Medical/Dental Staff
Bylaws
Of
St. Peter's Hospital

10/25/2017

ST PETER'S HEALTH PARTNERS

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PREAMBLE

In order to best serve the interests of St. Peter's Hospital (hereinafter "the Hospital") and the health care needs of the community which it serves, those who are privileged to attend patients in the Hospital are hereby organized into the Medical/Dental Staff of St. Peter's Hospital.

The members of the Medical/Dental Staff acknowledge and reaffirm their obligation to respond to those in need of health care services, especially the poor, in accordance with the mission of the Hospital, its status as a charitable institution, and the requirements of state and federal law.

ARTICLE I

NAME

The name of the organized medical staff shall be the Medical/Dental Staff of St. Peter's Hospital (hereinafter "the Staff").

ARTICLE II

RESPONSIBILITIES AND PURPOSES

Section 1. ***Organizational Responsibility.*** The Staff shall be responsible to the Board of Directors of the Hospital (hereinafter "the Board") for the fitness, adequacy, efficiency, cost and quality of medical care rendered to patients in the Hospital by:

a. establishing and maintaining professional standards of practice;

b. coordinating the clinical departments of the Hospital;

c. promoting the scientific and educational advancement of all members of the Staff through encouraging education and research;

d. acting as a liaison whereby medico-administrative problems may be discussed and resolved among the members of the Staff, the Hospital administration and the Board;

e. evaluating and making recommendations with respect to the professional competence of Staff members, applicants for Staff membership and the delineation of clinical privileges;

f. recommending, assisting and participating in the planning, implementation and review of procedures designed to insure the efficient and appropriate use of Hospital resources; and

g. developing bylaws, rules and regulations and policies of the Staff.

The Board has delegated its supervisory authority over the quality, credentialing, corrective action and governance activities of the Staff and Allied Health Professional Staff to the Board's Safety and Quality Improvement

Committee, subject to certain conditions as specified herein. Any references in these Bylaws or the rules and regulations or policies of the Staff to the "Board" or "Board of Directors" shall mean the Safety and Quality Improvement Committee, unless expressly stated otherwise. The Board reserves the right, in the Board's discretion, to cancel such delegation at any time or from time to time with respect to any or all matters.

Section 2. ***Responsibilities of Individual Staff Members.*** Each member of the Staff, to the extent consistent with their medical/dental staff category and clinical privileges, shall be responsible for:

a. providing patients with the quality of care which meets the professional standards of the Staff;

b. abiding by these Bylaws and, if adopted, the rules and regulations and policies of the Staff;

c. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Staff membership, including committee and on-call assignments;

d. preparing and completing in timely fashion medical records and other documents related to patient care, including but not limited to those pertaining to utilization review, for all the patients to whom the member provides care in the Hospital;

e. aiding in any Staff approved educational programs for medical students, interns, resident physicians, resident dentists, Staff physicians and dentists, nurses and other personnel;

f. working cooperatively with Staff members, nurses, hospital administration and others so as to promote and not adversely affect patient care, and adhering to the policies of the Staff and the Hospital governing Staff behavior and professional conduct;

g. making appropriate arrangements, as determined by the Staff, for coverage for his or her patients;

h. refusing to engage in improper inducements for patient referral;

i. participating in continuing education programs as determined by the Staff;

j. recommending, assisting and participating in the planning, implementation and review of procedures designed to insure the efficient and appropriate use of Hospital resources;

k. discharging such other Staff obligations as may be lawfully established from time to time by the Staff, or as may be provided in other provisions of these Bylaws or the rules and regulations or policies of the Staff.

ARTICLE III

CATEGORIES OF THE STAFF

Section 1. ***The Staff.***

a. The Staff shall be comprised of licensed physicians, dentists and podiatrists, divided into Attending, Courtesy, Adjunct, Telemedicine, Community-Based, and Emeritus categories. Physicians, dentists and podiatrists who provide clinical services within any Hospital inpatient or outpatient facility (i.e., New York Public Health Law Article 28 licensed space) must be members of either the Attending, Courtesy or Adjunct Staff.

b. Except as otherwise provided with respect to Emeritus Staff, practitioners shall be appointed to the Staff in the manner provided in Part II of these Bylaws.

Section 2. ***The Attending Staff.***

a. The Attending Staff shall consist of licensed physicians, dentists and podiatrists who expect to attend, admit or be involved in the care of at least 50 patients during each biennial appointment period. The 50 patient requirement may be waived by the Board upon the recommendation of the Medical Executive Committee.

b. Members of the Attending Staff shall participate in emergency department call-coverage rosters and schedules and may, within the scope of their clinical privileges, admit patients, perform procedures, give patient orders, direct a patient's care, and make entries into medical records. Attending Staff may choose to be removed from emergency department coverage responsibilities after attaining age 62 or after 25 years of service on the Staff, but are required to provide their department chief six months' prior notice. If either milestone occurs without the member providing notice, the member will remain on the emergency department call roster until six months after giving such a notice.

c. Members of the Attending Staff are eligible to vote on matters coming before the Staff for a vote, to hold office, and to serve on Staff committees, subject to the provisions of these Bylaws. Attendance at Staff meetings is a professional obligation and expectation of each Attending Staff member, but is not required.

Section 3. ***The Courtesy Staff.***

a. The Courtesy Staff shall consist of licensed physicians, dentists and podiatrists who expect to attend, admit or be involved in the care of not more than 50 patients during each biennial appointment period.

b. Members of the Courtesy Staff may be required, but are not entitled, to participate in emergency department call-coverage rosters and schedules. They may, within the scope of their clinical privileges, admit patients, perform procedures, give patient orders, direct a patient's care, and make entries into medical records.

c. Members of the Courtesy Staff may not hold office, but they may serve on Staff committees (either with or without vote) subject to the provisions of these Bylaws. Members of the Courtesy Staff may attend Staff meetings and are expected to do so whenever possible, but they shall not be permitted to vote on matters coming before the Staff.

