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## **PREAMBLE**

The Mount Sinai South Nassau, (the “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’s mission is to improve the health of the communities it serves with a commitment to providing the highest quality of care; educating current and future healthcare professionals; searching for new advances in medicine through the conduct of research; promoting health education; and caring for the entire community regardless of ability to pay.

It is recognized that the Medical Staff of the Hospital shares responsibility for the quality of patient care at the Hospital and must accept and discharge that responsibility, subject to the ultimate authority of the Governing Body of the Hospital. The cooperative efforts of the Governing Body of the Hospital, the President/Chief Executive Officer (“CEO”) (or designee), 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 desire to organize themselves into a Medical Staff in conformity with these Medical Staff Bylaws, Rules, and Regulations.

## **DEFINITIONS**

1. **ALLIED HEALTH PRACTITIONER (AHP):** shall mean an individual whose patient care activities require that his or her authority to perform specified patient care services be processed through medical staff channels or with involvement with medical staff representatives. The term AHP shall be deemed to include psychologists, doctoral scientists, physician assistants, specialist assistants, nurse practitioners, certified registered nurse anesthetists, licensed nurse midwives and such other allied health practitioners as the Governing Body of the Hospital shall determine with the input of the Medical Board, who may be accorded specific practice privileges in the Hospital limited to their area of competence.
2. **CHIEF EXECUTIVE OFFICER (CEO)/PRESIDENT of the HOSPITAL:** shall mean the individual appointed by the Governing Body of the Hospital to act on its behalf in the overall operations and administrative management of the Hospital.
3. **CLINICAL PRIVILEGES:** shall mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services to patients of the Hospital.
4. **DIRECTOR OF GRADUATE MEDICAL EDUCATION:** shall mean the individual appointed by the CEO who is responsible for the educational programs of the Hospital with respect to its graduate medical staff and medical students.
5. **EMERGENCY:** as pertains to clinical privileges, shall mean a condition in which a delay in the administration of treatment might reasonably be expected to result in serious harm to a patient.
6. **EXECUTIVE CREDENTIALS COMMITTEE:** shall mean the Executive Credentials Committee of the Governing Body of the Hospital with the authority to act on all applicants presented for initial appointment and subsequent reappointment by the Medical Board.

This Committee shall be composed of at least two (2) members of the Governing Body of the Hospital, the President of the Medical Staff or designee, the Medical Director, the Chairman of the Credentials Committee of the Medical Staff, and the CEO/President of the Hospital.

7. GOOD STANDING: shall mean that the medical staff member has met the attendance and other requirements of the Medical Staff during the previous Medical Staff Year, is not in arrears in dues payment, and is not under a suspension of his or her appointment, admitting or clinical privileges.
8. GOVERNING BODY of the HOSPITAL: shall refer to the Board of Directors of the Hospital.
9. GRADUATE MEDICAL STAFF: shall mean residents who are graduates of approved or recognized schools of medicine, dentistry, osteopathy or podiatry who are eligible to practice in accordance with the provisions of the Education Law of the State of New York and the New York State Hospital Code.
10. HOSPITAL: shall mean all of the facilities, and programs operated by and entities under the jurisdiction and purview of the Governing Body of Mount Sinai South Nassau including inpatient, outpatient and community-based facilities and programs.
11. MEDICAL BOARD: shall mean the Executive Committee of the Medical Staff as further defined in Article IX of these Bylaws.
12. MEDICAL DIRECTOR: shall mean the Chief Medical Officer who is a physician member of the Medical Staff in Good Standing, and appointed by and accountable to the Governing Body of the Hospital, 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, Rules and Regulations, applicable state and Federal laws and regulations and standards of applicable accrediting organizations.
13. 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 Governing Body of the Hospital in accordance with these 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 the organized health care arrangement with the Hospital (as that term is defined in 45 CFR 164.501) when exercising their clinical privileges in the Hospital for purposes of the HIPAA Privacy Rule and security regulations and standards of applicable organizations.
14. MEDICAL STAFF CREDENTIALS COMMITTEE: In accordance with Article X, Section 11 of the Bylaws, the Medical Staff Credentials Committee shall, upon request of the Medical Board, be responsible for further investigating, evaluating and making recommendations to the Medical Board relative to an applicant's initial application or subsequent reapplication in conformity with these Bylaws.
15. MEDICAL STAFF OFFICE: the office which, among other things, receives applications for Medical Staff membership and clinical privileges from practitioners wishing to be

members of the Hospital's Medical and AHP Staff. The Medical Staff Office processes the applications, makes all appropriate inquiries, and forwards completed applications to the Chairs of the Clinical Departments, the Credentials Committee, and the Medical Board for their review and approval.

16. **MEDICAL STAFF YEAR:** as used in these Bylaws shall mean the period from June 1<sup>st</sup> to May 31<sup>st</sup> or such other twelve-month period of time that the Governing Body of the Hospital shall, from time to time, designate as its "medical staff year."
17. **PHYSICIAN:** shall mean an individual who has been awarded the degree of doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.) who is licensed to practice medicine in the State of New York.
18. **PRACTITIONER:** shall mean, unless otherwise expressly limited, any appropriately licensed physician, dentist, podiatrist, or Allied Health Practitioner applying for, or exercising, staff membership, and/or clinical privileges at the Hospital.
19. **QUALITY REVIEW COMMITTEE:** shall mean the Quality Assurance Committee of the Board of Directors, which, in accordance with the Hospital Bylaws, is responsible for oversight of the Hospital's quality assurance activities.

## **ARTICLE I**

### **NAME**

The name of this organization shall be the "MEDICAL STAFF OF MOUNT SINAI SOUTH NASSAU," hereinafter referred to as the "Medical Staff".

## **ARTICLE II**

### **PURPOSES**

Section 1.        The purposes of this organization shall be:

a.        To render care to all patients admitted to or treated in any of the facilities, Departments or services of the Hospital, care which is without discrimination as to race, color, religion, gender, national origin, disability, sexual orientation, age, their ability to pay, or source of payment.

b.        To provide medical education and maintain the highest 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.

c.        To establish and maintain programs review and improve the quality and efficiency of patient care, medical education, research and related training programs including providing 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 Governing Body of the

Hospital 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.

d. To promulgate and enforce rules and regulations for the proper self-government of the Medical Staff.

e. To provide a means whereby problems of a medical-administrative nature may be efficiently addressed.

f. To promote a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of privileges to practice in the Hospital and the regular review and evaluation of the activities and performance of all individuals granted clinical privileges in the Hospital.

g. To recommend to the Governing Body of the Hospital the limitation or suspension of the privileges of practitioners who do not practice in accordance with the scope of their privileges, Medical Staff Bylaws, and standards of performance in policies and procedures, and to assure that corrective measures are developed and put into place, when necessary.

h. To promote compliance with the Hospital's Code of Conduct and the ethical standards of the respective professions of staff appointees.

i. To ensure that the Medical Staff participates in the measurement, assessment, and improvement of patient care processes, including, but not limited to, education of patients and their families subject, however, to the patient's right of confidentiality.

j. To promote discussion of issues concerning the patients, the Medical Staff and the Hospital with the Governing Body of the Hospital and the CEO through authorized representatives and structures of the Medical Staff, such as the Medical Board.

k. To assist the Governing Body of the Hospital in identifying community public health needs and in setting appropriate organizational goals and implementing programs to meet those needs and goals.

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

### **ARTICLE III**

#### **MEDICAL STAFF MEMBERSHIP**

##### Section 1. Nature of Staff Membership

Membership on the Medical Staff of the Hospital is limited to physicians, dentists, and podiatrists who have a current, unrestricted license and registration to practice medicine, dentistry, or podiatry, as applicable, in the State of New York. Membership is a privilege, which shall be extended only to those practitioners who meet and continue to meet the qualifications, standards, and requirements set forth in these Bylaws, Rules, and Regulations. In making decisions regarding the granting or denying of privileges and/or appointment to the Medical Staff, only criteria related

to the delivery of quality and efficient patient care in the Hospital, the applicant's professional qualifications and clinical competency, the Hospital's objectives, purposes, needs, resources and capabilities, and community need shall be used. Appointments and reappointments to the Medical Staff shall be made by the Governing Body of the Hospital following recommendation by the Medical Board as provided in these Bylaws, Rules, and Regulations.

Practitioners from outside organ procurement organizations designated by the Secretary of the United States Department of Health and Human Services, engaged solely at the Hospital in the harvesting of tissues and/or other body parts for transplantation, therapy, research or education purposes, pursuant to the Federal Anatomical Gift Act and the requirements of Section 405.25 of the Hospital Code, shall be exempt from the requirement to obtain medical staff membership or privileges.

## Section 2. Qualifications

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

1. Be practitioners who can demonstrate acceptable levels and quality of education and who have graduated from approved educational institutions;
2. Possess unrestricted and duly registered licenses to practice their respective professions in the State of New York, except in the case of practitioners granted Emeritus Staff membership, where current registration may be waived, or unless granted a specific waiver by the Department Chair approved by the Medical Board, and the Governing Body of the Hospital in the case of a practitioner with a limited license, as allowed by law;
3. With the exception of members of the Consulting Staff and Emeritus Staff as herein defined, practice his/her medical, dental or podiatric profession in or within a reasonable geographic area of the Hospital as defined by the Governing Body of the Hospital and maintained in the Administrative offices unless excepted by the Chairperson of the Department, and approved by the Medical Board and the Governing Body of the Hospital; and
4. Comply fully with the application process for staff membership and clinical privileges.

b. All Medical Staff applicants must satisfy all the responsibilities as set forth more specifically in Section 8 of this Article.

c. All members of the Medical Staff shall participate in relevant programs of continuing medical education as required by the appropriate Department Chair and complete CME credits as delineated in the Medical Staff Rules and Regulations or Hospital Policies during the initial two-year appointment and each subsequent reappointment period. Such participation must be documented in the member's Medical Staff credentials file. In specific cases, the Department Chairperson may request that the Governing Body of the Hospital extend the time to fulfill the CME credits requirement in extenuating circumstances.

d. Applicants must provide evidence of satisfactory physical and mental status as evidenced by a certificate signed by the practitioner's physician, which certificate shall specifically certify that the practitioner is free from or exercises control over any significant physical or behavioral impairment which, if not controlled, could present the possibility of interfering with the practitioner's performance of his duties and responsibilities.

e. Applicants must provide certification or other evidence of currently effective professional liability insurance, which is satisfactory to the Governing Body of the Hospital. Such certification of coverage shall require that the Hospital receive satisfactory notice of any reduction in, termination of, or failure to renew such insurance coverage. The Governing Body Hospital may, from time to time, establish minimum required limits of coverage, or types of coverage, which may vary according to the clinical privileges granted.

f. Board certification or board eligibility, as defined by requirements set forth by the specialty board in each practitioner's field of medicine, surgery, and specialty or subspecialty thereof, will also be considered, unless such consideration is waived by the Medical Board. Those individuals not board certified at the time of the application to the Medical Staff shall be expected to proceed diligently to obtain board certification. It will be expected that those individuals will sit for their boards at the next eligible time that these boards are given. Failure to pursue board certification, according to these guidelines, will be taken into consideration when the applicant comes up for bi-annual reappointment.

g. The "Code of Medical Ethics" of the American Medical Association shall govern the professional conduct of the members of the Medical Staff. Specifically, all members of the Medical Staff shall pledge that they shall not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services and that all fees shall be collected and retained by the individual physician in accordance with the value of the services rendered. In group or partnership practice, the division of fees will be in accordance with methods approved by the American Medical Association.

h. All members of the Medical Staff shall pledge themselves to maintain the standards and meet the requirements necessary to warrant, at all times, full accreditation of the Hospital by The Joint Commission and any applicable post-graduate professional training review or certifying boards/agencies, and for the Hospital to maintain licensure by the New York State Department of Health and Office of Mental Hygiene, as applicable.

i. No practitioner shall be automatically entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges merely because he/she is licensed to practice in this or in any other states or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she is a member of the faculty of a medical school, or because he/she had, or presently has, staff membership or privileges at another health care facility or in another practice setting; nor is any practitioner automatically entitled to appointment, reappointment, or particular privileges merely because he/she had or presently has staff membership or those particular privileges at this Hospital.

j. No practitioner shall be denied Medical Staff membership and/or clinical privileges on the basis of sex, race, creed, color and national origin, sexual orientation, or on the basis of any

other criteria lacking professional or legal justification, with the exception of ethical and moral qualifications.

Failure to satisfy the qualifications and/or requirements of Medical Staff membership shall be just cause for denial of Hospital privileges or revocation of privileges previously granted.

### Section 3. Allied Health Practitioners

Allied Health Practitioners (“AHP”) shall not be deemed eligible for Medical Staff membership. They shall, however, be subject in all respects to these Medical Staff Bylaws, Rules and Regulations and the Bylaws, Rules and Regulations of the Hospital, and shall carry out their professional activities in the Hospital subject to appropriate Departmental rules, regulations, policies and procedures as permitted by law. AHPs are required to pay dues, unless such requirement is specifically waived by the Medical Board.

AHPs shall be credentialed and reappointed in accordance with Medical Staff credentialing and reappointment processes set forth in Sections 6 and 7 of this Article to the extent appropriate. Wherever, in Sections 6 and 7 licensure is required, but not applicable to the particular category of AHP because licensure is not offered in New York, the AHP shall be required to maintain any certifications, registrations or other documentation that is mandatory in order to practice the profession in the State of New York.

AHPs may exercise privileges as are specifically granted to them in accordance with the New York State Education Department requirements and consistent with any limitations stated in these Bylaws of the Medical Staff or Hospital Rules and Regulations or policies. They are under the supervision of the Medical Staff as outlined in their specific delineation of privilege forms.

AHPs shall not be eligible to admit patients to the Hospital, vote on Medical Staff matters or hold any Medical Staff office.

### Section 4. Clinical Privileges

a. Every practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical and admission privileges specifically granted to him/her by the Governing Body of the Hospital at the specific site for which such privileges are granted.

b. Clinical privileges for each member of the Medical staff shall be delineated in writing at the time of appointment and each reappointment, in accordance with the procedure recommended by the Medical Board and approved by the Governing Body of the Hospital for the Clinical Department concerned, and shall be based on consideration of the practitioner’s delivery of quality and efficient patient care in the Hospital; patient welfare; the applicant’s professional qualifications, character, competence, and clinical performance (and sufficiency, scope and nature of quality assurance data or information to evaluate these areas); the Hospital’s objectives, purposes, needs, capabilities and resources; and community need, and such other relevant information as recommended by the Medical Board and approved by the Governing Body of the Hospital.

Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated competence, references which will include verification of medical license, DEA registration, medical school or other professional school attendance and National Practitioner Data Bank review. Applicants will also have an

appraisal by the Department in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. The Chairperson of the Department (or designee) shall supervise the provisional appointee for such length of time, as the Chairperson may, in his/her discretion, deem necessary.

c. Practitioners will be required to undergo focused professional peer evaluation (“FPPE”) upon an initial request for a privilege(s) and whenever events occur that warrant such FPPE in accordance with the policy titled “Physician and Allied Health Staff Competency Assessment” appended hereto.

d. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, information provided by Medical Staff members, review of the records of patients treated in this or other hospitals and review of the records of committees’ evaluation of the member’s participation in the delivery of medical care. Any modifications of appointment or clinical privileges shall be for the period of time remaining in the appointment current at the date of such modification. When a Medical Staff member requests addition of new privileges at a time other than initial appointment or reappointment, the Medical Staff Office will verify the license by primary source and query the National Practitioner Data Bank (NPDB) before the new privileges are granted.

e. Privileges granted to dentists and podiatrists shall be in accordance with the provisions set forth in this Article. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of Surgery; podiatrists shall be under the overall supervision of the Section Chief of Orthopedics. All dental and podiatry patients prior to surgery shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. All dental and podiatry surgical patients should have a dental or podiatric surgical history and physical on the chart in addition to the patient’s medical history and physical. A podiatrist on the medical staff may complete an H&P for their patient undergoing an ambulatory surgical procedure.

f. Privileges to perform a History and Physical (H&P)

1. Unless otherwise provided below, a complete H&P is required for all patients admitted or in observation status to the Hospital within 24 hours after admission and prior to any invasive or operative procedures.
2. A complete H&P must be performed no more than 30 days prior to admission then signed and updated prior to the patient entering the procedure room. A H&P that has been documented more than 30 days prior to the procedure does not meet the requirement as a current H&P and cannot be updated with an interval note. A new H&P is required. The only exception is during an emergency where there is documentation by the practitioner and a second physician that such a delay could lead to death or serious disability for the patient.

3. Prior to an operative or invasive procedure performed on an ambulatory basis, a directed H&P including the provisional diagnosis and indications for surgery must be performed within 30 days of the procedure. The H&P must be reviewed and updated as necessary with an interval note recording the changes or documenting that there is no change prior to the patient entering the procedure room. A H&P that has been documented more than 30 days prior to the procedure does not meet the requirement for a current H&P and cannot be updated with an interval note. A new H&P is required.
4. For outpatient procedures a directed H&P must be performed within 30 days of the procedure for patients undergoing procedures that put the patient at moderate risk. Moderate risk includes patients who present with co-morbid conditions that might increase their risk for complications, or procedures requiring sedation. The H&P must be reviewed and updated as necessary with an interval note recording the changes or documenting that there is no change, prior to the patient entering the procedure room. A H&P that has been documented more than 30 days prior to the procedure does not meet the requirement for a current H&P and cannot be updated with an interval note. A new H&P is required. Procedures that put the patient at minimal risk do not require a H&P but require a pre-procedure assessment note by the physician, including an assessment of medications, and other pertinent data prior to the procedure. Usually, these procedures are conducted in off-site locations and use only local anesthesia.
5. When an in-patient is discharged from an acute care stay and directly admitted to inpatient hospice or inpatient behavioral health, the original history and physical, if completed within 30 days, may be used for the hospice or psychiatric admission. The admitting practitioner for the hospice or behavioral health admission shall write an admission progress note and indicate any changes and/or “no-change”. If the original history and physical is more than 30 days old, a new history and physical must be completed.
6. When a patient is having a “staged procedure” with multiple admissions (e.g., bilateral cataracts, epidural injections/pain management procedures) the original H&P may be used for each admission and up-dated with an interval note provided the original H&P is not more than 30 days old. If the original H&P is more than 30 days old or there is a major change in the patient’s health status or medications since the previous H&P, a new H&P is required.
7. Only a member of the medical staff who is granted clinical privileges to perform an H&P may do so, except that that such responsibility may be delegated to an appropriately credential practitioner or resident as outlined below. Allied Health Practitioners may perform a H&P if granted clinical privileges to do so. H&Ps performed by Allied Health Practitioners must be countersigned by an appropriately privileged Medical Staff member within 24 hours, if required by applicable law. A resident may perform an

H&P under a Medical Staff member's supervision. This supervision will include reviewing and correcting medical record entries, when appropriate, and countersigning the H&P within 24 hours. An admission note by the Attending Medical Staff member is also required. A H&P may be completed by a physician who is not on the medical staff only for ambulatory surgery or procedures, provided that the physician is licensed to practice medicine in the State of New York. In such cases, the physician on staff of Mount Sinai South Nassau performing the surgery or procedures must:

- i. Review the H&P.
  - ii. Confirm the information and findings, updating any information and findings, as necessary.
  - iii. Sign and date the H&P as an attestation to its being current.
8. Additional details regarding the requirements for H&Ps may be included in the Rules and Regulations or policy approved by the Medical Board, as necessary to comply with applicable law, regulations, or accreditation standard.

g. Practitioners providing telemedicine services (referred to in this Section as "Telemedicine Practitioners") are not members of the Medical Staff unless specifically approved for Medical Staff membership by the Governing Body. Nevertheless, all Telemedicine Practitioners must have and maintain the qualifications listed in Section 2 of this Article, have their credentials reviewed by the Medical Board, and be granted privileges, by the Governing Body initially and at least every two years thereafter. To the extent permitted by law and accreditation standards, certain aspects of the credentialing process (e.g., collection of information, primary source verification) may be delegated to an outside entity, provided an agreement is put into place regarding the extent of such services and the Governing Body retains the responsibility for granting clinical privileges.

#### Section 5. Term of Appointment

The Governing Body of the Hospital shall grant appointments to the Medical Staff for a two-year period. Initial appointment to the Medical Staff, except for Courtesy and Consulting Medical Staff members, shall be provisional for a period of one (1) year. At the end of the one-year period, provisional members shall be presented to the Medical Board by the Department Chairperson to which he/she had been assigned with a recommendation to promote to regular staff membership, extend the provisional status (once only) for up to one year, or terminate the provisional status and privileges. The Medical Board shall consider the recommendation of the Department Chairperson along with the needs, objectives and resources of the Hospital and the qualification, competence and clinical performance of the provisional member (including the sufficiency, scope, and nature of quality assurance data or information to evaluate these areas) and recommend promoting the applicant to regular staff membership, extend the provisional status (once only) for up to one (1) year, or terminate the provisional status.

Termination of the medical staff appointment for employed or contracted Medical Staff members

shall be governed by Article V Section 9 in these Medical Staff Bylaws.

Section 6. Procedure for Appointment

a. Individuals who wish to request an application for appointment shall first be required to submit preliminary information as required by the Medical Staff to the Medical Staff Office or applicable Department. After receipt and evaluation of such information by the Chairperson of the Department in which privileges are requested, the Chairperson shall respond to the request in a manner consistent with the needs of the Hospital and the community as the Governing Body of the Hospital may define. Each application for membership on the Medical Staff will follow the procedure for appointments as set forth by the Hospital. The Chairperson will make a recommendation regarding the extent and site of clinical privileges to be approved.

b. A written application for membership on the Medical Staff shall be made in accordance with the provisions of Section 2805(k) of the Public Health Law, Section 405.6(b)(7) of the Hospital Code and The Joint Commission standards, and shall be made on the appropriate form to be supplied by the Hospital. Submission of an application for an appointment to the Medical Staff shall signify that the applicant:

1. is willing to comply with the application process, including, but not limited to, appearing for an interview, if necessary;
2. has received, read, and agrees to be bound by the rules and regulations of the Hospital and these Bylaws, Rules and Regulations of the Medical Staff;
3. authorizes and consents to the Hospital's inquiry into the applicant's training, experience, competence, character, ethical qualifications, health status and the Hospital's inspection of records relating thereto and waives confidentiality as to all information provided; and
4. affirms that the information provided by the applicant is complete, true, and accurate.
5. releases from any liability the Board of Directors and Medical Staff representatives for acts which have been performed in good faith and without malice in connection with evaluating the applicant's credentials.
6. releases from all liability, all individuals and all organizations who provide information including otherwise privileged or confidential information to Hospital or Medical Staff representatives in good faith and without malice concerning the applicant's ability, credentials, character, physical and mental health, and any other qualifications relevant to staff appointment.

c. The applicant shall have the burden of producing adequate information for proper evaluation of his/her competence, character, ethics, physical and mental ability, and other qualifications, and for resolving any doubts about such qualifications.

d. Upon receipt of a completed application, the Medical Staff Office shall process the application and verify the accuracy and completeness of the information provided in the

application. Primary source verification shall be performed by the Medical Staff Office of the applicant's medical education, including residency and fellowship training, license, malpractice history, Medicare/Medicaid provider status, DEA registration, and National Practitioner Data Bank information. A valid picture ID issued by a state, federal or other regulatory agency will be requested at the time of application to ensure that the individual requesting approval is the same individual identified in the credentialing documentation.

e. The appropriate Chairperson of the Department in which privileges are sought, shall arrange for an interview with the applicant for the purpose of assessing the competence of the applicant, and shall make his/her recommendations and findings, including the specific privileges to be conferred on the applicant together with any limitations thereon and the site of such privileges, to the Medical Board . The initial responsibility of recommendation as to delineation of privileges of the applicant shall be that of the Chairperson of the Department, and where applicable, the Director of the Division or Chief of the Section within the Department in which privileges are sought.

f. The Medical Board, upon receipt of the Department Chairperson's recommendation, shall consider the application during its next regularly scheduled meeting. The Medical Board shall consider standards of patient care, patient's welfare, the objectives of the Hospital, and the character, qualifications, and competency of the applicant. Objectives of the Hospital shall include but not be limited to the availability of health care professionals on the Medical Staff sufficient to serve the current or foreseeable needs of the Hospital's patients, and the availability of sufficient Hospital facilities, resources and support services to accommodate the clinical privileges requested by an applicant and/or currently held by the Medical Staff members. This provision shall not be interpreted so as to restrict the expansion of existing professional practices of members of the Medical Staff. The Medical Board may recommend approving or disapproving the application, refer the application to the Medical Staff Credentials Committee for further review or defer for future Medical Board action. A Medical Board recommendation to approve the application shall be submitted to the Executive Credentials Committee (or in the case of reappointments to the Quality Review Committee for its action at its next regularly scheduled meeting. A Medical Board recommendation to deny an application shall be forwarded to the Governing Body for its action at its next regularly scheduled meeting. A decision by the Medical Board to refer the application to the Medical Staff Credentials Committee, or to defer it, shall require reconsideration of the application by the Medical Staff Credentials Committee and/or the Medical Board at the relevant committee's next consecutive meeting, as appropriate.

g. The Hospital will use an expedited review process for the granting or renewal of privileges provided there is a complete application that has received favorable recommendation from the Medical Board and, unless otherwise determined by the Medical Board, there is no evidence of any of the following with respect to the applicant:

1. a current challenge or a previously successful challenge to licensure or registration
2. an involuntary termination of Medical Staff membership at another organization
3. an involuntary limitation, reduction, denial, or loss of clinical privileges

4. an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant

When the expedited review process is to be used, for initial application(s), the Medical Board recommendation(s) will be forwarded to the Executive Credentials Committee. The Executive Credentials Committee may approve the application, recommend to the Governing Body that the application be denied in whole or in part or refer the application back to the Medical Board for further review. Any approval granted by the Executive Credentials Committee shall be effective immediately and, shall be presented at the next scheduled meeting of the Governing Body. Any adverse recommendation made by this committee regarding an applicant is not considered to be effective until it is ratified by the Governing Body. A decision by the Executive Credentials Committee to refer the application to the Medical Board shall require reconsideration of the application by the Medical Board at its next consecutive meeting, as appropriate.

When the expedited review process is to be used, for reappointments, the Medical Board recommendation(s) will be forwarded to the Quality Review Committee which is composed of at least two Governing Body members, in addition to other individuals. The Quality Review Committee may approve the application, recommend to the Governing Body that the application be denied in whole or in part or refer the application back to the Medical Board for further review. Any approval granted by the Quality Review Committee shall be effective immediately and, shall be presented at the next scheduled meeting of the Governing Body. Any adverse recommendation made by this committee regarding an applicant is not considered to be effective until it is ratified by the Governing Body, except that a practitioner may be terminated by the Quality Review Committee for failure to provide sufficient services at the Hospital to allow for an evaluation of competency. Such termination may only occur if the Medical Staff member or Allied Health Professional has been notified at least six (6) months prior to his/her reappointment regarding lack of activity. Such termination is administrative and does not give the applicant the right to the procedural rights provided in Article V of these Medical Staff Bylaws. A decision by the Quality Review Committee to refer the application to the Medical Board shall require reconsideration of the application by the Medical Board at its next consecutive meeting, as appropriate.

h. If it is determined that the application does not meet the criteria for expedited credentialing process described above or the Executive Credentialing Committee or Quality Review Committee makes a negative recommendation, the Governing Body, upon receipt of the Medical Board's written recommendation, shall consider the application during its next regularly scheduled meeting and either make a determination on the application, refer it back to the Executive Credentials Committee or the Quality Review Committee, as appropriate, or defer it for further consideration. A recommendation to refer the application back to the Executive Credentials Committee or Quality Review Committee/Performance Improvement or to defer it shall require reconsideration of the application by the Governing Body or by the Executive Credentials Committee or Quality Review Committee, at the relevant committee's next consecutive meeting as appropriate.

i. Whenever the proposed decision of the Governing Body of the Hospital is contrary to the recommendation of the Medical Board, the Governing Body of the Hospital shall submit the matter to the Joint Conference Committee which shall convene and submit its recommendation to the Governing Body of the Hospital at its next regular meeting, but no more than thirty (30) days after receipt of the matter. The Joint Conference Committee is a committee of the Governing Body

of the Hospital as set forth in the Hospital's Corporate Bylaws. The Governing Body of the Hospital shall take action on the matter at its next regular meeting following receipt of the Joint Conference Committee recommendation, and such action shall constitute its decision. If affirmative, the applicant shall be informed as hereinafter provided.

j. If the action of the Governing Body of the Hospital is contrary to the applicant's request, the CEO shall promptly, but not greater than ten (10) days, so inform the applicant by certified mail, return receipt requested or overnight courier mail with return receipt.

k. If the decision of the Governing Body of the Hospital is favorable to the applicant, the CEO shall notify the applicant within ten (10) days by certified mail, return receipt requested, or overnight courier with return receipt, and shall notify the Department Chair and the Medical Board. A decision and notice to appoint shall contain the staff category to which the applicant is appointed and the Department and Section, if applicable, to which he/she is assigned and the delineation and site of privileges, including the inpatient and outpatient facilities of the Hospital.

l. Unless otherwise contained herein, completed applications must be acted on within ninety (90) days. To the extent that completed applications cannot be acted on within such time frame, the applicant must be notified of the basis for the delay and informed of the timeframe in which a final determination will be made, which shall not be greater than ninety (90) days from the date of the notice, unless mutually agreed in writing by the applicant and the Hospital or unless the fair hearing procedures contained in Article V of these Medical Staff Bylaws have been initiated.

m. A complete file of each applicant for initial appointment and reappointment, together with all documentary evidence, shall be maintained at the Medical Staff Office of the Hospital. Each file so retained shall be available at all times to the Department Chairpersons and the Quality Review Committee which is charged with the responsibility of overseeing and coordinating the maintenance of a file on each member of the staff. Any other Hospital committee considering the qualifications or conduct of a medical staff member, may review the Medical Staff Member's file with the approval of the Medical Board and after the Medical Staff Member has been notified.

n. The Hospital shall provide these Bylaws, Rules, and Regulations of the Medical Staff to all applicants to the Medical Staff and all Medical Staff Members who have been appointed to the Medical Staff and to Allied Health Practitioners granted clinical privileges. The Hospital will provide to such practitioners significant revisions to these Bylaws, Rules and Regulations of the Medical Staff, if any. All practitioners shall be responsible for keeping informed of such revisions.

