SUNNYVIEW REHABILITATION HOSPITAL

St. Peter’s Health Partners

MEDICAL STAFF BYLAWS

Medical Executive Committee Approved: July 14, 2016

Governor Board Approved: July 20, 2016

BYLAWS OF THE MEDICAL STAFF OF SUNNYVIEW HOSPITAL AND REHABILITATION CENTER
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BYLAWS OF THE MEDICAL STAFF OF
SUNNYVIEW HOSPITAL AND REHABILITATION CENTER

PREAMBLE

WHEREAS, Sunnyview Hospital and Rehabilitation Center (the hospital) is a non-profit corporation organized under the laws of the State of New York; and,

WHEREAS, its purpose is to serve as a rehabilitation hospital providing patient care and education; and,

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care, treatment and services in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital's governing body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and governing body are necessary to fulfill the hospital's obligations to its patients;

THEREFORE, the physicians, osteopaths, dentists, and podiatrists practicing in this hospital hereby organize themselves into a Medical Staff in conformity with these bylaws.

DEFINITIONS

1. The term “Medical Staff” means all medical physicians or osteopaths holding unlimited licenses, duly licensed dentists and podiatrists, who are privileged to attend patients in the hospital.

2. The term “governing body” means the Board of Directors of the hospital.

3. The term “Executive Committee” means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the governing body.

4. The term “Chief Executive Officer” means the individual appointed by the governing body to act in its behalf in the overall management of the hospital.

5. The term “Practitioner” means an appropriately licensed medical physician, with an unlimited license or an appropriately licensed dentist, podiatrist or osteopath.

6. The term “Allied Health Professional” means (A) Independent- This category of practitioners will consist of individuals who hold a doctorate in psychology and a New York State license or all others who may hold a New York State license if required by discipline as designated by the governing board; and, (B) certified physicians’ assistants, nurse practitioners and clinical technicians who are either employees of the hospital or of Medical Staff members.

7. The term “Peer” means another practitioner from the same professional discipline. This could refer to a specific discipline as in a peer reference or a more generic meaning as in a group of peers in a peer review investigation.
ARTICLE I: NAME

The name of this organization shall be the Medical-Dental Staff of Sunnyview Hospital and Rehabilitation Center.

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To insure that all patients admitted to or treated in any of the facilities, departments or services of the hospital shall receive the same standard of care, treatment or services throughout the hospital;

2. The Medical Staff insures a high level of professional performance of all practitioners and Allied Health Professionals authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner’s performance in the hospital.

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

4. To cooperate with the Albany Medical College and other teaching institutions to provide clinical education for doctors, nurses, therapists and other disciplines related to rehabilitation;

5. To initiate and maintain rules and regulations for self-government of the Medical Staff as agents of the hospital; and,

6. To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the governing body and the Chief Executive Officer.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

SECTION I: NATURE OF MEDICAL STAFF MEMBERSHIP

It is the policy of Sunnyview Hospital and Rehabilitation Center to prohibit discrimination in granting or denying Medical Staff membership or clinical privileges based on race, color, religion, sex, disability, or national origin. Membership on the Medical Staff of Sunnyview Hospital and Rehabilitation Center is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws.

SECTION 2: QUALIFICATIONS FOR MEMBERSHIP

a. Only physicians, osteopaths, dentists and podiatrists currently licensed to practice in the State of New York, DEA registered if required in department criteria, proof of malpractice liability insurance of at least $1 million/ $3 million, evidence of Board certification or proof of successful completion of post-graduate residency training program or the equivalent,
and other criteria that may be prescribed by the governing body after consultation with the Executive Committee shall be qualified for membership on the Medical Staff.

b. Only a physiatrist with whom the Hospital has a contractual relationship, otherwise, qualified in accordance with Article III, Section 2 of the Medical Staff Bylaws, shall be permitted to make an application to become a member of the Active Medical Staff or otherwise become a member of the Active Medical Staff. In the event a physiatrist submits an application in contravention of this restriction, the application shall not be considered and the Hearing and Appellate Review procedures shall not apply. Additionally, upon termination of the contractual relationship between the physiatrist and the Hospital for any reason or the expiration of the term of the contract, the physiatrist shall immediately resign his/her Active Medical Staff membership and privileges. Such resignation shall take place despite the Hearing and Appellate Review procedures.

c. Acceptance of membership on the Medical Staff shall constitute the staff member’s agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association or by the Code of Ethics of the American Dental Association, or American Podiatric Medical Association Ethic Guidelines, whichever is applicable.

SECTION 3: CONDITIONS AND DURATION OF APPOINTMENT

a. Initial appointments and reappointments to the Medical Staff shall be made by the governing body. The governing body shall act on appointments, reappointments or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these bylaws; provided that in the event of unwarranted delay (100 days following receipt of completed application) on the part of the Medical Staff, the governing body may act without such recommendations on the basis of documented evidence of the applicant’s or staff member’s professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

b. Medical Staff reappointments will be for a two-year period. The Medical Staff year begins on January 1. All initial appointments to the Medical Staff will be for a period of not more than two years beginning with Governing Board approval and subsequent appointment will be according to the department appointment schedule. This will place the applicant on the appropriate reappointment cycle. All initial appointments will have a preceptor designated for a period of one year, unless otherwise determined by the Department Chief. At the end of the preceptor period, if the report is unsatisfactory, recommendations will be made to continue the preceptorship or to terminate the practitioner’s privileges. In either case, the practitioner may exercise appeal rights as stipulated in these bylaws. Other practitioners and Allied Health Professionals appointed to the Medical Staff or allied health staff will be required to serve a preceptorship of not less than one year.

c. It shall be incumbent upon each individual member of the Medical-Dental Staff to inform the Chair of the Medical Executive/Credentials Committee, in a timely manner, of any changes made on a voluntary or involuntary basis or formal action initiated that could result in a change of his/her license, DEA registration, removal or denial of participation from any managed care program or plan for the reimbursement of services, professional liability insurance coverage, membership or employment status or clinical privileges of other health care facilities or affiliations and the disposition of medical malpractice claims.
d. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the governing body, in accordance with these bylaws.

e. Every application for staff appointment shall be signed by the applicant and shall contain the applicant’s specific acknowledgement of every Medical Staff member’s obligations to provide continuous care and supervision of his/her patients, to abide by the Medical Staff bylaws, rules and regulations, to accept committee assignments and to accept consultation assignments. In addition, every applicant will acknowledge any provision for release and immunity for the hospital in civil liability in order to gather all pertinent information needed to properly evaluate the applicant.

f. Practitioners in administrative positions who desire Medical Staff membership and/or privileges shall be subject to the same credentialing process as others on staff.

g. Continuous performance review monitoring shall include antibiotic/prescription utilization medication near misses, patient/peer complaints, Quantros incident analysis, infection control, IPRO/LIVANTA, utilization review, blood utilization, Medical Record delinquencies, morbidity, and mortality.

h. Trinity Health requires Serious Reportable Events (SREs) be reported to the Serious Reportable Events Council. The NQF-Endorsed list of SREs has been adopted for use for this purpose and it includes sentinel events and those resulting in permanent harm. A SRE – Incident Detail form, RCA, and work plan are to be completed within the established time frames. Every six-month follow up reports will be completed as requested. If the RCA identifies a problem with practitioner performance it will be referred to the practitioner’s department chair for further peer review and decisions with regard to need for monitoring or disciplinary action.

i. The New York Patient Occurrence Reporting and Tracking System (NYPORTS) is an adverse event reporting system implemented pursuant to New York State Public Health Law Section 2805-l, Incident Reporting. For the purpose of NYPORTS reporting, an occurrence is an unintended adverse and undesirable development in an individual patient’s condition occurring in a hospital. Serious occurrences defined as patient deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease, or proper treatment in accordance with generally accepted medical standards are investigated individually and require the hospital to conduct a Root Cause Analysis. If the Root Cause Analysis identifies a problem with practitioner performance it will be referred the practitioner’s department chair for further peer review and decisions with regard to need for monitoring or disciplinary action.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE MEDICAL STAFF

The Medical Staff shall be divided into attending, assistant attending, covering attending, consulting, and honorary categories. The Attending, Assistant Attending, Covering Attending, and Consulting Staff are eligible to vote only if they have been involved in the care of at least 20 inpatients or more upon reappointment. All members of the Medical Executive Committee or members on any Medical Staff Committees shall be eligible to vote.
SECTION 2: ATTENDING MEDICAL STAFF

The attending Medical Staff shall consist of Medical Staff members who regularly admit patients to the hospital, who are located within one-hour driving distance to the hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the attending Medical Staff, including, where appropriate, emergency service, care, and consultation assignments. Members of the attending Medical Staff shall be appointed to a specific department, to hold office, and to serve on Medical Staff committees and shall be encouraged to attend scheduled or special meetings.

