

BY-LAWS
OF THE
MEDICAL STAFF
OF
ST. JOSEPH'S HOSPITAL HEALTH CENTER
SYRACUSE, NEW YORK

Revised:

January 4, 1976
January 9, 1977
June 27, 1978
January 7, 1980
January 12, 1981
January 9, 1984
January 14, 1985
January 13, 1986
October 6, 1986
September 29, 1987
January 9, 1989
January 8, 1990
January 24, 1991
January 16, 1992
January 11, 1993
January 10, 1994
January 10, 1995
January 15, 1996
January 13, 1997
January 22, 1998
January 28, 1999
January 13, 2000
January 25, 2001
January 25, 2002
January 24, 2003
January 23, 2004
January 28, 2005
January 27, 2006
January 31, 2007
January 30, 2008
October 24, 2008
January 30, 2009
May 1, 2009
October 30, 2009
January 29, 2010
May 28, 2010
October 1, 2010
January 28, 2011
May 10, 2011

ST. JOSEPH'S HOSPITAL HEALTH CENTER

BY-LAWS OF THE MEDICAL STAFF

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P R E A M B L E

WHEREAS, St. Joseph's Hospital Health Center is a non-profit corporation, organized under the laws of the State of New York hereinafter referred to as "Hospital"; and

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

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care at the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Hospital Governing Body and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Body are necessary to fulfill the Hospital's obligation to its patients; therefore the physicians, dentists and midwives practicing at the Hospital hereby organize themselves into a Medical Staff in conformity with these By-Laws.

D E F I N I T I O N S

A. The term "Medical Staff" shall mean all physicians, dentists, and midwives, who are duly licensed and who are privileged to attend patients in St. Joseph's Hospital Health Center.

B. The term "Physician" shall mean an individual who has graduated from a college of medicine approved by the Liaison Committee on Medical Education and who has been awarded a degree, valid in the State of New York, of Doctor of Medicine, or an individual who has graduated from a college of osteopathy approved by the American Osteopathic Association and who has been awarded a degree, valid in the State of New York, of Doctor of Osteopathy, and who is licensed to practice medicine in the State of New York.

C. The term "Dentist" shall mean an individual who has graduated from a college of dentistry, approved by the Commission on Accreditation of the American Dental Association, and who has been awarded a degree, valid in the State of New York, of Doctor of Dental Surgery or Doctor of Medicine Dentistry and who is licensed to practice dentistry in the State of New York.

D. The term “Midwife” shall mean an individual who has obtained a license to practice midwifery under Title VIII Education Law – Article 140 in the State of New York.

II

The term "Governing Body" shall mean the Board of Trustees of St. Joseph's Hospital Health Center.

III

The term "Executive Committee" shall mean the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

IV

The term "Chief Executive Officer" shall mean the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.

BY-LAWS

ST. JOSEPH'S HOSPITAL HEALTH CENTER

MEDICAL STAFF

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of the St. Joseph's Hospital Health Center.

ARTICLE II

PURPOSE

The purposes of this organization shall be:

1. To ensure the highest quality medical care for all patients admitted to the Hospital or its outpatient programs.
2. To provide the best possible environment for medical education and the education of allied professions.
3. To initiate and maintain Rules and Regulations for self government of the Medical Staff.
4. 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

CONFIDENTIALITY

To the fullest extent permitted by law, all information, records and documentation collected and maintained pursuant to quality assurance activities, granting or renewal of privileges, and

incident reporting shall be kept confidential. For purposes of these By-Laws, all such activities of standing committees shall be considered quality assurance activities.

ARTICLE IV

MEDICAL STAFF MEMBERSHIP

Section 1. Qualification for Membership

A. Only those physicians, dentists, and midwives holding a verified current license to practice in the State of New York and offering evidence that their training, experience, current competence, professional techniques, proof of liability insurance as established in the Rules and Regulations of the Medical Staff, ability to work with others, and, if requested, health status are adequate to assure the Medical Staff and Governing Body that any patient treated by them will receive care compatible with current medical standards shall be eligible for Medical Staff membership.

B. No individual shall be automatically entitled to membership on the Medical Staff or to the exercise of any clinical privileges merely because he/she is licensed in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical examining board, or because he/she has clinical privileges or Staff membership at another hospital or free standing clinic. Medical Staff members under contract with the Hospital shall be subject to the same membership and privileging procedures as set forth in these By-Laws.

C. The majority of the Medical Staff shall be physicians.

Section 2. Acceptance of Membership

Acceptance of membership in the Medical Staff shall constitute the Staff member's agreement that he/she will strictly abide by the ethical principles of his/her profession and by the *Ethical and Religious Directives for Catholic Health Care Services*.

Section 3. Method of Selection

Each applicant for Staff membership shall complete and sign an application form. At a minimum, this document shall provide information relative to the applicant's professional education, training, professional experience, references who are knowledgeable about his/her competence and ethical character, verified current licensure, proof of current professional liability insurance, and a specific request for Staff assignments and clinical privileges. The application shall contain the applicant's pledge to:

- abide by and be governed by the Medical Staff By-Laws;
- maintain an ethical practice;
- provide for continuous care of his/her patients;
- refrain from fee splitting or other inducements relating to patient referral;
- refrain from delegating the responsibility for diagnosis or care of patients to a medical or dental practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;
- seek consultation whenever necessary;
- refrain from providing "ghost" surgical or medical services;
- acknowledge the requirement for release and immunity from civil liability provisions.
- afford patients their rights as outlined in Section 405.7 of the New York State Minimum Standards for Hospitals.

The application shall further provide information relating to involvement in any adverse malpractice action and to any previously successful challenges to licensure or registration or to loss of professional organizational membership or to loss of Medical Staff membership or privileges at another hospital or to loss of license to prescribe DEA scheduled drugs. Prior to the granting of privileges, the applicant shall also provide information as to any pending professional or dental

misconduct procedures or any pending medical malpractice actions in this State or another State. The substance of these allegations in such proceedings or actions will be required, and any additional information concerning such proceedings or actions as the applicant may deem appropriate. The applicant shall further provide information relating to any mental or physical impairment, incompetence or endangerment of patient safety or welfare, voluntary or involuntary resignation, withdrawal, limitation, reduction or loss of association or privileges with a hospital, voluntary or involuntary relinquishment of any license or registration, a criminal conviction, and any information relative to findings pertinent to violations of patients' rights.

The applicant shall provide the names of any facilities with which he/she is or has been associated. Further, in situations where such associations have been discontinued, the applicant shall provide the reasons for such discontinuance. There shall be a waiver by the applicant or dentist of any confidentiality provisions concerning the information to be provided to the Hospital pursuant to this requirement.

The National Practitioner Data Bank must be queried for information related to professional conduct and competence, licensure status, and malpractice claims experience of each physician, dentist, midwife, or clinical affiliate who applies for appointment to the Medical Staff.

The applicant will verify that the information provided is true and accurate.

In evaluating the applicant's eligibility for Medical Staff membership and/or privileges, consideration shall be given to the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his/her patients and to the patient care requirement for additional Staff members with the applicant's skills and training. An applicant's eligibility for Medical Staff membership and/or privileges shall not involve consideration of his/her gender, race, creed, national origin or sexual orientation.

Section 4. 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 ratification of appointments only after there has been a recommendation from the Medical Staff as provided in these By-Laws. In the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or Medical Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

B. Upon initial appointment, a focused professional practice evaluation of clinical performance will be conducted for a period of one year, which time period may be extended at the discretion of the Department Chairperson. Appointments and reappointments to the Medical Staff shall be for a period of not more than two (2) years. For the purposes of these By-Laws, the Medical Staff year commences on the 1st day of February and ends on the 31st day of January of each year.

C. 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 By-Laws.

D. Every application for Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff By-Laws and Rules and Regulations and to accept committee assignments.

ARTICLE V

CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Senior, Active, Consulting, Courtesy, and Associate Staff categories. The Medical Staff shall enforce and comply with the Medical Staff By-Laws.