#### Section 7. Reappointment Process

a. Prior to the expiration of his/her then current Medical Staff Membership, each Medical Staff Member shall, upon notice from the Medical Staff Office, submit to the Medical Staff Office a completed and signed reappointment application within the timeframe set forth in such notice. The application shall evidence such Medical Staff member's fitness for reappointment to the Medical Staff and retention of clinical privileges, and his or her compliance with the Hospital's Corporate Bylaws, these Medical Staff Bylaws, Rules and Regulations and

Hospital and Department policies and procedures. The application for reappointment shall include all information necessary to update and evaluate the qualifications of the applicant and shall contain the Medical Staff member's waiver of confidentiality as to all information provided. The application for reappointment shall also contain an affirmation by the applicant that the information provided is complete, true, and accurate. After receiving reasonable notice of the requirement to do so, failure of any such Medical Staff member to submit all of the required information in a timely fashion as prescribed by the Medical Staff Office, 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.

b. The completed application for reappointment shall be processed and verified by the Medical Staff Office except with respect to verification of education and training which had previously been completed. The information from all hospitals and other healthcare facilities or organizations with which the practitioner has been associated during at least the last five (5) years will be updated. Peer recommendations regarding the applicant may be obtained and evaluated where deemed necessary or appropriate by the Medical Staff Office or Quality Review Committee. Such peer recommendations shall address the applicant's medical clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, and professionalism.

c. All categories of the existing Medical Staff shall be reviewed for reappointment every two (2) years (or earlier as deemed necessary by the Chairperson of each respective Department concerning leave of absence requests), in conjunction and cooperation with the Quality Review Committee. The reappraisal and recommendation will be based on a review of the (1) ongoing monitoring of the practitioner's professional performance, judgment, and clinical/technical skills; (2) current mental and physical health status of the individual; (3) continuing education effort; (4) current licensure; (5) current competence to perform clinical privileges requested; (6) relevant training and experience; (7) maintenance of accurate, timely and complete medical records; (8) attendance at required Staff and Department meetings, service on Staff committees, teaching activities, participation in the education and supervision of Graduate Medical Staff as required by the Department; (9) performance of assigned Emergency Department on-call services; and (10) practitioner's record, including findings of any quality assurance and performance improvement program data and medical malpractice history, past professional performance and practice, use of the Hospital's facilities for his/her patients, and relations with other members of the Medical Staff, personnel and general attitude towards patients, the Hospital, Hospital Administration and the public. Each Chairperson will then submit to the Medical Board his/her written recommendations in regard to reappointment, non-reappointment, or change in staff category or rank of each member of his/her Department together with delineation and site of privileges and a note as to retention, extension, diminution or withdrawal of privileges, if applicable. The Chairpersons will supply specific information regarding the criteria used in making their recommendations for or against reappointment.

d. The Medical Board will review recommendations from the Chairpersons and, if the recommendation is favorable, submit its recommendation to the Quality Review Committee or the Governing Body, as applicable. If the recommendation of the Medical Board is unfavorable, the applicable practitioner will be notified by the CEO of his/her procedural rights as provided in Article V of these Medical Staff Bylaws.

e. In accordance with the expedited credentialing requirements in Section 6 of this Article, when the recommendation of the Quality Review Committee is favorable, the CEO will notify the practitioner of the determination within ten (10) days. If the recommendation of the Quality Review Committee is unfavorable, it will notify the Governing Body of this adverse recommendation, except that a practitioner may be terminated by the Quality Review Committee for failure to provide sufficient services at the Hospital to allow for an evaluation of competency. Such termination may only occur if the Medical Staff member has been notified at least six (6) months prior regarding the lack of activity and does not give the applicant access to the procedural rights provided in Article V of these Medical Staff Bylaws. If the recommendation of the Governing Body continues to be adverse to the practitioner and based upon professional competence and conduct relating to quality of care or services, the applicable practitioner shall be entitled to the procedural rights as provided in Article V of the Medical Staff Bylaws. If the Governing Body makes a positive determination, it will be considered to be final and the CEO will notify the practitioner of the determination within ten (10) days.

f. In the event that the operation of Article V, or such other good cause, prevents final action of the Governing Body of the Hospital on a specific reappointment application prior to the expiration of the current appointment period, the Governing Body of the Hospital shall reappoint the affected applicant for such lesser period or periods of time as will permit the Governing Body of the Hospital to dispose of all questions concerning the applicant's entitlement to reappointment, and to permit it to make a final determination with respect thereto. During this interval, the practitioner shall remain subject to the Bylaws, Rules and Regulations of the Medical Staff.

g. To the extent that reappointment decisions are based upon other than a practitioner's quality of care and/or professional competence, the Hospital will evaluate the impact that such decisions have on the quality of care, treatment and services at the Hospital.

h. Ongoing evaluation of the professional practice of all Medical Staff members shall be performed in between reappointments, in accordance with the Policy titled "Physician and Allied Health Staff Competency Assessment", appended hereto. This ongoing evaluation is integrated into the Hospital's and Medical Staff's performance improvement activities and is used to identify professional practice trends that impact on quality of care and patient safety. If such ongoing evaluation raises uncertainty regarding Practitioner's professional performance such that corrective action is warranted, the corrective action can be taken in accordance with Article IV of these Medical Staff Bylaws.

## Section 8. Responsibilities of Medical Staff Members

The ongoing responsibilities of each Medical Staff member throughout the term of membership shall include the following:

a. Rendering the highest quality professional care fully consistent with prevailing community standards of medical practice and conduct in his or her specialty, sub-specialty, or area of practice.

b. Caring for patients at the Hospital regardless of their race, color, creed, religion, gender, sexual orientation, age, marital status, national origin, or the ability to pay for such care.

Medical Staff members may not refuse to care for patients in the Hospital based on the patient's type of or lack of health insurance.

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

d. Providing continuous care for his or her patients, except that a Medical Staff member may inform a patient that he or she refuses to give advice with respect to or participate in any induced termination of pregnancy, in which case another member of the Medical Staff will be recommended to the patient to give such advice by the practitioner or the appropriate Department Chairperson.

e. Protecting the privacy, confidentiality, and security of patient information in accordance with the Hospital's Notice of Privacy Practices. In the event that the Hospital utilizes electronic or computer transmissions and authentications of medical record entries, orders, and/or other patient specific records, complying with Hospital policies to ensure appropriate and confidential use of such electronic transmissions and authentications by appropriate Hospital personnel.

f. Continuously meeting all performance standards promulgated by the Department Chairperson.

g. Attending Department meetings and participating in committees as assigned, and in continuing education activities according to Department guidelines.

h. Cooperating fully and with sustained interest in the overall functions and activities of the Hospital.

i. Fulfilling responsibility for timely and efficient services to the Outpatient/Emergency Department and other areas of the Hospital as assigned from time to time in accordance with the Rules and Regulations of the Medical Staff and applicable law.

j. Abiding by (i) all federal, state and local laws, rules and regulations including refraining from receiving or paying any fee or rebating a portion of a fee, or receiving or giving any other inducements or remuneration in exchange for patient referrals; (ii) the ethical standards of the practitioner's profession; (iii) these Medical Staff Bylaws, Rules and Regulations; (iv) the Hospital's Corporate Bylaws; and (v) all Hospital Administrative and Department policies, rules and regulations including, without limitation, those set forth in the Hospital's Guidelines for Clinical Pathways and Code of Conduct, each as may be amended from time to time.

k. Providing 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, he or she shall immediately notify the Hospital that such health or other impairment that might interfere with performance of the Medical Staff member's duties or might pose a potential health risk to patients.

l. Cooperating with and participating in the Hospital's quality assurance and performance improvement program, risk management, and malpractice prevention programs, and legal compliance program.

m. Maintaining professional liability insurance coverage as required by the Governing Body of the Hospital and providing an insurance certificate to the Hospital naming the Hospital as a certificate holder.

n. Disclosing (i) all involuntary terminations or non-renewals of medical staff membership or voluntary terminations or non-renewals made in order to avoid involuntary terminations or non-renewals, and/or all voluntary or involuntary limitations, reductions, loss or non-renewal of clinical privileges at any other facility; (ii) any termination, loss, limitation, or relinquishment of a professional license or DEA certificate or eligibility to participate in a federally funded health care program (e.g., Medicare or Medicaid); (iii) any pending action or proceeding that may result in any of the foregoing; (iv) any criminal conviction in any jurisdiction; (v) 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 Professional Discipline, Office of Health System Management, Department of Mental 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.

o. Preparing and completing in a timely manner the medical record and other required records for all patients he/she admits or for whom he/she provides care in the Hospital, as provided for in these Medical Staff Bylaws, and in the Rules and Regulations and other applicable Hospital policies, rules and regulations.

p. Participating in the education and appropriate supervision of the Graduate Medical Staff.

#### Section 9. Emergency Privileges

In the case of emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted in doing everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or are not requested, the patient shall be assigned to an appropriate member of the Medical Staff, for the purpose of this Section.

#### Section 10. Temporary Privileges

a. Temporary privileges may be granted only by the CEO (or designee), upon recommendation of the President of the Medical Staff (or designee), to an appropriately licensed practitioner when: (1) the Hospital has received a completed application; (2) the information available to the Hospital substantially supports a favorable determination concerning the practitioner's qualifications, ability and judgment to exercise the privileges requested; (3) there is no current or previously successful challenge to licensure or registration or involuntary termination of medical staff membership at another facility or involuntary limitation, reduction, denial or loss

of clinical privileges at another facility with respect to the applicant for temporary privileges; (4) the practitioner has satisfied the professional liability insurance requirements of these Bylaws; (5) the Hospital has verified licensure and competence to perform the privileges requested (*i.e.*, querying the NPDB and Office of Inspector General, among other steps); and (6) one of the following circumstances exists: (i) initial application to the Medical Staff is pending and there is a patient care need; (ii) reapplication following a Leave of Absence is pending or (iii) to fill a short term patient care or treatment need, other than as described below in Section 10.b. Such temporary privileges shall not exceed one hundred twenty (120) days.

b. The CEO (or designee), upon recommendation of the President of the Medical Staff, shall have the authority to grant temporary privileges to meet an important individual patient care need for a period not to exceed one (1) month, and possibly a second month depending on patient care needs. Temporary privileges are to be granted by the CEO (as designee of the Governing Body of the Hospital) or the CEO's designee upon the recommendation of the President of the Medical Staff or his/her designee only after a written request is made, and primary source verification of licensure, current competence, DEA certificate, Office of Professional Medical Conduct/Office of Professional Discipline, Office of Inspector General, and NPDB query is completed, and verification is made of a reference from at least one (1) healthcare colleague regarding the practitioner's current clinical competence. Nothing herein requires the CEO to grant temporary privileges to all who request such privileges.

c. The Department Chairperson, Division Director, or Section Chief in the Department in which the practitioner is requesting temporary privileges may impose special conditions or requirements of supervision, consultation, and reporting. Under all circumstances, the practitioner requesting temporary privileges must agree, in writing, to abide by these Bylaws, Rules and Regulations and all Hospital policies and procedures relating to his/her activities in the Hospital.

d. Temporary privileges shall be immediately terminated by the CEO or the Medical Director upon notice of failure by the practitioner who has been granted temporary privileges to comply with any imposed special conditions, or upon written demand by the Chairperson of the Department. In the event of such termination of temporary privileges, the practitioner shall not be entitled to the procedural rights in Article V of these Medical Staff Bylaws

#### Section 11. Disaster Privileges

- a. If the Hospital's Disaster Plan has been activated and the Hospital is unable to meet immediate patient needs, or if other area facilities are unable to meet patient needs, the President (and other individuals, as identified in the Hospital's Disaster Plan, with similar authority) may, on a case-by-case basis, consistent with professional licensing and other relevant state statutes, grant Disaster Privileges to selected Volunteer Practitioners and assign them to Medical Staff Departments consistent with their clinical expertise. The specific Disaster Privileges granted will be delineated by the relevant Department Chair.
- b. Practitioners must present a valid photo identification issued by a state or federal agency, complete an *Emergency/Disaster Privileges Application and Waiver*, and undergo credentialing and departmental oversight as set forth in the medical staff disaster privileges policy and procedure.

The Hospital has a mechanism (e.g., badging) to readily identify Volunteer Practitioners who have been granted Disaster Privileges that distinguishes them from other Hospital personnel.

Within 72 hours of granting Disaster Privileges, the Hospital shall make a decision, based on information obtained by evaluating the Volunteer Practitioner's professional practice, whether the Disaster Privileges should be continued, modified, or rescinded.

Any individual identified in the Hospital's Disaster Plan with the authority to grant Disaster Privileges shall also have the authority to terminate Disaster Privileges.

Authority to grant or rescind Disaster Privileges may be exercised in the sole discretion of the Hospital and will not give rise to a right to a Hearing or an appeal.

#### Section 12.      Leave of Absence

a. Any member of the Medical Staff may request, in writing, a leave of absence for a specified period of time. Such request shall be made in writing to the Medical Board, who shall review and evaluate the request and make a recommendation and forward it to the Governing Body of the Hospital. During the period of leave, the practitioner shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. Such leave of absence shall be for a period not in excess of one (1) year unless extended for good cause shown.

b. At least forty-five (45) days prior to the termination of the leave of absence, the practitioner may request reinstatement of privileges by submitting a written notice to that effect to the Chairperson in the Department in which the practitioner formerly had privileges. The Chairperson will review the request and the practitioner's credentials and make his/her recommendations concerning what privileges the practitioner shall be entitled to upon the termination of such leave of absence and the reinstatement of the practitioner's privileges to the Medical Board. The Medical Board shall make its recommendation to the Governing Body of the Hospital concerning termination of the leave of absence and reinstatement of privileges.

c. Failure, without good cause, to request reinstatement in accordance with these Bylaws shall be deemed a voluntary resignation and shall result in expiration of Medical Staff member's membership and privileges. A practitioner whose membership expires shall not be entitled to the procedural rights under Article V. A request for medical staff membership subsequently received shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

d. A practitioner who requests reinstatement after a leave of absence for health or disability reasons shall submit a health statement signed by his/her treating physician affirming that he/she is fit to safely and competently exercise the requested clinical privileges.

e. 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 7 of this Article III of these Bylaws at least two (2) months prior to his/her scheduled return.