SECTION 3: ASSISTANT ATTENDING STAFF

Same as above except practitioners are not board certified.

SECTION 4: COVERING ATTENDING

The covering attending Medical Staff shall consist of Medical Staff members who will be able to admit patients to the hospital under another Attending’s service. He/She shall provide continuous care of the patient, including where appropriate emergency service care, until the return of the assigned attending or designee. Covering attending shall not be eligible to hold office or to serve on Medical Staff committees and will not be required to attend Medical Staff meetings.

SECTION 5: CONSULTING STAFF

The consulting staff shall consist of specialists whose services will be necessary to serve particular patients. Duties of the consulting staff shall be to provide consulting service on request from any member of the Medical-Dental Staff who is attending a patient at Sunnyview Hospital and Rehabilitation Center and also to provide consultation in those cases, which are required by the rules of the hospital as related to their specialty. Attendance at Medical Staff meetings is encouraged but not required. Consultants may be granted admitting privileges to attend subacute patients only on a case-by-case basis in accordance with Medical Staff policy.

SECTION 6: HONORARY MEDICAL STAFF

The honorary Medical Staff shall consist of practitioners who are not active in the hospital and who are to be honored by emeritus positions. These may be practitioners who have retired from active hospital practice or who are of outstanding reputations, not necessarily residing in the community. Honorary staff members shall not be eligible to attend or consult on any patients. They may hold office or serve on standing Medical Staff committees. Honorary Medical Staff may vote only if they are serving on a Medical Staff Committee.

SECTION 7: SPECIAL REQUIREMENTS REGARDING PULMONOLOGISTS

To ensure a high standard of patient care through pulmonologist/intensivists, (i) no more than four pulmonologists, selected pursuant to objective procedures set forth in Hospital policies, may be members of the Attending Medical Staff at a time, and (ii) any pulmonologist who is a member of the Covering Attending Medical Staff must participate in clinical duties set forth in Hospital policies and must assume the same coverage responsibilities as members of the Attending Medical Staff.
ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1 - PRE-APPLICATION PROCESS

a. A pre-application for appointment to the Medical Staff shall be sent promptly, upon request, only to those individuals who indicate an intention to utilize the Hospital as required by the staff category to which they desire appointment.

b. A completed pre-application form with copies of all required documents must be returned to the Medical Staff Office within thirty (30) days after receipt of same if the individual desires further consideration.

c. Upon receipt of a completed pre-application form, the Medical Staff Office shall forward the pre-application to the Executive Committee for consideration.

d. Absent some mitigating factor, those individuals who meet the criteria shall be given an application for appointment, which shall be in a form approved by the Executive Committee. Individuals who fail to meet the criteria shall not be given an application and shall be so notified.

SECTION 2 - APPLICATION PROCESS

a. All applications for appointment to the Medical Staff shall be submitted by the applicant to the Medical Staff office, along with a current photograph. (e.g. driver’s license or passport or hospital picture ID card). The application shall contain a request for specific clinical privileges.

b. The application shall require detailed information including but not limited to information concerning the applicant’s professional qualifications, the names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can and are willing to provide adequate references pertaining to the applicant’s professional competence and character. These references may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty areas as the applicant.

c. The names and complete addresses of the department chairpersons of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great, or if a number of years have passed since the applicant worked at a particular hospital, the Executive Committee and the Board may take such factors into consideration.

d. Information as to whether the applicant’s Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily limited, relinquished, withdrawn, denied, revoked, suspended, subjected to probationary conditions, reduced or not renewed at any other hospital or health care facility.

e. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications. The hospital
has the burden of resolving any doubts about such qualifications by obtaining appropriate references, as well as providing evidence of current malpractice insurance. This will require a review of all hospital affiliations over the preceding 5 years of practice.

f. The applicant shall have the burden of producing information in the form of documentation of continuing medical/dental education.

g. The applicant must provide information of any past or pending medical/dental misconduct proceedings or malpractice actions in this or in any other state together with the substance of the allegations, challenges to any licensure or registration, voluntary or involuntary relinquishment of either voluntary or involuntary termination of Medical Staff membership, limitation, reduction or loss of clinical privileges. A waiver of any confidentiality provisions concerning required data will be provided in writing.

h. The applicant must not be excluded or otherwise ineligible from participation in Federal Health Care Programs, funded in whole or in part by the federal government, including but not limited to Medicare and Medicaid. For those applicants who are currently excluded or otherwise ineligible from participation in a federally funded health care program, including but not limited to Medicare and Medicaid, the President/CEO or Vice President of Medical Affairs shall notify the applicant by special notice that the application will not be processed because the applicant does not meet the basic qualifications for Medical Staff membership and/or clinical privileges. The Hospital’s refusal to process such an application does not entitle the applicant to any substantive or procedural rights, including a hearing.

i. In addition to information provided by a practitioner and/or obtained through the usual credentialing process, it is mandatory under Title IV of Public Law 99-660, Health Care Quality Improvement Act of 1986, that the hospital both query of and report to the National Practitioners Data Bank information as it relates to professional competence and conduct of practitioners and, in some cases, other licensed health care practitioners the following: medical malpractice payments, adverse licensure actions, adverse actions on clinical privileges and adverse actions on professional society memberships lasting more than 30 days.

If the hospital fails to report adverse actions on clinical privileges, the immunity protection provided under the Act will not apply to the hospital for professional review activities for a 3-year period.

It is the duty of the hospital’s authorized representative (a) to notify the Board of Medical Examiners within 15 days of the date the adverse professional review action was taken against a physician or dentist and (b) to report the voluntary surrender of Medical Staff membership or clinical privileges of a physician or dentist to the Board of Medical Examiners if the physician or dentist is under investigation for possible incompetence or improper professional conduct or the surrender is in lieu of an investigation. Hospitals must report adverse actions they have taken against the clinical privileges of a physician or dentist. Such actions include reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges. Hospitals may report such actions when taken against clinical privileges of health care practitioners (e.g. physicians’ assistants or nurse practitioners). Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient.
Revisions to such an adverse action previously reported must be reported.

j. Once verification of all pertinent information has been completed, the Medical Staff Office shall submit the application and all supporting materials to the Executive Committee for evaluation.

k. By applying for appointment to the Medical Staff, each applicant thereby agrees to appear if requested for personal interview in regard to the application. In addition, the applicant authorizes the hospital to consult with members of medical and administrative staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications and consents to the hospital’s inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for staff membership.

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

m. The applicant must submit a physical examination and recorded medical history signed by the applicant’s licensed health care provider. A certificate of immunization against rubella. A certificate of immunization against measles. Proof of a tuberculin skin test or FDA approved blood assay for the detection of latent tuberculosis infection prior to affiliation and annually thereafter for negative findings. Positive findings shall require appropriate clinical follow-up but no repeat tuberculin skin test or blood assay. Thereafter, annual reassessment of health status by the applicant is required. It shall be the right of Sunnyview Hospital Rehabilitation Center, through its Medical Staff Executive Committee and/or the hospital’s Chief Executive Officer, to require an independent medical examination (at any time) should a Medical Staff member or an applicant’s physical or psychological ability to meet the requirements of accepted patient care be questioned.

n. All documentation collected during initial application and subsequent reappointments will be maintained in an individual credential file and shall be the property of the hospital.

o. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: - The applicant’s current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant’s relevant training - The applicant’s current competence.

SECTION 3: APPOINTMENT PROCESS

a. After receipt of the completed application by the Medical Staff office, the Executive Committee shall examine the evidence of the character, professional competence,
qualifications and ethical standing of the practitioner and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, profile data from the American Medical Association (AMA). Further, all applicants for Medical Staff membership regardless of classification shall provide at the time of initial application or renewal, a current certificate of insurance by an insurance carrier licensed within the State of New York as verification of malpractice liability coverage with a minimum of $1 million/ $3 million per claim whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested. An interview may be scheduled with either the Chief of the Medical Staff, the Medical Director, or Department Chief at a mutually convenient time. All decisions regarding staff membership and granting of privileges shall be made with respect to the quality of care demonstrated by the applicant.

b. At its next regular meeting the Executive Committee shall determine whether to recommend to the governing body that the practitioner be provisionally appointed to the Medical Staff, that he/she be rejected for Medical Staff membership or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, and the probationary conditions relating to such clinical privileges.

c. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within 60 days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for staff membership.

d. When the recommendation of the Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the governing body, which shall take action within 60 days.

e. When the recommendation of the Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. If the recommendation is that the applicant be appointed but that some of the requested privileges not be granted, the applicant has an option of withdrawing the request. If the applicant does not exercise this option, no such adverse recommendation need be forwarded to the governing body until after the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these bylaws. Adverse recommendations shall be accompanied by reason(s) for such action.

f. If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee’s reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph d of this Section 2. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner, by certified mail, return receipt requested. The Chief Executive Officer shall also forward recommendation and documentation to the governing body but the governing body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article VIII of these bylaws.

g. At its next regular meeting after receipt of a favorable recommendation, the governing body or its Executive Committee shall act on the matter. If the governing body’s decision
is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these bylaws and until there has been compliance with subparagraph i. Of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

h. At its regular meeting after all of the practitioner’s rights under Article VIII have been exhausted or waived, the governing body, or its duly authorized committee, shall act in the matter. The governing body’s decision shall be conclusive, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the governing body shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

i. Whenever the governing body’s decision will be contrary to the recommendation of the Medical Staff Executive Committee, the governing body shall forward the matter for review and recommendations to a special review committee comprised of not less than 3 governing body members as appointed by the Chair of the Board and not less then 3 physician members as appointed by the Chief of the Medical Staff. The governing body shall take under consideration the recommendation of this committee before making its final decision.

j. When the governing body’s decision is final, it shall send notice of such decision through the Chief Executive Officer to the secretary of the Medical Staff, to the chairs of the Executive Committee and of the department concerned, and by certified mail, return receipt requested, to the practitioner.