Subsection 1.

The Senior Medical Staff shall consist of those physicians, dentists and midwives who, at the age of 60, request senior status, or at an earlier age at the discretion of the Executive Committee, if he/she has served ten (10) years as an attending practitioner. The Senior Staff shall have no regularly assigned duties. They may admit and attend private patients and may consult on patients upon request. They may vote, may not hold elective office, shall not be required to pay dues or attend Medical Staff meetings, and may serve on committees.

Subsection 2.

The Active Medical Staff shall consist of physicians, dentists and midwives, who regularly admit patients to the Hospital and who assume all functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, hold office, and serve on the Medical Staff committees and shall be required to attend Medical Staff meetings and pay dues. Members of the Active Medical Staff shall have the privilege of admitting and attending patients, shall attend service patients in the Hospital and in the outpatient programs as assigned. Members of the Active Medical Staff shall be classified as follows: Attending, Associate Attending, Assistant Attending, and Voluntary Assistant.

Subsection 3.

The Consulting Medical Staff shall consist of physicians and dentists who possess special talents, training and education. They may attend patients only upon request of a member of the attending staff, but are not eligible to admit patients. Members of the Consulting Medical Staff shall not be eligible to vote or hold office, and are not required to attend Medical Staff meetings or to pay dues. They may serve on committees.

Subsection 4.

The Courtesy Medical Staff shall consist of physicians, dentists and midwives, qualified

for Medical Staff membership who wish to attend private patients in the Hospital. Members of the Courtesy Medical Staff shall admit no more than four (4) patients a year, excluding normal newborns. Members of the Courtesy Medical Staff shall not be eligible to vote, serve on committees or hold office. Courtesy Medical Staff members are not required to attend Medical Staff meetings. They are required to pay dues. Courtesy Medical Staff members shall maintain Active privileges at another hospital within Onondaga County or a contiguous county.

Subsection 5.

The Associate Medical Staff shall consist of physicians, dentists and midwives, whose sphere of professional activity within the Hospital is limited to the Ambulatory Outpatient Departments (excluding procedures performed in the Operating Room). They shall perform such teaching and service assignments as requested by the appropriate Clinical Department Chairperson or his/her designated representative. The Associate Medical Staff members shall not be eligible to vote. They may not hold elective office but may hold appointive office. They shall not be required to pay dues or attend meetings.

Subsection 6.

A leave of absence may be granted by the Department Chairperson for a period of no more than one year. Requests shall be made in writing to the Department Chairperson. Prior to the resumption of clinical activities, a Medical Staff member must provide to the Chairperson, in writing, the reason for the leave of absence as well as any other information the Chairperson reasonably needs to evaluate the Medical Staff member's current competency and health status.

Subsection 7.

Organ Procurement: Practitioners from organ procurement organizations designated by the Secretary, U.S. Department of Health and Human Services, who are engaged in the Hospital solely in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational

purposes pursuant to the Federal Anatomical Gift Act and the requirements of the laws of the State of New York are exempt from the requirement to obtain Medical Staff appointment and privileges in order to carry out their activities in the Hospital.

Section 2. Initial Appointments

A. Upon initial appointment, a focused professional practice evaluation of clinical performance will be conducted.

B. Medical Staff applicant members shall be assigned to a Department where their performance shall be observed by the Chairperson of the Department or his/her representative to determine the eligibility of such members for regular Medical Staff membership and for exercising the clinical privileges initially granted to them. Members who have shown no clinical activity may advance to regular staff membership by providing proof of competent clinical activity at another institution. If the applicant has no clinical activity at another institution, presenting information from another competent source that has observed the applicant and can attest to his/her clinical competence must be provided for consideration.

C. An unfavorable focused professional practice evaluation will result in failure to advance an initial appointee to regular Medical Staff status and shall be deemed a termination of his/her Medical Staff appointment. An initial appointee whose membership is so terminated shall have the rights accorded by these By-Laws to a member of the Medical Staff who has failed to be reappointed.

Section 3. Clinical Affiliates

Members of medically related professions who play a significant role in the program of patient care at St. Joseph's Hospital Health Center may be appointed as Clinical Affiliates of the Hospital. Podiatrists who meet the qualifications as set forth in the Rules and Regulations of the Medical Staff may be privileged to admit patients to the hospital.

Section 4. Emeritus Status

Appointment to the Emeritus Medical Staff may be offered to physicians, dentists and midwives who have retired from the Medical Staff and who have retired from active patient care in the Hospital and who have served on the Medical Staff in an exemplary fashion.

Emeritus Medical Staff members are not required to have a current professional license. Emeritus Medical Staff members may attend Medical Staff and Department meetings as well as other activities sponsored by the Medical Staff. They shall not admit or attend patients in the Hospital and shall have no clinical privileges. They shall otherwise abide by the Medical Staff By-Laws and all other policies and rules of the Hospital. They may not vote, may not hold elective office, and shall not be required to pay dues.

Section 5. Dues

Dues shall be assessed by the Medical Staff at its Annual Meeting to support activities and obligations of the Medical Staff. Members in categories required to pay dues shall receive a notice of assessment annually, and payment will be due within sixty (60) days after such notice is received. Any Member who fails to pay dues will be ineligible for reappointment, subject to appeal to the Medical Executive Committee in case of hardship. Those Members not reappointed will need to reapply for membership on the Medical Staff.

ARTICLE VI

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment

A. Application for membership to the Medical Staff shall be presented in writing on the prescribed form which shall include authenticated qualifications and references by the applicant who shall also have signified his/her agreement to abide by the By-Laws, Rules and Regulations of the Medical Staff. All supporting documentation must be received within 180 days of the presentation of

the application form; otherwise the application will be deemed to have been withdrawn by the applicant. The completed application for membership shall be presented to the Chief Executive Officer of the Hospital who shall transmit it to the Credentials Committee within fifteen (15) days for evaluation.

All the specified documentation and information shall be maintained in the credentials file of each applicant.

B. Within sixty (60) days after the receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of character, professional competence, qualifications, a verified current licensure with the New York State Education Department, verification of identity, and ethical standing of the practitioner and shall determine through information contained in references given by the practitioner and other sources available to the Committee, including an appraisal from the Clinical Department Chairperson in which the privileges are sought, whether the practitioner has established and meets all necessary qualifications for the category of Medical Staff membership and the clinical privileges requested by him/her. Experience, ability and current competence in performing requested privilege(s) may include an assessment for proficiency in the following areas: Patient Care, Medical/Clinical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice. The Chairperson of every Department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations, including delineation of the practitioner's clinical privileges. These recommendations shall be based upon sufficient clinical performance information to make such a recommendation.

C. At its next regular meeting after receipt of the application and report of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the practitioner be appointed to the Medical Staff, that he/she be rejected for

Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint shall also specifically recommend the clinical privileges to be granted. The recommendation of the Executive Committee shall be transmitted to the Governing Board through the Chief Executive Officer.

When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within forty (40) days with a subsequent recommendation either for appointment with specified clinical privileges or for rejection for Medical Staff membership.

D. When the recommendation of the Executive Committee is adverse to the applicant, either in respect to the appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these By-Laws.

If, after considering the report and recommendation of the Hearing Committee and the hearing record, consistent with the provisions of Article VIII of these By-Laws, the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph C of this Section 1. 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 such 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 By-Laws.

At its next regular meeting, after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act in 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 By-Laws and until there has been compliance with subparagraph B of this Section 1. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

At its next 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 to the Executive Committee of the Medical Staff for further reconsideration. Any such referral back shall state the reasons therefor, 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 recommendations and new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the practitioner to the Medical Staff or to reject him/her for Medical Staff membership. All decisions to appoint shall include the delineation of the clinical privileges which the practitioner may exercise.

Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Governing Body shall submit the matter to the Joint Conference Committee as set forth in Article VIII, Section 6, subparagraph E for review and recommendation and shall consider such recommendation before making its decision final. 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 Chairperson of the Executive Committee, the Department concerned, and by certified mail to the practitioner.

