Services Staff upon the recommendation of the Department Director,
and with the approval of the Medical Board, and the Board of Trustees. A physician appointed
to the Special Services Staff shall have all of the qualifications and fulfill all of the requirements
for membership on the Medical Staff; his or her special service shall be limited and stipulated; he
or she shall not have the right to vote, hold office, serve on committees or sit with the Medical Board; he or she shall be encouraged but not required to attend designated departmental and/or divisional meetings; and his or her appointment to the Special Services staff may be terminated without any of the procedural rights set forth in Article VIII of these Bylaws when, in the opinion of the Department Director, the need for that special service no longer exists.

Section 4.2 THE EMERITUS STAFF

The Emeritus Staff shall consist of those Department Directors, Division Chiefs or other distinguished members of the Medical Staff nominated by a Department Director who have provided extraordinary clinical and academic service to the Hospital and provided distinguished service to it as a member of its Active Staff and who (i) have retired from the practice of medicine; (ii) desire to maintain their identification with the Hospital; and (iii) the Hospital desires to honor because of their prior service. Physicians who are appointed as Emeritus Staff members, after approval by the Medical Board and Board of Trustees, shall not have privileges to admit, care for or provide consultations respecting the care of hospital patients, nor shall they be eligible for membership on the Medical Board, or hold office or vote with respect to the Medical Staff. Membership on the Emeritus Staff does not carry any obligations to attend departmental meetings, carry malpractice insurance, or perform any other activities required of Active Staff members under these Bylaws.

Section 4.3 THE HONORARY STAFF

The Honorary Staff shall consist of those individuals who have served on the Hospital’s Active Staff and upon whom the Hospital wishes to bestow an honorific title for their years of service to the Hospital. Physicians who are appointed as Honorary Staff members shall not have privileges to admit, care for or provide consultations respecting the care of hospital patients, nor shall they be eligible for membership on the Medical Board, or hold office or vote with respect to the Medical Staff. Membership in the Honorary Staff does not carry any obligations to attend departmental meetings, carry malpractice insurance, or perform any other activities required of Active Staff members under these Bylaws.

ARTICLE V
DEPARTMENTS OF THE MEDICAL STAFF

Section 5.1 CLINICAL DEPARTMENTS

To promote the care and treatment of patients, the Board of Trustees may create such Clinical Departments as it from time to time deems advisable. Clinical Departments so established currently include the following: Anesthesiology, Emergency Medicine, Family Practice, Medicine, Gynecology, Pathology and Laboratory Medicine, Pediatrics, Radiology, Psychiatry and Surgery. The scope of services provided by each Clinical Department will be defined in writing and approved by the Medical Board. Each member of the Medical Staff shall be assigned to one of the Hospital's Clinical Departments. In exceptional circumstances, upon the recommendations of the Department Directors concerned and the Medical Board and
authorized by the Board of Trustees, a member of the Medical Staff may be assigned to and granted clinical privileges in more than one Clinical Department.

Subsection 5.1.1 DIVISIONS. Divisions, as major sub-units of Departments, may be established or dissolved upon the recommendation of the Department Director, pursuant to the approval of the Medical Board and the Board of Trustees. The establishment of a departmental Division shall be based upon some or all of the following criteria:

A. Recognition by sub-specialty Board examination and certification;
B. Traditional recognition as a clinical sub-specialty;
C. An organ system or scientific discipline, not limited to one (1) disease process; and
D. Inclusion of all clinical functions traditionally incumbent upon a sub-specialty, including patient care, teaching and research activities.

Subsection 5.1.1.1 APPOINTMENT OF DIVISION CHIEFS. Each Division shall have as its operational head a Chief, who shall be appointed by the Department Director with the approval of the Medical Board. The Division Chief shall report upon the operation of his/her Division, including any Sections within the Division, to the Department Director.

Subsection 5.1.1.2 DUTIES AND RESPONSIBILITIES OF DIVISION CHIEFS. The duties and responsibilities of Division Chiefs of Clinical Departments shall include, but not be limited to:

1. Responsibility to the Department Director for the functioning and administration of their Division, for the general supervision of both the clinical work and the Medical Staff administrative activities falling within it, and for departmental implementation of action taken by the Medical Board or directed by the Department Director by means which include, but are not limited to, close cooperation with the Department Director, Hospital Administration, the Medical Director/Vice President for Medical Affairs, and other disciplines and Departments, Divisions, Section and Services within the Department and the Hospital in all matters, including those affecting patient care.

2. Responsibility to give guidance on the overall medical policies of the Hospital and to make specific recommendations and suggestions to their Department Director and Hospital Administration regarding their own Divisions, including criteria for clinical privileges and proper utilization and management of resources, all in order to manage and assure quality patient care.

3. Responsibility for the continuous assessment and improvement of the quality of care and services provided within their Divisions by all appropriate means, including quality control programs and continuing surveillance of the professional performance of all members of the Medical Staff as well as all members of the Allied Health Professionals Staff assigned to their Division, and
for reporting regularly thereon to the Medical Board through their Department Director.

4. Responsibility to participate with the Hospital Administration in preparing such annual reports pertaining to their Division, including budgetary planning, as may be required by their Director or Medical Board.

5. Responsibility for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws and the Rules and Regulations within their Divisions.

6. Responsibility to transmit to the Medical Board through their Department Directors recommendations concerning the Staff category, rank, classification and the appointment, reappointment and delineation of clinical privileges for all practitioners within their Divisions.

7. Responsibility for the teaching, education and research programs in their Division, as well as the orientation of new members of the Medical Staff and Allied Health Professionals Staff to the functioning of their Division and the Hospital.

8. Responsibility for the coordination and integration of interdepartmental and intradepartmental services affecting their Divisions including, but not limited to, the integration of their divisions into their departments and further into the primary functions of the Hospital organization, as identified by the JCAHO and any other applicable accrediting or certifying boards or bodies.

9. Recommending to their Director members of their Division to participate in the Performance Improvement Coordinating Group.

Subsection 5.1.2 SECTIONS. Sections may be created or deleted as sub-units of a Division or of the Department at the discretion of the Department Director. The head of the Section shall be called the Section Head and shall be appointed by the Department Director and report to the Division Chief or the Department Director, as appropriate.

Section 5.2 DEPARTMENT DIRECTORS

Subsection 5.2.1 APPOINTMENTS. Directors of Clinical Departments ("Department Directors") shall be appointed by the Board of Trustees, be qualified by training and Board Certification in his or her specialty, experience and administrative ability for the position, and meet any requirements for persons who shall be designated as a Departmental Director by the Board of Trustees and as may be set forth in the JCAHO standards and/or New York State Public Health Law, including certification by an appropriate specialty board or affirmatively established comparable competence through the credentialing process. Appointment of a physician as a Department Director shall not affect the clinical privileges he or she is otherwise authorized to exercise at the Hospital, and the appointment shall be for that period as stated in the Department Director’s Employment Agreement with the Hospital.
Department Directors also may appoint Associate Directors, with the approval of the Medical Board.

Subsection 5.2.2 SELECTION OF DEPARTMENT DIRECTORS.

A. The Medical Director/Vice President for Medical Affairs will appoint an Ad Hoc Search Committee and serve as Director of this Ad Hoc Search Committee or designate such Committee’s Chairman.

B. The Ad Hoc Search Committee shall consist of at least the following individuals: The Medical Director/Vice President for Medical Affairs; two (2) Department Directors and two (2) other members of the Medical Staff, all of whom shall be selected by the Medical Director/Vice President for Medical Affairs. Other members of the Committee shall include the Executive Director of the Hospital; the System Chief Executive Officer or his designee; the System Chief Medical Officer; and the System Senior Vice President, Quality Management.

C. The Ad Hoc Search Committee shall canvass the field for qualified candidates and present to the Board of Trustees or its designated committee the name of one (1) qualified candidate. The Board of Trustees (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 Trustees or its designated committee 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.

Section 5.2.3 DUTIES. Among his or her duties, each Department Director shall:

A. Be accountable to the Medical Board, Executive Director and the Health System CEO, Chief Medical Officer and Chief Operating Officer for all clinical and administrative activities within his or her Clinical Department; establish, together with the Medical Board and Hospital Administration, the type and scope of services required to meet the needs of patients in the Hospital;

B. Give guidance to the Medical Board and Hospital Administration on the overall medical policies and procedures of the Hospital;

C. Make specific recommendations to the Medical Board and Hospital Administration concerning his/her own Clinical Department, including those relating to criteria for clinical privileges relevant to the care provided in the Clinical Department; sufficient numbers of qualified and competent practitioners within the Clinical Department to provide patient care and administrative services, and the space and resources necessary or desirable for the operation of the Clinical Department;

D. Make specific recommendations to the Medical Board as to the appointment, reappointment, qualification and delineation of clinical privileges, including the revision of such
clinical privileges in between reappointment periods for each member of the Medical Staff within the Clinical Department;

E. Ensure that all legal and regulatory requirements regarding the delineation of privileges and adequate supervision of Graduate Staff are met at all times within his or her Clinical Department;

F. Develop, implement and periodically review policies and procedures of the Clinical Department, as well as performance standards for members of the Medical Staff, that guide and support the provision of services in order to maintain and improve the quality of patient care and the proper functioning of the Department;

G. Make specific recommendations to the Medical Board and/or the Credentials Committee regarding the appropriate method for delineating privileges in new and emerging disciplines, taking into consideration how practitioners will function in a multidisciplinary manner when needed to provide the best care to patients;

H. Be responsible for the integration of the Clinical Department into the primary functions of the Hospital, and for the coordination and integration of interdepartmental and intra-departmental services affecting his or her Clinical Department;

I. Be responsible for the implementation of a program to continuously evaluate, monitor and improve the quality of care and services provided by the Clinical Department by all appropriate means, and report regularly thereon to the Medical Board;

J. Be responsible for continuing general supervision and surveillance of the professional performance in the Hospital of all individuals in the Clinical Department who have delineated clinical privileges, so that observance of the general rules, regulations and standards of professional care of the Hospital and the Medical Staff shall be maintained, and regularly report thereon to the Medical Board. As part of this surveillance, the Department Director shall update on an ongoing basis and periodically review practitioner profiles, tracking the quality assurance and performance improvement program reviews of each member of his or her Clinical Department; and determine when actions must be taken based on these reviews;

K. Appoint committees from among the members of the Active Staff in his or her Clinical Department to assist him or her in the performance of the duties described in Article III of these By-laws, and such other committees as may be necessary or appropriate to evaluate and monitor the quality and appropriateness of patient care, including, without limitation, the Performance Improvement Coordinating Group, in accordance with the Hospital Quality Assessment and Improvement Plan and Corporate Compliance Plan;

L. Be responsible for determining the qualifications and competence of personnel in the Department who are not licensed independent practitioners and who provide patient care services, and regularly report thereon to the Medical Board;
M. Be responsible for the enforcement within his or her Clinical Department of the Hospital’s Corporate By-Laws, the Hospital’s administrative and other departmental policies and procedures, and these Medical Staff By-Laws and the Rules and Regulations; and for the implementation within his or her Clinical Department of any actions taken by the Medical Board or the Board of Trustees;

N. Have the authority to order any practitioner in his or her Clinical Department to have a mandatory consultation or evaluation to determine fitness to provide clinical care;

O. Be responsible for the orientation and continuing education of all persons in the Clinical Department;

P. Assess and make recommendations to Hospital Administration concerning off-site resources for needed patient care activities not provided by the Clinical Department or the Hospital, provided that he or she must disclose any financial interest which he or a member of his family has in any such off-site resource in accordance with the Hospital’s conflict of interest policies and Code of Ethical Conduct;

Q. Assist in the preparation of such reports, including, without limitation, budgetary planning, pertaining to his or her Clinical Department as may be required by the Medical Board, Hospital Administration, the Executive Director of the Hospital or the Board of Trustees;

R. Be responsible for any other matter or activity, which federal, state or local law, or applicable accreditation standards designate as the responsibility of heads of Clinical Departments.

Section 5.3 DEPARTMENT MEETINGS/COMMUNICATION

Each Clinical Department shall hold meetings no fewer than ten times per year, such conferences, quality assurance and performance improvement program conferences, and other meetings as may be necessary to maintain an adequate review of the medical practice and medical records of the Department. The Director of each Clinical Department which is subdivided into permanent recognized Divisions is authorized to permit such Divisions to meet separately. Minutes of meetings of Departments and Divisions shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed, including Medical Board recommendations and actions pertaining to the Department; recommendations made; and actions taken. Accurate attendance figures shall be kept by each Department. The Department Director shall be responsible for communicating with the members of his or her Clinical Department respecting all clinical and administrative matters and may require attendance at departmental meetings as he or she deems appropriate or necessary to accomplish that purpose.