Section 4. ***The Adjunct Staff.***

a. The Adjunct Staff shall consist of licensed physicians, dentists and podiatrists who are employed or contracted (such as locum tenens) by the Hospital on a temporary or a part-time basis in order to provide physician, dental or podiatric coverage required by the Hospital.

b. Members of the Adjunct Staff may be recommended and subsequently granted admitting privileges, depending on their roles, as determined by the department chief. They may perform only those clinical services that are within the scope of their clinical privileges and the terms of their appointment. The clinical privileges of Adjunct Staff members are coterminous with their employment or contract and automatically terminate at the end of such employment or contract.

c. Members of the Adjunct Staff are not eligible to vote, hold office or serve on standing committees of the Staff.

Section 5. ***The Telemedicine Staff.***

a. The Telemedicine Staff shall consist of licensed physicians, dentists and podiatrists who provide diagnosis and/or consultations with respect to patients through telemedicine technologies. Members of the Telemedicine Staff may not practice within the Hospital's facilities.

b. Members of the Telemedicine Staff may be required, but are not entitled, to participate in emergency department call-coverage rosters and schedules through telemedicine technologies. They may provide consultations, but they may not admit patients, perform procedures or write orders.

c. Members of the Telemedicine Staff are not eligible to vote, hold office or serve on standing committees of the Staff.

d. Telemedicine Staff members shall be appointed in the manner provided in Part II of these Bylaws, but because they do not physically practice within the Hospital, Telemedicine Staff members shall be exempt from providing documentation of vaccinations or immunity and results of PPD testing (unless required by law or regulation).

Section 6. ***The Community-Based Staff.***

a. The Community-Based Staff shall consist of licensed physicians, dentists and podiatrists who practice within the community, who desire to maintain a professional affiliation with the Hospital, and who would like to follow the course of their patients' care when the patients enter the Hospital, but who do not wish to exercise any clinical privileges within the Hospital. The Community Based Staff may also include licensed physicians, dentists and podiatrists who are recognized specialists who have expressed a willingness to provide educational, administrative, and other non-clinical services for the Hospital.

b. Community-Based Staff members will not hold clinical privileges but shall be permitted to (1) visit their patients in the Hospital, (2) discuss their patient's care and concerns with those members of the Staff (and if applicable, House Staff) who are responsible for the patient's care within the Hospital, (3) view information regarding their patients in either paper or electronic format, and (4) attend educational programs and meetings of the Staff.

c. Community-Based Staff members may have access to the Hospital's electronic medical records system to the extent permitted by applicable law and regulations and may elect to receive training in the Hospital's electronic medical records systems and functions but are

not required to do so.

d. Community-Based Staff members may not participate in emergency department call-coverage rosters and schedules, admit patients, perform procedures, give inpatient care orders, direct a patient's care, or make entries into Hospital medical records.

e. Community-Based Staff members may not hold office, but they may serve on committees of the Staff (either with or without vote) subject to the provisions of these Bylaws. Community-Based Staff members may attend Staff meetings and are expected to do so whenever possible, but they shall not be permitted to vote on matters coming before the Staff.

f. Community-Based Staff members shall be appointed in the manner provided in Part II of these Bylaws, but because they neither hold nor exercise clinical or admitting privileges in the Hospital, Community-Based Staff members shall not be required to demonstrate clinical competence within the Hospital setting.

Section 7. ***The Emeritus Staff.***

a. The Emeritus Staff shall consist of practitioners in those fields entitled to be considered for membership on the Staff who have retired from active Hospital service and who, during their membership on the Staff, have faithfully fulfilled their responsibilities as individual Staff members as set forth in Article II of this Part and have either conducted a substantial portion of their clinical practice in the Hospital and/or provided valuable service to the Hospital as an officer of the Staff, department or division chief, or member of a committee of the Staff.

b. The Emeritus Staff shall be appointed by the Board on recommendation of the Medical Executive Committee.

c. Members of the Emeritus Staff do not have admitting or other clinical privileges and shall not be involved in the care of patients in the Hospital. They shall not be required to attend meetings. Members of the Emeritus Staff are not required to reapply for privileges.

ARTICLE IV

ALLIED HEALTH PROFESSIONAL STAFF AND HOUSE STAFF

Section 1. ***The Allied Health Professional Staff.***

a. The Allied Health Professional Staff shall consist of individuals who are not licensed physicians, dentists or podiatrists, but who provide medically related health care services involved in patient care. The composition of the Allied Health Professional Staff shall be set forth in the Allied Health Professional Staff Policy. The members of the Allied Health Professional Staff are not members of the Staff, but they may be appointed to serve on committees of the Staff, with or without vote, where permitted under these Bylaws or the rules and regulation or policies of the Staff.

b. The Board shall be responsible for making all appointments to the Allied Health Professional Staff and for the granting of clinical privileges to such appointees pursuant to the Allied Health Professional Staff Policy.