Section 2. Reappointment/Reappraisal Process

- A. The Executive Committee shall review all pertinent information available on

each practitioner, including consideration of his/her health status, and shall make recommendations to the Governing Body regarding reappointment and changes in category of appointment and in clinical privileges.

This process shall include a report by the appropriate Department Chairperson of the individual's continuing education effort made since the previous appointment and the individual's statement relative to any change in health status.

The minimum criteria for continuing education shall be:

1. Current American Medical Association Physician's Recognition Award; or
2. Current satisfaction of the continuing education requirement of a recognized specialty society; or
3. Passing a certification or recognition examination of a specialty board within the past three years;
or
4. Obtaining a certificate of additional training from a specialty board within the past three years; or
5. Completing an ACGME accredited residency or fellowship program within the past three years; or
6. Fulfillment of 50 hours of AMA category I credits for physicians, 30 hours of ADA credits for dentists and 30 hours of credits for midwives per reappointment cycle.

Other considerations shall include the individual's maintenance of timely, accurate, and complete medical records; his/her attendance at required Medical Staff and Department meetings; his/her service on Medical Staff and Hospital Committees when requested; and his/her patterns of care as demonstrated by reviews conducted by the appropriate Medical Staff committees. The Executive Committee shall have the authority to require the individual Medical Staff member to submit any evidence of his/her current health status.

Each Medical Staff member shall further provide information relating to involvement in any adverse settlement or judgment of malpractice actions, any successful challenges to licensure or registration, voluntary or involuntary relinquishment of any license or registration, and to loss of medical or dental organization memberships. The Medical Staff member shall provide the names of

any facilities with which he/she is or has been associated. Further, in situations where such associations have been voluntarily or involuntarily discontinued, the Medical Staff member shall provide the reasons for such discontinuance. Each Medical Staff member shall provide additional information regarding the voluntary or involuntary resignation, withdrawal, limitation, reduction or loss of association or clinical privileges at another facility. There shall be a waiver by the Medical Staff member of any confidentiality provisions concerning the information to be provided to the Hospital pursuant to this requirement.

In addition, it is required that the Medical Staff member provide information concerning the substance of allegations in any pending professional medical or dental misconduct proceeding or malpractice actions, and any additional information concerning such proceedings or actions as the practitioner may deem appropriate.

The Medical Staff member will verify and attest that the information provided is true and accurate.

The National Practitioner Data Bank must be queried at least every two years for information related to professional conduct and competence, licensure status, and malpractice claims experience of each Medical Staff member or clinical affiliate on staff.

Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

B. All information will be maintained in the credentials file of each Medical Staff member.

C. Thereafter, the procedure provided in Section 1 of this Article VI relating to recommendations on applications for initial appointment shall be followed.

Section 3. Revision of Privileges

A Medical Staff member may request a revision of his/her privileges at times other than

at appointment or reappointment. The request shall include pertinent information relative to the member's education, training, professional experience, references who are knowledgeable about his/her competence, current health status, pending professional misconduct proceedings or pending malpractice actions, and judgments or settlements of malpractice actions or any findings of professional misconduct. The National Practitioner Data Bank must be queried prior to granting a revision of privileges.

Requests for revised privileges may be recommended by the Department Chairperson and granted by the Governing Body in the same manner as requests for renewal of privileges. Adverse decisions regarding requests for revision of privileges shall entitle the affected practitioner to the procedural rights provided by Article VIII of the By-Laws.

Section 4. Emergency Privileges

In the case of an emergency, any member of the Medical Staff member to the degree permitted by his/her license and regardless of his/her service or Medical Staff status or lack thereof, shall be permitted and assisted to do everything possible to save the life of a patient, including using every facility of the Hospital necessary and calling for any consultation necessary or desirable. When an emergency situation no longer exists, such member of the Medical Staff must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an emergency is defined as a condition in which serious permanent harm would result to a patient without immediate treatment or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 5. Temporary Privileges

A. Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, and in order to fulfill an important patient care, treatment and

service need, the Chief Executive Officer or designee may, upon the basis of information then available, which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with the concurrence of the Medical Executive Committee, grant temporary admitting and clinical privileges to the applicant for a period not to exceed 30 days. Temporary clinical privileges may be extended for two separate 30-day intervals upon approval of the Governing Body. In exercising such privileges, the applicant shall act under the supervision of the Chairperson of the Department to which he/she is assigned. For the purpose of granting temporary membership and clinical privileges, the Department Chairperson may act on behalf of the Medical Executive Committee. All temporary clinical privileges that have been granted will be reported and ratified at the following Medical Executive Committee meeting.

B. Temporary admitting and clinical privileges may be granted, prior to the review by the Governing Body, to an applicant with a complete application that raises no concerns to the Department Chairperson, Medical Staff President and Hospital Chief Executive Officer.

C. Temporary clinical privileges may be granted for the care of a specific patient by the Chief Executive Officer or designee to a practitioner who is not an applicant for membership in the same manner and provided that there shall first be obtained such practitioner's signed acknowledgment that he/she has received and read copies of the Medical Staff By-Laws, 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. Such temporary privileges shall be restricted to the treatment of not more than two patients in any one Medical Staff year by any practitioner, after which such practitioner shall be required to apply for membership in the Medical Staff before being allowed to attend additional patients.

D. The Chief Executive Officer or designee may grant temporary clinical
privileges,
with the concurrence of the Medical Executive Committee to a practitioner of documented competence

and ethical standing who is serving as a locum tenens for a member of the Medical Staff for the term of the locum tenens, but not to exceed a period of 30 days. Temporary clinical privileges may be extended for two separate 30-day intervals upon approval of the Governing Body.

E. Criteria for granting temporary clinical privileges shall include:

- Verification of education;
- Demonstration of current competence;
- Verification of State professional licenses;
- Receipt of professional references (including current competence);
- Receipt of database profiles from the AMA, AOA, NPDB, OIG
Medicare/Medicaid Exclusions.

Section 6. Disaster Privileges

Practitioners who are not members of the Medical Staff or Clinical Affiliate Staff or do not have approved clinical privileges at the Hospital may practice at the Hospital during an “emergency” (defined as any officially declared emergency, whether it is local, state or national). Emergency disaster privileges may only be granted when the Hospital Emergency Preparedness Plan (Plan D) has been activated and the Hospital is unable to handle the immediate patient needs. The following procedure will be followed:

- All practitioners requesting temporary emergency privileges are to be referred to the Medical Staff Office.
- Any one of the following “key identification documents” is an acceptable form of identification for a practitioner to be granted temporary emergency privileges:
 - ⇒ A current hospital photo identification card.
 - ⇒ A current license to practice with valid photo identification issued by a state, federal or regulatory agency.

- ⇒ Identification indicating that the practitioner is a member of a state or federal disaster medical assistance team.
- ⇒ Identification from a municipal, state or federal entity indicating that the practitioner has been granted authority to administer patient care in emergency circumstances.
- ⇒ Presentation by a current Hospital or Medical Staff member with personal knowledge of the practitioner's identity.

In addition to the above, the practitioner shall complete the Disaster Credentialing Form.

- Verification of the information will be done as quickly as possible. Telephone inquiry will be obtained and documented from the hospital where active staff privileges are held. Verification of current, valid licensure will be obtained as soon as the immediate situation is under control and completed within 72 hours from the time the practitioner presents to the hospital via the applicable State's web site and/or direct telephone communication to the licensing agency. Queries to the National Practitioner Data Bank will be placed. Records of the verified information will be maintained.
- Any information that is gathered that is not consistent with that provided by the practitioner shall be referred to the Vice President for Medical Affairs immediately, who will determine the need for additional action.
- The Vice President for Medical Affairs or the Department Chairperson will review the request for temporary emergency privileges. The Chief Executive Officer or his physician designee will approve/disapprove the temporary emergency privileges on a case-by-case basis at his or her discretion.