SECTION 4: VERIFICATION OF IDENTITY/ORIENTATION

a. Prior to seeing any patients, the provider must make an appointment with the medical staff office to verify their identity in person (driver’s license, passport).

b. The provider must be oriented to Sunnyview Hospital and be provided with appropriate log-in information and instructions for use of systems, as well as other pertinent information.

c. The provider must possess a current photo identification badge, which must be clearly visible above the waist and worn at all times when seeing Sunnyview patients.

SECTION 5: REAPPOINTMENT PROCESS

a. At least 180 days prior to the expiration date of each practitioner’s reappointment, the Medical Staff Office shall e-mail a reappointment application to each appointee whose application is up for renewal.
b. A biennial consideration for reappointment of each Medical-Dental staff appointee shall occur as follows: All applicants for reappointment shall be reappointed by department according to a two-year schedule. An appointee’s request for a change in appointment category or in privileges may be processed in a year in which he/she is not scheduled for biennial review; however, such appointee’s reappointment shall also be reviewed in accordance with the schedule set forth above.

c. Within 30 days of receiving the reappointment application, each Medical-Dental Staff appointee shall submit to the Medical Staff Office a completed reappointment application form. A Medical-Dental Staff appointee’s failure to submit a completed application form in a timely fashion shall result in an automatic expiration of the appointment privileges without a hearing. In addition, the applicant will submit any and all information on pending malpractice cases which have arisen since the last reappointment. Each recommendation concerning the reappointment of a Medical Staff member shall be based upon such member’s current licensure status, malpractice history, documentation of continuing education, professional competence and clinical judgment in the treatment of patients, ethics and conduct, physical and mental ability to perform requested privileges, compliance with hospital bylaws and the Medical Staff bylaws, rules and regulations, cooperation with hospital personnel, use of the hospital’s facilities for patients, relations with other practitioners and general attitude toward patients, the hospital and the public, as well as a departmental recommendation.

If the applicant has had no patient activity during the previous reappointment term, the appointee shall be ineligible for reappointment, unless he/she provides coverage for another staff member or holds a specialty not otherwise represented.

When insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations. At least one peer recommendation should be in the same professional discipline as the applicant or be a department chief/chair with personal knowledge of the applicant’s ability to practice.

d. The hospital must query the Data Bank at the time it performs its scheduled review for reappointment of the members of its Medical Staff and at the time it performs its scheduled re-delineation of clinical privileges but no later than every two years.

e. The governing body will act at its first meeting following receipt of Medical Staff recommendations. The Executive Committee shall make written recommendations to the governing body, through the Chief of the Medical Staff, concerning the reappointment, non-reappointment, and/or clinical privileges of each practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

f. Failure to file an application for reappointment within the time period and completed as required by this section shall result in the automatic relinquishment of a practitioner’s privileges and prerogatives, as of their anniversary date. If the appointee fails to submit an application for reappointment, he/she shall be deemed to have resigned his/her appointment on the Medical-Dental staff.

g. Thereafter, the procedure provided in Section 3 of this Article V relating to recommendations on applications for initial appointment shall be followed.
SECTION 5: LEAVE OF ABSENCE

A Member of the Medical Staff may for good cause be granted a leave of absence for a definite period of time not to exceed twelve (12) months. Request for leave of absence shall be made to the Medical Staff Office in writing stating the reason for the request and shall state the beginning and ending dates of the leave. The Medical Staff Credentialing Coordinator shall transmit the request to the Medical Executive Committee which shall review and forward their recommendation for action by the Board. Should the Staff Member be denied a requested leave of absence, he/she shall have the right to appeal as provided in Article VIII of these Bylaws.

Thirty (30) days prior to the termination of a leave of absence, or at an earlier time a Medical Staff Member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. Criteria for reinstatement will be the same as those for reappointment. A failure without good cause to timely request reinstatement shall be deemed voluntary resignation from the Medical Staff.

A request for extension may be considered by the Medical Executive Committee, but in no event shall the Leave of Absence exceed the period of two years.

During the period of the leave, the member will not exercise clinical privileges or be required to attend meetings. Decision concerning reappointment will be suspended pending termination of leave. Upon written request by the member, this decision may be waived by the Medical Executive Committee under unusual circumstances.

ARTICLE VI: CLINICAL PRIVILEGES

SECTION 1: CLINICAL PRIVILEGES RESTRICTED

a. Every practitioner practicing at this hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the governing body, except as provided in Section 2 and 3 or this Article VI. Those privileges granted will be specific to the hospital and will be in accordance with state law and criteria established by the respective department(s). The hospital consistently determines there is sufficient space, equipment, staffing and financial resources in place or available within ninety days to support each requested privilege.

b. 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 on the applicant’s education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The applicant will provide appropriate information so that the hospital can establish qualifications and competency. Information regarding each practitioner’s scope of privileges is updated as changes in clinical privileges for each practitioner are made.

c. Periodic determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals and review of the records of the Medical Staff which document the evaluation of the member’s participation in the delivery of medical care.
d. Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. Dentists may not admit patients. They will provide dental care for patients when requested by the patient’s attending physician and under his/her supervision.

e. Privileges granted to podiatrists shall be based on their training, experience and demonstrated competence and judgment. Podiatrists may not admit patients. They will provide podiatric care for patients when requested by the patient’s attending physician and under his/her supervision.

The podiatrist may write orders within the scope of his/her license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. He/She shall agree to comply with all applicable Medical Staff bylaws, rules and regulations at the time of application for clinical privileges.

The delineation and granting of clinical privileges for podiatrists shall be accomplished in a manner consistent with the overall procedure established for the Medical Staff as detailed in Article V, the rules of procedures for corrective action as detailed in Article VII and the hearing procedure and appeal mechanism detailed in Article VIII.

f. The medical history and physical examination are completed and documented by a physician or other qualified licensed individual in accordance with state law and hospital policy. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia service.

g. Restricted privileges may be granted to licensed Physicians’ Assistants/ Nurse Practitioners functioning in a clinical capacity as personal representatives of practitioners currently holding staff privileges within the hospital. The delineated duties and responsibilities requested for the Physicians’ Assistant/ Nurse Practitioner must be specifically outlined by the responsible practitioner at the time of application and shall be based upon the individual's formal training and demonstrated competence and experience in carrying out the clinical activities. It shall be the responsibility of the Executive Committee to carry out a formal review of the requested privileges and to present a recommendation to the Safety & Quality Committee of the Board of Directors for consideration. The responsible practitioner shall retain at all times full responsibility for the care and treatment rendered by his/her representative and at no time shall the Physicians’ Assistant/ Nurse Practitioner be granted privileges outside the scope of their formal training or the parameters set out in their licensure and the applicable statutes.

Disciplinary and corrective action of Allied Health Staff will be carried out in a manner consistent with the mechanism established for a member of the Medical Staff as detailed in Articles VII and VIII.

- All Medical Staff members must undergo training, if needed, and become proficient in Sunnyview Rehabilitation Hospitals electronic medical record and associated
applicable clinical computer systems as well as any future electronic computer based medical records. This includes the enforcement of all policies/procedures related to electronic/computerized records.

SECTION 2: ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are not eligible to vote.

A. Independent Allied Health Professionals: These practitioners may provide patient care services within the limits of their professional skills and abilities. The degree of participation of independent Allied Health Professionals in patient care shall be determined according to protocol or privileges recommended by the Medical Staff and approved by the governing board.

Independent Allied Health Professionals shall:

1. Exercise independent judgment in their areas of competence, provided that the attending physician shall have the ultimate responsibility for patient care.

2. Participate in the treatment of patients under the general supervision or direction of the attending physician.

3. Record reports and progress notes on the patient’s records and write orders for treatment to the extent established in the rules and regulations of the Medical Staff, provided that such orders are within the scope of his/her license, certificate or other legal credentials.