ARTICLE VI
MEDICAL BOARD AND COMMITTEES

Section 6.1 THE MEDICAL BOARD AND ITS OFFICERS
Subsection 6.1.1  COMPOSITION. The voting members of the Medical Board shall consist of: (i) Department Directors; (ii) the Officers of the Medical Staff, who shall be the President, Immediate Past President, President-Elect and the Secretary/Treasurer; (iii) four “at-large” members of the Medical Staff selected by the Officers of the Medical Staff; and (iv) the Dean and Chief Academic Officer. In addition, the Regional Executive Director, Executive Director of the Hospital, Chief Medical Officer, the Senior Vice President, Quality Management, the Medical Director/Vice President for Medical Affairs, the Director of Medical Education, Director of Medical Informatics and the Nursing Executive of the Hospital shall be ex-officio members of the Medical Board with vote. In addition, there may be ex-officio members of the Medical Board without vote. Although it is expected that all members of the Medical Board diligently attend all of its meetings, in appropriate circumstances any member of the Medical Board may be represented at any meeting of the Medical Board by an alternate of his or her designation, upon a request to and approval by the Chair of the Medical Board. The alternate shall have the same voting rights as does the member he or she is representing.

Subsection 6.1.2  DUTIES. In addition to such other duties as may be prescribed elsewhere in these By-Laws and the Rules and Regulations, it shall be the duty of the Medical Board to govern the Medical Staff, and to advise the Board of Trustees, the Hospital’s Executive Director and the Health System CEO, Chief Medical Officer and Chief Operating Officer in matters relating to the welfare of the Hospital and the Medical Staff. The Medical Board also shall make Medical Staff recommendations to the Board of Trustees for its approval, such recommendations pertaining to: the structure of the Medical Staff; planning for clinical Departments; the mechanism used to review credentials and to delineate individual clinical privileges; recommendations of individuals for Medical Staff membership; recommendations for delineated clinical privileges for each eligible individual; the participation of the Medical Staff in organizational performance-improvement activities; the mechanism by which Medical Staff membership and clinical privileges may be terminated or limited, the mechanism for fair-hearing procedures; requirements for the medical care and treatment of patients in the Hospital, and programs of education, research and preventive medicine conducted at the Hospital; and the reports of the standing committees and subcommittees of the Medical Board and such special committees as may be appointed by the Chairman of the Medical Board.

The Medical Board also shall implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve care, and act on behalf of the organized Medical Staff between Medical Staff meetings. The actions of the Medical Board are subject to review and approval or disapproval by the Board of Trustees. Further, because of their responsibility for the overall Hospital operations, the Medical Board shall keep the Chief Executive Officer, Executive Director, Chief Medical Officer and Medical Director/Vice President for Medical Affairs apprised of important issues that may arise at the Hospital.

Subsection 6.1.3  OFFICERS. The voting officers of the Medical Board shall be its Chairman and Secretary. The Chairman and Secretary of the Medical Board shall be elected from the membership of the Medical Board for a two-year term, and may be re-elected for additional two-year terms. Election of the Chairman and Secretary of the Medical Board shall be
made by closed ballot at its March meeting, and shall be effected by a majority vote. Officers of the Medical Board must remain members in good standing on the Active Medical Staff during their term of office and failure to maintain such status shall immediately create a vacancy in the office involved.

Subsection 6.1.3.1 DUTIES OF THE CHAIRMAN OF THE MEDICAL BOARD. In addition to such others as may be specified in these Bylaws, the duties of the Chairman of the Medical Board shall be to:

A. Act in coordination and cooperation with the Executive Director of the Hospital and Medical Director/Vice President for Medical Affairs in all matters of mutual concern to the Hospital;

B. Call and preside over meetings of the Medical Board and be responsible for the agendas thereof;

C. Represent the views, needs and grievances of the Medical Board and the Medical Staff to the CEO, Executive Director, Chief Medical Officer and Board of Trustees.

D. Report on the policies of the Board of Trustees to the Medical Board and the Medical Staff;

E. Report to the Board of Trustees on the performance of, and maintenance of quality with respect to, the Medical Staff's delegated responsibility to provide medical and dental care;

F. Appoint the chairs and members (or delegate the appointment of members to the chairs) of all standing committees, subcommittees and any other ad hoc committees of the Medical Board, unless such appointments are otherwise provided for herein; and

G. Submit to the Board of Trustees regular reports concerning the professional activities of the Medical Staff of the Hospital. The reports shall set forth the procedure for granting clinical privileges and the delineation of clinical privileges in connection with appointments and reappointments to the Medical Staff.

Subsection 6.1.3.2 DUTIES OF THE SECRETARY. The Secretary shall also carry out specific tasks as assigned by the Chairman of the Medical Board. The Secretary shall cause to be kept accurate and complete minutes of all Medical Board meetings, and records of all appointments to the Medical Staff; call Medical Board meetings; attend to correspondence; and perform such other duties as ordinarily pertain to the office or as otherwise directed by the Chairman or Medical Board. In addition, the Secretary shall assume the duties and responsibilities of the Chairman of the Medical Board in the Chairman’s absence.

Subsection 6.1.3.3 RESIGNATIONS AND REMOVAL OF OFFICERS. Any officer of the Medical Board may resign at any time by giving written notice to the
Chairman of the Medical Board or, if the Chairman resigns, by giving written notice to the Secretary of the Medical Board. Unless otherwise specified in the notice, the resignation shall take effect upon delivery, and acceptance of the resignation shall not be necessary to make it effective. An officer of the Medical Board shall be removed for good cause, which shall include, but not be limited to (i) failure to carry out his or her duties as an officer of the Medical Board, or (ii) conduct which adversely affects the reputation of the Hospital in a material fashion or the conduct of the Hospital’s operations or affairs, upon a vote of two thirds of the members of the Medical Board present at the meeting in which removal is discussed. If at least three (3) members of the Medical Board believe that they have good cause, as set forth above, for the removal of an officer of the Medical Board, they shall present their request for removal in writing to the Executive Director of the Hospital who shall inform the officer of such request within three (3) days. At the next regular meeting of the Medical Board or at a special meeting called for such purpose, held no fewer than fifteen (15) days after a copy of the request for removal is given or mailed to the officer, the Medical Board shall inquire into and take action on the request for removal. The officer of the Medical Board who is not the subject of the request shall preside over and conduct the review. The officer, if he or she shall be present and request an appearance, shall be permitted to appear before the Medical Board and respond to the request, prior to a vote upon it by the Medical Board.

Subsection 6.1.3.4 RESIGNATIONS AND REMOVAL OF MEDICAL BOARD MEMBERS. A member of the Medical Board shall be removed for good cause, which shall include, but not be limited to (i) failure to carry out his or her duties as a member of the Medical Board, or (ii) conduct which adversely affects the reputation of the Hospital in a material fashion or the conduct of the Hospital’s operations or affairs, upon a vote of two thirds of the members of the Medical Board present at the meeting in which removal is discussed. If at least three (3) members of the Medical Board believe that they have good cause, as set forth above, for the removal of a member of the Medical Board, they shall present their request for removal in writing to the Chair of the Medical Board or the Medical Director who shall inform the Medical Board member of such request within three (3) days. At the next regular meeting of the Medical Board or at a special meeting called for such purpose, held no fewer than fifteen (15) days after a copy of the request for removal is given or mailed to the Medical Board member, the Medical Board shall inquire into and take action on the request for removal. The Chair of the Medical Board or the Medical Director shall preside over and conduct the review. The Medical Board member, if he or she shall be present and request an appearance, shall be permitted to appear before the Medical Board and respond to the request, prior to a vote upon it by the Medical Board.

Section 6.2 STANDING COMMITTEES OF THE MEDICAL BOARD

Subsection 6.2.1 CHARGE OF STANDING COMMITTEES. The Standing Committees are charged with developing and recommending for Medical Board approval the policies and procedures governing the functions or practices for which the Committee is responsible.
The Chairman of the Medical Board shall appoint the Chairs of the Standing Committees and the members thereof. However, the Chairman of the Medical Board may, at his or her discretion, delegate responsibility for appointment of committee members to the Committee Chairs.

Subsection 6.2.2 THE INDIVIDUAL STANDING COMMITTEES

The Standing Committees are:

The Credentials Committee
The Blood Utilization Committee
The Bylaws Committee
The Cancer Committee
The Continuing Medical Education/Medical Library Committee
The Graduate Medical Education Committee
The Health Information Management Committee
The Infection Control Committee
The Mass Casualties and Disaster Committee
The Medical Ethics Committee
The Medical Staff Health Committee
The Nominating Committee
The Performance Improvement Coordinating Group
The Pharmacy and Therapeutics Committee
The Radiation Safety Committee
The Surgical Case Review/Tissue Committee

CREDENTIALS COMMITTEE

A. Membership

The Credentials Committee shall be comprised of voting members consisting of at least one (1) member from the Departments of Medicine, Surgery, Gynecology, Pediatrics and Family Medicine, the Medical Director/Vice President for Medical Affairs, and the immediate Past President of the Medical Staff.

B. Functions

The Credentials Committee shall meet monthly to review one or more applications to the Medical Staff pursuant to Article III, Subsection 3.3.2 (E). The functions of the Credentials Committee, when it is called and meets, shall be:

(i) To review the completed applications and interview the designated applicants for membership on the Medical Staff.
(ii) To make recommendations to the Medical Board on each such applicant for Medical Staff membership regarding initial appointment, and delineation of clinical privileges, including specific consideration for the recommendations of the Director of the clinical department or Chief concerned in which such applicant requests privileges including recommendations by the Chair for the revision of privileges in between reappointment periods.

**BLOOD UTILIZATION COMMITTEE**

A. Membership

The Blood Utilization Committee shall consist of members of the Medical Staff, including the Director of the Blood Bank, or his designee, who shall be Chairman; the Director of the Department of Pathology, and such other representatives from the clinical services, including at least one (1) representative each from Medicine and Surgery, as in the judgment of the appointing authority, are necessary to fulfill the following functions:

B. Functions

1. This Committee shall review blood transfusions for their proper utilization, including the use of whole blood versus component blood elements. The evaluation of blood use shall include a review of the amount of blood requested, the amount used and the amount of wastage.

2. This Committee shall review and measure all blood use processes performed by the Hospital, including, but not limited to, ordering, distributing, handling, dispensing, administering, and monitoring blood and blood component effects on patients.

3. Such review may be performed through a retrospective audit mechanism, medical record review or any other patient specific review.

4. Each actual or suspected transfusion reaction shall be evaluated and documented.

C. Meetings

This Committee shall meet at least four (4) times annually, and shall report on its activities through the Performance Improvement Coordinating Group to the Medical Board.

**BYLAWS COMMITTEE**

A. Membership

The Bylaws Committee shall consist of the Chairman of the Medical Board, the Medical Director/Vice President for Medical Affairs and at least three (3) additional members of the Active Medical Staff appointed by him.

B. Functions
This Committee shall receive, review, evaluate, and offer recommendations regarding amendments and changes to the Bylaws and the Rules and Regulations of the Medical Staff, which recommendations shall be submitted to the Medical Board in accordance with Article XV of these Bylaws.

C. Meetings

This Committee shall meet at least annually and as many additional times as the Chairman thereof may direct.

CANCER COMMITTEE

A. Membership

Each of the required physician member specialties and required non-physician members, as listed in the Commission on Cancer, Cancer Program Standards. It shall also consist of other members as related to the scope of service at our facility.

B. Functions

1. This Committee shall furnish leadership in the cancer control program of the Hospital and shall compile, analyze and review statistics affecting the diagnosis and treatment of malignant diseases in the Hospital.

2. It shall oversee the operation of the Tumor Registry, with particular attention to the follow-up program, the development of special studies and survival and end results reports.

3. It shall plan, supervise and implement a continuing educational program for all Hospital personnel and for the Medical Staff regarding malignant disease.

4. It shall maintain liaison with other pertinent committees of the Medical Staff, as well as with state and local elements of the American Cancer Society, the New York State Department of Health and with the Department of Professional Services of the American College of Surgeons and its Committee on Cancer.

5. It shall maintain and review data on improving the performance of the Hospital’s cancer program.

C. Meetings

It shall meet at least quarterly and as many additional times as the Chairman thereof shall direct, and shall report on its activities through the Performance Improvement Coordinating Group to the Medical Board.

CONTINUING MEDICAL EDUCATION/MEDICAL LIBRARY COMMITTEE
A. Membership

The Continuing Medical Education/Medical Library Committee shall be comprised of voting members consisting of at least one member from each of the Clinical Departments. In addition to the voting members, representatives from Hospital Administration and a representative from the Hospital's Medical Library shall be non-voting members of the Committee.

B. Functions

1. This Committee shall establish and maintain, in consultation and concert with the North Shore - Long Island Jewish Health System, Inc. Continuing Medical Education Committee (the “System CME Committee”), guidelines and standards for the Hospital's continuing medical education program for members of the Medical Staff, AHP staff and nursing staff in order to promote the highest quality patient care by improving their medical knowledge and clinical skills by (i) providing them with the latest up-to-date medical information, (ii) enhancing the ability of individual practitioners to solve medical problems, (iii) broadening the ability of practitioners to care for different types of patients, (iv) presenting up-to-date information about medical ethics and morals in medical practice, and (v) supporting quality management and performance improvement issues that may benefit from continuing medical education activities.