## ARTICLE IV

### CORRECTIVE ACTION

#### Section 1. Internal Investigations

Concerns and complaints regarding a practitioner's clinical practice or competence may be made by Medical Staff members, Hospital staff, patients, and visitors. Such complaints should be sent or forwarded to the Medical Director who shall, within seventy two hours, initiate investigation into the matter and refer it to the appropriate Chairperson of the Department and his or her designees established pursuant to a policy approved by the Medical Staff and the Governing Body. If, as a result of any such investigation, corrective action is recommended, such recommendation will be acted upon as described below. The Medical Director or his/her designee will keep the Hospital's administration apprised of and updated on any internal investigation and corrective action, if applicable.

#### Section 2. Basis for Corrective Action.

a. A request for corrective action may be made with regard to any practitioner who is a member of the Medical Staff whenever (1) the conduct or condition, professional or otherwise, of such Medical Staff member: (i) is considered to be inconsistent with the Hospital's standards of patient care, patient welfare, or the objectives of the Hospital; (ii) reflects adversely on the Hospital or the practitioner; or (iii) results in disruption of Hospital operations; or (2) he/she fails to comply with any of (i) these Bylaws, Rules, and Regulations; (ii) the Hospital's rules, regulations or policies; or (iii) the policies of the practitioner's Department.

b. A request for corrective action shall be made to the President of the Medical Staff, by any member of the Governing Body, Officer of the Hospital, the Medical Director, any member of the Medical Board, except that a request for corrective action regarding the President of the Medical Staff shall be made to the CEO. 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 in these Bylaws, any request for corrective action by the Chairperson of the Department in which the practitioner has 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 Chairperson, upon receipt of the request for corrective action, the President of the Medical Staff shall refer the matter back to the practitioner's Chairperson for him/her to conduct a departmental investigation of the issues that gave rise to the request for corrective action. In the event that a corrective action request is made regarding the Chairperson, the investigation of the matter shall be conducted by the Medical Director.

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

1. A letter of admonition or reprimand;
2. A letter of warning;
3. Requirement of further clinical training or education in one or more specified areas and a restriction of the Medical Staff member's clinical

privileges until satisfactory completion of such training or education requirements;

4. Imposition of terms of probation or a supervision requirement;
5. Recommendation for the restriction, suspension, or termination of clinical privileges;
6. Recommendation for the suspension or termination of Medical Staff membership;
7. Automatic suspension or revocation of privileges or medical staff membership.

d. No person filing a request for corrective action in an individual capacity shall sit on any committee reviewing under this Article IV. The President of the Medical Staff shall ensure that a copy of such request for corrective action shall be mailed by certified mail, return receipt requested or overnight courier mail with return receipt, 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 Medical Staff member shall be accompanied by a copy of this Article IV and V of the Bylaws that sets forth the hearing process and any further communication between the Hospital and the affected Medical Staff member required under Article IV and V.

e. Any notices referred to in this Article IV shall be in writing and be given personally or sent by certified mail, return receipt requested or overnight courier mail with return receipt.

### Section 3. Summary Suspension or Limitation of Privileges

Under exceptional circumstances, where the conduct of any member of the Medical Staff threatens the health, safety, and welfare of the patients of the Hospital or is contrary to the objectives of the Hospital, the privileges of said Medical Staff member may be summarily suspended or limited. Summary suspension or limitation of privileges shall be taken only with the approval of the Medical Director, Chairperson of a Department, the President of the Medical Staff, and the CEO. However, where time does not permit consultation among such persons, the subject practitioner may be unilaterally suspended by the Medical Director, the Department Chairperson, or the CEO. Written notice of summary suspension shall be given to the subject practitioner by the person so acting, with a copy thereof to be filed in the office of the CEO. Specific reasons for such summary suspension need not be given in said notice, and a statement that is based upon the conclusion that the conduct of the subject practitioner threatens the health, safety, and welfare of the patients of the Hospital shall be deemed sufficient. Unless otherwise mutually agreed, within fourteen (14) days after a summary suspension, the Medical Board shall convene to review the summary suspension. If the Medical Board upholds the summary suspension, the practitioner shall be entitled to the hearing rights described in Article V. If the Medical Board recommends termination of the summary suspension, the recommendation will be forwarded to the Governing Body which shall review the recommendation at its next meeting or within thirty (30) days, whichever is shorter. If recommendation of the Governing Body is to terminate the suspension, the subject practitioner shall be immediately informed of the termination of the suspension. If the determination of the Governing Body is to continue, the summary suspension, the practitioner shall be afforded the Fair Hearing rights contained in Article V of these Medical Staff Bylaws. It will

be the responsibility of the Chairperson of the Department to assure continuity of care of the involved practitioner's hospitalized patients during his/her term of suspension or limitation of privileges.

Section 4. Automatic Suspension of Privileges

The actions listed below are considered to be administrative actions and, unless otherwise noted, shall not entitle the practitioner to the procedural rights provided in Article V. Whenever any of the actions specified in Article IV, Sections 4(a)(c)(e)(g) or (h) occur, the practitioner must immediately report it to the Medical Director. A failure to report, without good cause, shall be grounds for revocation or suspension of Medical Staff appointment, clinical privileges, and any Medical Staff offices and positions held, as applicable. Whenever any of the actions specified below are taken, it shall be presented at the next meeting of the Medical Board.

a. Whenever a practitioner's license, certificate or other legal credential authorizing him/her to practice in this State is revoked, his/her Medical Staff membership and Clinical Privileges shall be immediately and automatically revoked. Whenever a practitioner's license, certificate or other legal credential is limited or restricted by the applicable licensing or certifying authority, those clinical privileges which he/she has been granted that are within the scope of said limitation or restriction shall be immediately and automatically revoked. Whenever a practitioner's license, certificate or other legal credential is suspended or not current, his Staff Membership and clinical privileges shall be automatically suspended effective upon and for at least the term of the suspension or that period of time during which the license, certificate or other legal credential is not current. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her voting, office-holding and teaching prerogatives and responsibilities, if any, shall be automatically suspended effective upon and for at least the term of the probation.

b. A practitioner's privileges shall be suspended for a period of up to thirty (30) days when he/she has failed to comply with the Hospital's medical records requirements as set forth in such Bylaws, Rules and Regulations or Hospital Policies, in accordance with these Rules and Regulations and Policies, except in extenuating circumstances as determined by the Medical Director.

c. A practitioner who fails to maintain adequate and satisfactory professional liability insurance, or to provide documentation of adequate and satisfactory professional liability insurance, as required by the Governing Body shall be automatically suspended from practicing at the Hospital and shall remain suspended until such time as the Governing Body of the Hospital are satisfied that the required amount of such insurance is in full force and effect. Repeated failures of this nature will result in revocation of the practitioner's medical staff membership and privileges.

d. A practitioner who fails to pay Medical Staff Dues and assessment within ninety (90) days after notice shall be automatically suspended from practicing at the Hospital and shall remain suspended until such time as such payments are received unless the Medical Board grants an extension for a specified time due to extenuating circumstances.

e. Exclusion from eligibility or participation in any federally funded healthcare program (e.g. Medicare or Medicaid) shall result in automatic termination from the Medical Staff.

f. Failure to provide the Medical Staff Office with any and all documentation required by these Bylaws or by law including but not limited to proof of infection control training or the practitioner's health status shall result in automatic suspension until such documentation is provided in a form acceptable to the Governing Body.

g. Conviction of a criminal felony or crime of moral turpitude shall result in automatic termination from the Medical Staff.

h. Whenever a practitioner's DEA number is revoked, he/she shall immediately and automatically be divested at least of his/her right to prescribe medications covered by the number. Whenever a practitioner's DEA number is suspended or not current, he shall be divested at least of his right to prescribe medications covered by the number effective upon and for at least the term of the suspension or until he/she obtains a current DEA number.

i. Termination, expiration or non-renewal of a contract between the Hospital and a practitioner, or the Hospital and any other entity, facility or organization pursuant to which or as a result of which the practitioner has been granted privileges at the Hospital and Medical Staff appointment, for any reason whatsoever, shall, unless otherwise determined by the Hospital, result in automatic termination of the applicable practitioner's Medical Staff membership, and any provision of the Hospital's policies to the contrary notwithstanding, (i) the Hospital has no duty to provide notice, hearing, or review; (ii) the applicable practitioner is deemed to have waived such notice, hearing or review and (iii) the Hospital will be considered to be held harmless from any and all liability or loss incurred by the Hospital as a result of such termination, expiration or non-renewal.

Section 5. Alternative 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, the Department Chair, President of the Medical Staff, the Medical Director or the CEO shall each have authority to arrange for alternative medical coverage for the practitioner's patients still in the Hospital as in-patients or being treated in the outpatient facilities of the Hospital. The wishes of the patients concerned shall be considered in the selection of an alternative Medical Staff member.

**ARTICLE V**

**HEARING AND APPELLATE REVIEW PROCEDURE**

Section 1. Interviews

When the Medical Board is considering taking adverse action against a practitioner, the Medical Board shall have the discretion to offer an informal interview with the Medical Board to the practitioner in an attempt to resolve the underlying issues with the practitioner. The interview shall not constitute a hearing, shall be preliminary and informal in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the circumstances and may present information relevant thereto. The minutes shall record that an interview was held. A colleague on the medical staff may accompany the practitioner being interviewed. This interview shall take place at the next Medical Board meeting provided that the meeting is at least ten (10) days later. In the event that the practitioner declines the interview, the Medical Board may, in its discretion, proceed with the adverse action.

Section 2. Notice: Time Periods

- a. Any notices referred to in this Article V shall be in writing and sent by certified mail, return receipt requested or overnight courier mail with return receipt, by the CEO or Medical Director.
- b. All time periods referred to in this Article may be increased or decreased by mutual agreement.

Section 3. Right to Hearing and Appellate Review and Composition of Ad Hoc Hearing Committee

- a. Except as otherwise expressly provided in these Bylaws, when any Medical Staff member who had previously been granted Medical Staff membership and privileges receives a notice of recommendation of the Medical Board that will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges and is based upon professional conduct or competence relating to patient care or treatment, he/she shall be entitled to a hearing before an Ad Hoc Hearing Committee of seven (7) members of the active Medical Staff. Three (3) of these Committee members shall be appointed by the President of the Medical Staff in consultation with the Medical Board and three (3) shall be selected by the affected practitioner. These six (6) shall select the remaining committee member who shall be designated as chairman. In the event that the six (6) members of the Ad Hoc Hearing Committee are unable

to agree on a chairman, the President of the Medical Staff will appoint a member of the Medical Staff to this position. No member of the Medical Board or staff member who has actively participated in the consideration of the adverse recommendation, or who is in direct economic competition with the subject Medical staff member, shall be appointed a member of this Ad Hoc Hearing Committee. When the Medical Staff member receives notice that the recommendation of the Medical Board following such hearing is still adverse to the Medical Staff member, he/she shall then be entitled to appellate review by the Governing Body of the Hospital, in accordance with Section 7 of this Article, before the Governing Body of the Hospital takes final action.

b. When any Medical Staff member receives notice of a decision by the Governing Body of the Hospital that is based upon professional conduct or competence relating to patient care or treatment and that will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Medical Board with respect to which he/she was entitled to a hearing, he/she shall be entitled to a hearing before an Ad Hoc Hearing Committee of seven (7) persons, all of whom shall be either members of the Governing Body of the Hospital or the Active Medical Staff. Three (3) of these Committee members shall be appointed by the Governing Body of the Hospital; and three (3) shall be selected by the affected Medical Staff member. These six (6) members shall select the remaining committee member who shall be designated as chairman. In the event that the six (6) members of the Ad Hoc Hearing Committee are unable to agree on a chairman, the Chairman of the Governing Body of the Hospital will appoint a chairman from the Active Medical Staff. When the practitioner receives notice that the recommendation following such hearing is still adverse, he/she shall then be entitled to appellate review by the Governing Body of the Hospital. Such appellate review shall take place in accordance with the provisions of Section 7, below.

c. The notice of the adverse recommendation or decision shall inform the Medical Staff member of his/her right to request a hearing and the time limit within which to request a hearing, shall state the reasons for the proposed action and shall contain a summary of the Medical Staff member's rights in the hearing, namely:

1. To representation by an attorney or other person of the Medical Staff member's choice.
2. To have a record made of the proceedings and access to such record.
3. To call, examine, and cross-examine witnesses.
4. To present evidence determined to be relevant by the Ad Hoc Committee, regardless of its admissibility in a court of law.
5. To submit a written statement at the close of the hearing.
6. To an expedited hearing, if the action pertains to an existing Medical Staff member who is suspended.
7. Upon completion of the hearing, the right (a) to receive the written recommendation of the Ad Hoc Hearing Committee, including a statement of the basis for the recommendations; and (b) to receive the written decision

of the Governing Body of the Hospital, including a statement of the basis for the decision.

Section 4.            Request for Hearing and Waiver

a.        Upon receipt of the notice of adverse decision or recommendation referred to above, the Medical Staff member shall have the right to request to the CEO a hearing within thirty (30) calendar days of receipt of the notice. The failure of a Medical Staff member to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter, except that such failure to request a hearing shall not constitute a waiver of rights by the Medical Staff member where circumstances beyond his/her control prevent his/her timely request.

b.        When the waived hearing relates to an adverse recommendation of the Medical Board, such recommendation shall thereupon be effective against the Medical Staff member pending the Governing Body of the Hospital's decision on the matter, whereupon it shall become final. When the waived hearing relates to an adverse decision by the Governing Body of the Hospital, which is not based on a prior adverse recommendation of the Medical Board, such decision shall thereupon be final. Notice shall be given to the Medical Staff member of the waiver and its effect.

Section 5.            Notice of Hearing

a.        Within ten (10) days after a receipt of a timely request for hearing under these Bylaws, the Medical Board, or the Governing Body of the Hospital, whichever is appropriate, shall schedule such hearing and notice shall be provided to the Medical Staff member of the time and place of hearing. Except in cases of unusual complexity or for other good cause, the hearing shall not be less than thirty (30) calendar days nor more than sixty (60) calendar days from the date of the notice of hearing unless by mutual agreement, provided however, that a hearing requested by a Medical Staff member then under suspension shall be held as soon as arrangement can reasonably be made, but not later than thirty (30) days from the date of receipt of such Medical Staff member's request for hearing.

b.        The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff member is charged, and shall state the date, time and place of the hearing, and shall contain or have appended thereto a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Board, or Governing Body of the Hospital, as the case may be.