Section 2. ***House Staff.***

a. The "House Staff" is defined as those licensed physicians or persons holding a limited permit to practice medicine under Section 6525 of the Education Law or exempt from licensure under Section 6526 of the Education Law, who are participating as interns or residents in a graduate medical education program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or an equivalent accrediting agency approved by the New York State Education Department. Members of the House Staff may only provide patient care services under the supervision of a member of the Staff with privileges appropriate for the activities the House Staff member is performing. Nothing in this section shall be construed as in any way limiting the authority of members of the Staff to write orders for their patients or as requiring members of the Staff to participate in any graduate education program.

b. House Staff are authorized to serve in the Hospital pursuant to agreements between the sponsoring institution(s) and the Hospital. House Staff are not members of the Staff. Additional provisions concerning House Staff may be set forth in the rules and regulations and policies of the Staff and the Hospital.

ARTICLE V

CLINICAL DEPARTMENTS

Section 1. ***Departments.*** The clinical departments of the Staff shall be as follows: Anesthesiology; Cardiac & Vascular Services; Emergency Medicine; Family Medicine; Hospital Medicine; Medicine; Medical Imaging; Obstetrics and Gynecology; Pathology and Laboratory; Pediatrics; and Surgery.

Section 2. ***Organization of Departments.***

a. *Appointment of Department Chiefs*. Each department of the Staff shall have as its head a chief who will be responsible for the proper functioning of such department. The chief shall report to the Chief Medical Officer with respect to the operation of the department that the chief supervises. The members of the department shall recommend one of its members to serve as chief, except in the case of a department staffed under an exclusive physician service contract. The chief shall be appointed by the Board after receipt by the Board of the recommendation of the Medical Executive Committee. If the Medical Executive Committee's recommendation conflicts with the recommendation of the members of the department, representatives of the department and the Medical Executive Committee shall present their respective positions to the Board, and then the Board shall make its final decision. Department chiefs (other than chiefs of departments staffed under exclusive physician service contracts) shall serve for a term of three years, provided that they may be removed for cause (i) by a vote of at least two-thirds of the Attending Staff, or (ii) by the Board, after receipt of the recommendation of a joint conference committee comprised of three members of the Attending Staff appointed by the President of the Staff and three Board members appointed by the Chairperson of the Board. Chiefs may serve an unlimited number of terms. Chiefs of departments staffed under exclusive physician service contracts serve at the pleasure of the Board, which may appoint and remove the chief at any time, with or without cause. The Chief Medical Officer shall annually review the performance of the chiefs of the clinical departments.

b. *Appointment of Assistant Chiefs.* A department chief may appoint one or more assistant chiefs of the department to perform such duties as may be prescribed by the chief. Such assistant chiefs shall serve for a term of three years, and they may be appointed for additional successive terms, provided that their appointment shall nevertheless remain at

the pleasure of the appointing chief, who may remove the appointed assistant chief at any time, with or without cause, and further provided that such appointment shall automatically terminate upon the appointment of a new chief of the department in which the assistant chief serves. Upon the removal of the chief who appointed such assistant chief, the assistant chief will be automatically removed.

c. *Qualifications for Department Chiefs*. To be eligible to serve as a department chief, individuals must:

(1) have no pending adverse recommendations concerning staff appointment or clinical privileges;

(2) maintain an active affiliation or practice at the hospital, using it as their primary hospital;

(3) demonstrate their willingness to constructively participate in medical staff affairs, including quality review and peer review activities;

(4) demonstrate their willingness to faithfully discharge the duties and responsibilities of the position;

(5) be knowledgeable concerning the duties and responsibilities of the position;

(6) possess written and oral communication skills;

(7) possess and have demonstrated an ability for harmonious interpersonal relationships; and

(8) be qualified specialists in the field with respect to which they are appointed; Board Certification is one consideration.

d. *Responsibilities of Department Chiefs*. The chief of each department shall be responsible for:

(1) all clinically related activities of the department and the medical administration and supervision of the department and any divisions thereof, including the supervision and education of members of the House Staff;

(2) the clinical and administrative integration of the department into the Hospital organization;

(3) the coordination and integration of interdepartmental and intradepartmental services;

(4) the development and implementation of policies and procedures that guide and support the provision of services;

(5) the adequacy and quality of professional care of patients;

(6) making recommendations with respect to the qualifications of Staff members assigned to the department;

(7) determining the qualifications and competence of all personnel providing patient care services who are not licensed independent practitioners;

(8) making recommendations for a sufficient number of qualified and competent

persons to provide care and services;

(9) making recommendations to the Hospital administration as to the planning of hospital facilities, equipment, routine procedures, and other matters concerning patient care, including resources and space required for the operation of the department;

(10) enforcement within the department of the Hospital's corporate bylaws and these Bylaws and the rules and regulations and policies of the Staff;

(11) implementation within the department of actions taken by the Medical Executive Committee; representation of the department's recommendations concerning delineation of clinical Staff privileges, appointments and reappointments;

(12) developing and recommending the criteria used in the department for the delineation of clinical privileges; such criteria shall be consistent with and subject to these Bylaws, and the rules and regulations and policies of the Staff and the Hospital; such criteria shall be effective when approved by the Chief Medical Officer;

(13) participating in every phase of administration of the department through cooperation with the Patient Care Service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

(14) checking the medical reports in the department to determine whether they are promptly written, and acceptable in content and quality;

(15) providing for the orientation and continuing education of all persons in the department;

(16) appointing and organizing a departmental quality improvement committee to implement a process to monitor and evaluate medical care in all major clinical activities of the department. This monitoring and evaluation must at least include:

(a) The identification and collection of information about important aspects of patient care provided in the department;

(b) The identification of the indicators used to monitor the quality and appropriate-ness of the important aspects of care;

(c) The periodic assessment of patient care information to evaluate the quality and appropriateness of care; to identify opportunities to improve care; and to identify important problems in patient care; and

(d) Continuing review, assessment and improvement of the professional performance of all practitioners with clinical privileges in the department, and reporting regularly thereon to the Medical Executive Committee;

(17) assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the Hospital; and

(18) establishing the on-call schedule of the practitioners within the department,

which schedule shall be subject to the oversight and approval of the Medical Executive Committee in the event of an objection by an affected practitioner; the department chief may delegate responsibility for establishing an on-call schedule to a division chief.

e. *Responsibilities of Departments.*

(1) Each clinical department shall monitor and evaluate medical care in all major clinical activities of the department. This monitoring and evaluation must at least include: the identification and collection of information about important aspects of patient care provided in the department; the identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and the periodic assessment of patient care information to evaluate the quality and appropriateness of care; to identify opportunities to improve care; and to identify important problems in patient care.