- The practitioner shall be granted privileges on an emergency basis for his or her specialty. The Vice President for Medical Affairs or Department Chair shall assign tasks consistent with the Hospital's immediate needs. Practitioners shall wear identification armbands.
- Declaration by the Chief Executive Officer or his designee that the emergency is over will automatically terminate all temporary emergency privileges.

Section 7. Expedited Credentialing

An expedited process for appointment to the Medical Staff or Clinical Affiliate Staff and the granting of privileges may be utilized, provided that the applicant has submitted a complete application and the Credentials Committee and Medical Executive Committee have made a favorable recommendation for appointment. Expedited appointment to the Medical Staff and Clinical Affiliate Staff requires approval by at least two members of the Governing Body.

An applicant is ineligible for the expedited process if any of the following occur:

- The applicant submits an incomplete application.
- The Medical Staff Executive Committee makes a final recommendation that is adverse or has limitations.
- There is a current challenge or a previously successful challenge to the applicant's licensure or registration.
- The applicant has received an involuntary termination of Medical Staff membership at another organization.
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
- The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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 abusive or harassing, 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, the Chairperson of any Clinical Department, the Chairperson of any Standing Committee of the Medical Staff, the Chief Executive Officer, or the Governing Body. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.

B. The action of the Executive Committee on a request for corrective action may be one or more of the following: rejection or modification of the request for corrective action; issuance of a warning, a letter of admonition, or a letter of reprimand; imposition of terms of probation or a requirement for consultation; recommendation of reduction, suspension or revocation of clinical privileges; recommendation that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or recommendation that the practitioner's Medical Staff membership be suspended or revoked. Any recommendation by the Medical Executive Committee for revocation of membership or revocation or permanent reduction of clinical privileges must be supported by two-third (2/3) of the votes cast.

C. 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 By-Laws.

D. The Chairperson of the Executive Committee 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 action taken in connection herewith.

Section 2. Automatic Suspension

A. A temporary suspension of admitting privileges (No Admit List) shall be imposed after failing to complete medical records within thirty (30) days after discharge. The temporary suspension of admitting privileges and presence on the No Admit List shall remain in effect until all medical records that are over 30 days past discharge have been completed. If a physician fails to complete the delinquent records within 7 days (one week) of being placed on the No Admit List, this will be counted as one (1) occurrence of Automatic Suspension of Privileges.

B. Immediate and automatic suspension of a practitioner's clinical privileges will occur in any of the following instances. Should any of the following occur, it is the obligation of the practitioner to immediately notify the Chief Executive Officer of the Hospital with a copy sent to the pertinent Department Chairperson and the President of the Medical Staff, in writing by either e-mail or US mail.

- The practitioner's professional license has been revoked or suspended for any reason.
- The practitioner's DEA certificate has been revoked, suspended or on probation for any reason.
- The practitioner has failed to maintain the minimum specified amount of professional liability insurance as required in the Medical Staff Rules and Regulations.
- The practitioner's Medicaid or Medicare participation has been terminated or the practitioner revoked or excluded.

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

Section 3. Summary Suspension

A. Any one of the following - the Chairperson of the Executive Committee/ President of the Medical Staff, the Chairperson of a Clinical Department, the Chief Executive Officer, and 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 and safety at 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. Specific circumstances that may warrant summary suspension include, but are not limited to: a pattern of practice below generally accepted standards; grossly negligent care; evidence of gross incompetence; practicing while impaired by alcohol, drugs, physical disability or mental disability; or a significant violation of the Code of Conduct.

C. 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 By-Laws.

D. Immediately upon the imposition of a summary suspension, the Chairperson of the Executive Committee or responsible Department Chairperson 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.

E. If there have been more than three (3) consecutive weeks of occurrences of Automatic Suspension or six (6) cumulative weeks of occurrences of Automatic Suspension within the Medical Staff year due to incomplete medical records over thirty (30) days old, the following shall

occur:

1. Procedure following Three (3) Consecutive Occurrences of Automatic Suspension or Six (6) Cumulative Occurrences of Automatic Suspension:

Step I. The Health Information Management Manager or designee will bring the name of the practitioner to the attention of the President of the Medical Staff, the Chairperson of the appropriate Clinical Department and the President of the Hospital.

Step II. The President of the Medical Staff will forward a certified/return receipt letter to the practitioner. The letter of notification will specify that:

A. He/She will have (seven) 7 days from the day the letter was received to complete all delinquent and incomplete medical records.

B. If he/she fails to complete the medical records by the end of the seven (7) day period, he/she will automatically be placed on Summary Suspension with a complete loss of privileges.

A registered or certified letter signed by the President of the Medical Staff will then be sent notifying the practitioner of Summary Suspension.

C. If placed on Summary Suspension, he/she must provide to the President of the Medical Staff in writing or in person an explanation of his/her failure to comply and request removal from Summary Suspension. Upon approval of the President, his/her privileges will be reinstated.

D. A letter with a timeline of listed occurrences and actions taken will then be forwarded to the President of the Medical Staff for placement on the agenda of the next Medical Executive Committee meeting.

E. All documentation/written communications pertaining to this event will be filed in the practitioner's credentialing file.

Step III. When any practitioner is placed on Summary Suspension for a second time during any Medical Staff year for failure to complete medical records, the practitioner's Medical Staff

membership shall be revoked subject to the practitioner's rights under Article VIII. Upon completion of all delinquent and incomplete medical records, the practitioner will be eligible to reapply for membership to the Medical Staff.

ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and Appellate Review

A. When any practitioner receives notice of a request for corrective action to the Executive Committee that 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 the Executive Committee of the Medical Staff.

B. If the decision of the Executive Committee following such hearing is 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.

Section 2. Request for Hearing

A. The Chief Executive Officer shall be responsible for giving prompt written notice of a request for corrective action or decision to any affected practitioner who is entitled under these By-Laws to a hearing or to an appellate review, by certified mail, return receipt requested. Notice shall include the actions or recommended actions proposed to be taken against the practitioner, the reasons therefore, and that the practitioner's rights in the hearing are as set forth in this Article VIII, a copy of which shall accompany the notice.

B. The practitioner's request for hearing or appellate review must be in writing, addressed to the Chairperson of the Executive Committee with a copy to the Chief Executive Officer and must be made within thirty (30) days of the mailing of the notice of corrective action.

C. The failure of a practitioner to request a hearing or an appellate review to which

he/she is entitled by these By-Laws within thirty (30) days of the mailing of a notice of corrective action shall be deemed a waiver of his/her right to such hearing or to any appellate review to which he/she might otherwise have been entitled in the matter, and the decision or recommendation shall be effective as against the practitioner in the same manner as a final decision of the Governing Body.

Section 3. Notice of Hearing

A. Within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or 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, which date shall not be less than thirty (30) nor more than ninety (90) days after the date of the notice of hearing, unless mutually agreed upon between the parties.

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, a list of the witnesses, if any, expected to testify at the hearing on the part of the hearing body, and any other reasons or subject matter that were considered in making the adverse recommendation or decision.

Section 4. Composition of Hearing Body

A. When a hearing relates to a request for corrective action, such hearing shall be conducted by the Executive Committee, and shall include, on a non-voting basis, an impartial peer of the affected practitioner appointed by the President of the Medical Staff.

B. When a hearing relates to an appeal from a decision of the Executive Committee, such hearing shall be conducted by the Governing Body or a Hearing Committee appointed by the Governing Body which committee shall report the evidence and its recommendations to the Governing Body.

Section 5. Conduct of Hearing

A. There shall be at least a majority of the members of the hearing body present when the hearing takes place, and no member may vote by proxy. Any member who is in direct economic competition with the practitioner or who made the request for an investigation or for corrective action shall be disqualified.