Section 6.            Conduct of Hearing

a.        All of the members of the Ad Hoc Hearing Committee must be present when the hearing takes place and at the time of any decision or vote unless otherwise agreed by the chairman of the Ad Hoc Hearing Committee and the Medical Staff member. The CEO or Medical Director (or their designee) shall be present at all meetings.

b.        An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee and may be accomplished by the use of court

reporter or electronic recording unit. Costs associated with creating the record shall be shared evenly by the practitioner and the Hospital.

c. The personal presence of the Medical Staff member requesting the hearing shall be required. A Medical Staff member who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights to the hearing and to have accepted the adverse recommendation or decisions involved.

d. The affected Medical Staff member shall have the right to be represented by an attorney-at-law or other person of the Medical Staff member's choice, at any phase of the hearing and appellate review procedure at his/her own expense. The Medical Board and/or Governing Body of the Hospital shall also have a right to be represented by an attorney-at-law (hospital counsel) at any phase of the hearing and appellate review procedure. Said Hospital counsel shall be selected and compensated by the Hospital.

e. The chairman of the Ad Hoc Hearing Committee, or his/her designee, shall preside over the hearing to determine the order of the procedure, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Ad Hoc 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. The Medical Staff member shall have no right of pre-hearing discovery.

f. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence except that testimony shall be taken under oath. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rules which might make evidence inadmissible over objection in a civil or criminal action. The Medical Staff member requesting the hearing shall, prior to or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.

g. The Medical Board shall appoint one of its members, another Medical Staff member, or another designated individual to represent it at the hearing when its action has prompted the hearing. The Governing Body of the Hospital shall appoint one of its members to represent it at the hearing when its action has prompted the hearing. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision. Thereafter, the affected Medical Staff member shall have the right and reasonable opportunity to present testimony or evidence tending to show that the charges or grounds involved are not based upon substantial evidence, or are arbitrary, capricious, or unreasonable. He/she shall also be permitted to submit a written statement at the close of the hearing.

h. The affected Medical Staff member and/or his/her representative and the Medical Board or the Governing Body of the Hospital, as appropriate, and/or its representative shall have the following rights: to call and examine witnesses on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence.

i. The Ad Hoc Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the Medical Staff members, for the purpose of permitting the introduction of new or additional evidence or for the purpose of consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Ad Hoc Hearing Committee may thereupon conduct its deliberations with only the members of the Committee present.

j. Within twenty (20) days after the close of the evidence, the Ad Hoc Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Board or to the Governing Body of the Hospital, whichever appointed it. The report may recommend affirmation, modification, or rejection of the original adverse recommendation of the Medical Board, or decision of the Governing Body of the Hospital. Within thirty (30) days after receipt of the Ad Hoc Hearing Committee report, the Medical Board or the Governing Body of the Hospital, as appropriate, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Ad Hoc Hearing Committee and all other documentation considered, to the CEO, who shall promptly send notice of the result to the Medical Staff member, to the President of the Medical Staff, and to the Governing Body of the Hospital. If the decision is adverse to the Medical Staff member, such notice shall inform him/her of his/her right to appeal.

Action by the Governing Body of the Hospital pursuant to this Section shall become the final decision of the Governing Body of the Hospital and the matter shall be considered finally closed without any further appellate review.

#### Section 7. Appeal to the Governing Body of the Hospital

a. Within thirty (30) days after receipt of a notice of an adverse recommendation or decision by the Medical Board made after the hearing, the affected Medical Staff member may request appellate review of such action by written notice delivered to the CEO in person or mailed to him/her by certified mail, return receipt requested or overnight courier mail with return receipt. Such notice may request that the appellate review be limited to the record on which the adverse recommendation or decision is based, or that the record be supplemented by the practitioner's further written statements and/or oral argument.

b. If the appellate review is not requested within thirty (30) days, the affected practitioner shall be deemed to have waived his/her right to same and to have accepted such adverse recommendation or decision, which shall become immediately effective and final.

c. As soon as practicable after receipt of such notice of request for appellate review, the Governing Body of the Hospital shall schedule a date for such review, including an oral argument, if such has been requested, and shall send written notice via certified mail, return receipt requested, through the CEO to notify the affected Medical Staff member of the date so scheduled or in the case of an oral argument, of the time, place and date so scheduled. The date of the appellate review shall not be less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the notice of request for appellate review, except that when the Medical Staff member requesting the review is under suspension which is then in effect, such review shall be scheduled

as soon as the arrangements for it may reasonably be made, but no more than thirty (30) days from the date of receipt of such notice.

d. The affected Medical Staff member shall have access to the report and record (and transcript, if any) of the Ad Hoc Hearing Committee and all other material, favorable and unfavorable that was considered in making the adverse recommendation or decision against him/her. He/she may submit a written statement in his/her on behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified. The Medical Staff member may also request oral argument. This written statement may cover any matter raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the appellate review body through the CEO by certified mail, return receipt requested or overnight courier mail with return receipt and shall be received by the review body at least ten (10) days prior to the date scheduled for appellate review. A written statement may also be submitted by the Medical Board and if submitted, the CEO shall provide a copy thereof to the Medical Staff member which shall be received by the practitioner at least ten (10) days prior to the date scheduled for appellate review.

e. The Governing Body of the Hospital shall review the record created of the proceedings together with any written statements submitted pursuant to subparagraph (d) of this Section for the purpose of determining whether the adverse recommendation or decision was not based upon substantial evidence or was arbitrary, capricious, or unreasonable. If oral argument is requested as a part of the review procedure, the affected Medical Staff member and his/her attorney or other representative, if any, shall be present at such appellate review and shall be permitted to speak against the adverse recommendation or decision. The Medical Staff member shall answer questions put to him/her by any member of the Governing Body of the Hospital. The Medical Board shall also be represented by an individual who shall answer questions put to him/her by any member of the Governing Body of the Hospital.

f. The appellate review shall be conducted on the record of the hearing. In the event that, in the discretion of the Governing Body of the Hospital, unusual circumstances warrant the consideration of new or additional matters not raised during the original hearing, or in the Ad Hoc Hearing Committee report, an adjournment, at the request of any appropriate party, shall be granted for the purpose of permitting discovery and submission of any relevant evidence bearing upon the new or additional matters tendered.

#### Section 8. Final Decision of Governing Body of the Hospital

a. Within twenty (20) days after the conclusion of the appellate review, the Governing Body of the Hospital shall make its final decision in the matter and shall send a notice to the Medical Board and the affected Medical Staff member.

#### Section 9. Employed or Contracted Practitioners

. Termination, expiration or non-renewal of a contract between the Hospital and a practitioner, or the Hospital and any other entity, facility or organization pursuant to which or as a result of which the practitioner has been granted privileges at the Hospital and Medical Staff appointment, for any reason whatsoever, shall, unless otherwise determined by the Hospital, result in automatic termination of the applicable practitioner's Medical Staff membership, and any

provision of the Hospital's policies to the contrary notwithstanding, (i) the Hospital has no duty to provide notice, hearing, or review; (ii) the applicable practitioner is deemed to have waived such notice, hearing or review and (iii) the Hospital will be considered to be held harmless from any and all liability or loss incurred by the Hospital as a result of such termination, expiration or non-renewal.

Section 10.      Additional Considerations

a. Notwithstanding any other provisions of these Medical Staff Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter, which shall have been the subject of action by the Medical Board or the Governing Body.

b. By requesting a hearing or appellate review, an applicant or Medical Staff member agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability.

c. The CEO or his designee shall report to the New York Office of Professional Medical Conduct and/or to the New York State Department of Education and the National Data Bank or other authorities, as required by State or Federal law, any adverse professional review action.

**ARTICLE VI**

**FAIR HEARING PROCESS FOR ALLIED HEALTH PROFESSIONALS**

Section 1.      Basis for Fair Hearing

Each AHP is subject to the same disciplinary and corrective actions as are provided for Medical Staff members in Article IV of these Medical Staff Bylaws, including, but not limited to, privilege suspension, modification, or termination. Whenever an action is taken that is adverse to an AHP's, clinical privileges and is based upon professional competence or conduct, the AHP will, in accordance with his or her employment status, be offered the due process procedures described below. The due process procedures set forth below shall not, except in extraordinary circumstances, apply to disciplinary actions involving formal warning, probation, or recommendation to participate in counseling. Corrective actions taken for reasons clearly unrelated to professional incompetence, or violation of the standards of conduct are specifically excluded from the appeal mechanisms; however, when reasonable doubt shall be shown to exist, the appeal mechanisms shall apply.

Section 2.      Fair Hearing Process

a. Upon a determination by the Medical Board to impose an action that is adverse to the clinical privileges of a AHP employed by the Hospital, as described above, the Medical Director shall notify the AHP in writing. Such notice shall indicate that the employed AHP is entitled to the due process procedures in the Hospital's Human Resources policies and procedures. Employed AHPs shall not be entitled to the due process procedures described below.

b. Upon a determination by the Medical Board to impose an action that is adverse to the clinical privileges of a AHP that is not employed by the Hospital (referred to in this Article as

a Voluntary AHP), as described above, the Medical Director shall notify the AHP. Such notice shall advise the AHP that he/she may appeal and request a hearing by submitting the request in writing, to the Medical Director within fourteen (14) days following receipt of the written notification of disciplinary action. The failure of a Voluntary AHP to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter.

c. On receiving such an appeal, the Medical Director will, within fifteen (15) business days, appoint an Ad Hoc Committee to be chaired by the Vice President of Medical Staff, who will appoint two other physicians to serve on the committee to hold a hearing regarding the Voluntary AHP's appeal. Together with the written notice of time and place of the appeal hearing, the Medical Director shall also provide the Voluntary AHP with a copy of all evidence supporting the written notification of disciplinary action and maintained by the Department Chair. The appeal hearing must be held not less than fifteen (15) days and no more than thirty (30) days from the date of receipt of written intent to appeal from the Voluntary AHP.

d. The Voluntary AHP making the appeal shall be given an opportunity to review the evidence maintained by the Department Chair and to rebut it in front of the Ad Hoc Committee at the hearing. Also, in consideration of due process, the Voluntary AHP making the appeal will be allowed to present additional written evidence. The Voluntary AHP will only be allowed to present witnesses in special circumstances and solely at the Hospital's discretion. The Voluntary AHP may be accompanied by his/her supervising physician who must be an active member of the medical staff.

e. Following the hearing, the Ad Hoc Committee will provide all relevant documentation and a written report of its conclusions and recommendations to the Medical Director.

f. If the Medical Director recommends that the disciplinary action be withheld or terminated, such recommendation shall be sent to the Medical Board for its recommendation and the Governing Body for its final determination.

g. If the Medical Director upholds the decision for dismissal or proposed disciplinary action or proposes a modified disciplinary action, this decision will be communicated, in writing, to the AHP making the appeal within ten (10) business days. The voluntary AHP shall have fifteen (15) business days from receipt of that communication to request, in writing, an appeal to the Chief Executive Officer, or his/her designee, whose decision on such appeal shall be forwarded to the Governing Body and its determination on the matter shall be final. This review shall be based solely on the record unless the Chief Executive Officer, or his/her designee, determines that circumstances require a hearing de novo. All materials reviewed by the Ad Hoc and the Medical Director shall be available to the Chief Executive Officer, or his/her designee, for his/her review. The major purpose of this review shall be to assure that the involved AHP has been afforded due process with an appropriate resultant course of action. Within ten (10) business days of completion of the review, the Chief Executive Officer, or his/her designee, shall issue a written recommendation to the Governing Body approving, denying, or modifying the recommendation of the Medical Director.

h. Upon the Governing Body's final determination on the matter, the Chief Executive Officer shall, within ten (10) days provide written notification to the Voluntary AHP of such final determination.

i. Dismissal of a Voluntary AHP for unsatisfactory performance and/or professional misconduct is reportable as provided in the Administrative Policy entitled "Professional Conduct Reporting." Voluntary AHP's rights and protection in this area are those consistent with institutional policies. Voluntary AHP grievances involving harassment shall be handled in accordance with Hospital policies.

## ARTICLE VII

### CATEGORIES OF THE MEDICAL STAFF

#### Section 1. Categories Established

a. The Medical Staff shall be divided into the following categories:

1. Emeritus Staff
2. Consulting Staff
3. Active Staff
4. Courtesy Staff
5. Community Based Staff
6. Provisional Staff
7. House Physician
8. Organ Procurement Practitioners

b. All appointments to the Medical Staff, except those to Emeritus Staff, shall be made as provided in Article III, Section 5 hereof and shall designate the category to which the appointment is made and the delineated privileges and the site of such privileges, which shall accompany the appointment. Only members in Good Standing on the Active Staff may vote or hold office.

#### Section 2. Emeritus Staff

a. Physicians, dentists, podiatrists, or licensed midwives who have been a member of the Active Staff for at least ten (10) years and retired from active hospital practice who so desire, may become members of the Emeritus Staff.

b. Members of the Emeritus Staff (1) shall not vote, hold office, or serve on Standing Medical Staff committees except that such individuals may be invited to attend specific committee meetings where their contribution is deemed valuable; (2) will not be required to pay dues or attend continuing medical education; and (3) will not have clinical privileges, shall not be eligible to admit patients, and will not be entitled to the procedural rights of Article IV or V of these Bylaws.

c. Application for appointment to the Emeritus Staff shall be submitted by the applicant to the Medical Board, which after consultation with the applicant's Department Chairperson, after review of the applicant's file, and after consideration shall forward such

application together with its recommended action, to the Governing Body of the Hospital, which shall make the final determination with respect to same.

### Section 3. Consulting Staff

a. The Consulting Staff shall consist of physicians, dentists, and podiatrists of widely recognized professional ability and reputation in the area of their specialty who have been invited to join the Consulting Staff. Applications for membership on the Consulting Staff will not be accepted, unless the Consulting Staff member has been invited to join the Medical Staff. Appointment to the Consulting Staff will conform generally to the appointment requirements set forth in Article III hereof.

b. Members of the Consulting Staff (1) shall be privileged to admit no more than twelve (12) patients per year; (2) shall not be required to pay dues or attend meetings except in those instances where cases in which they were involved are being discussed; (3) shall be required to attend continuing medical education; and (4) otherwise satisfy the requirements set forth in the Medical Staff Bylaws, Rules and Regulations. The Department Chair may recommend that physicians and dentists with more than ten (10) years of Active Staff membership be exempt from the limitations of patient admissions per year as Consulting Staff.

c. The Consulting Staff shall be required to provide on-call services to the Emergency Department, as assigned, unless waived by the Medical Director. Members of the Consulting Staff shall be available for consultation in their particular specialty at the request of the professional staff or in any case where consultation is required by the Rules and Regulations of the Medical Staff.