(2) Each department shall recommend, subject to approval and adoption by the department chief and Chief Medical Officer, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the Hospital's quality improvement program in the monitoring and evaluation of patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each department shall document the actions taken and evaluate the effectiveness of such actions.

(3) In discharging these functions, each department shall report after each meeting to the appropriate committee detailing its analysis of patient care and to the appropriate committee whenever further investigation and action is indicated, involving an individual member of the department and division.

f. *Department Meetings.* Each department shall hold meetings, the frequency of which will be determined by the department chief, but will be as often as needed to fulfill its responsibilities. In addition, a department meeting shall be held upon the written request of a majority of the members of the department. At all meetings of the department, the activities of the department shall be reviewed and evaluated with particular attention being given to quality improvement activities in the department. Members of the department are encouraged to attend a minimum of 50 percent (50%) of all meetings. Records of attendance may be, and material discussed at such meetings shall be, recorded and reviewed by the Medical Executive Committee.

g. *Department Quality Improvement Committee.* When required by the Medical Executive Committee or pursuant to a contract with the Hospital, the chief of each department shall appoint and organize a departmental quality improvement committee. The committee shall review the quality of patient care rendered by members of the department. Prior to November 15 of each year, each departmental quality improvement committee will conduct its own review in such a manner as to comprehensively evaluate the completeness of its medical records, the quality of medical care being rendered in the department, hospital utilization, and the clinical performance of Staff members exercising clinical privileges within the department. A report of such review shall be transmitted to the Medical Executive Committee no later than December 1 of the following year.

Section 3. ***Creation of Divisions; Appointment of Division Chiefs; Division Meetings.*** The departments may include divisions when such division will contribute to their efficiency. A department chief may create divisions within his or her department subject to the approval of the Medical Executive Committee. The department chief, upon creation of a division, may also appoint a division chief, subject to the approval of the Medical Executive Committee. Division chiefs shall serve for a term of three years. Division chiefs may serve an unlimited number of terms, provided that their appointment shall nevertheless remain at the pleasure of the department chief and the Medical Executive Committee, which may remove the division chief at any time, with cause. Division chiefs shall report to the chief of the department in which the division resides with respect to the operation of the division. Meetings of the members of a division shall be held at the direction of the division chief or upon the written request of a majority of the members of the division.

ARTICLE VI

OFFICERS OF THE STAFF, AT-LARGE REPRESENTATIVES TO THE MEDICAL EXECUTIVE COMMITTEE AND REPRESENTATIVES TO THE BOARD

Section 1. ***Officers.*** The officers of the Staff shall be the President, Vice-President, Secretary and Treasurer. Officers shall hold office for two years or until a successor is elected. Officers must be members of the Attending Staff.

a. The President shall preside as chair at all meetings of the Medical Executive Committee and the Staff, shall be an *ex-officio* member, with vote, of all committees of the Staff, and shall perform such other duties as may be prescribed herein. The responsibilities of the President shall include the organization and administration of the Staff in accordance with these Bylaws, and the rules and regulations and policies of the Staff; coordination and cooperation in all medico-administrative matters with the Hospital administration for the purpose of effectuating the policies adopted by the Board; and the functioning of the clinical organizations of the Hospital, including supervision (which may be by designee) over the clinical work in all departments. The President shall be a non-voting member of the Safety and Quality Improvement Committee of the Board of Directors. After serving two consecutive, complete two-year terms of office, the President shall be ineligible to succeed himself or herself. No one shall be qualified for the position of President until he or she has served at least one year on the Medical Executive Committee.

b. The Vice-President shall assume and discharge all of the duties and responsibilities of the President in the absence or disability of the President and perform other such duties as may be prescribed herein or assigned by the President.

c. The Secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the President, attend to all correspondence, shall collect the annual dues and keep records thereof, report to the Staff at the annual meetings, and assume and discharge all duties and responsibilities of the President and the Vice-President in the absence or disability of them, and perform such other duties as may be assigned by the President or provided herein.

d. The Treasurer shall collect the annual dues and keep records thereof, report to the Staff at the annual meetings, and assume and discharge all duties and responsibilities of the President and the Vice-President in the absence or disability of them and the Secretary, and perform such other duties as may be assigned by the President or provided herein.

Section 2. ***Qualifications of Officers***. To be eligible to serve as an officer of the Staff, individuals must:

a. have no pending adverse recommendations concerning Staff appointment or clinical privileges;

b. be a member of the Attending Staff and maintain an active clinical practice at the Hospital;

c. demonstrate their willingness to constructively participate in medical staff affairs, including quality review and peer review activities;

d. demonstrate their willingness to faithfully discharge the duties and responsibilities of the position;

e. be knowledgeable concerning the duties and responsibilities of the position;

f. possess good written and oral communication skills; and

g. possess and have demonstrated an ability for harmonious interpersonal relationships.