Applications for clinical privileges as an independent Allied Health Professional shall be generally processed in accordance with the procedure set forth for appointment to the Medical Staff, including a current certificate of insurance by an insurance carrier licensed within the State of New York as verification of malpractice liability coverage with a minimum of $1 million/ $3 million aggregate per claim or medical incident.

B. Dependent Allied Health Professionals: The employer of the individual who is seeking approval as a dependent Allied Health Professional shall present a written statement of the clinical duties and responsibilities of said individual to the applicable department chairperson and to the Executive Committee for review and recommendation, prior to utilizing said individual within the hospital. The employer shall complete such forms as may be requested by the Executive Committee.

To employ or extend privileges only to registered physician’s assistants and registered specialist’s assistants whose training and experience are within the scope of practice for which the physician or physicians to whom they are assigned are qualified.

The employer of the dependent Allied Health Professional shall assume full responsibility, and be fully accountable for the conduct of said individual within the hospital. It is the further responsibility of the employer of the dependent Allied Health Professional to acquaint said individual with the applicable rules and regulations of the Medical Staff and the hospital, as well as appropriate attending Medical Staff and hospital personnel with whom said individual shall have contact at the hospital. Said employer shall furnish
evidence of professional liability insurance coverage, at a minimum of $1 million/ $3 million aggregate per claim or medical incident, for such individual.

The clinical duties and responsibilities of an Allied Health Professional within the hospital shall terminate if the Medical Staff appointment of the employer is terminated for any reason or if the employer’s clinical privileges are curtailed to the extent that the professional services of said individual within the hospital are no longer necessary or permissible to assist the employer, or if malpractice insurance of such employer is cancelled. In the event of a lapse of time between employers, a leave of absence can be requested by the Allied Health Professional.

All Allied Health Professional personnel will be subject to a formal bi-annual reappraisal of their clinical activities by the appropriate department chairperson.

Procedures to be used for purposes of reappraisal and re-delineation of clinical privileges will be of the same general nature as those for Medical Staff members.

No physician shall be designated to supervise and direct more than six registered physician’s assistants, registered specialist’s assistants, or a combination thereof.

SECTION 3: TEMPORARY PRIVILEGES

a. Temporary privileges may be granted in the following circumstances: 1) Practitioner represents a specialty not on staff; 2) The only specialist on staff is unavailable due to illness, vacation, etc, and another specialist has to cover; 3) Practitioner is currently treating the patient; 4) The application of the practitioner is completely credentialed by the Medical Staff Office and has been reviewed by the Department Chief/Medical Director (or designee). On favorable recommendation, the CEO (or designee) may grant temporary appointment pending ratification by the Executive Committee, and the Safety & Quality Committee of the Board of Directors for no longer than 120 days; and 5) In a disaster situation, when the hospital’s emergency management plan has been activated and the hospital is unable to handle immediate patient needs.

b. Temporary clinical privileges may be granted by the Chief Executive Officer (or designee) upon the recommendation of the department chief, chief of staff or medical director for the care of a specific patient, until the patient is discharged, to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph a. of this Section 3, provided that there shall first be obtained such a practitioner’s signed acknowledgement that he/she has received and read copies of the Medical Staff bylaws, rules and regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. In addition, the practitioner shall place on file in the Medical Staff Affairs Office DEA registration and proof of current malpractice coverage, at a minimum of $1 million/ $3 million aggregate per claim or medical incident. Online license verification will be done; a reference check will be conducted with a primary hospital or peer review, an AMA profile will be obtained online (when applicable) and the National Practitioners Data Bank will be queried.

c. The Chief Executive Officer may permit a practitioner serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 30 days, providing all of his/her credentials have first been approved by the department chair concerned and by the chief of the Medical
Staff or the Medical Director. Any such practitioner shall place on file copies of their current New York State registration, DEA registration and malpractice coverage with the Medical Staff office.

d. Special requirements of supervision and reporting may be imposed, by the departmental chair concerned, on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the practitioner to comply with such special conditions.

e. The Chief Executive Officer may, at any time, upon the recommendation of the chief of the Medical Staff or the chair of the department concerned, terminate a practitioner's patient(s) then under his/her care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 2a of Article VII of these bylaws, and the same shall be immediately effective. The appropriate departmental chair, or in his/her absence, the chief of the Medical Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

SECTION 4: EMERGENCY/DISASTER PRIVILEGES

Disaster privileges may be granted when the hospital's emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. The Chief Executive Officer, Medical Director, Chief of the Medical Staff or their designee(s) has the option to grant disaster privileges. The decision to grant privileges to any individual is made on a case-by-case basis and is at the option of the Chief Executive Officer or his/her designee.

In the case of an Emergency/Disaster granting clinical privileges to volunteer Practitioners who are not members of the Medical Staff or Allied Health Professional Staff to provide health care services to the Hospital's patients during a “state of emergency".

Such privileges may be granted upon presentation of a valid picture identification issued by a state, federal or regulatory agency; and one of the following:

- A current picture hospital identification card that clearly identifies professional designation.
- A current license to practice, primary source verification of licensure.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- The Medical Reserve Corps (MRC).
- The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).
- Other recognized state or federal response hospital or group.
- Identification indicating that the individual has been granted authority by a government entity to render patient care, treatment, and services in disaster circumstances.
- Confirmation by a licensed independent practitioner currently privileged by the hospital or Medical Staff member(s) with personal knowledge regarding the practitioner’s
identity and ability to act as a licensed/unlicensed independent practitioner during a disaster.

Such authority to act in an emergency shall in all events be subject to the oversight and control of the Medical Director, Chief of the Medical Staff or the Hospital Chief Executive Officer as the case may be or their respective designees. The performance of volunteer licensed/unlicensed independent practitioners who are granted disaster privileges will be assigned written disaster responsibilities and overseen by either direct observation, mentoring or medical record review by the Chief of the Medical Staff, Medical Director, Department Chairs or their designee(s).

When possible the Medical Staff Office will collect the following documents from the volunteer licensed/unlicensed independent practitioners:

Current license to practice medicine, DEA and or State Controlled License Certificates (if applicable), current malpractice insurance face sheet with limits of liability and expiration, name and address of institution(s) where the practitioner or provider currently holds privileges and evidence of compliance with annual TB skin testing or symptoms assessment.

Licensed/unlicensed independent practitioners will be assigned unit specific duties once they check in with the Medical Staff Office and/or Administration (Incident Command Center).

Licensed/unlicensed independent practitioner’s duties will be assigned based on the current Medical Staff privileges for that provider as assigned once they are on the unit.

Volunteer licensed/unlicensed independent practitioners and other volunteer practitioners when possible will receive a picture identification badge from Human Resources indicating their title and that they are a volunteer due to the disaster. In the event a picture identification badge cannot be made, the provider will receive a manual identification badge stored in the mobile privilege case in the Medical Staff Office. Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner’s arrival if granted disaster privileges should continue.

As soon as the immediate situation is under control or within 72 hours, which ever is first, from the time the volunteer licensed/unlicensed independent practitioner presents to the organization, the primary source verification process of credentials and privileges of individuals who receive disaster privileges must be started. This process is identical to Section 3 Temporary Privileges, as set forth in these Bylaws. Emergency/Disaster temporary privileges may be granted by the Chief Executive Officer, Medical Director, Chief of the Medical Staff or designee(s). Privileges will terminate immediately upon identification of any adverse information about the practitioner, and, in any case, privileges will be granted only for the duration of the emergency and until patients can be assigned to an appropriate member of the Medical Staff.

In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (e.g. no means of communication or lack of resources), it is expected that it be done as soon as possible. Documentation as to why primary source verification could not be performed in the required time frame; evidence that demonstrates the ability to continue to provide adequate care, treatment and services; and the attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the
volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

ARTICLE VII: CORRECTIVE ACTION

SECTION 1: PROCEDURE

a. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the hospital, corrective action against such practitioner may be requested by any officer of the Medical Staff, by the Chief Executive Officer or by the governing body, as agents of the hospital. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by references to the specific activities or conduct which constitute the grounds for the request.

b. Whenever the corrective action could be a reduction or relinquishment of clinical privileges, the Executive Committee shall forward such request to the chair of the department wherein the practitioner has such privileges. Upon receipt of such request, the chair of the department shall immediately appoint an ad hoc committee to investigate the matter.

c. Within 15 days after the department’s receipt of the request for corrective action, the department shall make a report of its investigation to the Executive Committee. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the departmental ad hoc investigating committee. At such interview, he/she shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the department and included with its report to the Executive Committee.

d. Within 15 days following a receipt of a request for corrective action, or following receipt of a report from a department following the department’s investigation of a request for corrective action involving reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

e. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement of consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner’s staff membership be suspended or revoked.
f. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article VIII of these Bylaws.

g. The chief of the Medical Staff shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all actions taken in connection therewith. After the Executive Committee has made its recommendation in the matter, the procedures to be followed shall be as provided in Article V, Section 2 and in Article VIII if applicable, of these bylaws.