### Section 4. Active Staff

The Active Staff shall consist of physicians, dentists, and podiatrists practicing in the community served by or within a reasonable distance of the Hospital who, are selected and appointed in accordance with Article III of these Bylaws. They shall (1) be eligible to attend meetings, vote, sit on committees and hold office of the Medical Staff; (2) be permitted to admit patients and exercise clinical privileges as delineated in accordance with these Medical Staff Bylaws; and (3) satisfy all the requirements and responsibilities set forth in the Medical Staff Bylaws, Rules and Regulations including attendance at Medical Staff, Department, and assigned committees (of which they are members) meetings, payment of dues and assessments as established by the Medical Staff, attendance at continuing medical education activities as required and where appropriate, assume all the functions and responsibilities for emergency service care and consultation assignments.

### Section 5. Courtesy Staff

a. The Courtesy Staff shall consist of physicians, dentists, and podiatrists, and allied health professionals who have less than five patient interactions per year, unless otherwise authorized by the applicable Department Director. Appointment to the Courtesy Staff will conform to the appointment and reappointment requirements set forth in Article III hereof. In addition, at the time of reappointment, courtesy Staff members will be required to provide [2] letters of recommendation that confirm the practitioner's ability to perform the privileges requested and meet the requirements of Article III, Section 7.

b. Members of the Courtesy Staff shall (1) be privileged to admit and treat patients up to five (5) patient interactions per year; (2) be required to pay dues and assessments as established by the Medical Staff; (3) not be eligible to vote or hold office on the Medical Staff but are eligible to serve on Medical Staff committees; (4) be required to attend Departmental conferences or meetings unless they show proof of regular attendance at an approved Departmental meeting in another accredited hospital; and (5) shall otherwise satisfy the requirements set forth in the Medical Staff Bylaws, Rules and Regulations.

c. If a member of the Courtesy Staff exceeds five (5) patient interactions per year without the express approval of the applicable Department Chairperson, he/she shall be automatically transferred to Active Staff status and shall be required to comply with the requirements therewith.

d. The Courtesy Staff shall not be required to provide on-call services to the Emergency Department unless required by the applicable Department Chairperson. Members of the Courtesy Staff shall be available for consultation in their particular specialty at the request of the professional staff or in any case where consultation is required by the Rules and Regulations of the Medical Staff. Each such consultation shall be considered a patient interaction.

#### Section 6. Community-Based Staff

a. The Community Practitioner Staff shall consist of physicians, dentists and podiatrists who meet the qualifications set forth in Article III, Section 2 hereof, and have an interest in being a member of the Medical Staff.

b. Community Practitioner Staff shall not be entitled to receive clinical privileges

c. The Community Practitioner Staff shall be credentialed and appointed the same as all other Medical Staff members in accordance with Article III; except that, because Community Practitioners are not entitled to clinical privileges, they shall not be required to demonstrate competence.

d. Community Practitioners are not eligible to take emergency room call, vote, hold office, or serve on Medical Staff committees. While their attendance at Medical Staff or departmental meetings is not mandatory, it is expected that they will attend and participate in such meetings whenever possible.

e. Community Practitioners: (1) shall be permitted to visit their patients in the hospital; (2) may discuss case with house staff and attending staff, but cannot give orders or direct the patient's care; (3) may view information regarding their patients but may not enter orders or write notes in the medical record; and (4) may be required to pay dues and assessments as established by the Medical Staff.

#### Section 7. Provisional Staff

The Provisional Staff shall consist of physicians, dentists, and podiatrists who have applied for membership to the Active Staff and been appointed to such status, during the initial one-year period following such appointment, or members who may have been granted one year Provisional Status for failing to meet the requirements for retention on the active Medical Staff. They shall be

members of the Provisional Staff as defined in Article III, Section 4, and Section 5. During that year, they shall have all the privileges and obligations of the Active Staff except holding office, voting, and will not be entitled to the procedural rights of Article IV or V of these Bylaws. The Provisional Staff shall be reviewed annually, and in no case shall any reappointment to Provisional Staff exceed one additional year.

Section 8.            House Physician

House Physicians shall consist of physicians who are employed by the Hospital, at the discretion of the Department Chair, to meet the needs of the Hospital. All House Physicians must be appointed in accordance with Article III of these Bylaws. They shall not have admitting privileges and their appointment to the Medical Staff shall terminate automatically if the House Physician's employment with the Hospital is terminated. The House Physician should have previous experience acceptable to the Hospital in the area in which he or she is to be employed, and have the approval of the Chair of the Department in which he or she is to be employed. They must have completed at least one year of residency in an accredited ACGME, AOA, Podiatric, or Dental training program.

Section 9.            Organ Procurement Practitioners

Practitioners from outside organ procurement organizations designated by the Secretary of the United States Department of Health and Human Services, engaged solely at the Hospital in the harvesting of tissues and/or other body parts for transplantation, therapy, research or education purposes, pursuant to the Federal Anatomical Gift Act and the requirements of Section 405.25 of the Hospital Code, shall be exempt from the requirement to obtain Medical Staff membership or privileges.

**ARTICLE VIII**

**DEPARTMENTS OF THE MEDICAL STAFF**

Section 1.            Departments of the Medical Staff

a.        Departments may be divided into Divisions and Sections. Each Department shall have a Chairperson, each Division shall have a Director ("Division Director"), and each Section shall have a Chief ("Section Chief").

b.        The Departments of the Medical Staff shall be as follows:

1.        Anesthesiology.
2.        Emergency Services.
3.        Family Practice.
4.        Internal Medicine.
5.        Obstetrics and Gynecology.
6.        Pathology.
7.        Pediatrics.
8.        Psychiatry.

9. Radiology.
10. Surgery.

Section 2. Department Organization

- a. Each Department shall have a Chairperson appointed annually by the Governing Body of the Hospital who shall act as the director of the Department. The Chairperson of each Department may, after review by the Medical Board and subject to the approval of the Governing Body of the Hospital, recommend one or more Division Directors (who may substitute for the Chairperson in his/her absence) and one or more Section Chiefs. All Chairpersons, Division Directors, and Section Chiefs must have been granted Medical Staff memberships and clinical privileges in accordance with these Bylaws, Rules, and Regulations.
- b. Each Chairperson, Division Director and Section Chief shall have exhibited leadership ability generally, be Board Certified or shall have affirmatively established comparable competence in a specialty appropriate to his/her Department, and shall be willing and able to faithfully discharge the functions of his/her office.

Section 3. Duties of Department Chairpersons

Each Chairperson, as part of his/her duties shall:

- a. Be accountable for all professional and administrative activities within his/her Department to the Medical Board, Hospital Administration, Medical Director and Chief Operating Officer.
- b. Maintain overall supervision of the professional performance of all practitioners with clinical privileges in his/her Department.
- c. Be responsible for implementation within his/her Department of actions taken by the Medical Board, required by the Hospital Bylaws, or the Medical Staff Bylaws, Rules and Regulations.
- d. Transmit to the Medical Board his/her recommendations concerning the staff classification and the reappointment of all practitioners in his/her Department, and shall submit such reports and recommendations to the Performance Improvement Committee as are required by these Bylaws and those of the hospital.
- e. Be responsible for delineating clinical privileges and the site of such privileges for all practitioners in his/her Department.
- f. Be responsible for the discipline of all practitioners in his/her Department.
- g. Be responsible for the teaching, education, and research program in his/her Department.

- h. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the Medical Board, the CEO, or the Governing Body of the Hospital.
- i. Ensure that there is established within the Department criteria consistent with the policies of the Medical Staff and of the Governing Body of the Hospital, for the granting of clinical privileges and for the holding of office in the Department.
- j. Ensure that the Department shall establish a Performance Improvement Committee within the Department or committees responsible for conducting a review of the records of discharged patients and other pertinent records and for selecting cases for presentation at the quarterly Departmental meeting in order to contribute to the continuing education of every practitioner and to the process of developing criteria to promote quality patient care. Such presentation should include a consideration of selected deaths, patients with infections, complications, or errors in diagnosis and treatment, and utilization of hospital facilities.
- k. Ensure that Departmental Performance Improvement meetings are held no fewer than ten (10) times per year to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.
- l. Ensure that a report is submitted to the Medical Board, to the Governing Body of the Hospital and to the Medical Staff Performance Improvement Committee detailing such Departmental analysis of patient care.
- m. Be responsible for the integration of the Department's services with the Hospital's primary functions.
- n. Be responsible for the coordination and integration of interdepartmental and intradepartmental services.
- o. Be responsible for the development and implementation of policies and procedures that guide and support the provision of services by that Department.
- p. Be responsible for the recommendation of a sufficient number of qualified and competent persons to provide care and service.
- q. Determine the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care services.
- r. Be responsible for the continuous assessment and improvement of the quality of care and services provided.
- s. Be responsible for the maintenance of appropriate quality control programs.
- t. Be responsible for the recommendation of space and other resources needed by the Department.

u. Be responsible for assessing and recommending to the President/CEO, Medical Director and to the Medical Board any off-site sources for needed patient care services not provided by the Department or the Hospital.

v. Be responsible for recommending to the Medical Board criteria for clinical privileges that are relevant to the care provided in the Department.

w. Be responsible for formulation and promulgation of policies for admission to the hospital for inpatients in accordance with the Federal and New York State Law and standards of good medical practice.

x. Consult with and recommend to the Continuing Medical Education (“CME”) Committee the minimum number of hours of CME per year that shall be required of Medical Staff members as a condition for maintaining their delineated clinical privileges.

y. Take steps to ensure that members of the Department, in the measurement, assessment and improvement of patient care processes, include those designed to further the education of patients and their families concerning the particular medical problems with which they are faced, subject, however, to the limits of the patient’s right to confidentiality.

#### Section 4. Division Directors/Section Chiefs

Division Directors and Section Chiefs shall be recommended by the Chairperson of the Department and shall be appointed by the Governing Body of the Hospital. They shall be responsible and accountable to the Chairperson for performance of his/her duties, and shall perform all duties assigned by the Chairperson. Section Chiefs shall also be responsible and accountable to the Division Director and shall perform all duties assigned by the Division Director. Division Directors and Section Chiefs may be removed from their positions as provided by the Corporate Bylaws of the Hospital.

#### Section 5. Assignment to Departments

The Executive Credentials Committee or the Credentials Committee of the Medical Staff, as the case may be, after consideration of the recommendations of the Chairpersons of the Departments will recommend initial Department assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

#### Section 6. Family Practice

a. A Practitioner may have clinical privileges in one or more Departments in accordance with the Practitioner’s education, training, experience, and demonstrated competence. Any such Medical Staff member shall be subject to all of the Rules and Regulations of each Department in which the Practitioner is granted privileges.

b. The delineation of privileges must be approved by the Chairpersons of all Departments in which clinical privileges are granted.

Section 7.        Meetings

- a.     Departmental meetings shall be held at least quarterly.
  1.     It is required of a member of the Active Medical Staff to attend at least fifty percent of the regular Departmental meetings during the calendar year, unless excused by the Medical Board or by the Chairperson of the Department for just cause, and non-attendance may be the grounds for denial of the member's reappointment to the Medical Staff.
  2.     Members of the Department of Family Practice shall attend at least fifty percent of the meetings of the Department of Family Practice. Attendance annually, at a minimum of fifty percent of the meetings in any of the other Departments in which their primary professional interest lie, may be substituted.
- b.     Division and Section meetings shall be held at least quarterly.
- c.     A record of all Departmental, Division, and Section meetings and attendance records shall be maintained which includes the conclusions resulting from the review and evaluation of patient care, recommendations, and actions taken. Such records shall be maintained by the Department.

**ARTICLE IX**

**OFFICERS OF THE MEDICAL STAFF**

Section 1.        Titles

The officers of the Medical Staff shall be:

- a.     President
- b.     Vice-President
- c.     Secretary
- d.     Treasurer

Section 2.        Nomination and Election of Officers and Members-at-Large

- a.     The Nominating Committee, every two (2) years, shall present to the March Quarterly meeting of the Medical Staff, a slate of qualified candidates for the offices of Vice- President, Secretary and Treasurer and Members-at-Large to serve on the Medical Board. Additional nominations may be made from the floor at the March or June Quarterly meeting. At the June annual meeting, a member of the Active Medical Staff shall be elected to serve in each of those capacities for a two (2) year period.
- b.     The Vice-President, Treasurer, Secretary and Members-at-Large shall be elected by closed ballot from among the candidates nominated as set forth above, by a majority vote cast by those Active Staff members in Good Standing present at the

June annual meeting of the Medical Staff. If no candidate for a given office receives a majority vote on the first ballot, a run-off election shall be held immediately between the two candidates receiving the highest number of votes. The candidate receiving the majority of the votes shall be declared elected.

- c. The Vice-President of the Medical Staff automatically assumes the role President when the President's term ends, and a successor Vice President is elected.

### Section 3. Vacancies

a. President: In the event that a vacancy in the office of President shall occur at any time, the Vice-President shall immediately assume the duties of that office, and the office of Vice-President shall thereupon be deemed vacant. Upon the automatic succession of the Vice-President, he shall serve the remainder of the unexpired term of the President, if any, and his or her own term as President.

b. Vice-President, Secretary, Treasurer, Members-at-Large: When a vacancy in any of these positions occurs, the President of the Medical Staff with the advice and consent of the Medical Board shall designate a member of the active Medical Staff in Good Standing who shall immediately assume the duties of that position. The Medical Staff member shall serve the remainder of the unexpired term until the next election, except, however, for the position of Vice-President. In that event, the President (or designee) shall give notice that at a special meeting of the Medical Staff to be held on a stated date, time and place (not less than thirty (30) days nor more than forty-five (45) days after the date of notice), an election for Vice President will be held to fill that vacancy for the remainder of the unexpired term.

c. Only Active Members of the Medical Staff in Good Standing qualify for positions of President, Vice-President, Secretary, Treasurer, and /or Members-at-Large. If any practitioner who has taken such a position ceases during the term of office to be such a member of the Medical Staff in Good Standing, such failure shall immediately create a vacancy in the position involved.

### Section 4. Term of Office

The term of each of the officers of the Medical Staff shall be two (2) years from the date of their election or until a successor is elected and assumes office to serve out the remainder of the term. Unless otherwise provided herein, no officer may serve more than one term, except that former officers may be eligible to hold office after they have not held office for a two-year period.