2. The chairman of the CME/Medical Committee shall be the Medical Staff’s representative to the System CME Committee and shall report to the Committee and to the Medical Board, as appropriate, on the activities thereof, through such participation, this Committee shall coordinate the continuing medical education (CME) activities of the Hospital with those of the other System hospitals and the System’s Department of Professional and Public Health Education.

3. This Committee shall be responsible for ensuring the continuing medical education program of the Hospital and the courses offered by it are consistent with the guidelines of the Medical Society of the State of New York for continuing medical education accreditation. This Committee shall oversee the development and maintenance of uniform intradepartamental and interdepartmental requirements for continuing medical education and implement continuing medical education requirements for appointment and reappointment to the Medical Staff.

4. This Committee shall review and approve all continuing medical education programs and award appropriate credit for qualified programs.

5. This Committee shall regularly advise and report to the Medical Board and Hospital Administration on all matters concerning continuing medical education, including, but not limited to, the adequacy of financial and staff support for continuing medical education at the Hospital. This Committee shall publish a written annual report detailing its activities for the prior year.

6. This Committee shall insure the proper organization, supervision and use of the professional library of the Hospital and shall analyze the changing needs of the Hospital's library services.
7. It shall be responsible for the acquisition, custody and control of all professional books and periodicals, whether by purchase, subscription or gift, which are considered of value to the Medical Staff. It shall also concern itself with the deletion of any outmoded material contained in the Hospital's professional library.

8. It shall promulgate rules and regulations governing the use of such professional library and, in conjunction with Hospital Administration, and with the approval of the Medical Board, be responsible for all financial matters relating to such library.

C. Meetings

This Committee shall meet at least quarterly and as many additional times as the Chairman may direct.

GRADUATE MEDICAL EDUCATION COMMITTEE

The Graduate Medical Education Committee (GMEC) has the responsibility for monitoring and advising on all aspects of graduate medical education. It reports to the Medical Board and the Dean and Chief Academic Officer of the North Shore-Long Island Jewish Health System.

A. Membership

The GMEC membership will consist of the Directors of the Departments involved in graduate training programs; the Program Director of each core program; the Dean and Chief Academic Officer of the Health System; the Chair of the Medical Board; the Executive Director of the Hospital; the Medical Director/Vice President for Medical Affairs; at least four (4) members of the graduate staff; and, such other invited attendees as designated by the Dean and/or Committee Chair, including educators from other System institutions.

B. Functions

1. The Committee will establish and implement policies to ensure the quality of the education and the work environment for residents in graduate medical/dental education, including appropriate oversight of program structure; organization; goals and objectives; and processes for selection, promotion, evaluation and corrective action. The Committee will assure that residents may raise and resolve issues pertinent to their education and work environment.

2. The Committee will conduct regular internal reviews of all accredited programs including subspecialty programs to assess their compliance with the requirements of the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), AOA and other national certifying agencies, and with those of the Hospital. These reviews will be conducted in a manner consistent with the specifications of the accrediting agencies.
3. The Committee will regularly review all ACGME, AOA and ADA letters of accreditation as well as other certifying agency letters and monitor plans for the correction of any identified areas of non-compliance.

4. The Committee will collect intramural information and make recommendations for funding resident positions, including benefits and support services consistent with institutional policies and government agencies.

5. The Committee will oversee and monitor programs in their compliance with resident duty hours and supervision in accordance with the requirements of the ACGME, the AOA, the ADA, the State of New York and other accrediting agencies and with the standards set by the Hospital.

6. The Committee will assure that the residents’ curriculum includes topics as required by the ACGME, the AOA, the ADA and other appropriate certifying agencies and those set forth in the core curriculum competencies. The Committee will assure that residents have the opportunity to participate in departmental scholarly activity in accordance with applicable program requirements.

7. The Committee will seek solutions to problems which arise in graduate medical education programs, in cooperation with the programs of the other System teaching hospitals and consistent with the policies of the North Shore-Long Island Jewish Health System and its Graduate Medical Education Consortium.

8. The Committee will participate in and cooperate with the North Shore-Long Island Jewish Health System Graduate Medical Education Consortium in establishing educational policies for the Health System.

C. Meetings

The Committee will meet as often as needed, but no less than ten (10) times per year, and shall report on its activities to the Medical Board.

HEALTH INFORMATION MANAGEMENT COMMITTEE

A. Membership

The Health Information Management Committee shall consist of five members of the Medical Staff, together with representatives from Admitting, Dietary, Hospital Administration, Nursing, Quality Management, Respiratory Therapy, and Social Work, as well as the Director of Health Information Management, all of whom shall be voting members of the Committee. The representatives of the non-clinical departments shall be appointed by the Chairman of the Medical Board upon the recommendation of the relevant department head. The Director of Health Information Management shall act as the Secretary of the Committee. When deemed appropriate by the Committee, representatives from other disciplines, which contribute substantially to the medical records, may be invited as guests to attend meetings. Such invitees shall not be deemed members of the Committee and shall have no power to vote.
B. Functions

1. This Committee shall make recommendations on professional policy relating to the maintenance of medical records/medical information for all patients of the Hospital which meet desirable standards for usefulness in patient care and which have validity as historical documents.

2. This Committee shall be responsible for establishing and coordinating a process involving the medical and ancillary departments that meets the requirements of the JCAHO (and all other applicable accrediting and certifying boards and bodies) and the New York State Department of Health for the review of medical records to assure appropriate clinical information is contained within the patient's chart.

3. The Committee shall conduct such reviews as are requested by the Performance Improvement Coordinating Group.

4. It shall review each month a sufficient number of medical records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof.

5. It shall make recommendations to the Medical Board and to the Performance Improvement Coordinating Group whenever necessary or desirable relative to any changes in the format of the medical record, as well as to its proper filing, indexing, storage, retention period and availability, together with any recommended rules and regulations in connections therewith.

6. It shall review the monthly rates of incomplete charts and work with the appropriate Department Directors to develop corrective action plans to ensure the appropriate completion of such charts. It may recommend disciplinary action against members of the Staff who are chronically delinquent or deficient in attending to their medical records.

C. Meetings

This Committee shall meet at least quarterly, and shall report on its activities to the Medical Board.

INFECTION CONTROL COMMITTEE

A. Membership

The Environment and Infection Control Committee shall consist of members of the Active Medical Staff, including one representative from each of the Departments, the Infection Control Nurse, and Administration and may include representatives from the Employee Health Service, Ambulatory Care Services, Nursing Department, Supervisor of the Operating Suite and Department of Pathology. The Committee may invite to its deliberations as ex-officio members without power to vote, representatives from the Dietary, Pharmacy, Central Service, Housekeeping, Laundry, and Engineering and Maintenance Departments.

B. Functions

1. This Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, and review and analysis of actual infections and the promotion of a preventative and corrective program designed to minimize infection hazards.
2. It shall be charged with the supervision of infection control in all phases of hospital activity, including: operating rooms, delivery rooms, recovery rooms, special care units, sterilization procedures by heat, chemicals and otherwise, isolation procedures, prevention of cross-infection by anesthesia apparatus of inhalation therapy equipment, testing of hospital personnel for carrier status, methods of disposal of infectious material and other situations as requested by the Medical Board.

C. Meetings

This Committee shall meet at least once a month, and shall report on its activities through the Performance Improvement Coordinating Group to the Medical Board.

MASS CASUALTIES AND DISASTER COMMITTEE
A. Membership

The Mass Casualties and Disaster Committee shall consist of at least five (5) members of the Medical Staff, together with the Executive Director and the Chief Executive Officer or their designee, who shall be an ex-officio member thereof.

B. Functions

1. This Committee shall be actively responsible for the continuous updating and implementation of the Hospital Disaster Manual covering the reception, treatment and disposition of mass casualties, which Manual shall be subject to approval by the Medical Board and shall make provision for the following:

   (i) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

   (ii) An efficient system of notifying and assigning personnel.

   (iii) Unified medical command under the direction of a designated physician and designated substitutes.

   (iv) Conversion of all useable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

   (v) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.

   (vi) A special disaster medical record, e.g. an appropriately designed tag, which accompanies the casualty as he is moved.

   (vii) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy.

   (viii) Maintaining security in order to keep relatives and curious persons out of the triage area.
(ix) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual and advance arrangements with communications media to help provide organized dissemination of information.

2. It shall act as an advisory subcommittee to the Joint Conference/Professional Affairs Committee in relation to the medical aspects of the Hospital’s external and internal disaster plans.

C. Meetings

This Committee shall meet at least twice a year and as many additional times as the Chairman may direct, and shall report to the Medical Board as appropriate and at least annually.

THE MEDICAL ETHICS COMMITTEE

A. Membership

The Medical Ethics Committee shall be multi-disciplinary and composed of members interested in the ethical dimensions of medicine and patient care and can include physicians, administrators, legal counsel, nurses, social workers and clergy. The Chairman of the Medical Board shall appoint representatives of the Medical Staff to the Ethics Committee. The Executive Director shall appoint all other committee members.

B. Functions

1. Such Committee shall provide a forum for interdisciplinary dialogue concerning ethical issues and shall assist Hospital Administration and the Medical Staff in addressing ethical issues related to the clinical service, teaching and research roles of the Hospital and shall provide a forum for discussion of ethical issues.

2. It shall also assist Hospital Administration and the Medical Staff in the education of Hospital practitioners in ethical issues, and shall, among other things, develop, and monitor the use and effectiveness of, a method to assist Hospital practitioners in decisions relative to care and treatment at the end of life, care and treatment of the terminally ill, and for resolution of conflict in treatment decisions; provided, however that such method shall not authorize the Committee to make any decisions with respect to the care and treatment of a particular patient nor interfere with the attending physician's responsibility for the care and treatment, and the decisions related to the care and treatment of any patient all of the above goals will be accomplished while maintaining patient confidentiality.

3. The Committee shall report on its activities to the Medical Board, and in addition, it shall regularly report to Administration on its educational activities related to members of the Medical Staff and on its activities to develop and maintain a method to assist Hospital practitioners in decisions relating to patient care.

C. Meetings

This Committee shall meet at the call of the Chair thereof.
THE MEDICAL STAFF HEALTH COMMITTEE (MSHC)

A. Membership

The Committee shall be comprised of at least three (3) voting members, who shall be the Medical Director/Vice President for Medical Affairs and such other voting or non-voting members (which may include, without limitation one (1) or more psychiatrists, physiatrists and neurologists) appointed by the Chairman of the Medical Board as appropriate to address the particular condition or concerns with respect to the affected practitioner. The Committee is part of the Hospital’s quality assurance/performance improvement and malpractice prevention program, and its members shall have the legal immunity associated with that program. The Director of the department of the practitioner involved shall be permitted to attend and participate in the proceedings of the Committee without vote.

B. Function and Purpose

The Committee shall:

1. Develop and periodically review policies and procedures related to the health of the Medical, Graduate and Allied Health Professional Staffs, to ensure that such policies and procedures include mechanisms for (i) education of the Medical, Graduate and Allied Health Professional Staff about illness and impairment recognition issues specific to such professionals; (ii) self-referral by professionals; (iii) referral of affected practitioners to appropriate professional internal or external resources for diagnosis and treatment; (iv) maintenance of confidentiality except as limited by law, ethical obligation or concerns about patient safety; (v) evaluation of the credibility of a complaint, allegation or concern; (vi) monitoring of the affected practitioner and patient safety throughout the rehabilitation process; and (vii) reporting to the Medical Staff leadership instances in which a practitioner is providing unsafe treatment. The Committee shall report on such matters to the Medical Board.

2. Provide professional advice to and consultation with departmental chairpersons and hospital administrative personnel, as necessary, on individual matters of practitioners’ physical and mental health as it relates to the functions and duties of such practitioners, in accordance with such duly adopted policies and procedures.

3. Provide professional consultation and coordinate and monitor assistance and rehabilitation activities with respect to practitioner impairment including impairments related to physical and mental health and substance abuse or addiction, among such impaired practitioners, their departmental chairpersons and other hospital administrative personnel as appropriate, and the Committee for Physician’s Health of the Medical Society of the State of New York and/or other outside agencies authorized to participate in such activities.

4. Through such activities, aid practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients, provided that if at any time during the diagnosis, treatment or rehabilitation phase of the process it is determined that the practitioner is
unable to safely perform the privileges he or she has been granted, the Committee shall forward the matter to the Chairman of the Medical Board for corrective action under Article VIII of these Bylaws.

C. Meetings

The Committee shall meet as often as necessary. A permanent record of all proceedings and recommendations shall be maintained. Where part or all of any such meeting pertains to an individual practitioner, such proceedings shall be deemed confidential and, except as provided in Article XI to these Bylaws, the records thereof shall be redacted from any reports to the Medical Board.