Section 3. ***Members-at-Large of the Medical Executive Committee***. Two to seven members of the Attending, Courtesy and/or Community-Based Staff shall be elected or appointed, as provided in this Article, to serve as members-at-large on the Medical Executive Committee. The Medical Executive Committee shall determine the number of members-at-large (subject to the foregoing limit) and the categories of Staff (Attending, Courtesy and/or Community-Based) to be elected each year or every other year when it appoints the Nominating Committee. Each member-at-large shall serve for a term of two years, or until his or her successor is elected. A member-at-large may not serve in that capacity for more than three successive terms. Following a year's absence from the Medical Executive Committee, a Staff member who ceased to serve because of the term limits may be nominated and if elected begin a first two-year term.

Section 4. ***Election of Officers and Members-at-Large.*** Elections of officers of the Staff and members-at-large to the Medical Executive Committee shall be held at the last regular meeting of the Staff of the calendar year. Nominations for officers and members-at-large shall be presented by a Nominating Committee previously appointed by the Medical Executive Committee. Such nominations shall be posted for review by the Staff at least 30 days prior to the date of the election. Nominations may also be made by petition signed by at least 10 members of the

Attending Staff and submitted to the President at least 15 days prior to the date of the election. The officers and members-at-large shall be elected by majority vote of those members of the Attending Staff who are present at the meeting if there are two candidates for the position being filled, or by plurality vote of those members of the Attending Staff who are present at the meeting if there are more than two candidates for one or more positions being filled. If there is no contest, the Chair may instruct the Secretary to deposit one ballot for the officers and members-at-large named.

Section 5. ***Removal from Office***. Officers of the Staff and members-at-large to the Medical Executive Committee may be removed for cause by the vote of at least two-thirds of the Attending Staff present at any meeting of the Staff. Officers and members-at-large may be removed temporarily by the Medical Executive Committee, for cause, until the next regular meeting of the Staff or special meeting of the Staff called for the purpose of considering such removal. For the purposes of this section, "cause" shall include but not be limited to failure to perform the responsibilities of the office, professional incompetence, conduct disruptive to the functioning of the Staff, dishonesty, or conviction of a crime involving moral turpitude. Any officer or member-at-large whose Staff membership is suspended for any reason shall be suspended from office for the duration of such suspension.

Section 6. ***Vacancies in Office.***

a. *President*. If there is a vacancy in the office of President, the Vice President shall assume the office of President for the balance of the term. If the Vice President is unable or unwilling to succeed to the office of President, the Secretary shall assume the office of President for the balance of the term. If the Secretary is unable or unwilling to succeed to the office of President, the Treasurer shall assume the office of President for the balance of the term. If the Treasurer is unable or unwilling to succeed to the office of President, a special election will be held at the next meeting of the Staff for the purpose of electing a President to serve for the balance of the term. The Medical Executive Committee shall call a special meeting of the Staff for such purpose if the next regular Staff meeting will not be held for more than 45 days.

b. *Vice President, Secretary and Treasurer*. Vacancies in the office of Vice President, Secretary or Treasurer shall be filled, for the balance of their term, by special election at the next meeting of the Staff. The Medical Executive Committee shall call a special meeting of the Staff for such purpose if the next regular Staff meeting will not be held for more than 45 days.

c. *Nominations and Elections to Fill Officer Vacancies*. At any Staff meeting where a special election is held to fill a vacancy in an officer position, nominations shall be received from members of the Attending Staff present at the meeting and such vacancies shall be filled by majority vote of the Attending Staff present at the meeting.

d. *Members-at-Large*. Vacancies in members-at-large to the Medical Executive Committee

shall be filled, for the balance of their term, by special election at the next meeting of the Staff.

Section 7. ***Medical Staff Representatives on the Board.***

a. *Appointment*. As stated in Section 1.a. of this Article VI, the President of the Staff shall be a non-voting member of the Safety and Quality Improvement Committee of the Board of Directors. When the Board requests a member or members of the Attending Staff to represent the Staff on the Board or Board committees, in each case with the right to vote (hereinafter, collectively, the "Medical Staff Representatives") the Medical Executive Committee of each separately licensed general hospital within the St. Peter's Health Partners system that has a Board comprised of the same individuals (i.e., a so-called "mirror board") at the time of the request will propose a candidate. An *ad hoc* Nominating Committee appointed by the President shall be responsible for submitting nominations to the Medical Executive Committee for the position of Medical Staff Representative. The Medical Executive Committee's recommendation of a Medical Staff Representative shall be determined by a majority vote. The Board will receive a number of nominations equal to the number of such mirror-board hospitals at the time of the request. The appointment of a Medical Staff Representative to the Board is subject to the approval of the corporate member of the Hospital.

b. *Term of Office*. Once appointed to the Board, a Medical Staff Representative shall be eligible to serve for no more than three consecutive terms (or such fewer number of terms as is prescribed in the Hospital's corporate bylaws). A Medical Staff Representative may, however, be appointed for subsequent terms after a one-year absence from the Board if permitted by the Hospital's corporate bylaws.

c. *Removal*. The Medical Executive Committee may recommend the removal of a Medical Staff Representative from the Board, for cause. For purposes of this paragraph, "cause" shall include but not be limited to failure to perform the responsibilities of the office, professional incompetence, conduct disruptive to the functioning of the Staff, dishonesty, or conviction of a crime involving moral turpitude. The Medical Executive Committee shall recommend that the Hospital's corporate member suspend from the Board any Medical Staff Representative whose Staff membership is suspended, for the duration of suspension of Staff membership. The suspension or removal of a Medical Staff Representative from the Board is subject to the approval of the corporate member of the Hospital.

d. *Vacancies*. If a vacancy occurs in the position of Medical Staff Representative, the Medical Executive Committee shall recommend a replacement at its next regular meeting if so requested by the Board. Once appointed by the Hospital's corporate member, the Medical Staff Representative may serve for the balance of the unexpired term, subject to paragraph c of this Section 7.

e. The provisions of this Section 7 are in all events subject to the provisions of the certificate of incorporation and corporate bylaws of the Hospital, as they may be amended from time to time. In the event of any conflict between the provisions of the certificate of incorporation and/or corporate bylaws and these Bylaws, the provisions of the certificate of incorporation or corporate bylaws, in that order, shall prevail over the conflicting provision of these Bylaws.