SECTION 2: SUMMARY SUSPENSION

a. Any one of the following - the chief of the Medical Staff, Medical Director, the chair of a clinical department, the Chief Executive Officer and/or the Executive Committee of either the Medical Staff or the governing body- shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

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

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

d. Immediately upon the imposition of a summary suspension, the chief of the Medical Staff or responsible department chair shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

SECTION 3: AUTOMATIC RELINQUISHMENT

a. A temporary suspension in the form of withdrawal of a practitioner’s admitting privileges, effective until medical records are completed, may be imposed for failure to complete medical records within 30 working days of a patient’s discharge.

b. Action of the State Board of Medical Examiners revoking or suspending a practitioner’s license or placing him/her on probation, shall automatically relinquish all of his/her hospital privileges.
c. Exclusions from Government Programs:

Whenever a practitioner is excluded or otherwise ineligible for participation in federally funded health care programs, including but not limited to Medicare and Medicaid, his/her Medical Staff membership and/or clinical privileges shall be automatically revoked, effective as of the time that he/she is excluded or is otherwise made ineligible for participation in federally funded health care programs, including but not limited to Medicare and Medicaid. If the practitioner is later reinstated to federally funded health care programs, he/she may re-apply for Medical Staff membership and/or clinical privileges.

d. It shall be the duty of the chief of the Medical Staff to cooperate with the Chief Executive Officer in enforcing all automatic relinquishments of privileges.

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 1: RIGHT TO HEARING AND TO APPELLATE REVIEW

a. When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the governing body, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Executive Committee following such hearing is still adverse to the affected practitioner, he/she shall then be entitled to an appellate review by the governing body before the governing body makes a final decision on the matter.

b. When any practitioner receives notice of a decision by the governing body that will 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 Executive Committee of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a committee appointed by the governing body, and if such hearing does not result in a favorable recommendation, to an appellate review by the governing body, before the governing body makes a final decision on the matter.

c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he/she is entitled.

SECTION 2: REQUEST FOR HEARING

a. The Chief Executive Officer shall be responsible for giving prompt written notice of an adverse recommendation or decision, including reason(s) for action to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.

b. The failure of a practitioner to request a hearing to which he is entitled by these bylaws within 15 days following the delivery of the notice 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. The failure of a practitioner to request an appellate review 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 appellate review on the matter.

c. When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing committee appointed by the governing body, the same shall thereupon become and remain effective against the practitioner pending the governing body’s decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the governing body, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the governing body provided for in Section 7 of this Article VIII. In either of such events, the Chief Executive Officer shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

SECTION 3: NOTICE OF HEARING

a. Within 15 days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee of the governing body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than 30 days from the date or receipt of request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than 15 days from the date of receipt of such practitioner’s request for hearing.

b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

SECTION 4: COMPOSITION OF HEARING COMMITTEE RELINQUISHMENT

a. When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc committee of not less than 3 members of the Medical Staff appointed by the chief of the Medical Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as chair. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select representative group due to the size of the Medical Staff.

b. When a hearing relates to an adverse decision of the governing body that is contrary to the recommendation of the Executive Committee, the governing body shall appoint a hearing committee to conduct such hearing and shall designate one of the members of this committee as chair. At least one representative from the Medical Staff shall be included on this committee when feasible.

SECTION 5: CONDUCT OF HEARING
a. There shall be at least a majority of the members of the hearing committee, who are not in direct economic competition with the practitioner involved, present when the hearing takes place and no member may vote by proxy.

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 a court reporter, electronic recording unit, and detailed transcription or by the taking of adequate minutes.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Article VIII and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

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

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

f. Either a hearing officer, if one is appointed, or the chair of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. 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 rule which might make evidence inadmissible over objection in a civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

h. The Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The governing body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

i. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce evidence, to cross-examine any witness on any matter relevant to the issue of
the hearing, to challenge any witness and to rebut any evidence and to submit a statement at the close of the hearing. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

j. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, neither the affected practitioner, nor the Executive Committee of the Medical Staff or the governing body, shall be represented at any phase of the hearing procedure by an attorney at law unless the hearing committee, in its discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practitioner, the Executive Committee of the Medical Staff, or the governing body, of the right to legal counsel in connection with preparation for the hearing or for a possible appeal; and, if a hearing officer is utilized, he/she may be an attorney at law.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

l. Within 15 days after final adjournment of the hearing, the 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 Executive Committee or to the governing body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the governing body. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article V of these bylaws.

SECTION 6: APPEAL TO THE GOVERNING BODY

a. Within 15 days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may, by written notice to the governing body delivered through the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the governing body. Such notice may request that the appellate review by held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner’s written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

b. If such appellate review is not requested within 15 days, the affected practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article VIII.

c. Within 15 days after receipt of such notice of request for appellate review, the governing body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than 5 days, nor more than 15 days, from the date of receipt of notice of request for appellate review, except that when the
practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than 15 days from the date of receipt of such notice.

d. The appellate review shall be conducted by the governing body or by a duly appointed appellate review committee of the governing body of not less than 3 members.

e. The affected practitioner shall have access to the report and record of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He shall have 5 days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which he disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters 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 governing body through the Chief Executive Officer by certified mail, return receipt requested, at least 5 days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the chair of the hearing committee appointed by the governing body and, if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least 5 days prior to the date of such appellate review by certified mail, return receipt requested.

f. The governing body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at the appellate review, shall be permitted to speak against the adverse recommendation or decision and shall answer questions put to him/her by any member of the appellate review body. The Executive Committee or the governing body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

g. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the governing body or the committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

h. If the appellate review is conducted by the governing body, it may affirm, modify or reverse its prior decision, or in its discretion, refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation within 5 days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

i. If the appellate review is conducted by a committee of the governing body, such committee shall, within 5 days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the governing body affirm, modify or reverse its prior decision, or refer the matter back to the Executive Committee for
further review and recommendation within 15 days. Such referral may include a request that the Executive Committee of the medial staff arrange for a further hearing to resolve disputed issues. Within 15 days after receipt of such recommendation after referral, the committee shall make its recommendation to the governing body as above provided.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the hospital bylaws, all action required of the governing body may be taken by a committee of the governing body duly authorized to act.

SECTION 7: FINAL DECISION BY GOVERNING BODY

a. Within 15 days after the conclusions of the appellate review, the governing body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee’s last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee’s last such recommendation, the governing body shall refer the matter to a special review committee for further review and recommendation. The composition of this committee shall be not less than three governing body members as appointed by the Chair of the Board and not less than three physician members as appointed by the Chief of the Medical Staff. The governing body shall include in its notice of decision, a statement that a final decision will not be made until the review committee’s recommendation has been received. At its next meeting after receipt of the committee’s recommendation, the governing body shall make the final decision with like effect and notice as first above provided in this Section 7.

b. Notwithstanding any other provision of these 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 Executive Committee of the Medical Staff, or by the governing body, or by a duly authorized committee of the governing body, or by both.

SECTION 8: EFFECT OF ACTIONS BY AND LEAVES OF ABSENCE AT ANOTHER ST. PETER’S HEALTH PARTNERS FACILITY

a. In the event the medical staff membership or privileges of a medical staff member at another St. Peter’s Health Partners facility are revoked, suspended, limited or reduced for any cause other than non-payment of dues or non-completion of medical records, the Board may, in its discretion, impose a similar revocation, suspension, limitation or reduction on the medical staff membership or privileges of the medical staff member at this Facility, without affording the medical staff member any further due process or fair hearing rights. Such action shall become effective as provided in a written notice to the medical staff member from the Board.

b. In the event a medical staff member is granted a leave of absence at another St. Peter’s Health Partners facility, the member shall be deemed to have requested a leave of absence at this Facility, and the request shall be acted upon as provided for in these bylaws.

c. In the event the St. Peter’s Health Partners Facility that took an initial
action described in paragraphs (a) or (b) above thereafter reinstates or restores the medical staff membership or privileges of the medical staff member, then such member's membership or privileges at this Facility, if impaired at this Facility pursuant to paragraphs (a) or (b) above, shall automatically be similarly reinstated or restored. However, such reinstatement or restoration shall not bar this Facility from pursuing any corrective action it might otherwise pursue under these bylaws, subject to the due process and fair hearing requirements of these bylaws.

d. Medical staff members shall be deemed to authorize the Board and Medical Director of this Facility to obtain from any other St. Peter’s Health Partners facility, and to authorize such other St. Peter’s Health Partners facility to disclose, otherwise confidential information relating to the actions described in paragraphs (a) and (b), provided the information is used solely for the purposes of this Section, the confidentiality of the information is maintained by this Facility, and the statutory protection from disclosure for such information is not impaired.