NOMINATING COMMITTEE OF THE MEDICAL BOARD

A. Membership

On or about January 1st of each alternative year, the Chairman of the Medical Board, in consultation with the Medical Director/Vice President for Medical Affairs and Executive Director of the Hospital shall appoint a Nominating Committee of five members of the Medical Board (including a designated chairman) and the Executive Director.

B. Functions

1. On or before March 1st of each year, the Committee shall submit to the Medical Board the names of qualified nominees (together with background data on such nominees) to fill the role of Chairman and Secretary of the Medical Board.

2. In the event that the Chairman or the Secretary of the Medical Board shall be or become unable to serve for any reason whatsoever, the Nominating Committee shall submit to the Chairman of the Medical Board the name or names of candidates whom the Committee wishes to have considered to fill such vacancy.

3. It shall perform such other functions and responsibilities as are set forth in these Bylaws or as are ordinarily performed by a Nominating Committee.

C. Meetings

The Committee shall meet upon the call of the Chairman.

THE PERFORMANCE IMPROVEMENT COORDINATING GROUP

A. Membership
The membership of the Performance Improvement Coordinating Group shall represent the Hospital leadership and be appointed by the Medical Board, and shall include the Clinical Director from each of the Clinical Departments or his/her designee and the Secretary/Treasurer of the Medical Staff. Additional members shall include the Nurse Executive, Administration, members from clinical or support services, the Risk Manager, the Safety Officer, Infection Control Nurse, a member of the Graduate Staff and a member of the Health System’s Department of Quality Management.

B. Functions

The Performance Improvement Coordinating Group shall:

1. Function in a multi-disciplinary capacity, providing leadership and guidance in the Hospital’s organizational performance improvement activities, medical staff professional review, health information management, utilization management, infection control, risk management, Hospital safety program, special care nutritional support, and pharmacy and therapeutics functions thereby implementing a unified program that improves organizational performance by establishing multi-disciplinary teams to design, measure, assess and improve the organizational functions identified by the JCAHO (and any other applicable accrediting and certifying boards and bodies).

2. Oversee, coordinate and prioritize quality assurance and performance improvement activities by, among other things, approving and administering an annual Hospital-wide Performance Improvement Plan by:

   • Promoting and assisting, where needed, in the development of the methodology for the plan by focusing on its design, implementation, measurement methodology, means of assessment and improvement, and

   • Assisting in coordinating the dimensions of performance with patient care and organizational functions.

   • Reappraising the Hospital’s quality assurance, quality management, performance improvement, risk management and safety programs for their effectiveness and the degree to which they integrate and coordinate their efforts and apply to all departments, services and practitioners of the Hospital.

3. Receive and analyze reports from each hospital department/service (as appropriate) regarding all Hospital activities concerned with quality, utilization and risk management, integrate and, coordinate such activities to the degree possible, and recommend additional activities, and modification of existing activities as needed, as well as combination of activities, when appropriate, from all interdepartmental performance improvement committees which report to the Performance Improvement Coordinating Group and to the Medical Board.

4. Assure the use of information gathered regarding problems identified in the revision of Hospital policies and procedures.
5. Promote and assist, where needed, in the development of multi-disciplinary standards of care for all patient activities with particular reference to existing rules and regulations of the professional staffs.

6. Establish procedures for effective utilization of Hospital services and a mechanism for the provision of discharge planning by identifying utilization related problems, including the appropriateness and medical necessity of admissions, continued stays and support services, delays in the provision of support services, as well as length of stay norms.

7. Identify general areas of potential risk in all clinical aspects of patient care and safety, including at a minimum, all areas of concern identified in Part 405.6 of the New York State Hospital Code, establish corrective action plans therefor, and monitor the outcomes of such plans in order to reduce malpractice claims and the probability of harm to patients.

8. Receive, evaluate and coordinate reports of all improvement team activities and share information related to outcome and performance concerning all quality management and performance improvement activities.

9. Coordinate and oversee all functions identified in Part 405.6 of the New York State Hospital Code to be coordinated and overseen by this Committee.

10. Send representatives to committees composed of representatives of the Hospital and other System Hospitals in order to identify, share develop, and improve best practices for patient care at the Hospital.

11. Meet in an executive session comprised of physician and nursing members of the Performance Improvement Coordinating Group to review adverse patient outcomes and sentinel events.

12. Send representatives to, and receive reports from, committees comprised of representatives of the Hospital and other System Hospitals in order to identify, share, develop, and improve best practices for patient care at the Hospital. Administrative support for, and coordination of all such committee’s activities shall be provided by the Health System’s Department of Quality Management and coordinated with the Hospital’s Department of Quality Management.

13. Send representatives to committees comprised of representatives of the Hospital and other System Hospitals in order to identify, share, develop, and improve best practices for patient care at the Hospital. Administrative support for, and coordination of all such committee’s activities shall be provided by the Health System’s Department of Quality Management and coordinated with the Hospital’s Department of Quality Management.

C. Meetings and Reports

The Performance Improvement Coordinating Group shall meet no less frequently than six (6) times per year.
Reports

1. The Performance Improvement Coordinating Group shall report monthly to the Medical Board and Executive Director. Reports shall include the status of current performance improvement activities.

2. The Performance Improvement Coordinating Group shall report at least quarterly through the Medical Board to the Joint Conference Committees of the Board of Trustees. Reports shall include:

   - The status of organization performance improvement activities undertaken during the reporting period; and
   
   - Pertinent findings and recommendations of quality management and performance improvement activities throughout the Hospital.

PHARMACY AND THERAPEUTICS COMMITTEE

A. Membership

   The Pharmacy and Therapeutics Committee shall consist of representatives from the Departments of Anesthesiology, Emergency Medicine, Medicine, Gynecology, Pediatrics, Radiology, Surgery and Family Practice, as well as a representative from the Graduate Medical Staff, together with the Chief Pharmacist who shall serve as Secretary to the Committee, and one (1) representative each from the Nursing Department and from Hospital Administration.

B. Functions

1. This Committee shall be responsible for the development and surveillance of medication utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall serve as the organizational line of communication and liaison among the Medical Staff, the Nursing Department and the Pharmacist concerning all matters of medication usage.

2. This Committee shall organize and systemize medication use policies, processes and procedures throughout the Hospital through the development of hospital policies and standards regarding the evaluation, appraisal, selection, procurement, storage, prescribing or ordering, preparation and dispensing, use, and administration of all medications within the hospital.

3. This Committee shall monitor the effects of medications on the Hospital’s patients and shall develop safety and other procedures relating to the use of medications within the Hospital, through the evaluation of clinical data regarding new drugs or preparations requested for use in the Hospital.

4. It shall serve as an advisory group to the Hospital Medical Staff and the Pharmacist on matters pertaining to the choice of available medications.

5. It shall develop and review periodically a Formulary or Drug List for use in the Hospital by identifying an appropriate selection of medications which should be available within the
Hospital for prescribing and ordering, and by developing procedures for prescribing or ordering and procuring medications not available in the Hospital. It shall also identify medications to be stocked in the Hospital Pharmacy and/or on the nursing unit floors and by other services.

6. It shall develop policies designed to prevent duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

7. It shall evaluate and approve all protocols concerned with the use of investigational or experimental medications.

8. This Committee shall review all untoward and significant adverse drug reactions.

9. It shall report to the Medical Board on all of its activities, and its recommendations regarding medication policies, processes and procedures shall be made to the Medical Board for its approval.

C. Meetings

This Committee shall meet at least once a month.

RADIATION SAFETY COMMITTEE

A. Membership

The Radiation Safety Committee shall include the Director of Radiology, who shall be Chairperson, the Radiation Safety Officer, a representative of Administration, a physician of the Division of Radiation Oncology, the Radiation Physicist, a representative of Department of Nursing, and at least one (1) additional individual qualified in the use of ionizing radiation.

B. Functions

1. The primary function of this Committee is to serve as the administrative body responsible for the safe use of radioactive materials and ionizing radiation-producing machines within the Hospital, and shall report through the Performance Improvement Coordinating Group to the Medical Board.

2. It shall make recommendations to Administration regarding the proper use, transport, and storage of all radioactive material in the Hospital as set forth in the New York State Sanitary Code, the New York State Hospital Code, and the codes, directives, and standards of all regulatory agencies including, but not limited to, the Bureau of Environmental Radiation Protection of the New York State Health Department; the Department of Transportation; the Department of Environmental Conservation; the New York State Department of Labor; the Occupational Safety and Hazard Administration; and the United States Food and Drug Administration.

3. Under the Hospital’s Broad Scope Radioactive Materials License, it shall review and grant permission for, or disapprove, the use of radioactive material within the Hospital.

4. Under the provision of the Hospital’s Broad Scope Radioactive Materials License, all authorized users of radioactive materials must be approved by this Committee.
5. It shall prescribe special conditions that will be required during a proposed use of radioactive material such as requirements for bio-assays, minimum level of training and experience of users or any other conditions that the Committee shall consider advisable.

6. It shall receive and review records and reports from the Radiation Safety Office, or individuals with delegated responsibility for radiation health and safety practices in the Hospital.

7. It shall recommend corrective action to correct radiation related safety infractions and implement improvements to the Radiation Safety Policies and Procedures. The Committee will take corrective actions as opportunity for improvements are identified.

8. It shall review the institutional training programs for the safe use of radioactive materials.

9. It shall review annually the diagnostic and therapeutic quality assurance programs for compliance with regulations.

10. A Radioactive Drug Research Committee (RDRC) shall serve as a subcommittee. In accordance with the provisions of Title 21 Code of the Federal Regulation Section 361.1, the RDRC shall approve, or disapprove, and monitor research with radioactive drugs in humans which are intended to obtain basic information and not to carry out a clinical trial.

11. It shall submit to the appropriate governmental bureaus and agencies having jurisdiction over its activities such reports as may be required by applicable governmental regulations.

C. Meetings

This Committee shall meet at least quarterly and as many times as the Chairperson may direct. A quorum shall consist of at least one-half the voting Committee membership, and must include the Radiation Safety Officer and the Administration representative.

SURGICAL CASE REVIEW/TISSUE COMMITTEE

A. Tissue Review

1. Membership

There shall be a Tissue Committee which shall consist of members, including the Director of the Department of Surgery, or his designee; the Director of the Department of Pathology, or his designee; the Director of the Department of Medicine, or his designee; and one (1) additional member of his Department designated by him; the Director of the Department of Gynecology, or his designee; and one (1) member of the Department of Pediatrics, together with representatives of such other Departments, Divisions and Sections of the Hospital as, in the judgment of the Medical Board, are necessary to carry out the Committee’s functions as listed below.

2. Functions

A. The major function of this Committee is that of improvement of patient care by the review of documented work protocols.

B. This Committee shall be assigned the responsibility of performing a medical audit on all patients undergoing surgery or other invasive procedures, in whom:
(i) there exist major discrepancies between the preoperative and postoperative diagnoses in pathology reports;

(ii) the tissue removed does not in and of itself justify the performance of surgery,

(iii) there is a major discrepancy between pre-operative and postoperative diagnosis.

C. This Committee shall be assigned the responsibility of performing a medical audit on all patients undergoing surgery or other invasive procedures whose physicians show a pattern or patterns of discrepancies between pre-operative and postoperative diagnoses.

D. The Tissue Committee shall also perform such other medical audits as it from time to time deems appropriate.

E. To achieve its purpose the Tissue Committee shall have access to all necessary medical and ancillary records of Hospital patients.

F. Matters within the Committee’s jurisdiction which are under question shall be referred to the appropriate Department Director for his investigation and report back to the Committee.

G. Quality management issues shall be referred to the appropriate Department Director.

H. The Tissue Committee shall complete focus reviews of procedures identified for focus review by the Performance Improvement Coordinating Group and shall report thereon to the Performance Improvement Coordinating Group.

I. The Tissue Committee shall meet at least once a month and written reports of conclusions, actions taken, and results of actions taken shall be maintained and forwarded through the Surgical Performance Improvement Coordinating Group and to the Performance Improvement Coordinating Group, and through the Performance Improvement Coordinating Group and to the Medical Board.

B. Non-Tissue Review

A. Review of all cases in which no tissue is removed shall be performed monthly by those Departments/Services performing procedures to help assure that the procedures performed in the Hospital are justified and of high quality. When, following a systematic process which confirms that the procedure performed is justified and of high quality, subsequent reviews may consist of an adequate sample of cases.

B. Written reports of conclusions, actions taken and results of actions taken shall be maintained and forwarded to the Department Performance Improvement Coordinating Group, and Department Director, and shall be reported to the Performance Improvement Coordinating Group as part of the Department performance improvement/utilization review report, and through the Performance Improvement Coordinating Group to the Medical Board.

Section 6.3 MEDICAL BOARD AND COMMITTEE MEETINGS

Subsection 6.3.1 MEDICAL BOARD MEETINGS. The Medical Board shall meet regularly once each month and shall submit a report on each such meeting to the Secretary of the Board of Trustees. Any action taken by the Medical Board shall require a majority vote of those present. A majority of voting members of the Medical Board shall constitute a quorum. The
Medical Board shall honor a request for a closed ballot vote made by at least fifteen (15%) percent of the voting members present at the meeting.