B. 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.

C. Postponement of hearings beyond the time set forth in these By-Laws shall be made only with the approval of the hearing body. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

D. The hearing need not be conducted strictly according to the rules of the law relating to the examination of witnesses or presentation of evidence. The Executive Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person authorized to do so who is designated by the Executive Committee or by affirmation under penalty of perjury to the presiding officer. Any evidence determined relevant by the presiding officer, including hearsay, shall be admissible if it is the sort of evidence upon which responsible persons customarily rely in the conduct of serious affairs, regardless of the existence of any common law rule which might make evidence inadmissible over objection in a civil or criminal action. The Chairperson of the Executive Committee shall appoint a member of the Medical Staff to present the case against the practitioner. Both sides shall be entitled to call, examine and cross-examine witnesses, to present documentary evidence determined to be relevant by the presiding officer and to submit prior to the close of the hearing written memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing records. The Executive Committee may, itself, interrogate witnesses and call additional witnesses if it deems necessary or appropriate.

E. The practitioner and the Executive Committee may have legal counsel present and may consult with and receive advice from counsel, but such counsel shall have no right to interrogate witnesses, offer evidence or otherwise actively participate in the proceedings.

F. The Executive Committee shall arrange for the presence of a stenographer at the hearing and shall, upon payment of the reasonable cost of same by the practitioner, provide the practitioner with a written transcript of the proceeding.

G. The hearing body 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 body may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

H. Within thirty (30) days after final adjournment of the hearing, the hearing body shall make a written report and recommendation, which shall include a statement of the basis for the recommendation, and shall forward the same and all other documentation to the Chief Executive Officer. Any recommendation by the hearing body for revocation of membership or revocation or permanent reduction of clinical privileges must be supported by two-third (2/3) of the votes cast.

6. Appellate Review: Appeal to the Governing Body

A. Within thirty (30) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision of the Executive Committee relating to a reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff, he/she may, by written notice to the Governing Body delivered to the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the Governing Body.

B. If such appellate review is not requested within thirty (30) days after date or receipt of a notice of such adverse recommendation or decision, 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 thirty (30) 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.

D. The Governing Body shall act as the appellate body. It shall review the record created in the proceedings, and shall consider any written statements for the purpose of determining whether the decision against the affected practitioner was justified. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such 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 Governing Body.

E. The Governing Body may affirm, modify or reverse the prior decision of the Executive Committee or, in its discretion, refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation within twenty (20) 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. If any proposed corrective action by the Board of Trustees will substantially modify the recommendation of the Executive Committee, the Board shall submit the matter to an ad hoc Joint Conference Committee for review and recommendation prior to making its final decision. This Committee shall be appointed by the Board and shall be composed of an equal number of members of the Board and members of the Active Medical Staff.

F. Notice of the final determination of the Board, including a statement of the basis for the decision, will be promptly sent by certified mail, return receipt requested, from the Chief Executive Officer to the affected practitioner and to the Executive Committee.

G. 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 By-Laws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 7. Reapplication after Adverse Appointment Decision

An applicant receiving a final adverse decision regarding appointment or expulsion is not eligible to reapply for appointment to the Medical Staff or the Clinical Affiliate Staff for a period of one year from the date of the final adverse decision. Any such reapplication shall be processed as an initial application. The applicant will be expected to submit such additional information as the Medical Staff and the Governing Body may require to determine that the basis for the earlier adverse action no longer exists.

ARTICLE IX

CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments and Services

A. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who shall be responsible for the overall supervision of the clinical work within his/her Department and the Vice-Chairperson who shall serve during the absence of the Chairperson. Where appropriate a Department may have Clinical Sections which shall be organized as specialty subdivisions within a Department, shall be directly responsible to that Department within which they function, and shall have a Chief of the Section. All appointments to the Medical Staff shall be made in one or more of the Clinical Departments, and where applicable, a Clinical Section.

B. The Medical Staff of the Hospital shall be organized into Clinical Departments with respective Sections where appropriate, as follows:

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine
4. Internal Medicine

5. Obstetrics and Gynecology
6. Pathology
7. Pediatrics
8. Psychiatry
9. Radiology
10. Surgery

Section 2. Qualification, Selection and Tenure of Department Chairpersons, Vice-Chairpersons, and Section Chiefs

A. Each Chairperson, Vice-Chairperson, and Section Chief shall be a member of the Active Medical Staff best qualified by training, experience, and demonstrated ability for the position and shall be Board certified in his/her specialty or demonstrate equivalent qualifications.

B. The Governing Body shall appoint each Department Chairperson after receiving and considering recommendations for appointment from the Executive Committee of the Medical Staff. The Executive Committee shall submit its recommendation after consultation with the pertinent Department.

The Department Chairperson shall appoint each Section Chief after receiving and considering recommendations from the members of the Department Section.

C. Each Chairperson shall serve a four-year term and shall be eligible for reappointment by the Governing Body through the process defined in Section 2, subparagraph B of this Article.

D. Each Vice-Chairperson shall be qualified, selected and have tenure as described for the Chairperson in subparagraphs A, B, and C of this section.

E. Each Section Chief shall serve for the duration of the term of the Department Chairperson, but not longer than four (4) years. He/she shall be eligible for reappointment so long as he/she fulfills the responsibilities and duties to the satisfaction of the Section Members and Department Chairperson.

F. A Chair, Vice Chair or Section Chief may be removed for cause by following

the same procedures by which they were selected. Conditions for removal of such departmental officer may include, but are not limited to, failure to adequately perform his/her duties as an officer of the department.

Section 3. Functions of Department Chairpersons/Section Chiefs

A. Each Chairperson shall:

1. Be accountable for all professional and administrative activities within his/her Department.
2. Be a member of the Executive Committee giving guidance on overall medical policies of the Hospital, and making specific recommendations and suggestions regarding his/her own Department in order to insure quality patient care.
3. Maintain continuing surveillance of the professional performance of the Medical Staff members who exercise privileges in the Department and render regular reports on each member, at least at the time of reappointment -- reappraisal.
4. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who are currently members of the Clinical Affiliate Staff.
5. Be responsible for enforcement of the Hospital By-Laws and of the Medical Staff By-Laws, Rules and Regulations within his/her Department.
6. Be responsible for implementation within his/her Department of actions taken by the Executive Committee of the Medical Staff.
7. Recommend to the Executive Committee, Medical Staff category and classification and the reappointment and delineation of clinical privileges for all practitioners in his/her Department.
8. Recommend to the Executive Committee the criteria for clinical privileges that are relevant to the care provided in the department.

9. Recommend clinical privileges for each member of the department.

10. Assume ongoing responsibility for support of the program of medical education conducted within the Department. Be responsible for the orientation and continuing education of all practitioners in the Department and for the Residents assigned to the Department.

11. Participate in every phase of administration of his/her Department through cooperation with the Clinical Services and the Hospital Administration in matters affecting patient care, including personnel, facilities, supplies and other resources.

12. Assist in the preparation of such annual reports, including budgetary planning, pertinent to his/her Department as may be required by the Executive Committee, the Chief Executive Officer or the Governing Body.

13. Maintain quality control programs, as appropriate.

14. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital.

15. Coordinate and integrate interdepartmental and intradepartmental services.

B. Each Section Chief shall:

1. Serve under the direction of and be accountable to the Chairperson of his/her Clinical Department with the responsibilities and duties assigned by the appropriate Department Chairperson.

2. Be responsible for the overall supervision of the clinical work within his/her Section.

3. Be accountable for all professional and administrative activities within his/her Section.

4. Participate in the continuing surveillance of the professional performance of the Medical Staff members in his/her Sections and assist the Clinical Department

Chairperson at the time of the reappointment-reappraisal process and in the delineation of clinical privileges.

Section 4. Functions of the Vice-Chairperson

Each Vice-Chairperson shall assume the functions of the Chairperson during the absence of the Chairperson or when the Chairperson has a conflict of interest with respect to a member of the department as determined by the President of the Medical Staff.

Section 5. Functions of the Departments

Each Clinical Department shall:

1. Establish its own criteria, consistent with 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.
2. In conjunction with the Medical Quality Council, establish criteria for conducting a primary, concurrent or retrospective review of records of patients and other pertinent departmental sources of medical information relating to patient care for the purpose of assessing the quality and appropriateness of care. Such review shall be timely and shall include consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnoses and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems.
3. Meet separately to review and analyze the clinical work of the Department.