### Section 5. Duties and Responsibilities of the President

The President (a) shall preside, with full voting privilege, at all Medical Staff meetings; (b) shall be a member ex-officio, without vote, of all Medical Staff Committees; (c) shall be a member of the Joint Conference Committee; (d) shall, after consultation with the Medical Board, appoint all committees of the Medical Staff and their chairmen; (e) shall be the presiding officer of the Medical Board; (f) shall recommend for service of committees of the Governing Body of the Hospital all those who are to serve as representatives of the Medical Staff in that capacity; (g) shall report the view, policies, needs and grievances of the Medical Staff to the Governing Body of the Hospital, and to the CEO of the Hospital; (h) shall work in coordination and cooperation with the Medical Director and CEO of the Hospital in all matters of mutual concern within the Hospital; (i)

and jointly with the Medical Director, shall interpret the policies of the Governing Body of the Hospital to the Medical Staff; (j) shall be the spokesman/spokeswoman of the Medical Staff in its external professional and public relations; and (k) carry out all duties usually pertaining to the office of the President.

Section 6. Duties and Responsibilities of the Vice-President

The Vice-President shall be the President-Elect and shall serve as chairman of the Medical Staff Performance Improvement Committee. The Vice President shall be a member of the Medical Board, (acting as its Vice-President) and the Joint Conference Committee of the Governing Body of the Hospital and shall perform such other duties as may be assigned to him/her by the President. In the event of resignation, disability, or death of the President, he/she will assume the Presidency for the remainder of the term of the President.

Section 7. Duties and Responsibilities of the Secretary

The Secretary shall be a member of the Medical Board, acting as its Secretary and shall keep accurate and complete minutes of all Medical Board meetings, whether Regular or Special; shall keep records of all appointments to the Medical Staff; call meetings of the Medical Staff; attend to correspondence; and perform such other duties as ordinarily pertain to the office of Secretary or as otherwise directed by the President. The Secretary shall serve as the chairman of the Health Information Management Committee. In case of vacancies in the offices of both President and Vice-President, he/she shall preside until these vacancies are filled.

Section 8. Duties and Responsibilities of the Treasurer

The Treasurer shall be a member of the Medical Board and Chairman of the Finance Committee of the Medical Staff, and shall keep full and accurate accounts of all funds received and distributed for or on behalf of the Medical Staff in permanent books which shall at all times remain the property of the Medical Staff. He/she shall prepare or cause to be prepared, a financial statement of Medical Staff funds for presentation at each Quarterly Staff Meeting. He/she shall be responsible for supervising the collecting of the medical staff dues, cause to be conducted an audit of the Medical Staff funds at least one time per year and such other duties as are delegated to him or her by the President. The Treasurer will review any request for more than \$5,000 and present the request for vote at the next meeting of the Medical Staff.

Section 9. Resignation and Removal of Elected Officers

- a. Any Officer or Member-at-Large may resign at any time by giving written notice to the Medical Board or Governing Body of the Hospital. Such resignation shall take effect on the date of receipt or at any later time specified in such notice.
- b. An officer or Member-at-Large may be removed for cause if he or she fails to continuously satisfy the qualifications for the position; (i) fails to attend (3) consecutive meetings or 50% of the total meetings in one Medical Staff year without good cause; (ii) becomes subject to a summary or automatic suspension, or corrective action taken against the officer or Member-at-Large, which results in a final adverse decision other than to take no action, imposed by operation of Articles IV and/or V; (iii) develops a physical or mental impairment that renders the officer

or Member-at-Large incapable of fulfilling the duties of his/her office or position, said impairment being agreed to by unanimous vote of the remaining members at any meeting of the Medical Board. In the event of the foregoing, the CEO shall notify the officer or Member-at-Large by certified mail, return receipt requested or overnight courier, return receipt requested, and such action will become effective immediately.

- c. Removal proceedings without cause may be instituted against any officer of the Medical Staff or Member-at-Large by petition signed by Twenty (20) Active Staff members in Good Standing, which shall be presented at any Regular meeting of the Medical Staff for consideration and discussion. Removal shall be effected by a two-thirds (2/3) vote by secret ballot of the Active Staff Members in Good Standing present at the special meeting of the Medical Staff as set forth in Article X, Section 4 of these Bylaws.
- d. Removal of the officer or Member-at-Large shall not entitle him/her to a Fair Hearing hereunder.

#### Section 10. Medical Director

The Medical Director shall be a physician licensed in the State of New York who shall be qualified to be a member of the Medical Staff at the time of appointment and who must obtain Medical Staff membership as a condition of appointment.

The duties of the Medical Director must be defined by the Administration and the Governing Body of the Hospital, under the guidance of New York State regulations. However, nothing in this definition of duties shall be construed to infringe upon the rights, duties, and obligations of the Medical Staff as specified and enumerated in the remainder of these Bylaws. As Medical Director, he/she will not be a voting member of the Medical Board.

### **ARTICLE X**

#### **COMMITTEES OF THE MEDICAL STAFF**

##### Section 1. Categories, Appointments and Modifications

a. There shall be a Medical Board and such other standing and special committees of the Medical Staff, Departments, Divisions, Sections or other clinical units, as are necessary and desirable to perform any of the functions listed elsewhere in the Medical Staff Bylaws, Rules and Regulations or any of the related manuals maintained by the Medical Staff or Hospital. The composition, functions, reporting and meeting requirements of the standing and special committees of the Medical Staff shall be approved by the Medical Board. Any committee, whether of the Medical Staff, Department, Division, or Section or other clinical unit, or whether standing or special, that carries out any function or activity required by these Medical Staff Bylaws, or Rules and Regulations or policies, shall be deemed a duly appointed and authorized committee of the Medical Staff. The following standing committees of the Medical Staff are established and charged:

1. Medical Board

2. Medical Staff Performance Improvement Committee
3. Bylaws
4. Cancer Care
5. Credentials
6. Health Information Management
7. Pharmacy and Therapeutics
8. Nominating
9. Utilization Review

b. Except as otherwise provided for herein, appointment and/or reappointment to such committees shall be for one year and shall be automatic if no action is taken.

c. The President of the Medical Staff may, with the prior approval of the Medical Board, alter the number, nature, organization, composition, and function of any Standing Committee except the Medical Board and the Nominating Committee.

d. Non-Medical Staff consultants on Medical Staff committees are not voting members except where mandated by State or Federal Law.

#### Section 2. Records to be Maintained

A permanent and concise record shall be kept of attendance and all proceedings of all committees of the Medical Staff. A report of all committee meetings shall be forwarded to the Medical Board unless otherwise stated.

#### Section 3. Quorum/Attendance

The quorum for all Standing and/or Special committees shall be a majority of the membership of such committee. A minimum of 50% attendance at scheduled meetings will be required by all members on an annual basis.

#### Section 4. Medical Board

##### a. Composition

The Medical Board shall be the Executive Committee of the Medical Staff and shall act for the Medical Staff as a whole. It shall be confirmed by and is responsible to the Governing Body of the Hospital for the conduct of the medical affairs of the Hospital. The President of the Medical Staff shall be the presiding officer of the Medical Board. It shall consist of the following voting members:

1. The President of the Medical Staff
2. The Vice-President of the Medical Staff (President Elect)
3. The Secretary of the Medical Staff
4. The Treasurer of the Medical Staff

5. The Immediate, Past President of the Medical Staff
6. The Second Previous, Past President of the Medical Staff
7. Members elected at Large
8. Clinical Chairpersons of the following Departments:
  - i. Anesthesia
  - ii. Emergency Services
  - iii. Family Practice
  - iv. Internal Medicine
  - v. Obstetrics and Gynecology
  - vi. Pathology
  - vii. Pediatrics
  - viii. Psychiatry
  - ix. Radiology
  - x. Surgery
9. The Chief Executive Officer

The composition of the Medical Board shall be maintained so that the elected members hold a minimum of 50% of the available voting positions. Members-at-Large shall be elected where necessary to maintain this ratio. All members of the Medical Board hold their membership by virtue of their elected or appointed position, as applicable. In the event a member no longer retains such position, he/she shall no longer be a member of the Medical Board (i.e., members of the Medical Board are removed when they no longer hold the position that affords them membership on the Medical Board).

#### Section 5. Duties and Responsibilities of the Medical Board

In addition to those heretofore and hereafter specified in these Bylaws and in the Corporate Bylaws of the Hospital, the duties and responsibilities of the Medical Board shall include:

- a. Responsibility for the implementation, effectiveness, and coordination of all general policies and medical activities of the Staff, and its various Departments, Divisions and Sections.
- b. Receiving and acting upon the minutes and reports of all Medical Staff committees except the Nominating Committee.
- c. Providing formal liaison with and considering and recommending action to the CEO of the Hospital and to the Governing Body of the Hospital on all matters of medico-administrative and medical nature.

d. Fulfilling the Medical Staff's accountability to the Governing Body of the Hospital for the medical care rendered to patients of the Hospital by implementing and reporting on the activities and mechanisms for monitoring and evaluating the quality of patient care, identifying and resolving problems, and identifying opportunities to improve care.

e. Responsibility to ensure professional and ethical conduct on the part of all members of the Medical Staff and of recommending and/or instituting disciplinary measures where indicated.

f. Carrying out those duties and responsibilities enumerated in The Joint Commission Accreditation Manual as well as the Codes, Rules and Regulations of the Commissioner of Health of the State of New York and the statutes of the State of New York for a "Medical Board" or equivalent body.

g. To perform such other and additional duties as are reasonably necessary to carry out the foregoing relating to medical care at the Hospital.

h. Consider recommendations of the Bylaws Committee and report to the Medical Staff on proposals for changes in these Medical Staff Bylaws.

#### Section 6. Authority to Act on Behalf of the Medical Staff

Unless otherwise indicated herein (e.g., approval of amendments to the Medical Staff Bylaws), the Medical Board is empowered to act for the Medical Staff in the interval between Medical Staff meetings. Such delegation may be removed by a recommendation based upon a two-thirds vote of the Medical Staff at a meeting in which there is a quorum present, provided such recommendation is approved by the Governing Body.

#### Section 7. Meetings, Quorum and Voting Requirements of the Medical Board

a. The Medical Board shall meet regularly once each month at a date and time designated by the President of the Medical Staff in the notice of the meeting. In addition, Special meetings may be called at any time by the President of the Medical Staff or by any six (6) members of the Medical Board on one (1) week's written notice. With the consent of the Medical Board, the President of the Medical Staff may direct that the Medical Board not meet for one specified month during a Medical Staff Year.

b. A majority of the voting membership of the Medical Board shall be necessary to constitute a quorum for the conduct of business.

c. Unless otherwise specifically set forth in these Bylaws, the affirmative vote of at least a majority of the voting membership of the Medical Board shall be required for the approval of any action taken or recommendations made by the Medical Board.

d. Attendance at meetings of the Medical Board is mandatory except for good cause. Any non-elected member who fails to attend three (3) consecutive meetings or 50% of the total meetings in any Medical Staff year without good cause shall be referred to the CEO for corrective action.

e. All elected members of the Medical Board shall serve for a period of two years or until a successor is elected or appointed as set forth in Article VIII, Section 3 of these Bylaws.

Section 8. Medical Staff Performance Improvement Committee

- a. This committee shall be composed of the Vice-President of the Medical Staff, the Chairmen of the Performance Improvement Committees of each Department of the Medical Staff, the Chairman of the Utilization Review Committee and the CEO of the Hospital or designee. In addition, representatives of the Department of Medical Records, Nursing, the Governing Body of the Hospital, and other disciplines may be invited to attend.
- b. This committee shall meet not less than four times per year.
- c. Functions: The committee shall
  1. be responsible for surveillance, assessment, review, and implementation of quality improvement and assurance initiatives involving medical practice in the Hospital.
  2. study, evaluate and recommend to the Medical Board the policies and procedures for performance improvement efforts and programs, including the monitoring of indicators to evaluate the use of operative and other procedures that place patients at risk.
  3. promote and assist, where needed, in the development of multi-disciplinary standards of care for all patient activities with reference to existing rules and regulations of the professional staff.
  4. promote educational objectives of the Hospital.
  5. promote improved utilization of the Hospital facilities.
  6. endeavor to ensure medically ethical conduct.
  7. consider governmental and third-party insurance requirements in regard to quality improvement.
  8. serve as liaison with the Peer Review Committee of the Nassau County Medical Society and with any Professional Review Organization which may have jurisdiction over the Hospital.

Section 9. Bylaws Committee

- a. This committee shall consist of no less than five (5) members of the Active Medical Staff in Good Standing, appointed by the President of the Medical Staff.

- b. This committee shall meet as often as necessary but at least once a year to review or make recommendations regarding the Bylaws, Rules, and Regulations of the Medical Staff.
- c. It shall be the purpose of the committee to review or make recommendations for changes or amendments to the Bylaws and to review annually the Bylaws in order to keep them relevant in regard to changes in medical practice and changes in applicable laws and accreditation standards.

Section 10. Cancer Care Committee

- a. In order to provide leadership for an effective cancer program at the Hospital, the Cancer Committee shall be established and maintained as a multidisciplinary standing committee of the Medical Staff. Membership of the Cancer Committee shall be broadly representative of practitioners caring for patients with cancer at the Hospital and its outpatient facilities. Goals of the committee are to encourage improvement in the prevention, early diagnosis, pre-treatment evaluations, treatment of cancers, staging, rehabilitation, supportive care, and surveillance necessary to insure the above.
- b. The membership of the Cancer Committee shall be broadly representative of Board Certified or Board Eligible Physicians from all medical specialties and Allied Health Practitioners involved in the care of patients with cancer at the hospital and its outpatient facilities. Members shall be appointed by the President of the Medical Staff upon the recommendation of the Medical Director of Oncology Services.
  - 1. Physicians required to be included are representatives from the following clinical areas:
    - i. Diagnostic Radiology
    - ii. Pathology
    - iii. Radiation Oncology
    - iv. Medical Oncology
    - v. Surgery
    - vi. Cancer Liaison Physician
    - vii. Pain Management/Palliative Care Specialist (can be a physician or non-physician)
  - 2. Non-physician members required to be included from the following areas:
    - i. Administration
    - ii. Cancer Program

- iii. Oncology Nursing
  - iv. Social Services
  - v. Rehabilitation
  - vi. Performance Improvement
  - vii. Cancer Registry/Certified Cancer Registrar
3. Additional committee members may include but are not limited to representatives from the following areas:
- i. Clinical Research Data Manager
  - ii. American Cancer Society Representative
  - iii. Psychiatric or Mental Health Professional
  - iv. Specialty Oncology Physicians
  - v. Internal Medicine
  - vi. Family Practice
  - vii. Other physician and non-physician professionals involved in the care of cancer patients.
- c. The committee will meet at least quarterly, with documentation of activities and attendance.
- d. The Cancer Committee shall have the following functions/authority:
- 1. Provide patient's access for a consultative service in all major disciplines through a Tumor Board.
  - 2. Provide educational programs and conferences to include major sites of cancer seen at this Hospital.
  - 3. Monitor and evaluate care rendered to patients with cancer at the Hospital.
  - 4. Appoint a physician-advisor to actively supervise the Cancer Registry for quality control of abstraction, staging and reporting.
  - 5. Provide direction of program activities by developing and evaluating annual goals and assigning activity coordinators.
- e. Cancer Conferences are an integral part of improving the care of cancer patients by contributing to the management process and outcomes of patients as well as providing education to all who attend.