Subsection 6.3.2 STANDING COMMITTEE MEETINGS. Unless otherwise expressly provided elsewhere in these By-Laws each standing committee and subcommittee of the Medical Board shall hold not fewer than four (4) meetings each year. Minutes of each meeting shall be kept and shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed; recommendations made; and actions taken. Copies of such minutes and of all committee and subcommittee reports and recommendations shall be forwarded by each committee to the Medical Board.

Subsection 6.3.3 SPECIAL MEETINGS. The Chairman of the Medical Board, Executive Director and Medical Director/Vice President for Medical Affairs may call special meetings of the Medical Board upon such notice as may be practicable under the circumstances.

Section 6.4 OTHER COMMITTEES

Unless otherwise expressly provided elsewhere in these By-Laws other special committees may be appointed by the Chairman of the Medical Board in such number and of such composition as the Medical Board may deem necessary or desirable to properly carry out the duties of the Medical Board and the Medical Staff. Such committees shall confine their activities to the purposes for which they were appointed, shall report to the Medical Board, and shall have only such power of action as is specifically granted by the Medical Board.

ARTICLE VII COMMITTEE ON QUALITY

The Committee on Quality will serve as a liaison between the Corporation’s Medical Board and the Board of Trustees. Quality information, which includes the results of measures that evaluate clinical performance of the Corporation, generated by Medical Board committees, such as the Performance Improvement Coordinating Group, may be presented to the Committee on Quality for review to better understand how the Corporation meets accepted standards of practice. The Committee on Quality also may review analyses of sentinel events in order to understand how these incidents can be prevented in the future, to communicate lessons learned and for establishing best practices. Medical staff credentialing matters, such as appointments and reappointments, approved by the Corporation’s Medical Board that are presented to the Board of Trustees or its Executive Committee may be presented through the Committee on Quality, together with the recommendation of the Committee on Quality thereon with regard to approval. The Committee on Quality will meet not less than ten times per year, and will be comprised of members of the Board of Trustees and senior leadership representing administration, nursing and the Medical Staff.

ARTICLE VIII CORRECTIVE ACTION FOR MEDICAL STAFF MEMBERS

Section 8.1 CORRECTIVE ACTION PROCESS DEFINED
Subsection 8.1.1 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 By-Laws, the Rules and Regulations, the Corporate By-Laws, rules, regulations or policies, or the policies of his or her Clinical Department. Such request for corrective action shall be made to the Chairman of the Medical Board by any Trustee or Officer of the Corporation, the Executive Director of the Hospital, the Department Director, or any member of the Medical Board, provided that a request for corrective action regarding the Chairman of the Medical Board shall be made to the Medical Director/Vice President for 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 of these By-Laws, any request for corrective action by the Director of the Department in which the practitioner holds clinical privileges shall be based upon a prior investigation. If a request for corrective action is made by any person other than the practitioner’s Department Director, upon receipt of the request for corrective action, the Chairman of the Medical Board shall refer the matter back to the practitioner’s Department Director for him or her to conduct a departmental investigation of the issues that gave rise to the request for corrective action. In the event that a request for corrective action is made regarding a Department Director, the investigation of the matter shall be conducted by the Medical Director/Vice President for Medical Affairs.

No person filing a request for corrective action in an individual capacity shall sit on any committee reviewing the request under this Article VIII. The Chairman of the Medical Board shall ensure that a copy of such request for corrective action shall be sent via overnight delivery service or personal delivery 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 forwarded to the affected practitioner shall be accompanied by a copy of this Article VIII that sets forth the hearing process. Any further communications between the Hospital and the affected practitioner required under this Article VIII shall be sent via overnight delivery service or personal delivery.

Subsection 8.1.2 CORRECTIVE ACTION: GENERAL RULES

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

(i) requirement of further clinical training or in-Department education in specified areas that is a restriction of a practitioner’s clinical privileges.

(ii) imposition of terms of probation.

(iii) a recommendation for the restriction, suspension or termination of clinical privileges.

(iv) a recommendation for suspension or termination of Medical Staff membership.
B. Any action recommended pursuant to 8.1.2 (a) (i) through (iv) above shall entitle the Medical Staff member to the procedural rights provided in Subsection 8.1.3 of this Article VIII. In the event of a summary suspension of a practitioner’s clinical privileges and/or Medical Staff membership, the procedures set forth in Section 8.2 shall apply. If a corrective action is upheld by final action by the Board of Trustees, 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.

C. Any request for corrective action may be withdrawn by the person requesting it at any time prior to the consideration of the matter by the Hearing Committee. Notice of such withdrawal shall be provided to the affected practitioner by the person withdrawing it.

Subsection 8.1.3 RIGHT TO HEARING. Any practitioner who has received notice of a request for corrective action as set forth in subsection 8.1.2 (a) (i) through (iv) above is entitled to a hearing before a Hearing Committee pursuant to the procedures set forth in this Article. 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 III of these By-laws of an adverse recommendation with respect to appointment to the Medical Staff, or to reappointment to the Medical Staff or to a restriction and/or reduction of the practitioner's clinical privileges is entitled to a hearing in accordance with the procedures set forth in this Article. In the event the practitioner elects to not have a hearing or does not respond to the notice, the Medical Board shall act on the request for corrective action at its next regular meeting.

Subsection 8.1.4 REQUEST FOR HEARING. A request for a hearing before a Hearing Committee shall be made by the practitioner in writing and sent to the Chairman of the Medical Board via overnight delivery service or personal delivery within thirty (30) days of receipt by the practitioner of notice of the request for corrective action or adverse recommendation. If the practitioner fails to request a hearing within such time limitation, or to appear at the time set for the hearing, he or she shall be deemed to have waived the right to a hearing, as set forth in Subsection 8.1.7 of this Article VIII.

Subsection 8.1.5 SCHEDULING AND NOTICE OF HEARING. The Chairman of the Medical Board (or designee) shall schedule the hearing and shall notify the practitioner by overnight delivery service or personal delivery, 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 who has been summarily suspended in accordance with these By-Laws, 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 8.1.6 COMPOSITION AND SELECTION OF THE HEARING COMMITTEE. The hearing shall be conducted by a Hearing Committee, consisting of five (5) voting members. Three (3) members shall be members of the Medical Board and two (2) members shall be members of the Active Staff, 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 recommendation. Members of the Medical Board or Active Staff who are direct economic competitors of the practitioner shall not sit on the Hearing Committee. Any challenge by the practitioner to any member of the Hearing Committee shall be made in writing to the Chair of the Hearing Committee no less than fifteen (15) days prior to the date of the Hearing. If the challenge is regarding the Chair of the Hearing Committee, it shall be made by the practitioner to the Executive Director of the Hospital.

Subsection 8.1.7 CONDUCT OF THE HEARING. The practitioner must be present at the hearing, and both the practitioner and the Hospital shall be entitled to present relevant evidence and witnesses on his/her or its behalf, to question witnesses appearing on behalf of the other party and to submit a written statement at the close of the hearing. A record of the hearing shall be made by such method as shall be determined by the Chair of the Hearing Committee. Such hearing shall not be open to the public and documents and testimony shall be maintained in strict confidence by all participants and witnesses, consistent with Article 28 of the Public Health Law. The hearing shall not be subject to any formal rules of evidence or procedure, and the Hearing Committee may permit the presentation of evidence and witnesses subject to such restrictions and limitations as it may impose and as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. There shall be no right to pre-hearing discovery. Rulings with respect to evidence and witnesses shall be made by the Chair of the Hearing Committee. A majority of the members of the Hearing Committee shall constitute a quorum. The practitioner and the Hospital each may elect to be represented at the Hearing by legal counsel. At its option, the Hearing Committee also may be advised by legal counsel, provided that the attorney appointed to advise the Hearing Committee is not the same attorney as the attorney representing the Hospital before the Hearing Committee. The Hearing Committee, through its Chair, shall make such additional rules as it deems necessary to ensure a fair and expeditious handling of the matter. It shall be the obligation of counsel for the Hospital to present, in the first instance, the request for corrective action or adverse recommendation and the reasons supporting the request for corrective action. In order to reverse the recommendation, the affected practitioner shall have the obligation to persuade the Hearing Committee, by clear and convincing evidence, that the reasons supporting the request for corrective action lack any factual basis or that such basis, or any action based thereon, is either arbitrary, unreasonable or not in compliance with applicable law. At the conclusion of the Hearing, both parties may
submit simultaneously a written statement to the Hearing Committee. Failure without good cause of the practitioner to appear at the hearing shall constitute a waiver of his or her rights under these By-Laws. The Hearing Committee shall determine if the reason a practitioner fails to appear at the Hearing is good cause.

Subsection 8.1.8 DECISION OF HEARING COMMITTEE; RATIFICATION BY MEDICAL BOARD. Within fourteen (14) days of the completion of the hearing, the Hearing Committee shall issue a decision, by majority vote of the Hearing Committee, either upholding the adverse recommendation or terminating or modifying such recommendation. Such 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 recommendation. Neither the affected practitioner, nor his or her representative, may attend the Medical Board meeting at which the Hearing Committee recommendation is being presented for ratification. Upon its ratification, by majority vote of those present at the meeting, the Chair of the Hearing Committee Medical Board (or designee) shall forward copies of its decision to the Secretary of the Board of Trustees, to the affected practitioner via overnight delivery service or personal delivery, and to counsel for the Hospital who presented the case. In the event the Medical Board does not ratify the Hearing Committee's decision, the Medical Board can either issue its own decision, request clarification of the Hearing Committee’s decision or re-review the Hearing record. Any vote by the Medical Board to reject or modify a Hearing Committee's decision shall require a two-thirds majority of the Medical Board voting members present at the meeting.

Subsection 8.1.9 RIGHT OF APPEAL. Should the Medical Board ratify an adverse decision of the Hearing Committee or render its own decision restricting, suspending or terminating the practitioner’s clinical privileges or Medical Staff membership, the affected practitioner may request an appellate review by written notice to the Board of Trustees within ten (10) days after receipt of the adverse decision of the Hearing Committee. The Hospital shall also have ten (10) days to request an appellate review of a decision of the Hearing Committee that is adverse to the Hospital. A written request for appellate review shall be upon written notice to the other party, and shall include identification of the grounds for the appeal and 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 constitute final action, with no further notice or proceeding required, except that the Medical Board’s decision shall be forwarded and accepted by the Board of Trustees. Upon such acceptance by the Board of Trustees, the decision is final.

Subsection 8.1.10 APPELLATE REVIEW COMMITTEE. If a request for appellate review is made in accordance with Section 8.1.9 of these By-Laws the Board of Trustees shall appoint an Appellate Review Committee, which shall be composed of three (3) members of the Board of Trustees. A Chair of the Appellate Review Committee shall be appointed by the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as that person did not take part in a prior proceeding on the same matter. For purposes of the appellate review, both parties shall have access to the decision and record of the Hearing Committee and all other material that was considered by the Hearing Committee in making its decision, unless any such material is otherwise exempt from disclosure by law.
Subsection 8.1.11  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. Unless the Chair of the Appellate Review Committee authorizes a different schedule, this statement shall be submitted to the Appellate Review Committee and to the opposing party within twenty (20) days of the date of receipt by the Board of Trustees of the request for appellate review. The opposing party shall submit a responsive statement within twenty (20) days of receipt of the appealing party’s statement. After receiving both statements, the Chair of the Appellate Review Committee shall schedule a date, time and place for the appellate review and shall give written notice of the schedule to the parties. The date of the appellate review shall not be more than twenty (20) days from the date that the Appellate Review Committee received the opposing party's statement, unless agreed to by the Chair of the Appellate Review Committee and all parties. The Appellate Review Committee shall review the record created at the Hearing Committee, the statement of appeal and the responsive statement for the purpose of determining whether the decision of the Hearing Committee had a rational basis. The decision of the Hearing Committee and/or 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 Section 8.1.7 above and the facts and circumstances of the case. The Chair of the Appellate Review Committee may, in his or her sole discretion, allow oral argument or accept additional written evidence, subject to a foundational showing that such evidence could not have been made available at the hearing in the exercise of reasonable diligence. New or additional matters not raised at the hearing, nor otherwise reflected in the record, shall not be introduced at the appellate review unless the Appellate Review Committee, in its sole discretion, decides to consider such new matters.

Subsection 8.1.12  DECISION OF APPELLATE REVIEW COMMITTEE; RATIFICATION BY THE BOARD OF TRUSTEES. 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 Hearing Committee or remand the matter to the Hearing Committee for reconsideration. The Appellate Review Committee shall then submit its decision to the Board of Trustees for final action, and recuse themselves from any consideration of the matter by the Board of Trustees. Upon final action, the Board of Trustees shall forward copies of its decision to the Medical Board, to the affected practitioner, via overnight delivery service or personal delivery b, and to the counsel for the Hospital.