ARTICLE IX: OFFICERS

SECTION 1: OFFICERS OF THE MEDICAL STAFF
a. The officers of the Medical Staff shall be: 1. Chief, 2. Vice-Chief and 3. Secretary

SECTION 2: QUALIFICATIONS OF OFFICERS

Only those active/honorary staff appointees who are a doctor of medicine or osteopathy and satisfy the following criteria shall be eligible to serve as Medical Staff officers, department chiefs, and committee chairpersons:

a. be appointed in good standing to the Medical Staff of the hospital and continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

b. have no pending adverse recommendations concerning staff appointment or clinical privileges;

c. be currently Board certified in his/her specialty or affirmatively established comparable competence through the credentialing process;

d. maintain an active/honorary clinical practice at the hospital;

e. have constructively participated in Medical Staff affairs, including quality review and peer review activities;

f. be willing to discharge faithfully the duties and responsibilities of the position which the individual holds

g. be knowledgeable concerning the duties of the office;

h. possess written and oral communication skills; and

i. possess and have demonstrated ability for harmonious interpersonal relationships.
All Medical Staff officers, department chiefs and committee chairs must possess at least the above qualifications and maintain such qualifications during their term of office.

SECTION 3: ELECTION OF OFFICERS

a. Officers shall be elected at the annual meeting of the Medical Staff. All members of the Medical Staff shall be eligible to vote. Voting can be by ballot for contested positions. When a nominee does not receive a majority vote, the nominee with the least votes will be dropped and successive votes taken until a nominee receives a majority vote.

b. The nominating committee shall consist of three members of the Medical Staff appointed by the chief of the Medical Staff. This committee shall offer one or more nominees for each office.

c. Nominations may also be made from the floor during the annual meeting by voting members of the Medical Staff.

SECTION 4: TERM OF OFFICE

All officers shall serve a 2 year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year (or on some other fixed date).

SECTION 5: VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except for the chief, shall be filled by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the chief, the vice-chief shall serve out the remaining term.

SECTION 6: DUTIES OF OFFICERS

a. CHIEF

1. act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the hospital; call, preside at and be responsible for the agenda of all general meetings of the medical chief: The chief shall serve as the chief administrative officer of the Medical Staff to:

2. staff;

3. serve as chair of the Medical Staff Executive Committee;

4. serve as ex officio member of all other Medical Staff committees without vote;

5. be responsible for the enforcement of Medical Staff bylaws, rules and regulations, for implementation of sanctions where these are indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

6. appoint committee members to all standing, special and multi-disciplinary Medical Staff committees except the Executive Committee;
7. represent the views, policies of the governing body to the Medical Staff and report to the governing body and to the Chief Executive Officer;

8. receive and interpret the policies of the governing body to the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care;

9. be responsible for the educational activities of the Medical Staff;

10. be the spokesman for the Medical Staff in its external professional and public relations; and,

11. be responsible for providing overall supervision of the Performance Improvement program as it relates to Medical Staff activities. Works with appropriate Medical Staff committees and department chiefs to implement the PI program and has responsibility to insure their active participation in the program. Any recommendations developed by the Chief of the Medical Staff or department chiefs who submit recommendations to the Chief for consideration will be referred as appropriate to the various hospital committees involved in quality improvement or to the appropriate committees of the Medical Staff.

b. VICE-CHIEF: In the absence of the chief, he/she shall assume all the duties and have the authority of the chief. He/She shall be a member of the Executive Committee of the Medical Staff. He/She shall automatically succeed the chief when the latter fails to serve for any reason.

c. SECRETARY: He/She shall be a member of the Executive Committee of the Medical Staff. He/She shall be the secretary of the ad hoc bylaws committee whenever it convenes, unless this becomes a standing committee and perform other duties assigned to this position.

SECTION 7: REMOVAL OF AN OFFICER

a. An officer of the Medical Staff may only be removed by the Safety & Quality Committee of the Board of Directors upon recommendation from the Executive Committee after the procedure has been completed. Removal of a physician from office shall not affect his/her clinical status as a member of the Medical Staff.

b. The decision to remove an officer of the Medical Staff shall be one of extreme sanction for misconduct, grave ethical offense or injurious performance with damage to the patient, Medical Staff, hospital administration or governing body interests or to the community.

c. The process for removal may be initiated by 3 qualified attending members of the Medical Staff, the hospital administration with the support of the Chief Executive Officer and the Medical Director or by the governing body. If the governing body initiates sanction, it shall be by majority vote in an official meeting in which a verified quorum is present to act upon the request. If the initiative comes from the attending Medical Staff or hospital administration, then there shall be at least 3 persons as co-signers of the petition for removal.
d. The petition shall state the reason for removal, the effects of the misconduct upon patient interests, hospital, Medical Staff or community and a description of the action or lack of action. Proof of damage resulting from the misconduct is not necessarily required to petition for removal or initiate due process.

e. A petition for the removal of the Chief of the Medical Staff shall be submitted to the Vice Chief and the Secretary. Any such action involving another officer of the Medical Staff shall be submitted to the Chief of the Medical Staff. In either case, the petition shall be brought forth to the Ethics Committee within 3 days of its receipt.

f. Such petition shall be issued and presented to the Medical Staff through the Ethics Committee. The Ethics Committee shall be required to meet within one week of notification by the Chief of the Medical Staff or Vice Chief of such petition being filed. It shall be responsible for issuing a brief report on the action, submitting the petition to remove an officer to either the Chief or Vice Chief of the Medical Staff no later than 10 days following its meeting.

g. The Chief or Vice Chief of the Medical Staff shall call a special meeting of the Medical Staff as outlined in Article XII, Section 2 at which a quorum shall be established and documented. The affected officer shall be present. The petition for the removal of the officer, the Ethics Committee report and any formal written statement made by the affected officer shall be read. Any oral statement made by the affected party shall be heard. In the absence of the affected officer, his/her official statement must be read. In addition, the attending Medical Staff must agree upon the proceedings. Each member shall vote for approval or rejection of such petition by secret ballot. The decision may be subject to appeal either by the affected officer or the persons that submitted the petition. Results of this meeting will be forwarded to the Safety & Quality Committee of the Board of Directors for comment and final vote.

h. Removal or reinstatement shall be agreed upon by the majority of members present as stipulated in Article XII, Section.

i. Any affected officer of the Medical Staff shall have the right to appeal the adverse decision of the Medical Staff or the governing body. The hearing and appellate review procedure set forth in Article VIII shall be followed.

j. Each session/meeting of any committee, Medical Staff or governing body dealing with the process of removal or a Medical Staff officer shall be documented in the minutes. These minutes have to be read and approved by the Chief or Vice Chief of the Medical Staff and 2 other members from the meeting.

k. A report of all decisions and actions taken shall be issued and copies delivered to the affected officer by certified mail, the governing body, the Chief Executive Officer and Chief of the Medical Staff.

l. All documentation relating to the proceedings for the removal of the Medical Staff officer shall be kept as privileged information and subject to strict confidentiality with the exception of a duly issued subpoena of a competent court.

ARTICLE X: CLINICAL DEPARTMENTS
SECTION 1: ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES

A department is a unit created within the Medical Staff with primary responsibility for the review and improvement of the quality of care. As such, to be eligible to exist as a department or division, each must:

a. be chaired by an individual qualified in accordance with these bylaws;

b. fulfill all of the department functions outlined in these bylaws.

If the Executive Committee determines that an existing department no longer fulfills these qualifications, it shall upon the approval of the board, dissolve the department and assign its members to another department.

Departments with services to which patients may be admitted shall be:

1. Orthopedic surgery 3. Rheumatology

Departments which support the above departments shall be:

1. Internal Medicine/ Family Practice 2. Radiology

SECTION 2: QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRS

a. Each chair shall be a board certified member of the active/honorary staff qualified by training, experience and demonstrated ability or has recognized comparable competence as established through the credentialing process. Each chair shall be a member of the attending, assistant attending, consulting, or honorary Medical Staff, willing and able to discharge the functions of his/her office, and be either board certified or shall have been determined to possess equivalent qualifications by the Executive Committee.

b. Each chair shall be appointed by the Executive Committee for a 2-year term subject to approval of the governing body.