ARTICLE VII

CHIEF MEDICAL OFFICER

Section 1. ***General Duties.*** The Chief Medical Officer shall serve as the coordinator among the Board, the Staff, and the Hospital administration; supervise the implementation of these Bylaws; organize and coordinate the activities of the Staff with respect to its internal relationships; supervise the quality of care provided in the Hospital; implement the wishes and directives of the Board, Staff and Hospital administration; assist Staff committees in the execution of their responsibilities; serve as an ex-officio member of all the Staff committees; provide clinical oversight and coordinate the quality of patient care of the Outpatient and Emergency Departments; serve as the Hospital's medical public relations representative; and represent the Hospital and Staff with various civic and paramedical organizations. The Chief Medical Officer must become a member of the Attending or Courtesy Staff within six months of his or her appointment.

Section 2. ***Reports to the Board.*** Prior to each regularly scheduled meeting of the Board, the Chief Medical Officer shall review the activities and reports of the various committees of the Staff for the purpose of informing the Board as to those activities and reports. Upon the request of any member of the Board, the Chief Medical Officer shall secure and make available to the Board member the written report of any committee of the Staff.

ARTICLE VIII

COMMITTEES OF THE STAFF

Section 1. ***Designation***. There shall be a Medical Executive Committee of the Staff, a Credentials Committee, and such other standing, ad hoc and special committees responsible to the Medical Executive Committee as may from time to time be necessary and desirable to perform the Staff functions set forth in these Bylaws and the rules, regulations and policies of the Staff. Subject to the provisions of these Bylaws, the title, composition, duties and other attributes of committees may be set forth in the rules and regulations or policies of the Staff or in the case of ad hoc or special committees, in the minutes of the Medical Executive Committee creating the committee.

Section 2. ***Medical Executive Committee.***

a. *Composition.* The Medical Executive Committee shall be composed of the President, Vice-President, Secretary and Treasurer of the Staff; the immediate past President of the Staff who has most recently left office; the chiefs of all departments of the Staff; the chair

of the Credentials Committee; and two to seven members-at-large elected by the Staff in accordance with Part I, Article VI, Section 3 of these Bylaws. The Chief Executive Officer, the Chief Medical Officer, and the Chief Nursing Officer of the Hospital shall serve as non-voting members of the Medical Executive Committee, provided that they may make and second motions at meetings of the Committee. If a member who is on the Medical Executive Committee by virtue of his or her office is elected an officer of the Staff, an additional member shall be elected by the Staff.

b. *Duties.* The Medical Executive Committee is charged with the duties of: providing for the review of these Bylaws and any rules, regulations and policies of the Staff and recommending any necessary or appropriate amendments thereto; analyzing and reviewing the clinical and research work performed in the Hospital and the medical records maintained therein for the purpose of ascertaining whether clinical investigations of patients are being performed with the written and informed consent of the patients; recommending to the Board policies governing patient care by advising the Chief Executive Officer of the Hospital on all matters concerning medical administration of the Hospital; recommending to the Board one member of the Attending Staff to represent it on the Board; implementing and executing all directives of the Board and the Staff; supervising the work of all other Staff committees and reviewing and acting upon the reports of these committees; hearing and considering matters that any individual member of the Staff may wish heard; requesting any member of the Staff to meet with the Medical Executive Committee to inform it concerning any matters that the Medical Executive Committee may desire, with the understanding that such member is not a member of, or to have a vote in determining matters before, the Medical Executive Committee; rendering a report to the Staff of all actions taken by it at each regular meeting; reviewing and making recommendations to the Board with respect to applications for appointment or reappointment to the Staff; reviewing and making recommendations to the Board with respect to any matters concerning disciplinary action against any member of the Staff, any complaints against such a member, or any alleged violation of any of the provisions of these Bylaws, the rules, regulations or policies of the Staff or of the Bylaws of the Hospital, or any breach of professional ethics or conduct; convening Staff committees, including the Nominating Committee, as needed; communicating on a regular basis with those Staff members who are responsible for supervising House Staff and with the Board, concerning the performance and educational needs of the House Staff; and performing such other duties as may be prescribed herein or hereafter assigned by the Board.

c. *Meetings.* The Medical Executive Committee shall meet once a month, or upon the call of the President, the Chief Executive Officer of the Hospital or any two members of the Committee. A quorum shall consist of the presence of fifty percent of the voting members of the Committee, including the President or the Vice-President. Except as otherwise provided in these Bylaws, the Medical Executive Committee shall act by majority vote of those members present, provided a quorum is present. The Committee shall maintain a permanent record of its proceedings and actions.

d. *Delegated Authority.* The Medical Executive Committee is empowered to act on behalf of the Staff in the interim between Staff meetings. In addition, the Medical Executive Committee is delegated the authority to propose and approve, on behalf of the Staff, the adoption or amendment of rules, regulations and policies of the Staff.