Each surgical division of the Medical Staff shall review the findings of the pertinent care evaluations including tissue review, whether tissue was removed or not, and for the acceptability of the procedure chosen.

4. Submit a report to the Executive Committee detailing each departmental meeting

including analysis of patient care.

5. Form a department executive committee, appointed by the chair with the consent of the members, to act on behalf of the department between regularly scheduled departmental meetings. Membership of a departmental executive committee shall include the department chairperson, vice chairperson and at least three other active members of the department. A quorum of the executive committee shall consist, at a minimum, of the chairperson (or vice chair in his/her absence) of the department and at least two other members of the executive committee. The executive committee shall maintain minutes of their proceedings, which are sent to department members.

Section 6. Assignment to Departments

The Executive Committee shall, after consideration of the recommendations of the Clinical Departments as transmitted through the Credentials Committee, recommend initial Department assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

Section 7. Family Medicine

A. The Chairperson of the Department of Family Medicine shall develop and maintain privileges to be accorded members of the Department of Family Medicine in consultation with the Chairpersons of the other pertinent Clinical Departments. This shall constitute the basis of Family Medicine in the Hospital upon approval of the Executive Committee and Board of Trustees.

B. An individual member of the Department of Family Medicine may request additional privileges based on education, training, experience and demonstrated competence. Such privileges shall require the recommendation of the Department Chairperson of the specific specialty for which those privileges are normally associated and shall, upon approval of the Board of Trustees, be under the jurisdiction and rules of that specific specialty Department.

C. The Chairperson of the Department of Family Medicine shall consult with other relevant Department Chairpersons during the recredentialing process of Department members.

ARTICLE X

OFFICERS

Section 1. Officers of the Medical Staff

The Officers of the Medical Staff shall be:

- A. President
- B. Vice President
- C. Secretary-Treasurer

Section 2. Qualifications of Officers

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Candidates for office will have demonstrated administrative ability through experience and prior participation in Medical Staff activities and be recognized by their peers for their clinical competence and leadership skills. Candidates for the offices of President and Vice President/President Elect must have served on the Medical Executive Committee for a period of two years.

Section 3. Election of Officers

A. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.

B. The Nominating Committee shall offer one or more nominees for each office.

C. Nominations may also be made by petition signed by at least twenty (20) members of the Medical Staff and filed with the Secretary of the Medical Staff at least ten (10) days prior to the annual meeting.

Section 4. Term of Office

All Officers shall serve a two year term from their election date or until a successor is elected. Officers shall take office immediately prior to the adjournment of the annual meeting at which they are elected.

Section 5. Vacancies in Office

Vacancies in office except for the Presidency, occurring during the Medical Staff year shall be filled by action of the Executive Committee of the Medical Staff. Should a vacancy in the office of the President occur, the Vice-President shall serve out the remaining term.

Section 6. Duties of Officers

A. The President shall:

1. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;
2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
3. Serve as Chairperson 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 By-Laws, and Rules and Regulations; for implementation of sanctions where they 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, needs and grievances of the Medical Staff

to the Governing Body and to the Chief Executive Officer; and

8. Receive and incorporate 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 responsibilities to provide medical care.

B. The Vice President shall:

1. In the absence of the President, assume all duties and have the authority of the President.
2. Be a member of the Executive Committee.
3. Automatically succeed the President when the latter fails to serve for any reason.

C. The Secretary-Treasurer shall:

1. Be a member of the Executive Committee of the Medical Staff.
2. Keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence and perform such other duties as ordinarily pertain to this office.
3. Also serve as Secretary of the Executive Committee.
4. Collect dues and pay bills on behalf of the Medical Staff.

Section 7. Removal of Officers of the Medical Staff

An officer of the Medical Staff may be removed for cause by a two-thirds vote of the Executive Committee. Conditions for removal of an officer of the Medical Staff may include, but are not limited to, failure to adequately perform his/her duties as an officer of the Medical Staff and/or as a member of the Executive Committee. The affected officer shall have the right to submit the decision for appeal to the Medical Staff. In such event, a two-thirds vote of all voting members of the Medical Staff is required to confirm the Executive Committee action.

Section 8. Director of Medical Education

A. A Director of Medical Education may be appointed by the Governing Body with the concurrence of the Executive Committee of the Medical Staff.

B. The Director of Medical Education shall:

1. Assume overall direction of all programs of medical education in the Hospital, including undergraduate, graduate and postgraduate programs.
2. Appoint all Departmental educational coordinators and direct their teaching activities.
3. Appoint all interns and residents; maintain effective liaison with the SUNY Health Science Center at Syracuse College of Medicine.
4. Serve as a member of the Active Medical Staff.
5. Serve as a permanent member of the Executive Committee.
6. Function as Chairperson of the Department of Medical Education and the Medical Education Committee. Provide regular reports to the Executive Committee regarding departmental activities including, but not limited to the safety and quality of patient care provided by, and the related educational and supervisory needs of residents.
7. Be responsible for implementing the requirements of governmental and medical education accrediting agencies pertaining to residents, unlicensed physicians and medical students.
8. Act as a liaison between Medical Staff and the professional library staff and make recommendations concerning the operations of the medical library, including selection of publications and knowledge-based information services.
9. Function as a liaison between the Medical Education Committee and the Executive Committee.

Section 9. Medical Staff Director of Corporate Compliance

A. The Vice President of the Medical Staff shall serve as the Medical Director of Corporate Compliance and shall sit on the Hospital's Corporate Compliance Committee. In the event the vice president is unable to serve in this capacity due to a conflict of interest, the Medical Director of Corporate Compliance shall be appointed by the President of the Medical Staff and confirmed by the Medical Executive Committee. This Director may also hold another office or position in Medical Staff Leadership. This Director shall be free of conflicts of interest to the satisfaction of the Medical Executive Committee.

B. The Medical Staff Director of Corporate Compliance shall:

1. Participate in the review and amendment of any elements of the Business Conduct and Code of Ethics that impact the activity and oversight of Medical Staff members.
2. Participate in the investigation of pertinent complaints about members of the Medical Staff or initiated by members of the Medical Staff.
3. Serve as a liaison between the Office of Corporate Compliance and the Medical Executive Committee.
4. Serve as a member of the Medical Staff.
5. Serve as a member of the Medical Executive Committee.
6. Chair an ad hoc committee of three additional members, appointed by the Medical Staff President, to investigate substantive allegations regarding members of the Medical Staff, and to report the findings of the committee to the Medical Executive Committee for action.

ARTICLE XI

COMMITTEES

Committees of the Medical Staff shall be Standing or Special. Standing Committees of the Medical Staff are:

1. Executive
2. Credentials
3. Nominating
4. Health Information Management
5. Pharmacy and Therapeutics
6. Infection Control
7. Medical Quality Council
8. Health
9. Research Committee

Each of the Standing Committees, except the Executive Committee, shall have a Chairperson, and if appropriate, Vice-Chairperson, appointed annually by the President of the Medical Staff in consultation with the Department Chairperson.

Section 1. Executive Committee

A. Composition

The Executive Committee shall be a Standing Committee, whereby the majority of the voting Medical Executive Committee members are fully licensed doctors of medicine or osteopathy actively practicing in the Hospital, and shall consist of the Officers of the Medical Staff, the immediate past President of the Medical Staff, the Director of Medical Education, the Medical Staff Director of Corporate Compliance, the Chairperson of each Clinical Department, the Performance Improvement Chairperson, a voting member from the Clinical Affiliate Staff actively practicing in the Hospital elected from the Clinical Affiliate Staff for a term of three (3) years, nine (9) Members-at-Large, three (3) of whom shall be elected at each annual meeting of the Medical Staff for a term of three (3) years, and may include other Licensed Independent Practitioners. The Chief Executive Officer and the Chief Nursing Officer or their designee, and the By-Laws Committee Chair shall serve as ex-officio members of the Executive Committee without vote.