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

Section 8.2  SUMMARY SUSPENSION AND PROCEEDINGS

Subsection 8.2.1  SUMMARY SUSPENSION AND NOTICE. Whenever action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations, the Department Director, the Chairman of the Medical Board,
the Chief Medical Officer, Medical Director/Vice President for Medical Affairs and, the Executive Director of the Hospital, each shall have the authority to summarily suspend all or any portion of the clinical privileges granted by the Hospital to a member of the Medical Staff. The practitioner shall be given notice of such suspension, and the reason or reasons therefor, in person, and/or overnight delivery service by such individual(s) (or designee) as promptly as shall be practicable under the circumstances. Such suspension shall become effective immediately upon imposition.

Subsection 8.2.2 REQUEST FOR A CORRECTIVE ACTION, NOTICE AND MEDICAL BOARD PROCEEDINGS. Within three (3) days of the summary suspension, a summary suspension review committee, comprised of the Medical Director, or designee in his or her absence, another Department Director selected by the Medical Director, and the President of the Medical Staff and in his or her absence the next most senior officer, shall be convened by the Chairman of the Medical Board as an advisory group to the Department Director who imposed the summary suspension. If the Chairman of the Medical Board imposed the summary suspension, then the summary suspension review committee shall be convened by the Medical Director. Unless the Committee, upon reviewing the facts and circumstances of the matter that gave rise to the summary suspension, recommends, by a unanimous vote, that the Department Director should terminate the summary suspension, it will remain in effect. In the event the Committee recommends by unanimous vote that the summary suspension should be terminated, the Department Director may elect to recommend a different corrective action, which will then proceed in accordance with Section 8.1 of these Bylaws.

In the event the committee supports the summary suspension recommendation of the Department Director, a written request for a summary suspension corrective action stating the facts upon which the practitioner's summary suspension was based shall be filed with the Chairman of the Medical Board or the Medical Director by the person directing or the Department Director recommending the suspension and a copy given to the practitioner personally or overnight delivery service. The person or committee directing or the Department Director recommending the suspension may supplement the request for corrective action by providing further information to the Chairman of the Medical Board or the Medical Director within ten (10) days after the suspension and a copy of the additional information submitted to the Chairman of the Medical Board or the Medical Director shall be given to the practitioner personally or overnight delivery service as soon as practicable. All further proceedings on the written request for corrective action, including the hearing procedures to be afforded the affected practitioner, shall be in accordance with the provisions of Section 8.1 of these By-Laws.

Subsection 8.2.3 WITHDRAWAL OF SUSPENSION. A summary suspension may be withdrawn by the committee or person imposing the same at any time prior to the consideration of the matter by the Hearing Committee of the Medical Board. Notice of such withdrawal of suspension shall be provided to the affected practitioner by the Committee or person withdrawing it.

Section 8.3 ALTERNATE MEDICAL COVERAGE
Immediately upon any termination, limitation or suspension of a practitioner's Medical Staff membership or any termination, limitation or suspension of his or her clinical privileges, either under this Article or Article III of these By-Laws, the Department Director, Chairman of the Medical Board, the Medical Director/Vice President for Medical Affairs, or the Executive Director of the Hospital shall each have authority to arrange for alternate medical coverage for the practitioner's patients still in the Hospital. The wishes of the patients concerned shall be considered in the selection of an alternate practitioner.

Section 8.4 AUTOMATIC TERMINATION OF MEDICAL STAFF MEMBERSHIP

Notwithstanding any other provisions of these By-Laws, the Medical Staff membership of a practitioner shall be terminated automatically, without any of the procedural rights set forth in this Article VIII, 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 Director, the Medical Director/Vice President for Medical Affairs and to the Executive Director of the Hospital immediately. Upon removal of the sanction, the practitioner may reapply for Medical Staff membership and clinical privileges in accordance with these By-Laws.

Notwithstanding any other provisions of these By-Laws, the Medical Staff membership of a practitioner shall automatically terminate, without the procedural rights set forth in this Article VIII, upon the termination of a contract between the Hospital and any other facility or organization pursuant to which the practitioner has been granted privileges at the Hospital and appointed to the Medical Staff of the Hospital. Such Medical Staff member may at that time re-apply for Medical Staff membership as a voluntary attending physician.

Section 8.5 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 VIII, 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 By-Laws and the Rules and Regulations, (iii) upon failure to provide the Credentialing 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 Medical Director/Vice President for Medical Affairs or Chairman of the Medical Board that the practitioner is in compliance with the requirements of the Hospital and these By-Laws 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
Section 8.6 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, Graduate Staff or Allied Health Professional Staff membership. Furthermore, by accepting membership on the Medical Staff, Graduate Staff or Allied Health Professional 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 By-Laws.

ARTICLE IX
THE GRADUATE STAFF

Section 9.1 NATURE OF GRADUATE STAFF MEMBERSHIP

The Graduate Staff shall consist of the residents and clinical fellows in training at the Hospital in such numbers as may be approved from time to time and appointed annually by the Board of Trustees upon recommendations of the Department Directors concerned and the Medical Board. Members of the Graduate Staff must be graduates of schools of medicine, dentistry, osteopathic medicine or podiatry that are recognized by the Hospital and shall be limited in their practice in accordance with the provisions of the Education Law of the State of New York and other applicable statutes and regulations. The professional responsibilities, duties and assignments of each member of the Graduate Staff shall be as prescribed by his or her Department Director and Program Director who shall ensure that the specific treatments and procedures each Graduate Staff member is authorized to provide and is delineated in writing, meets the Hospital’s standard of care and that the supervision required to perform those treatments and procedures is specified. Acceptance of membership on the Graduate Staff shall constitute the Graduate Staff member’s agreement to abide by these By-Laws and the Rules and Regulations. In the event of a conflict between the provisions of any Graduate Staff manual or agreement with the Hospital and these By-Laws or the Rules and Regulations, these By-Laws or the Rules and Regulations, as applicable, shall control.

Section 9.2 REMEDIAL ACTION FOR GRADUATE STAFF MEMBERS

If, in the discretion of the Program Director or Department Director, the performance of a graduate staff member is below the expected academic level, a course of remediation should be implemented. The time, course and content of the remedial process must be prescribed in writing by the Program Director or Department Director and provided to the graduate staff.
member at the commencement of the process. A refusal by the graduate staff member to abide by the remedial process prescribed by his or her Department shall constitute grounds for corrective action and possible termination from the training program.

Section 9.3 CORRECTIVE ACTION FOR GRADUATE STAFF MEMBERS

Subsection 9.3.1 CORRECTIVE ACTION. Corrective action regarding a member of the Graduate Staff may include a restriction, suspension or termination of clinical privileges, including on a summary basis, or the involuntary non-renewal of a contract, whenever the Graduate Staff member’s conduct, condition, professional or otherwise, 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 character or competence of such Graduate Staff member; or results in disruption of Hospital operations. A corrective action also may be taken with regard to any Graduate Staff member who fails to comply with any of these By-Laws or the Rules and Regulations, the Corporate By-Laws, the provisions set forth in any Graduate Staff Manual, the Graduate Staff member's agreement with the Hospital, or any rules, regulations or policies of the Board of Trustees. A corrective action may be imposed with regard to such Graduate Staff member by the Chair of the Hospital’s Graduate Medical Education (“GME”) Committee, Program Director or Director of the Department to which the Graduate Staff member is assigned, the Hospital’s Executive Director, or the Medical Director/Vice President for Medical Affairs.

The corrective action may include, without limitation, the restriction, suspension or termination of the Graduate Staff member’s clinical privileges. The corrective action shall be in writing and shall set forth the facts upon which it is based, and shall be forwarded to the Chair of the GME Committee.

Subsection 9.3.2 NOTICE. The Chair of the GME Committee shall ensure that a copy of the corrective action is mailed by overnight delivery service or personal delivery to the Graduate Staff member as soon as may be practicable under the circumstances. At the same time, the affected Graduate Staff member shall be advised of his or her right to request that a Graduate Staff Review Committee be formed to review the corrective action. Such request must be made in writing and shall set forth the facts upon which it is based, and shall be forwarded to the Chair of the GME Committee.

If the corrective action is a summary action, the meeting may be accelerated, upon the request of the Graduate Staff member, to take place on a date that is more than fifteen (15) days, but less than thirty (30) days from the date the Chairman of the Medical Board receives the request. Absent such a request by the Graduate Staff member, the corrective action will be implemented. The Graduate Staff member may submit a written statement of his or her position to the Graduate Staff Review Committee provided that the statement is received by the Committee not less than five (5) days prior to the date of the scheduled Committee meeting.
Subsection 9.3.3   GRADUATE STAFF REVIEW COMMITTEE. If requested, a Graduate Staff Review Committee shall be appointed by the Chairman of the Medical Board to review a corrective action made with respect to a Graduate Staff member. The Graduate Staff Review Committee shall consist of (i) the Chair of the GME Committee, or his or her designee, who shall Chair this Committee, (ii) an Attending physician who has not supervised the Graduate Staff member, and (iii) a member of the Graduate Staff. The Graduate Staff member shall be permitted to appear before the Committee provided that a written statement requesting such an appearance is received by the Committee not less than five (5) days prior to the date of the Committee meeting. Failure of the Graduate Staff member to appear shall be deemed a waiver of any such privilege at such meeting and during any subsequent proceedings under these By-Laws. No later than five (5) days prior to the scheduled meeting, the Graduate Staff member may request in writing to the Chair of the Committee that he or she be represented by legal counsel during his or her appearance before the Committee. If the Graduate Staff member is to be represented at the Committee meeting by legal counsel, the Department shall be represented by legal counsel as well. A record of the Committee meeting shall be made by such method as shall be determined by the Chair of the Graduate Staff Review Committee. The meeting shall not be considered to be a formal hearing and therefore shall not be subject to any formal rules of evidence or procedure. The introduction of any relevant information shall be determined by the Chair. In order to reverse the corrective action, the Graduate Staff member shall have the obligation to persuade the Committee that the corrective action lacks any factual basis or that is either arbitrary, unreasonable or not in compliance with applicable law.

Subsection 9.3.4   GRADUATE STAFF REVIEW COMMITTEE ACTION. The action the Graduate Staff Review Committee may take on the request for corrective action shall be in writing. The Committee may accept, reject or modify the request for corrective action, or take any other action that the Committee deems appropriate under the circumstances.

Subsection 9.3.5   NOTICE OF DECISION TO THE GRADUATE STAFF MEMBER. A copy of all Graduate Staff Review Committee decisions shall be given to the Graduate Staff member, the Medical Director/Vice President for Medical Affairs, the Program Director, the Department Director and the Medical Board within fifteen (15) days after the Committee's Report is written along with a statement of the reasons therefor.

Subsection 9.3.6   RIGHT OF APPEAL. Should the Graduate Staff Review Committee uphold the corrective action, the Graduate Staff member may request an appeal of the matter before the Dean and Chief Academic Officer. The request must be in writing and made within ten (10) days of the Graduate Staff member’s receipt of the decision of the Graduate Staff Review Committee. Upon receipt of the request for an appeal, the Dean and Chief Academic Officer will review the Graduate Staff member’s record, the basis of the request for corrective action and the Graduate Staff Review Committee’s Report and decision. The Dean and Chief Academic Officer may request and consider any additional information he deems necessary. Upon completion of his review, the Dean and Chief Academic Officer will notify the Graduate Staff member, the Department Director, the Medical Director/Vice President for Medical Affairs, the Program Director and the Medical Board of his decision in writing within ten (10) days of the issuance of his decision. The decision of the Dean and Chief Academic Officer will be final and binding upon all parties. Failure by the Graduate Staff member to make a request for an appeal
within the time frame set forth in this Paragraph will be deemed to be a waiver by the Graduate Staff member of any further appeal of this matter, and the decision of the Graduate Staff Review Committee shall be deemed conclusive and final.

Subsection 9.3.7 FINALITY OF ACTION. Decisions of the Dean and Chief Academic Officer shall be conclusive and final. There shall be no further Hospital proceedings.

Subsection 9.3.8 THE HOSPITAL’S BY-LAWS. Nothing contained herein shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the By-Laws of the Hospital or elsewhere in these By-Laws or the Rules and Regulations.

Section 9.4 WITHDRAWAL OF SUSPENSION.

A summary suspension may be withdrawn by the committee or person imposing the same at any time prior to a meeting of the Graduate Staff Review Committee.

Section 9.5 THE CORPORATION’S BY-LAWS.

Nothing contained herein shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the By-Laws of the Hospital or elsewhere in these By-Laws or the Rules and Regulations.