Section 3. ***Credentials Committee.***

a. *Composition.* The Credentials Committee shall consist of the Vice President of the Staff and at least four members of the Attending, Courtesy and/or Community-Based Staff, who shall be appointed by the President of the Staff. In addition, the chiefs of all departments, the Chief Medical Officer and the Director of Credentials shall serve as non-voting members of the Committee, the latter as recording secretary. Up to two

representatives from the Allied Health Professional Staff may be appointed as non-voting members as the President of the Staff determines is appropriate, in consultation with the Chief Medical Officer. The chair of the Credentials Committee will be appointed by the President of the Staff.

b. *Duties.* The Credentials Committee shall:

(1) Review the credentials of all practitioners and applicants for clinical privileges and membership on the Staff or Allied Health Professional Staff, including personal interviews wherever possible, and to make written recommendations for membership and delineation of clinical privileges, all in accordance with the provisions of Part II of these Bylaws. The Credentials Committee shall have the authority to require any member of the Staff or Allied Health Professional Staff, practitioner or applicant to submit evidence of his or her current physical and mental status as determined by a physician acceptable to the Credentials Committee;

(2) Every other year review all information available regarding the competence of current members of the Staff and Allied Health Professional Staff and, as a result of such reviews, to make written recommendations for reappointments and the granting of privileges;

(3) At the request of the Medical Executive Committee or the Board, and consistent with Part III of these Bylaws, investigate any alleged misconduct, breach of professional conduct or other conduct prejudicial to the program and activities of the Staff and Hospital by members of the Staff and Allied Health Professional Staff; and

(4) Review and recommend criteria for privileges that have been forwarded from the department chiefs.

c. *Meetings, Reports and Recommendations.* The Credentials Committee shall meet as often as necessary to accomplish its duties (but at least annually), shall maintain a permanent record of its findings, proceedings and actions, and shall report its recommendations to the Medical Executive Committee, the Chief Executive Officer and the Board.

Section 4. ***Standing Committees.*** The Medical Executive Committee may, by resolution and upon approval by the Board, and without amendment of these Bylaws, establish standing committees other than the Medical Executive Committee and the Credentials Committee to perform one or more Staff functions. In the same manner, the Medical Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange the structure, duties and composition of such standing committees, other than the Medical Executive Committee and the Credentials Committee, as needed to better perform the Staff functions.

Section 5. ***Ad Hoc and Special Committees***. The Medical Executive Committee may, by resolution and without amendment of these Bylaws, establish *ad hoc* and special committees of the Staff, as appropriate. These committees shall report to the Medical Executive Committee.

ARTICLE IX

MEETINGS OF THE STAFF

Section 1. ***Voting.***

a. Only members of the Attending Staff shall have the right to vote on matters coming before the Staff for a vote.

b. Except as otherwise provided in these Bylaws, a quorum at any meeting of the Staff shall consist of those Attending Staff present at the meeting at the time the action is taken. A majority vote of those Attending Staff members present shall constitute action by the Staff, provided that officers shall be elected by a plurality of those Attending Staff members present.

c. There shall be no voting by proxy.

d. When authorized by the Medical Executive Committee, matters may be submitted to the vote of the members of the Attending Staff by written or electronic ballot, in lieu of a meeting of the Staff, according to such procedures as are approved by the Medical Executive Committee. Where action is taken by written or electronic ballot, a quorum shall consist of those Attending Staff who submit their ballot by the deadline for voting established by the Medical Executive Committee.

Section 2. ***Scheduled Meetings.*** The Staff shall meet at least once annually. Additional meetings may be called in accordance with Section 3 of this Article. Meetings of the Staff shall be held at the Hospital, unless another location is specified by the President. At the last meeting of the calendar year, the retiring officers, department chiefs and committee chairs shall make their annual reports, and there shall be an election to fill any open positions for officers and members-at-large to the Medical Executive Committee.

Section 3. ***Special Meetings.*** Special meetings of the Staff may be called at the request of the Chief Executive Officer of the Hospital, the President or the Medical Executive Committee. Special meetings may also be called by the written request of ten percent of all Attending Staff members. Notice of such meetings shall be posted on the Staff bulletin board and given to each department chief promptly after the decision is made to hold such a meeting. Such meetings shall be held at the Hospital unless otherwise specified by the President.

Section 4. ***Rules of Procedure.*** Meetings of the Staff shall be conducted in conformity with *Roberts Rules of Order*.

Section 5. ***Attendance Requirements.*** All Staff members are encouraged to attend Staff meetings and committee, department and division meetings. Meeting attendance is a professional obligation and expectation of each Staff member but is not required.

ARTICLE X

AMENDMENTS TO THE MEDICAL/DENTAL STAFF BYLAWS

These Bylaws may be amended in the following manner. No amendment of the Bylaws shall be effective until approved by the Board of the Hospital in the manner set forth in Section 2 of this Article.

Section 1. ***Amendments Initiated by the Medical Executive Committee, the Staff or the Bylaws Committee***.

a. Bylaws amendments may be proposed by the Staff at any regular or special meeting of the Staff, by the Bylaws Committee, or by the Medical Executive Committee in conformity with this Article. All Bylaws amendments proposed by the Staff or by the Bylaws Committee shall be presented to the Medical Executive Committee, which may approve, disapprove, or approve with modifications.

b. Proposed Bylaws amendments presented to the Medical Executive Committee may be referred to the Bylaws Committee for review and comment.

c. Notice of Proposed Amendments. After the Medical Executive Committee has approved Bylaw amendments, regardless of from where such proposed amendments originated, the Medical Executive Committee shall provide the proposed amendments to the Staff prior to holding a special meeting for a vote as provided for in Article IX of this Part I. Such proposed amendments must be provided via e-mail or in writing to all Attending Staff members who would be eligible to vote at a meeting of the Staff for a period of not less than 21 days nor more than 45 days.