SECTION 3: FUNCTIONS OF DEPARTMENT CHAIRS

Each chair shall:

a. be accountable for all professional and administrative activities within his/her department, unless otherwise provided by the hospital;

b. be a member of the Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care;

c. maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report regularly thereon to the Executive Committee;
d. appoint a departmental committee to conduct the initial phase of patient care review required by these bylaws;

e. be responsible for enforcement of the hospital bylaws and of the Medical Staff bylaws, rules and regulations within his/her department;

f. be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff;

g. transmit to the Executive Committee his/her department’s recommendations concerning the staff classification, departmental criteria for privileges, the reappointment and the delineation of clinical privileges for all practitioners in his/her department;

h. be responsible for the orientation teaching and continuing education of all persons in his/her department or service;

i. participate in every phase of administration of his/her department through cooperation with the nursing service and the hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques; and,

j. assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Chief Executive Officer or the governing body.

k. assess and make recommendations regarding off-site sources for patient care services not provided by the department or hospital.

l. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

m. continuous assessment and improvement of the quality of care, treatment, and services.

n. maintenance of quality control programs, as appropriate.

o. Recommends space and other resources needed by the department or service.

SECTION 4: FUNCTIONS OF DEPARTMENTS

a. Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and of the governing body, for the granting of clinical privileges and for the holding of office in the department.

b. Each department shall have a department chair with the overall responsibility for the supervision and satisfactory discharge of assigned functions of the department.

b. Each department shall meet separately to review and analyze on a peer-group basis the clinical work of the department.

c. A report shall be submitted regularly to the Executive Committee detailing such departmental analysis of patient care.
SECTION 5: ASSIGNMENTS TO DEPARTMENTS

The Executive Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the credentials committee, recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

SECTION 6: REMOVAL OF CLINICAL DEPARTMENT CHAIR

The chair of the clinical department may only be removed by the Safety & Quality Committee of the Board of Directors following the same removal procedure which is established for the removal of an officer of the Safety & Quality Committee of the Board of Directors. Prior to considering such action, the board shall request the recommendation of the Executive Committee of the Medical Staff. Removal of a physician from a departmental chair shall not affect his/her clinical status as a member of the Medical Staff. Established disciplinary procedures as set out in Articles VII and VIII shall prevail.

ARTICLE XI: COMMITTEES

SECTION 1: EXECUTIVE COMMITTEE

a. Composition: The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, medical director, the chair of each clinical department, one representative from the orthopedic department, two representatives from the department of physical medicine and rehabilitation and one representative each from rheumatology and cardiology/pulmonary departments. Other ad hoc positions may be filled with outside physicians at the discretion of the committee for a one-year term. Representatives shall be members of the attending, consulting, or honorary staff in good standing. Selection and nomination are irrespective of one’s profession. The hospital’s Chief Executive Officer is an ex-officio member without vote. The chief of the Medical Staff will serve as chair. All members holding office on the Executive Committee shall be eligible to vote.

b. Duties: The duties of the Executive Committee shall be:

1. to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these bylaws;

2. to coordinate the activities and general policies of the various departments;

3. to receive and act upon committee reports;

4. to implement policies of the Medical Staff not otherwise the responsibility of the departments;

5. to provide liaison between Medical Staff and the Chief Executive Officer and the governing body;

6. to recommend action to the Chief Executive Officer on matter of a medico-administrative nature;
7. to make recommendations on hospital management matters to the governing body through the Chief Executive Officer;

8. to fulfill the Medical Staff's accountability to the governing body for the medical care rendered to patients in the hospital;

9. to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;

10. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

11. to review the credentials of all applicants and to make recommendations for staff membership, assignments to department and delineation of clinical privileges;

12. to review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;

13. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted; and,

14. to review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments and the assignment of practitioners to the various departments or services as provided in Articles V and VI of these bylaws.

15. to organize the Medical Staff’s performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities.

c. Meetings: The committee shall meet at least 10 times annually and maintain a permanent record of its proceedings and actions.

d. Quorum: A quorum of three will be necessary for acting on routine business of the Executive Committee of the Medical Staff. However, the current requirement of quorum will be maintained for changes relating to the Bylaws.

e. The Nominating Committee will recommend representatives for the Executive Committee. The Medical Staff Office Coordinator will send a letter to the representative requesting their interest in being a member of the Executive Committee. Any additional nominees can be nominated at the annual meeting. Voting will be completed at this meeting. Attending, Assistant Attending, Covering Attending, and Consulting Medical Staff are eligible to vote only if they have been involved in the care of at least 20 inpatients or more upon reappointment, are members of any Medical Staff Committee, and members holding office on the Executive Committee are eligible to vote. Such changes shall become effective when approved by the Safety & Quality Committee of the Board of Directors.
f. A representative of the Medical Staff may only be removed by the Safety & Quality Committee of the Board of Directors following the same removal procedure, which is established for the removal of an officer of the Safety & Quality Committee of the Board of Directors. Prior to considering such action, the board shall request the recommendation of the Executive Committee of the Medical Staff and consult with the Safety & Quality Committee of the Board of Directors. Removal of a physician from a departmental chair shall not affect his/her clinical status as a member of the Medical Staff. Established disciplinary procedures as set out in Articles VII and VIII shall prevail.

g. The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf is approved by the voting members of the Medical Staff.

SECTION 2: CREDENTIALS COMMITTEE

a. All members of the Executive Committee shall be appointed to the credentials committee.

b. Duties: The duties of the credentials committee shall be:

1. to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles V and VI of these bylaws;

2. to make a report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges.

c. Meetings: The credentials committee shall meet when there are applicants to be considered. The permanent record of its proceedings and actions are included under the “Credentials Committee” report of the Executive Committee minutes.

SECTION 3: MEDICAL CARE MONITORING COMMITTEE

a. Composition and Structure: The medical care monitoring committee shall consist of at least three representatives of the Medical Staff. There shall be a designated Chair responsible for the medical record function, drug utilization, blood utilization, and pharmacy and therapeutic functions. Other committee members will include a representative from nursing, social work, and hospital administration. The medical records supervisor and the Medical Staff services coordinator will be members and may be delegated to act as its secretary.

b. Duties: The MCMC will be responsible for the following functions and provide results of its reviews to the credentials committee to assist in their reappraisal activity:

1. Drug Usage Evaluation: to assure the appropriate safe and effective prophylactic, therapeutic and empiric use of drugs in the organization.

2. Medical Record Review: to review the quality of documentation in the medical record and take necessary actions for improvement.
3. Pharmacy, Therapeutics & Infection Control Function: to define and evaluate adverse drug reactions; develop and maintain a drug formulary; and develop or approve policies and procedures for drug selection, distribution, handling, use and administration; to be responsible for supervision of infection control in all phases of the hospital activities.

4. Utilization Review: to conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services, blood utilization, and all related factors which contribute to the effective utilization of hospital and physician services. It shall also formulate a written utilization review plan for the hospital.

c. Written Utilization Review Plan: The plan, as approved by the Utilization Review Committee and the Medical Care Monitoring Committee must be in effect at all times and must include all of the following elements:

a. the organization and composition of committee(s) which will be responsible for the utilization review function;

b. frequency of meetings;

c. the types of records to be kept;

d. the method to be used in selecting cases on a simple or other basis;

e. the definition of what constitutes the period of extended duration;

f. the relationship of the utilization review plan to claims administration by the third party;

g. arrangements for committee reports and their dissemination; and,

h. responsibilities of the hospital’s administrative staff in support of utilization review.

Extended Duration Evaluations: The committee shall evaluate the medical necessity for continued hospital services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

1. No physician shall have sole review responsibility for any extended stay cases in which he/she was professionally involved.

2. All decisions that any further inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out-of-hospital facilities and services.

3. Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending physician shall be given great weight.
4. All decisions that any further inpatient stay is not medically necessary shall be given by written notice to the chair of the appropriate department, to the Chief Executive Officer and to the attending physician, for such action, if any, as may be warranted.

d. Meetings: The Utilization Review Committee will meet 6 times per year (at least quarterly) and maintain a permanent record of its proceedings and activities, and make a quarterly report of these to the Medical Care Monitoring Committee. However, the Utilization Review Committee will be responsible for handling utilization issues at the time they occur.

e. Quorum: A quorum for committee action will be two members of the Medical Staff.

SECTION 4: PHARMACY, THERAPEUTICS & INFECTION CONTROL COMMITTEE

a. Composition: Membership shall consist of at least 2 representatives of the Medical Staff, the infection control practitioner and 1 member each from nursing service and hospital management and the Director and/or designee of the Ellis Pharmacy, since the pharmacy is operated by the Ellis Hospital, and all other participation at the discretion of the committee.

b. Duties: The committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital. It shall also perform the following specific functions:

1. serve as an advisory group to the hospital Medical Staff and the pharmacist on matters pertaining to the choice of available drugs;

2. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

3. develop and review periodically a formulary or drug list for use in the hospital;

4. prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

5. evaluate clinical data concerning new drugs or preparations requested for use in the hospital; and,

6. establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

It shall be accountable to the Medical Care Monitoring Committee for the surveillance of hospital infection potentials, review and analysis of actual infections, promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital’s activities including:
1. sterilization procedures by heat, chemicals or otherwise;
2. isolation procedures;
3. prevention of cross-infection;
4. testing of hospital personnel for carrier status;
5. disposal of infectious material; and,
6. other situations as requested by the Executive Committee

c. Meetings: This committee shall meet at the discretion of the chair, shall maintain a record of its proceedings and activities and shall report thereon to the Medical Care Monitoring Committee.