ARTICLE X
THE ALLIED HEALTH PROFESSIONAL STAFF

Section 10.1 NATURE OF ALLIED HEALTH PROFESSIONAL STAFF MEMBERSHIP

The Allied Health Professional Staff shall consist of the members of those allied health professions who hold an advanced degree and are registered and/or licensed and/or certified, as applicable, pursuant to the New York State Education Law. Such Allied Health Professional Staff may be authorized from time to time to practice their professions at the Hospital, including, but not limited to:

- psychologists,
- research scientists, as defined by the Medical Board,
- certified registered nurse anesthetists,
- physicians’ assistants,
- nurse practitioners,
- orthotists,
- prosthetists,
- audiologists,
- speech pathologists,
- Such individuals who are not involved in direct patient care activities, and others who may be accorded the ability to practice their profession at the Hospital, as defined by the Medical Board.
Allied Health Professional Staff members shall have their privileges reviewed every two years by the Board of Trustees, upon the recommendations of the Department Directors concerned, and the Medical Board following evaluation thereby of the qualifications of such practitioners and only after all required inquiries have been made. Members of the Allied Health Professional Staff shall have completed acceptable courses of education and training and shall possess such licenses and authorizations to practice their professions as the law may require. Members of the Allied Health Professional Staff shall be assigned to appropriate clinical Departments, and when required by regulation, law, JCAHO standards, or hospital policy shall practice only under the supervision and/or collaboration of a physician member of the Medical Staff designated in writing by the Department Director concerned or his or her designee. Each Department shall define in writing the duties and responsibilities of each category of Allied Health Professional performing patient care activities in that Department.

Section 10.2 CORRECTIVE ACTION FOR ALLIED HEALTH PROFESSIONAL STAFF MEMBERS

Subsection 10.2.1 REQUEST FOR CORRECTIVE ACTION. A request for corrective action may be made with regard to any member of the Allied Health Professional Staff whenever his or her conduct, condition, professional or otherwise, 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 character or competence of such Allied Health Professional Staff member; or results in disruption of Hospital operations. A request for corrective action also may be made with regard to any Allied Health Professional Staff member who fails to comply with any of these By-Laws, the Rules and Regulations, the Corporate By-Laws, or any rules, regulations or policies of the Board of Trustees. A request for corrective action may be made with regard to such Allied Health Professional Staff member to the Chairman of the Medical Board by the Director of the Department to which the Allied Health Professional Staff member is assigned, or by the Hospital’s Executive Director.

The request for corrective action may include, without limitation, a recommendation of the restriction, suspension or termination of the Allied Health Professional Staff member’s clinical privileges. Such request for corrective action shall be in writing and shall set forth the facts upon which it is based.

Subsection 10.2.2 NOTICE. The Chairman of the Medical Board shall ensure that a copy of such request for corrective action is mailed by overnight delivery service or personal delivery to the Allied Health Professional Staff member as soon as may be practicable under the circumstances. At the same time, the affected Allied Health Professional Staff member shall be advised of his or her right to appear before an Allied Health Professional Staff Review Committee meeting at which the request for corrective action will be presented for consideration, which shall not be less than fifteen (15) days following the date on which the notice thereof is mailed to the Allied Health Professional Staff member, and he or she requests that such Committee be formed. Absent such a request by the Allied Health Professional Staff member, the recommendation for corrective action will be implemented. The Allied Health Professional Staff member may submit a written statement of his or her position to the Allied Health...
Subsection 10.2.3 ALLIED HEALTH PROFESSIONAL STAFF REVIEW COMMITTEE. An Allied Health Professional Staff Review Committee shall be appointed by the Chairman of the Medical Board to review a request for corrective action made with respect to an Allied Health Professional Staff member. At the meeting of the Allied Health Professional Staff Review Committee, the Committee shall inquire into and take action on the request for corrective action. The Allied Health Professional Staff Review Committee shall consist of (i) the Hospital’s Medical Director/Vice President for Medical Affairs, who shall Chair this Committee, (ii) an Attending physician not a member of the Department to which the Allied Health Professional Staff member is assigned, and (iii) a member of the Allied Health Professional Staff from the same discipline. The Allied Health Professional Staff member shall be permitted to appear before the Committee prior to its taking any action provided that a written statement requesting such an appearance is received by the Committee not less than five (5) days prior to the date of the Committee meeting. Failure of the Allied Health Professional Staff member to appear shall be deemed a waiver of any such privilege at such meeting and during any subsequent proceedings under these By-Laws. Such proceedings may be adjourned, at the discretion of the Chair of the Committee, or they may be continued to a subsequent meeting if, in the judgment of the Chair of the Committee, adequate consideration cannot be given to the request for corrective action at one meeting or further information or evidence with respect to the Allied Health Professional Staff member needs to be obtained. No later than five (5) days prior to the scheduled meeting, the Allied Health Professional member may request in writing to the Chair of the Committee that he or she be represented by legal counsel during his or her appearance before the Committee. If the Allied Health Professional Staff member is to be represented at the Committee meeting by legal counsel, the Department shall be represented by legal counsel as well. A record of the committee meeting shall be made by such method as shall be determined by the Chair of the Allied Health Professional Review Committee. The proceedings shall not be subject to any formal rules of evidence or procedure, and the Chair may permit the presentation of witnesses and other evidence subject to such restrictions and limitations as he or she may impose. Rulings with respect to evidence and witnesses shall be made by the Chair.

Subsection 10.2.4 ALLIED HEALTH PROFESSIONAL STAFF REVIEW COMMITTEE ACTION. The action the Allied Health Professional Staff Review Committee may take on the request for corrective action shall be in writing and the Committee may accept, reject or modify the request for corrective action, or take any other action that the Committee deems appropriate under the circumstances.

Subsection 10.2.5 NOTICE OF DECISION TO THE ALLIED HEALTH PROFESSIONAL STAFF MEMBER. A copy of all Allied Health Professional Staff Review Committee decisions shall be given to the Allied Health Professional Staff member, the Department Director and the Medical Board within fifteen (15) days after the Committee’s Report is written along with a statement of the reasons therefor.
Subsection 10.2.6 RIGHT OF APPEAL. Should the Allied Health Professional Staff Review Committee uphold the recommendation of corrective action, the Allied Health Professional Staff member may request an appeal of the matter before the Executive Director, unless the Executive Director is the person recommending the corrective action. In that event, any appeal requested will be to the Medical Director. The request must be in writing and made within ten (10) days of the Allied Health Professional Staff member’s receipt of the decision of the Allied Health Professional Staff Review Committee. Upon receipt of the request for an appeal, the Executive Director will review the Allied Health Professional Staff member’s record, the basis of the request for corrective action and the Allied Health Professional Staff Review Committee’s Report and decision. The Executive Director may request and consider any additional information he deems necessary. Upon completion of his review, the Executive Director will notify the Allied Health Professional Staff member, the Department Director, the Medical Director and the Medical Board of his decision in writing within ten (10) days of the issuance of his decision. The decision of the Executive Director will be final and binding upon all parties. Failure by the Allied Health Professional Staff member to make a request for an appeal within the time frame set forth in this Paragraph will be deemed to be a waiver by the Allied Health Professional Staff member of any further appeal of this matter, and the decision of the Allied Health Professional Staff Review Committee shall be deemed conclusive and final.

Subsection 10.2.7 FINALITY OF ACTION. Decisions of the Executive Director shall be conclusive and final. There shall be no further Hospital proceedings.

Subsection 10.2.8 THE HOSPITAL’S BY-LAWS. Nothing contained herein shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the By-Laws of the Hospital or elsewhere in these By-Laws or the Rules and Regulations.

Section 10.3 SUMMARY SUSPENSION AND PROCEEDINGS

Subsection 10.3.1 SUMMARY SUSPENSION AND NOTICE. A Department Director or his or her designee, the Medical Director and the Executive Director of the Hospital each shall have the authority, whenever action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations to summarily suspend all or any portion of the appointment and/or privileges granted by the Hospital to a member of the Allied Health Professional Staff. Any member so suspended shall be given notice of such suspension, and the reason or reasons therefor, by overnight delivery service or personal delivery as promptly as shall be practicable under the circumstances. Any such suspension shall be effective immediately.

Subsection 10.3.2 REQUEST FOR CORRECTIVE ACTION, NOTICE AND ALLIED HEALTH STAFF REVIEW COMMITTEE PROCEEDINGS. Within three (3) days of the summary suspension, a written request for corrective action stating the facts upon which the Allied Health Staff member’s summary suspension was based shall be filed with the Chairman of the Medical Board by the person(s) directing the suspension and a copy given to the Allied Health Staff member by overnight delivery service or personal delivery. The Allied Health Staff Review Committee shall take action on the request for corrective action at a meeting held no less than five (5) days after a copy of the request for corrective action is mailed to the Allied Health Professional Staff member. The request must be in writing and made within ten (10) days of the Allied Health Professional Staff member’s receipt of the decision of the Allied Health Professional Staff Review Committee. Upon receipt of the request for an appeal, the Executive Director will review the Allied Health Professional Staff member’s record, the basis of the request for corrective action and the Allied Health Professional Staff Review Committee’s Report and decision. The Executive Director may request and consider any additional information he deems necessary. Upon completion of his review, the Executive Director will notify the Allied Health Professional Staff member, the Department Director, the Medical Director and the Medical Board of his decision in writing within ten (10) days of the issuance of his decision. The decision of the Executive Director will be final and binding upon all parties. Failure by the Allied Health Professional Staff member to make a request for an appeal within the time frame set forth in this Paragraph will be deemed to be a waiver by the Allied Health Professional Staff member of any further appeal of this matter, and the decision of the Allied Health Professional Staff Review Committee shall be deemed conclusive and final.
Health Staff member. The person(s) directing the suspension may supplement the request for corrective action by providing further information to the Allied Health Staff Review Committee within ten (10) days after the suspension and a copy of the additional information submitted to the Allied Health Staff Review Committee shall be given to the Allied Health Staff member by overnight delivery service or personal delivery prior to the Allied Health Staff Review Committee meeting. All further proceedings on the written request for corrective action and any supplemental information shall be in accordance with the provisions of Section 10.2 above. In the event that the proceedings before the Allied Health Staff Review Committee are adjourned in accordance with Subsection 10.2.3, upon the request of the Allied Health Staff member, the Allied Health Staff Review Committee shall consider the need for the immediacy of the Allied Health Staff member’s suspension at its initial meeting.

Subsection 10.3.3 WITHDRAWAL OF SUSPENSION. A summary suspension may be withdrawn by the committee or person imposing the same at any time prior to a meeting of the Allied Health Staff Review Committee.

Subsection 10.3.4 THE CORPORATION’S BY-LAWS. Nothing contained herein shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the By-Laws of the Hospital or elsewhere in these By-Laws or the Rules and Regulations.

ARTICLE XI
IMPAIRED MEMBERS OF THE MEDICAL STAFF, GRADUATE STAFF AND ALLIED HEALTH PROFESSIONAL STAFF

Section 11.1 INVESTIGATION OF POSSIBLE IMPAIRMENT

When the Director of a Department or the Medical Director/Vice President for Medical Affairs obtains information indicating that a member of the Medical Staff, Graduate Staff, or Allied Health Professional Staff in his or her Department has an impairment of physical or mental function that interferes, or is likely to interfere, with the Staff member’s ability to provide care for his patients or otherwise meet the standards set forth in these Bylaws and the Rules and Regulations, the Department Director and the Medical Director/Vice President for Medical Affairs shall promptly discuss with that practitioner the nature and cause of the perceived impairment. The Department Director or the Medical Director/Vice President for Medical Affairs shall refer the matter to the Medical Staff Health Committee of the Medical Board to determine the need for remedial action. The Medical Staff Health Committee shall report its recommendation back to the referring Director.

Section 11.2 REMEDIAL ACTION/VOLUNTARY REMEDIES

Remedies will depend upon the nature of the impairment, the nature of the practitioner’s responsibilities, the practitioner’s acknowledgment of the impairment and other relevant circumstances. Such remedies may include, without limitation, a leave of absence (if the Staff member is an employee, such leave may be paid or unpaid) in order for the practitioner to seek the necessary medical or psychiatric care and assistance, either
through existing programs of the Medical Society of the State of New York for impaired physicians and physician assistants, through other outside agencies authorized to participate in such activities, or through an alternative means of assistance which is satisfactory to the Medical Director/Vice President for Medical Affairs and Department Director. In addition to the foregoing, such remedies may include, without limitation, voluntary acceptance by the Medical Director/Vice President for Medical Affairs and Department Director of a reduction of the practitioner’s clinical privileges or voluntary resignation from the Medical, Graduate or Allied Health Professional Staff. It shall be within the discretion of the Department Director with the concurrence of the Medical Director/Vice President for Medical Affairs to take such remedial action as he or she deems necessary and appropriate in accordance with these Bylaws, including without limitation, the direct referral of a physician or physicians’ assistant to the Committee for Physician’s Health of the Medical Society of the State of New York, and as such committee exists for the benefit and assistance of practitioners, there shall be no procedural rights afforded to a practitioner as a result of any such referral.

Section 11.3 REQUEST FOR, OR SUMMARY CORRECTIVE ACTION

In the event that the affected practitioner fails to follow the recommendation of the Department Director under the preceding paragraphs to address the perceived impairment, or if, for any other reason, the Department Director or Medical Director/Vice President for Medical Affairs deems it necessary, proceedings may be commenced under and in accordance with Article V or IX of these Bylaws with respect to Medical Staff and Graduate Staff members respectively, or under and in accordance with the policies and procedures of the Article X with respect to Allied Health Professionals, including, without limitation, the summary suspension of clinical privileges.