No more than three (3) Members-at-Large may be elected from any one Department. Should any Member-at-Large become an Officer or Department Chairperson, another member from the same Department is to be elected by the Executive Committee for the duration of the term. In the event of a vacancy due to death or resignation, the Executive Committee is empowered to elect a

replacement.

A Member-at-Large may be removed for cause by a two-thirds vote of the Executive Committee. Conditions for removal of a Member-at-Large may include, but are not limited to, failure to perform his/her duties as a Member-at-Large. The affected Member-at-Large shall have the right to submit the decision for appeal to the Medical Staff. In such event, a two-thirds vote of all voting members of the Medical Staff is required to confirm the Executive Committee action. In the event of a death, resignation or removal, another member from the same Department is to be elected by the Executive Committee for the duration of the term.

B. Duties

The duties of the Executive Committee shall be:

1. To represent and act on behalf of the Medical Staff between meetings of the Medical Staff subject to such limitations as may be imposed by these By-Laws;
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 the Medical Staff and the Chief Executive Officer and the Governing Body;
6. To recommend action to the Chief Executive Officer on matters of a medical-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;
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 make recommendations for Medical Staff membership, assignments to Departments and delineation of clinical privileges;

12. To review periodically all information available regarding the performance and clinical competence of Medical Staff members and, as a result of such review, to make recommendations for reappointment 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 the Medical Staff corrective or review measures when warranted;

14. To be responsible for the development and maintenance of methods for protection and care of Hospital patients and others at the time of internal and external disaster.

Specifically, the Executive Committee shall be responsible for the adoption and periodic review of a written plan to safeguard patients at the time of an internal disaster, particularly fire; shall assure that all key personnel rehearse fire drills consistent with established current standard; shall adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital and that it adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disasters; and shall assure that the plan is rehearsed by key personnel at least twice yearly;

15. To report at each general Medical Staff meeting.

16. To make recommendations to the Governing Body regarding the process used to review credentials and delineate privileges as well as the structure of the organized Medical Staff.

C. Meetings

The Executive Committee shall meet at least eleven (11) times a year and maintain a

permanent record of its proceedings and actions. Issues to be discussed and/or voted upon between Executive Committee meetings may be addressed via secure e-mail. Unanimous consent to proceed via secure e-mail is required from those Executive Committee members present and voting at the meeting immediately preceding the e-mail transaction.

Section 2. Credentials Committee

A. Composition

The Credentials Committee shall be a standing committee and shall consist of a Chairperson and five (5) members of the Active Medical Staff, appointed by the President. A member of the Clinical Affiliate Staff, appointed by the President and actively practicing in the Hospital, will serve as a non-voting member of the Committee for the deliberation of Clinical Affiliate applications.

B. Duties

1. To review the credentials of all applicants for Medical Staff membership and make recommendations for membership and delineation of clinical privileges.
2. To 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.
3. At the request of the Department Chairperson, to review a request for transfer to the Active Medical Staff from another staff category.
4. At the request of the Department Chairperson, to review a request for a revision of privileges at times other than at reappointment.
5. The Credentials Committee shall maintain a permanent record of its proceedings and actions.

Section 3. Nominating Committee

A. Composition

The Nominating Committee shall consist of the immediate past President of the Medical Staff who shall serve as Chair, and two (2) members of the Active Medical Staff appointed by the President. In the event the immediate past President is unable to serve, the Chair of the Nominating Committee shall be appointed by the President.

B. Duties

The Nominating Committee shall present candidates for election as Officers and for Members-at-Large on the Executive Committee, one (1) month prior to the annual meeting.

Nominations may also be made by petition signed by at least twenty (20) members of the Medical Staff and filed with the Secretary of the Medical Staff at least ten (10) days prior to the annual meeting.

Section 4. Health Information Management Committee

A. Composition

The Health Information Management Committee shall consist of at least one representative of the Medical Staff from each Clinical Department and one each from the Clinical Services and from the Hospital Administration. The Health Information Management Director shall be a member of this Committee.

B. Duties

The Health Information Management Committee shall be responsible for assuring that all medical records meet that highest standards of patient care usefulness and of historical validity, and that the medical records reflect realistic documentation of medical events through complete and timely documentation. This also includes the review and recommendation for approval of forms used in the legal medical record. The Committee shall conduct a regular review of concurrent and retrospective medical records to assure that they properly reflect compliance with all documentation requirements. The Health Information Management Committee identifies and takes action to inform providers when improvement in documentation compliance is necessary.

C. Meetings

The Health Information Management Committee shall meet at least ten (10) times each year and shall maintain a permanent record of its proceedings and activities.

Section 5. Pharmacy and Therapeutics Committee

A. Composition

Membership shall consist of at least four (4) representatives of the Medical Staff, and one each from the Pharmaceutical Service, Clinical Services and the Hospital Administration. At least one Hospital pharmacist shall be a member of and act as Secretary to the Committee.

B. Duties

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

1. Serve as an advisory group to the Medical Staff and the pharmacists on matters pertaining to the choice of available drugs;
2. Make recommendations concerning drugs to be stocked in the clinical units and by other services;
3. Develop formulary and review periodically (the Hospital drug list);
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

use in the Hospital;

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

7. Review reports of drug reactions and make appropriate recommendations; and

8. Maintain a subcommittee to assess and improve the safety of the medication safety use process.

C. Meetings

The Pharmacy and Therapeutics Committee shall meet at least quarterly and report to the Executive Committee.

Section 6. Infection Control Committee

A. Composition

The Infection Control Committee shall consist of at least one representative from each Clinical Department, together with one representative from Clinical Services, Housekeeping, Home Care, the Hospital Administration, Infection Control Office Patient Safety and Risk Management and ad hoc members as necessary from Facilities Services, Pharmacy, Central Sterile and Nutritional Services.

B. Duties

The Infection Control Committee shall be responsible for oversight of the recommended surveillance of nosocomial or health care acquired infections and the associated prevention and control activities. The committee will analyze actual infections and shall make appropriate recommendations for the control of infections within the Hospital as well as review Centers for Disease Control and Prevention and New York State Department of Health advisories, recommendations and guidelines.

C. Meetings

The Infection Control Committee shall meet at least quarterly, shall maintain a record of its proceedings and activities and shall report quarterly to the Medical Executive Committee.

Section 7. Medical Quality Council

A. Composition

The Medical Quality Council shall consist of a physician and alternate from each of the Clinical Departments: Anesthesia, Emergency, Family Medicine, Medicine, Pathology, Obstetrics/Gynecology, Pediatrics, Psychiatry, Radiology and Surgery. The Medical Quality Council is chaired by the Performance Improvement Chairperson. The Performance Improvement Director shall be a member and attend all meetings. Non-physicians shall be appointed by the President of the Medical Staff in consultation with Administration. The Chairperson of the Medical Quality Council shall be a voting member of the Medical Staff Executive Committee.

B. Duties

The Medical Quality Council is formed for the purpose of integrating and coordinating the Hospital's peer review process and quality improvement functions. Its primary function is to provide a forum for the resolution of the Medical Staff multi-disciplinary patient care issues as well as the ongoing review of policies and procedures related to the peer review process. The Medical Quality Council utilizes a systems analysis approach through project work teams to improve the quality and safety of care, support better outcomes and reduce the risk of health care errors.

The Medical Quality Council will assess data collected through the peer review process. Identified trends, multi-disciplinary issues and opportunities for improvement will be reviewed by the Medical Quality Council and shared with Medical Staff members with identified performance problems.

Multi-disciplinary project work teams are convened through the Medical Quality Council when opportunities for improvement are identified for intensive assessment by the Performance Improvement and Safety Steering Council. Project work teams will provide monthly

minutes and progress reports as needed to the Medical Quality Council. Membership and frequency of meetings is determined by the focus of the initiative.

The file of Performance Improvement activities for each member of the Medical Staff shall be maintained by the Performance Improvement office. The individual member's Performance Improvement profile will be updated at least annually.