ARTICLE XII: MEDICAL STAFF MEETINGS

SECTION 1: REGULAR MEETINGS

An annual staff meeting shall be held at the last quarterly Medical Staff meeting each year before the end of the staff year of the hospital.

SECTION 2: SPECIAL MEETINGS

a. The chief of the Medical Staff or the Executive Committee may call a special meeting of the Medical Staff at any time. The chief shall call a special meeting within 15 days after receipt by him/her of a written request for same signed by not less than one-fourth (1/4) of the active staff and stating the purpose for such meeting. The Executive Committee shall designate the time and place of any special meeting.

b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally, by electronic communication or by mail, to each member of the active staff not less than 5 or more than 15 days before the date of such meeting, by or at the direction of the chief of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 3: QUORUM

A majority of the voting staff, consisting of the Attending, Assistant Attending, Covering Attending, and Consulting Staff are eligible to vote only if they have been involved in the care of at least 20 inpatients or more upon reappointment, are members of the Medical Executive Committee or are on any Medical Staff Committees present shall constitute a quorum for purposes of amendment of these bylaws, rules and regulations, and for all other actions.
SECTION 4: ATTENDANCE REQUIREMENTS

The active Medical Staff is encouraged to attend scheduled or special meetings.

SECTION 5: AGENDA

a. The agenda at any regular Medical Staff meeting may include:

   Administrative:
   1. Call to order
   2. Acceptance of the minutes of the last regular and of all special meetings
   3. Unfinished business
   4. Communications
   5. Report from the Chief Executive Officer of the hospital
   6. Reports of departments
   7. Reports of committees
   8. New business

   Professional:
   9. Review and analysis of the clinical work of the hospital
   10. Reports of medical committees
   11. Discussion and recommendations for improvement of the professional work of the hospital
   12. Adjournment

b. The agenda of special meetings shall be:
   1. Reading of the notice calling the meeting
   2. Transaction of business for which the meeting was called
   3. Adjournment

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

SECTION 1: REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. The orthopedic, physical medicine and rehabilitation, rheumatology, and cardiopulmonary departments shall hold regular meetings at least monthly to review and evaluate the clinical work of practitioners with privileges in the department.

SECTION 2: SPECIAL MEETINGS

A special meeting of any committee or department may be called by or at the request of the chair or chief thereof, by the chief of the Medical Staff, or by 1/3 of the group’s current members, but not less than 2 members.

SECTION 3: NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any special meetings or of any regular meeting not held pursuant to resolution shall be given to each member of the
committee or department not less than 5 days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 4: QUORUM

Forty (40%) percent of the active Medical Staff members of a committee or department, but not less than 2 members, shall constitute a quorum at any meeting.

SECTION 5: MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by 2/3 consent in writing, setting forth the action so taken, signed by the required number of members entitled to vote.

SECTION 6: RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and have no vote.

SECTION 7: MINUTES

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

SECTION 8: ATTENDANCE REQUIREMENTS

a. The active Medical Staff is encouraged to attend scheduled or special meetings.

b. A practitioner whose patient’s clinical course is scheduled for discussion at a regular departmental meeting shall be so notified and shall be expected to attend such meeting. If such practitioner is not otherwise required to attend the regular monthly departmental meeting, the chief of the Medical Staff shall, through the Chief Executive Officer, give the practitioner advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from the standard clinical practice is involved, the notice to the practitioner shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

c. Failure by a practitioner to attend any meeting with respect to which he was given notice that attendance was mandatory, unless excused by the Executive Committee upon a showing of good cause, shall result in an automatic relinquishment of all or such portion of the practitioner’s clinical privileges as the Executive Committee may direct, and such
suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the chair his/her department, or by the Executive Committee if the chair is the practitioner involved, until but not later than the next regular departmental meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE XIV: IMMUNITY FROM LIABILITY

The following shall be expressed conditions to any practitioner's application for or exercise of clinical privileges at his/her hospital:

First, 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.

Second, that such privilege shall extend to members of the hospital's Medical Staff and of its governing body, its other practitioners, its Chief Executive Officer 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 XIV, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the governing body or of the Medical Staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, 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. applications for appointment or clinical privileges; 2. periodic reappraisals for reappointment or clinical privileges; 3. corrective action, including summary suspension; 4. hearings and appellate reviews; 5. medical care evaluations; 6. utilization reviews; and, 7. other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

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

Sixth, 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 Article XIV in favor of the individuals and organizations specified in paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.
Seventh, that the consents, authorizations, releases, rights, privileges and immunities provided by Section 1 and 2 of Article V of these bylaws for the protection of this hospital’s practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

ARTICLE XV: RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, in which any special meeting on notice, or by the majority of the Medical Staff who vote electronically. Such changes shall become effective when approved by the Safety & Quality Committee of the Board of Directors.

ARTICLE XVI: CONTINUING EDUCATION

All medical/allied health staff members are required to participate in continuing education related to their area of specialization to assure that any patient treated by them in the hospital will be given the highest quality of medical care.

ARTICLE XVII: REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption and amendment of the related rules, policies, and protocols developed to implement various sections of these Bylaws.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT

All proposed amendments, whether originated by the Executive Committee, another standing committee or by a Member of the Attending category of the Medical Staff, shall be reviewed and discussed by the Executive Committee prior to an Executive Committee vote. Such amendment may be recommended to the Board:

A. By the Executive Committee after a majority vote, provided that the proposed amendment(s) is/are first distributed to the voting members in writing at least twenty-one (21) days prior to an Executive Committee vote. The Executive Committee’s recommendation may be acted upon by the Board unless more than ten percent (10%) of the voting Staff members object in an informal written poll. If more than ten percent (10%) of the voting Staff members object to a proposed amendment, the Chief of the Medical Staff or the Executive Committee will schedule and hold a general staff meeting at which the proposed amendment will be presented, discussed, and acted upon. The affirmative vote of a majority of those
voting Staff members present and voting is required for passage. The Attending, Assistant Attending, Covering Attending, and Consulting Staff are eligible to vote only if they have been involved in the care of at least 20 inpatients or more upon reappointment. All members of the Medical Executive Committee or members on any Medical Staff Committees shall be eligible to vote.

B. The Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the committee’s judgment, technical or legal modifications or clarifications, reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective when approved by the Safety & Quality Committee of the Board of Directors. Adoption or amendment of medical staff bylaws cannot be delegated.

In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the medical executive committee, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

The Executive Committee’s recommendation may be acted upon by the Board unless more than ten percent (10%) of the voting Staff members object in an informal written poll. If more than ten percent (10%) of the voting Staff members object to a proposed amendment, the Chief of the Medical Staff or the Executive Committee will schedule and hold a general staff meeting at which the proposed amendment will be presented, discussed, and acted upon. The affirmative vote of a majority of those voting Staff members present and voting is required for passage.

C. These Bylaws shall persist and remain in effect regardless of merger, acquisition, sale of the Hospital, or other change in corporate relationships until new Bylaws are approved by the Medical Staff and Board of Directors of such new corporation or entity.

D. The Medical Staff Bylaws, Rules and Regulations, and policies and the governing body Bylaws are compatible with each other and are compliant with law and regulation.

E. The organized medical staff complies and enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others.

F. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

SECTION 3. JOINT CONFERENCE AMENDMENT

If the Safety & Quality Committee of the Board of Directors has determined not to accept a recommendation submitted to it by the Executive Committee, the Executive Committee is entitled to a Joint Conference between the officers of the Board and the officers of the
Medical Staff. Such Joint Conference shall be for purposes of further communicating the Board’s rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the Executive Committee’s recommendation. Such a Joint Conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request of same submitted by the Chief of the Medical Staff.

**AMENDED** BY THE BOARD OF DIRECTORS ON **AUGUST 24, 2010** AFTER RECEIPT OF RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON AUGUST 13, 2010.

**AMENDED** BY THE BOARD OF DIRECTORS ON **MARCH 22, 2011** AFTER RECEIPT OF RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON MARCH 11, 2011.

**AMENDED** BY THE BOARD OF DIRECTORS ON **January 31, 2013** AFTER RECEIPT OF RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON January 4, 2013.

**AMENDED** BY THE BOARD OF DIRECTORS ON **January 20, 2016** AFTER RECEIPT OF RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON DECEMBER 10, 2015.

**AMENDED** BY THE BOARD OF DIRECTORS ON **July 20, 2016** AFTER RECEIPT OF RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON July 14, 2016.