Section 11.4 CONFIDENTIALITY

The discussions and investigations by the Department Director, the Medical Director/Vice President for Medical Affairs and the Medical Staff Health Committee with respect to the suspected impairment of a practitioner shall be deemed confidential. However, in the event that the practitioner exercises his or her procedural rights under these Bylaws, the Department Director and Medical/Vice President for Medical Affairs Director may disclose the content of the discussions and investigations to any person or committee with the authority to investigate, hear or review the matter under these Bylaws.

ARTICLE XII
MEDICAL STAFF OFFICERS AND MEETINGS

Section 12.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff, who shall be elected and appointed in accordance with this Article, shall be:

President
President-Elect

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Section 12.2 QUALIFICATIONS OF OFFICERS

The right to hold elective office on the Medical Staff shall be limited to those Medical Staff Members who have attained a minimum of three (3) years of continuous service in good standing on the Active Medical Staff of the Hospital and who, as determined by the Medical Board, shall use the Hospital as the primary hospital of their clinical practices. No member of the Active Medical Staff practicing in the Hospital shall be ineligible for election as an officer of the Medical Staff, or shall otherwise be ineligible for membership on the Medical Board, solely because of his or her professional discipline or specialty. All officers must remain members in good standing during their term of office and failure to maintain such status shall immediately create a vacancy in the office involved.

Section 12.3 NOMINATION, ELECTION AND TERM OF OFFICE OF OFFICERS OF THE MEDICAL STAFF

A. On or before March 31st in each hospital year, the Nominating Committee of the Medical Staff, which shall be comprised of the Medical Staff Officers, shall submit to the Secretary/Treasurer of the Medical Staff, who in turn shall circulate to the entire Medical Staff, the names of qualified nominees (together with background data on each such nominee) to fill the single yearly vacancy on the Medical Staff as indicated below. Additional nominations for such office may be made by the written petition of at least twenty-five (25) members of the Active Staff and filed not later than April 15th with the Secretary/Treasurer of the Medical Staff.

B. The Secretary/Treasurer shall post a ballot on the Medical Staff bulletin board by April 30th of each year, which ballot shall include the names and background data on the nominees of the Nominating Committee together with any nominees nominated for office by the petition of members of the Active Staff in accordance with the preceding subsection.

C. At the regular annual meeting of Medical Staff in May of each year, election to the office of Secretary/Treasurer shall be held and the results announced at the meeting of the Medical Staff. The election shall be by (i) closed ballot if there is more than one candidate, or (ii) a show of hands if there is only one candidate, and shall be by majority vote. If no candidate receives a majority vote cast on the first ballot, the two (2) candidates receiving the highest number of votes shall be balloted again and the candidate receiving the majority of the votes shall be declared elected.

D. The elected candidate shall serve on the Medical Staff for a total of four (4) consecutive years as follows:

- During the first year he or she shall serve as Secretary/Treasurer of the Medical Staff.
- During the second year he or she shall serve as President-Elect of the Medical Staff.
During the third year he or she shall serve as President of the Medical Staff.

During the fourth year he or she shall serve as Immediate Past President of the Medical Staff.

E. All Medical Staff Officers shall take office as of July 1st in each Hospital year.

In the event that any officer of the Medical Staff (other than the Immediate Past President) shall be or become unable to serve for any reason whatsoever, (including being recalled from office), or shall resign during the middle of his or her term, then the other Medical Staff Officers shall each advance in position to the next position. Then, pending the next scheduled meeting of the Medical Staff, the Medical Board shall elect by majority vote of its members a member of the Active Staff to that portion of the unexpired term of the then vacant position of Secretary/Treasurer of the Medical Staff which shall occur prior to the Medical Staff’s next regularly scheduled meeting. At the next scheduled Medical Staff meeting, the Medical Staff shall elect (pursuant to the above described procedures, excepting for the above identified months) an individual to fulfill the remaining portion of the unexpired term of the position of Secretary/Treasurer, or if the term has expired, a new individual to such office for a complete term.

Section 12.4 DUTIES AND RESPONSIBILITIES OF THE PRESIDENT OF THE MEDICAL STAFF

A. The President of the Medical Staff shall call and preside at all meetings of the Medical Staff.

B. He or she shall serve as the responsible representative of the Medical Staff to receive and interpret the policies of the Medical Board to the Staff.

C. He or she shall present the views, policies, needs and grievances of the Medical Staff to the Medical Board and to the Executive Director of the Hospital.

D. He or she shall be a member ex-officio of all committees of the Medical Staff.

E. He or she shall be a voting member of the Medical Board.

Section 12.5 DUTIES AND RESPONSIBILITIES OF THE PRESIDENT-ELECT OF THE MEDICAL STAFF

The President-Elect of the Medical Staff shall, in the absence of the President of the Medical Staff, assume all of his or her duties and authority. In addition, he or she shall perform such other duties as may be assigned by the President. The President-Elect shall be a voting member of the Medical Board.

Section 12.6 DUTIES AND RESPONSIBILITIES OF THE SECRETARY/TREASURER OF THE MEDICAL STAFF
A. The Secretary/Treasurer of the Medical Staff shall keep accurate and complete minutes of all Staff meetings and shall transmit signed copies thereof to the Executive Director of the Hospital.

B. The Secretary/Treasurer shall notify all officers of the Staff of their election and all members of Staff committees of their appointment and of the objectives for which the committees were created. The Secretary shall notify all members of each meeting called on the order of the President of the Medical Staff.

C. The Secretary/Treasurer shall preserve as part of the records of the Staff for reference or possible publication, all papers read before the Staff and the discussion thereof. He or she shall attend to all correspondence and submit to the Board of Trustees, and upon request, to any committee thereof, reports of the professional services rendered by the Staff.

D. The Secretary/Treasurer of the Medical Staff shall Chair its Finance Committee, which shall be comprised of the officers of the Medical Staff and two (2) at large members of the Medical Staff chosen by the Chairman of the Medical Board. Through the Secretary/Treasurer the Finance Committee shall (i) set the level of mandatory dues, (ii) oversee the collection of such dues, (iii) be the custodian of any Staff funds, (iv) keep an accurate account of any such funds entrusted to the Finance Committee, and (v) be accountable to the Medical Board and the Medical Staff for the expenditure of funds.

E. The Secretary/Treasurer shall perform such other duties as ordinarily pertain to the office of Secretary/Treasurer.

F. The Secretary/Treasurer shall be a voting member of the Performance Improvement Coordinating Group and the Medical Board.

Section 12.7 DUTIES AND RESPONSIBILITIES OF THE IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF

The Immediate Past President of the Medical Staff shall be a voting member of the Medical Board.

Section 12.8 RECALL OF OFFICERS OF THE MEDICAL STAFF

Failure of an officer of the Medical Staff to carry out to a substantial degree of the duties and responsibilities of his or her office, for a reason which does not result in such officer's ceasing to remain a member in good standing on the Active Medical Staff, shall subject such officer to recall from office at a Special Meeting of the Medical Staff. In the event of recall, the vacancy created thereby shall be filled in the manner provided for in Section 13.3 E. of this Article XII.

Section 12.9 MEETINGS OF THE MEDICAL STAFF

A. The Medical Staff shall hold its Annual Meeting in the month of May of each year.
B. Except as may be specifically provided otherwise in these Bylaws, fifty (50) voting member of the Medical Staff present at the meeting shall constitute a quorum for voting purposes at all meetings of the Medical Staff.

C. Each member of the Medical Staff shall be encouraged to attend all Meetings of the Medical Staff, the agendas of which shall be set by the President of the Medical Staff.

ARTICLE XIII
IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for appointment to the Medical Staff and/or clinical privileges at the Hospital and continuation of any such appointment and/or privileges.

A. Any act, communication, report, recommendation, or disclosure, with respect to any practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and/or maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

B. Such privilege shall extend to members of the Hospital's Medical Staff and the Board of Trustees, the Medical Board, the Hospital Administration, employees and agents of the Hospital, and to third parties, who supply information to any of the foregoing authorities to receive, release, or act upon the same. For the purpose of this Article XIII, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Medical Board or the Medical Staff.

C. To the fullest extent permitted by law, there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure.

D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's activities, including, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension and hearings thereon and any actions pursuant to Articles VIII, IX or X (4) medical care evaluations, (5) utilization reviews, and (6) other hospital, Department or committee activities related to quality patient care and professional conduct or other provisions of these By-Laws.

E. The acts, communications, reports, recommendations, and disclosures referred to in this Article XIII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might be relevant to the practitioner's appointment to the Medical Staff, his or her privileges, or patient care.
In furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases, waivers of liability, confidentiality statements or other documents in accordance with the tenor and import of this Article XIII, immunizing individuals and organizations specified in paragraph XIII B, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under federal, state and local statutes, rules and regulations.

ARTICLE XIV
RULES AND REGULATIONS & ASSOCIATED POLICIES

The Medical Board shall adopt such medical staff Rules and Regulations and associated medical staff policies as may be necessary for the proper conduct of the work of the Medical Staff. Such Rules and Regulations and associated policies may be amended at any regular meeting of the Medical Board without prior notice or any special meeting in accordance with these By-Laws. Amendments shall become effective when approved by the Board of Trustees.

ARTICLE XV
REVIEW AND AMENDMENTS

These By-Laws, the medical staff Rules and Regulations, and associated medical staff policies shall be reviewed at least once in each two-year period by the Medical Board to decide whether revision is appropriate to ensure that the By-Laws, the Rules and Regulations, and the associated policies reflect the Hospital’s current practices with respect to Medical Staff organization and functions and are consistent with applicable legal and other requirements. Proposed amendments to these By-Laws, the medical staff Rules and Regulations, and associated medical staff policies may be initiated by the Medical Board or the Board of Trustees. Amendments so initiated shall be effective when (i) approved by the Medical Board, by a majority vote at any regular or special meeting of the Medical Board, and (ii) approved by the Board of Trustees. The Board of Trustees may unilaterally amend these By-Laws, the medical staff Rules and Regulations, and associated medical staff policies, only if the amendment is necessary to conform them to applicable statutes, regulations, judicial decisions or to ensure compliance with JCAHO standards to maintain accreditation.

When the Medical Board proposes to amend or adopt medical staff By-Laws, medical staff Rules and Regulations and associated medical staff policies, 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 medical staff By-Law, medical staff Rule or Regulation or associated medical staff policy, it shall communicate such fact to the members of the Medical Staff.

In the event it becomes necessary for the hospital to urgently amend a Rule or Regulation of the Medical Staff, or an associated medical staff policy, in order to comply with any law or regulation, the Medical Board shall have the authority to provisionally adopt and the Board of Trustees may provisionally approve 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 XVI of these Bylaws shall be implemented.

The Credentialing Office shall ensure that all members of the Medical Staff are notified of amendments to these By-Laws, the medical staff Rules and Regulations and associated medical staff policies. Members of the Medical Staff shall keep informed of such amendments.

**ARTICLE XVI**

**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 By-Law, medical staff Rule and Regulation, or associated medical staff policy, or other significant matter under the purview of the Medical Board. A written petition to trigger the conflict management process signed by at least twenty-five (25) members of the Medical Staff shall be submitted to the President of the Medical Staff. The petition shall include (a) a clear statement of the reason for the conflict and the terms of any alternative By-Law, Rule and Regulation or associated policy, and (b) the designation of 3 members of the Medical Staff as selected by the petitioners to serve as the petitioners’ representatives.

Within one week after receipt of the petition, the President of the Medical Staff shall convene a meeting between the 3 petitioners’ representatives and 3 physician voting members of the Medical Board as selected by the Chair of the Medical Board.

The representatives of the Medical Board and the petitioners 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 petitioners’ representatives. If such a resolution proposes a medical staff By-Law, medical staff Rule and Regulation, or associated medical staff policy that has not been previously submitted to the Medical Staff, such resolution shall follow the process outlined in Article XV above.

If the parties’ representatives are unable to reach a resolution, they may, by mutual agreement, utilize the System Chief Medical Officer and/or other 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 Board of Trustees for its consideration in making a final decision with respect to the proposed medical staff By-Law, medical staff Rule and Regulation, or associated medical staff policy, or other matter. The Board of Trustees shall determine the method by which unresolved conflicts are submitted to the Board.
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 XVII**

**ADOPTION**

Subject to the provisions of the Hospital's By-Laws, these By-Laws of the Medical Staff shall become effective and shall replace any previous By-Laws of the Medical Staff after these shall have been adopted at a regular or special meeting of the Medical Board and approved by the Board of Trustees.

ADOPTED by the Medical Board with amendments on May 9th, 2014.

Chairman of the Medical Board

APPROVED by the Board of Trustees with amendments on June 19, 2014.

President & Chief Executive Officer
Plainview Hospital

Executive Director
Plainview Hospital
Assistant Secretary, Board of Trustees