Changes in committee functions or procedures may be made as needed by the approval of the Executive Committee of the Medical Staff.

C. Meetings

The Medical Quality Council shall meet monthly at least nine (9) times each year and provide a written report to the Medical Staff Executive Committee and to Hospital Administration as appropriate. The Medical Quality Council will provide an annual report to the Performance Improvement and Safety Steering Council.

Section 8. Health Committee

The Health Committee will consist of two members of the Department of Psychiatry, one member of the Department of Medicine and one member of the Department of Family Medicine, none of whom are members of the Executive Committee of the Medical Staff. The purpose of this Committee is to identify, through referral or self-referral, and assist sick or impaired members of the Medical Staff and to protect patients from such sick or impaired members while optimizing the likelihood that the practitioner can safely reassume or continue their clinical duties and responsibilities, when appropriate.

Section 9. Research Committee

A. Composition

The Research Committee shall consist of physician and non-physician members in accordance with the requirements of federal and state regulations. The majority of the members shall

be physicians.

B. Duties

The Research Committee shall function as the Institutional Review Board for human research and shall conduct its business in accordance with the requirements of federal and state regulations.

C. Meetings

The Research Committee shall meet at least ten (10) times a year, shall maintain a record of its proceedings and activities and shall report to the Executive Committee on a regular basis.

Section 10. Special Committees

Special Committees shall be created from time to time by the Executive Committee for special tasks as circumstances warrant. Special Committees shall limit their activities to the accomplishment of the task for which created and appointed, and shall have no power to act except as is specifically conferred by action of the Executive Committee. A permanent record of the proceedings and actions shall be maintained and reported to the Executive Committee as appropriate. Upon completion of the task for which appointed, such Special Committee shall stand discharged.

ARTICLE XII

MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

The annual meeting of the Medical Staff shall be held in January of each year. The agenda shall include reports of review and evaluation of the work done in the Clinical Departments in the performance of required Medical Staff functions and the election of Officers and Executive Committee Members-at-Large.

Section 2. Special Meetings

The President of the Medical Staff may call a special meeting of the Medical Staff at

any time. The President shall call a special meeting within fourteen (14) days after receipt by him/her of a written request for same, signed by not less than one-quarter of the Active Medical Staff and stating the purpose of such meeting. The President shall designate the time and place of any special meeting. The written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the Medical Staff not less than 96 hours before the date of such meeting by or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Medical Staff member at his/her address as it appears on the records of the Hospital. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Quorum

A. Forty (40) voting members or ten (10%) percent of the total voting members of the Active Medical Staff, whichever is the lesser, shall constitute a quorum at any regular or special meeting.

B. Absentee ballots and proxy votes are not valid.

Section 4. Agenda

A. The agenda of any regular Medical Staff meeting shall be:

1. Call to order.
2. Acceptance of the minutes of last regular meeting and those 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, including elections.
 9. Review and analysis of the clinical work of the Hospital.
 10. Reports of the Medical Committees.
 11. Discussion and recommendations for improvement of the professional work of the Hospital.
 12. Adjournment.
- B. The agenda at the 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, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least twelve (12) times each year to review and evaluate the clinical work of practitioners with privileges in the Department. A meeting of the departmental executive committee may substitute for eight (8) of these meetings, provided the department meets at least once each quarter year. At the Department business meetings, the principal agenda item is the review of clinical work done in the Department as evidenced by detailed attention to all the facets of the Performance Improvement reports.

Meetings shall be chaired by the committee or department chairperson, or by the vice-chairperson in the absence of the chairperson. If neither the chairperson or vice-chairperson can attend

a regular meeting, the chairperson may appoint a chair pro tem for the sole purpose of conducting such meeting.

Section 2. Special Meetings

A special meeting of any Committee or Department may be called by or at the request of the Chairperson or Chairpersons thereof; by the President of the Medical Staff; or by one-third of the Committee members, but not less than two members.

Section 3. Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the Committee or Department not less than 48 hours before the time of such meeting by the person or persons calling the meeting.

Section 4. Quorum

Ten (10%) percent of the Active Medical Staff members of the Committee or Department, but not less than two (2) members, shall constitute a quorum at any meeting, with the exception of the Medical Staff Executive Committee for which a quorum shall be fifty (50%) percent of the members.

Section 5. Manner of Action

The action of a majority of the members present at a meeting in which a quorum is present shall be the action of a Committee or Department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote.

Section 6. Rights of Ex-Officio Members

Persons serving under these By-Laws as ex-officio members of a Committee shall have all the rights and privileges of regular members except they shall not be counted in determining the

existence of a quorum.

Section 7. Minutes

The 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 in each matter. There shall be full documentation within the minutes of the Department meetings reflecting detailed attention to all the facets of the Performance Improvement reports. The minutes shall be signed by the presiding officer and copies thereof shall be forwarded to the Executive Committee. Each Committee and Department shall maintain a permanent file of the minutes of each meeting.

Section 8. Attendance Requirements

Each member of the Active Medical Staff shall be required to attend not less than fifty percent (50%) of all meetings of each Department (or Section) and Committee of which he/she may be a member each year. Any member absent from seventy five percent (75%) or more of scheduled Department or Committee meetings in any staff year must have the requirement waived in writing by the Department Chairperson to be eligible for reappointment to the Active Medical Staff. Failure to meet the foregoing annual attendance requirements, unless excused by the Chairperson, shall be grounds for corrective action leading to removal from such Department or Committee and to revocation of Medical Staff membership. Reinstatement of Medical Staff members whose membership has been revoked because of absence from Department or Committee meetings shall be made only upon application, and all such applicants shall be processed in the same manner as applications for initial appointment.

ARTICLE XIV

IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application and/or reapplication for, or exercise of, clinical privileges at this Hospital:

1. 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 purposes 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.

2. That such privilege shall extend to members of the Hospital's Medical Staff and 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 whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

3. That there shall be, to the fullest extent permitted by law, 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.

4. 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:

- A. Applications for initial appointment and clinical privileges;
- B. Periodic reappraisals for reappointment and/or renewing/revising clinical privileges;
- C. Corrective action, including summary suspension;
- D. Hearings and appellate reviews;
- E. Medical care evaluations;
- F. Utilization reviews; and
- G. Other Hospital, departmental, service or Committee activities related to

quality patient care and interprofessional conduct.

5. 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.

6. 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 2, 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 and the Federal government.

7. The consents, authorizations, releases, rights, privileges and immunities provided by Section 1 and 2 of Article VI of these By-Laws 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.

8. For immunity purposes, all proceedings, records and activities of relevant committees are considered to be peer review activities.

ARTICLE XV

RULES AND REGULATIONS

The Executive Committee of the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these By-Laws, subject to the approval of the Governing Body. Such Rules and Regulations shall become effective when approved by the Governing Body. The Medical Staff By-Laws, Rules and Regulations,

and policies and the Governing Body By-Laws shall not conflict.

ARTICLE XVI

REGULATORY COMPLIANCE

The Medical Staff of St. Joseph's Hospital Health Center shall abide by all Federal and State regulations pertaining to the Medical Staff organization, including but not limited to, full compliance with all applicable statutes and regulations for reporting misconduct, and shall assist the Administration in its obligation to report disciplinary actions against any member of the Medical Staff.

ARTICLE XVII

AMENDMENTS

The By-Laws shall be reviewed annually. These By-Laws may be amended after submission of the proposed amendment at any regular or special meeting of the Executive Committee of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds affirmative vote of the Active Medical Staff present. Amendments so made shall be effective when approved by the Governing Body. The Governing Body approves and complies with the Medical Staff By-Laws.

ARTICLE XVIII

ADOPTION

These By-Laws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous By-Laws, and shall become effective when approved by the Governing Body of the Hospital.

APPROVED:

April 27, 2011

Marya Gendzielewski, M.D.
President, Medical Staff

May 10, 2011

Sister Mary Obrist
Secretary, Board of Trustees