1. Conferences will be offered facility-wide on a weekly basis, in accordance with the ACOS/COC COMP approval category and on an emergency basis as needed. The required number of cases discussed, and physician attendance requirements will be set by the committee on an annual basis.
2. Case presentations will be a representation of the case mix seen at the hospital, largely prospective (minimum 75%), patient-oriented and consultative with a few didactic presentations.
3. Minutes of this multidisciplinary conference will be maintained by the Cancer Registry.

Section 11. Medical Staff Credentials Committee

- a. This committee shall consist of the Chief Executive Officer (or designee) and at least one (1) member from each of the following Departments:
  1. Family Practice
  2. Internal Medicine
  3. Obstetrics and Gynecology
  4. Pediatrics
  5. Psychiatry
  6. Surgery
- b. This committee shall meet upon the recommendation of the Medical Board.
- c. The Medical Staff Credentials Committee shall interview applicants individually who have not received an affirmative appointment decision from the Medical Board. The Medical Staff Credentials Committee shall further investigate, evaluate, and make recommendations to the Medical Board relative to the applicant's initial application or subsequent reapplication in conformity with these Bylaws.

Section 12. Health Information Management Committee

- a. This committee shall be chaired by a member of the Medical Staff selected by the President of the Medical Staff and consist of at least 5 members of the Medical Staff in Good Standing and a representative from the Department of Health Information Management, Patient Care Services, Administration and Performance Improvement.
- b. This committee shall meet at least nine times per year.
- c. The Health Information Management Committee functions are as follows:

1. This committee shall be responsible for the maintenance of medical records that meet desirable standards for usefulness in patient care and have validity as historical documents. The currently maintained medical records describing the conditions and progress of the patient, the therapy provided, the results thereof and the placement of responsibility for all actions shall be sufficiently complete to assure comprehensibility at any time.
2. It shall review each quarter an appropriate number of medical records of patients discharged the previous month to insure that the recorded clinical information is pertinent, adequate and complete for the purpose of optimum medical care and evaluation and in accordance with the Bylaws, Rules and Regulations of the Medical Staff of the hospital.
3. The committee shall make recommendations whenever necessary regarding changes in the format of the medical record as well as regarding its proper filing, indexing, storage, retention, and availability.
4. It shall recommend rules and regulations to the Medical Board regarding medical records and shall refer to the Clinical Chairperson of the Department any member of the Medical Staff who is chronically delinquent or deficient in attending to their records.
5. The functions of this committee shall generally conform to regulations, rules and procedures recommended and established by federal, state, and local agencies and by administrative agencies involved with recognized and accepted health care standards.

Section 13.      Pharmacy and Therapeutics Committee

- a. This committee shall include at least one representative each from the following Departments:
  1. Internal Medicine
  2. Surgery
  3. Family Practice
  4. Ob/Gyn
  5. Pediatrics
  6. Anesthesia

And shall also include the members of the pharmacy, nursing and the CEO or designee.
- b. This committee shall meet at least quarterly and shall hold such additional meetings as the Chairman shall deem appropriate.

- c. The Pharmacy and Therapeutics Committee shall have the following functions:
  - 1. This committee shall be responsible for the development and surveillance of drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. This responsibility shall include review of antibiotics utilization and the problem of drug reaction and interaction.
  - 2. The committee shall serve as an advisory group to the hospital's Medical Staff and the Pharmacy Department on matters pertaining to the choice of available drugs.
  - 3. This committee shall develop and review periodically a formulary or drug list for use in the hospital to be approved by the Medical Board. It shall also be responsible for the approval of a hospital Diet Manual approved by the Medical Board.

Section 14. Nominating Committee

- a. The Nominating Committee shall consist of five (5) members of the Active Medical Staff in Good Standing elected biannually. Two of these shall be elected by the Medical Board prior to the December Quarterly Staff meeting preceding the bi-annual June election, and the names of the two so elected shall be included in the notice of the December Quarterly Staff meeting. At that meeting, the Active Staff members shall elect three additional members. The five members shall choose one member to serve as Chairman. The recommendations of the Nominating Committee shall be announced at the March Quarterly staff meeting. No member shall serve on this committee for two successive terms. No incumbent officer shall be a member of this committee. No member of the Nominating Committee may be nominated or recommended by the committee as a candidate for Medical Staff office.
- b. This committee shall meet as often as necessary to carry out its functions on the call of the Chairman.
- c. It shall be the function of the committee to review the qualifications of the candidates for Medical Staff Office and to prepare a slate of candidates in accordance with these Bylaws.

Section 15. Utilization Review Committee

- a. This committee shall consist of the Director of Utilization Review and at least six members of the Active Medical Staff in Good Standing appointed by the President of the Medical Staff. In addition, representatives from Administration, Performance Improvement, Social Work, Nursing and Utilization Review may be invited to attend.
- b. This committee shall meet at least quarterly.

- c. The functions of this committee shall be:
1. To ensure proper utilization of the hospital with respect to the necessity for admission, proper classification of admission, length of stay, use of clinical facilities to insure proper utilization of the hospital's outpatient and clinic facilities.
  2. The committee shall implement and, if necessary, update the approved utilization review plan of the hospital. It shall carry out such duties in compliance with applicable federal, state, and local statutory administrative law.
  3. The committee shall delegate one or more of its members to sit on the Utilization or similar committee of the Nassau County Medical Society.
  4. The committee shall make recommendations to the Medical Board regarding improvements in the utilization of the hospital and its facilities.

Section 16. Special Committees

Special Committees may be appointed from time to time by the President of the Medical Staff for such purposes, as he/she shall deem appropriate. The term and authority of such committee shall be defined at the time of appointment but said term shall not extend beyond one (1) Medical Staff Year unless reappointed. Special Committees shall confine their work to the fulfillment of the purposes for which they were created and shall report to the Medical Board.

**ARTICLE XI  
STAFF MEETINGS**

Section 1. Regular Meetings/Quorum

a. Regular meetings of the Medical Staff shall be held quarterly in the months of October, December, March, and June each year for the transaction of business of the Medical Staff. Such meetings shall be generally held on the first Tuesday of the month, but a different day may be specified by the President of the Medical Staff, as necessary, preferably at a regularly scheduled meeting of the Medical Staff, but in no case less than thirty (30) days prior to the meeting.

b. Thirty (30) members of the Active Medical Staff in Good Standing shall constitute a quorum for the transaction of business at any meeting.

Section 2. Annual Meeting

The Annual Meeting of the Medical Staff shall be the June meeting. At this meeting, the officers and committees shall make their reports, and officers shall be elected in accordance with these Bylaws and shall take office at the end of the meeting.

Section 3. Notice of Meetings

Notice of all meetings shall be sent to all members of the Medical Staff at least ten days prior to

the meeting. Such notice shall state the date, time, and place of the meeting.

Section 4. Special Meetings of the Medical Staff

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff or at the request of the Governing Body of the Hospital, the Medical Board or on the petition of any 20 members of the Active Medical Staff. This meeting must be called within three weeks of the date of the request. At any Special meeting, no business shall be transacted except that stated in the notice calling the meeting. Written notification of the meeting must be mailed not less than 10 nor more than 20 days in advance of the meeting.

**ARTICLE XII  
IMMUNITY FROM LIABILITY**

Section 1. Statutory Protection

Pursuant to Section 6527 of the Education Law of the State of New York, and pursuant to 42 U.S.C. Section IIII2, no Medical Staff Member who serves as a member of (1) a committee established to administer a utilization review plan of a hospital or (2) a committee of the Medical Staff of a hospital having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, shall not be liable in damages to any person for any action taken or recommendation made by him/her within the scope of his/her function as a member of such a committee, provided that such action or recommendation is taken without malice and in the reasonable belief after reasonable investigation that the act or recommendation was warranted, based upon the facts disclosed.

Section 2. Conditions of Membership

The following shall be an express condition to any practitioner's application for, or exercise of, clinical privileges at the Hospital:

a. That any act, communication, report, recommendation, or disclosure, with respect to any such 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 maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

b. That such privileges shall extend to members of the Hospital's Medical Staff, the Medical Board thereof, the Governing Body of the Hospital, its other practitioners, the CEO and his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Governing Body of the Hospital or of the Medical Staff.

c. That such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) application for appointment or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action including summary suspension; (4) hearings and appellate review, and (5) other Hospital,

Departmental, service or committee activities related to quality patient care and inter-professional conduct.

d. That the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other factor that might directly or indirectly have an effect on patient care.

e. That in furtherance of the foregoing, each practitioner shall upon request of the Hospital, execute releases in accordance with the tenor and import of this Section in favor of the individuals and organizations specified above, subject to such requirements including those of good faith, absence of malice and the exercise of reasonable effort to ascertain truthfulness, as may be applicable under the statutory and common law of the State of New York.

### **ARTICLE XIII PARLIAMENTARY PROCEDURE**

All meetings of the Medical Staff, whether Regular or Special, or of its committees, whether regular or special, as outlined in these Bylaws, shall be regulated by modified Robert's Rules of Order and minutes of meetings shall be kept.

### **ARTICLE XIV DUES AND ASSESSMENTS**

Active Medical Staff members must fulfill the payment of the annual dues and assessments as agreed by the Medical Staff for each Medical Staff Year. Payment will be a condition of appointment and reappointment. The Medical Board will review the amount of the dues periodically. Dues are paid at the time of reappointment for two years. A member who fails to pay Medical Staff Dues and assessments within ninety (90) days after notice by certified mail, return receipt requested, shall be automatically suspended from practicing at the Hospital and shall remain suspended until such time as such payments are received pursuant to Article IV Section 4 of these Bylaws.

### **ARTICLE XV AMENDMENTS TO BYLAWS**

Proposed amendments to the Bylaws shall be referred to the Bylaws Committee from either the Governing Body of the Hospital, the Medical Board, or any committee, Department, Division or Section of the Medical Staff or the Medical Director. Proposed amendments may be sent to the Medical Board for information.

To be adopted, an amendment to the Bylaws shall require a two-thirds (2/3) vote of the Active Staff in Good Standing who are present at a Medical Staff meeting or by a vote in favor of the amendment by a majority of the ballots returned within fifteen (15) days of being mailed or electronically transmitted to all Active Staff in Good Standing (e.g., if 500 ballots are mailed and 100 are returned within 15 days, 51 of the returned ballots must be in favor of the amendment in order for it to be passed). If a vote is to be taken at a Medical Staff meeting, notice of proposed amendments must be given to the Medical Staff by mail at least thirty (30) days but not more than sixty (60) days in advance of the Regular or Special Medical Staff Meeting in which the proposed

amendments will be considered. For purposes of this Article a quorum is considered to be those voting members of the Medical Staff present at the meeting.

The Medical Staff's affirmative action shall be forwarded to the Governing Body of the Hospital for its action. Amendments shall be effective when approved by the Governing Body, which shall review and act on the amendment at its next regularly scheduled meeting.

## **ARTICLE XVI RULES AND REGULATIONS/POLICIES AND PROCEDURES**

The Medical Board shall adopt such Rules and Regulations as may be necessary for the proper conduct of the work of the Medical Staff and as necessary to implement more specifically the general principles found in these Bylaws. Such Rules and Regulations shall be supplementary to these Bylaws. Unless otherwise provided here, these Rules or Regulations may be amended at any Regular meeting of the Medical Board, following notice to the Medical Staff of the proposed amendment. Amendments to the Rules and Regulations shall be presented to the Medical Staff at its next meeting following approval by the Governing Body.

The Medical Staff may adopt policies and procedures which shall be appended hereto. Policies and procedures may be recommended to the Governing Body by a majority vote of the Medical Board, following communication to the Medical Staff regarding the proposed policy. Such policies become effective when adopted by the Governing Body and shall be presented to the Medical Staff at its next scheduled meeting following Governing Body approval.

In addition, the Medical Staff, through the verbal report of its President or by written submission signed by twenty percent (20%) of its membership may communicate with, or propose Rules and Regulations and policies directly to, the Governing Body. When amendments to the Rules and Regulations or policies are communicated directly to the Governing Body, the Medical Staff must first communicate the proposed amendment to the Medical Board.

In cases where there is a documented need for an urgent amendment to Rules and Regulations or policies in order to comply with law, regulation or accreditation standard, the Medical Board may provisionally adopt, and the Governing Body may provisionally approve such urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified of the provisional amendment through a direct mailing or electronic transmission. If the Medical Staff, through its President, does not notify the CEO/President of its objection to the provisional amendment within ten (10) days of notification, the provisional amendment will become permanent. If there is a conflict, the process described below in Article XVII is followed and, if applicable, a revised amendment submitted to the Governing Body for action. The provisional amendment shall remain in effect until a revised amendment is adopted by the Governing Body.

**ARTICLE XVII**  
**CONFLICTS BETWEEN MEDICAL BOARD AND MEDICAL STAFF**

If a conflict arises between the Medical Staff and the Medical Board, including a conflict involving a proposal to adopt a Rule and Regulation or policy, the Joint Conference Committee, as described in the Hospital Bylaws, shall meet to identify potential resolutions to the conflicted issues. The Joint Conference Committee shall call a special meeting to review the issue prior to any action related to the conflicted issue or prior to the submission of disputed Rule and Regulation or policy to the Governing Body. If the Joint Conference Committee is unable to resolve the matter, it shall be referred to the Governing Body for action. The Joint Conference Committee may be convened upon request of the Medical Staff President acting on behalf of the Medical Board or a by petition of twenty percent (20%) of the voting members of the Medical Staff.

**ARTICLE XVIII**  
**ADOPTION**

These Bylaws shall be adopted at any meeting of the Active Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Governing Body of the Hospital and be equally binding on the Governing Body of the Hospital and Medical Staff. Anything contained in these Bylaws to the contrary notwithstanding, the members of all pre-existing categories, ranks and classifications of the Medical Staff service immediately preceding the effective date of these Bylaws shall continue to serve with the same powers, duties, rights and responsibilities possessed at such time until the expiration of their term or the expiration of the Medical Staff Year in which these Bylaws are adopted, whichever shall occur first. Medical Staff Rules and Regulations are adopted by the Medical Board and shall be equally binding on the Governing Body of the Hospital, the Medical Staff and Allied Health Practitioners, and shall replace any previous Rules and Regulations.

**MOUNT SINAI SOUTH NASSAU  
OCEANSIDE, NEW YORK**

**MEDICAL STAFF BYLAWS**

Approved Board of Directors:

6/29/87

6/27/88

10/3/88

4/30/90

3/03/92

6/26/95

9/30/96

11/25/96

1/27/97

9/22/97

9/28/98

1/25/99

9/22/99

6/13/00

11/27/00

1/22/01

6/11/02

9/23/02

11/28/06

9/26/17

1/28/2020

6/16/2020