d. Comment Period. At the conclusion of the Notice period, the Medical Executive Committee shall afford any interested member of the Staff to attend a meeting of the Medical Executive Committee for the purpose of providing comments or suggested modifications to the bylaw amendments under consideration. Any such Staff member wishing to do so must provide notice in writing to the Medical Executive Committee of his/her intention to attend the Medical Executive Committee meeting and of his/her position, in writing. After such opportunity, the Medical Executive Committee shall vote to approve, disapprove, or approve with modifications the Bylaws amendments. Should any changes occur, the Medical Executive Committee must again provide the Notice and Comment Period as provided for herein.

e. All proposed Bylaws amendments approved by the Medical Executive Committee, after having been subjected to the Notice and Comment opportunities provided for above, shall be submitted to the Staff for approval in the manner set forth in Article IX of this Part I.

Section 2. ***Approval by the Board.***

a. Bylaws amendments approved by the Staff shall be forwarded, together with any comments of the Medical Executive Committee, to the Board, which shall approve, disapprove or approve with modifications. If the Board rejects or proposes to modify an amendment, the Medical Executive Committee shall be entitled to a joint conference between the officers of the Board and the officers of the Staff. Such joint conference shall be for the purposes of further communicating the Board's rationale for its action and to permit the officers of the Staff to fully articulate the rationale for the amendment approved by the Staff. Such joint conference shall be scheduled by the Chief Executive Officer within four weeks after the Board's action on the proposed amendment.

b. If the Board modifies any amendment approved by the Staff, such amendment, as modified, shall be returned to the Medical Executive Committee, which may accept or reject the modifications adopted by the Board. If the Medical Executive Committee accepts the modifications, the amendment shall be submitted to the Staff for approval or disapproval in accordance with Article IX of this Part I. If the Medical Executive Committee rejects the modifications, the amendment shall again be submitted to the Board, which may either approve or disapprove the amendment as approved by the Staff.

ARTICLE XI

MEDICAL STAFF RULES, REGULATIONS AND POLICIES

Section 1. ***Approval and Notification.*** Rules, regulations and policies as may be necessary to implement more specifically the general principles found within these Bylaws or to regulate the proper conduct of Staff organizational activities and the clinical practices that are required of each practitioner in the Hospital may be adopted by the Medical Executive Committee or proposed by the Staff, subject to the approval of the Board, in accordance with the following procedures:

a. Except as provided in paragraph (b) of this Section, any proposed rule or regulation, or amendment thereto, being considered by the Medical Executive Committee shall be communicated to the members of the Staff before the proposed rule or regulation is adopted by the Medical Executive Committee and sent to the Board for approval. The Medical Executive Committee, in its discretion, may permit members of the Staff to attend any meeting of the Medical Executive Committee for the purpose of commenting upon any proposed rule or regulation or amendment thereto.

b. In the event there is a documented need for an urgent amendment to rules and regulations of the Staff, or the adoption of a new rule or regulation of the Staff, necessary to comply with law or governmental regulation, the Medical Executive Committee may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the rules and regulations of the Staff without prior communication to the Staff. In such event the provisional amendment shall be promptly communicated to the Staff, and members of the Staff may submit to the Medical Executive Committee any comments regarding the amendment. Upon petition signed by at least five percent of the Staff, the provisional amendment may be submitted to the conflict management process described in Article XII, Section 2 of this Part I. The results of the conflict management process shall be communicated to the Medical Executive Committee, the Staff, and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

c. Any policy adopted by the Medical Executive Committee and approved by the Board shall be promptly communicated to the Staff.

d. Any communication to the Staff required under this Article may take any one or more of the following forms: bulletin board posting, announcement during departmental meetings, announcement during meetings of the Staff, inclusion in the medical staff newsletter and/or mail. The manner of giving such communication shall be determined in the sole discretion of the Medical Executive Committee, and the failure of any members of the Staff to receive such communication or actual notice of any action by the Medical

Executive Committee or the Board shall not invalidate any rule, regulation or policy, or amendment thereto, approved by the Medical Executive Committee and the Board.

e. Rules, regulations and policies, and amendments thereto, may also be proposed to the Board by the Staff, by majority vote of the Attending Staff present at any regular or special meeting of the Staff. Any such proposal may be brought before the Staff only by petition signed by at least five percent of the Attending Staff, and the proposal must be submitted to the Medical Executive Committee for review and comment before such proposed rule, regulation or policy, or amendment thereto, is voted on at a Staff meeting. Any rule, regulation or policy, or amendment thereto, approved by the Staff shall be presented to the Board along with any comments from the Medical Executive Committee.

f. All rules, regulations or policies of the Staff shall become effective only after approval by the Board.

ARTICLE XII

CONFLICT MANAGEMENT

Section 1. ***Right to Audience.*** Each member of the Staff has the right to an audience with the Medical Executive Committee in the event the member is unable to resolve an issue, working with his or her respective department chair. Upon the member's presentation of a written request, the member shall be afforded an opportunity to meet with the Medical Executive Committee to discuss the issue.

Section 2. ***Conflicts between Staff and Medical Executive Committee.*** In the event of a conflict between members of the Staff and the Medical Executive Committee on any issue, including but not limited to the adoption of any rule, regulation or policy of the Staff, or any amendment thereto, upon a petition signed by at least five percent of the members of the Staff, the matter shall be submitted to a conflict management process. The conflict management process shall be set forth in a policy of the Staff approved by the Medical Executive Committee and Board.

Section 3. ***Joint Conference Committee.*** Upon the written request of either the Medical Executive Committee or the Board, a joint conference committee shall be convened, consisting of (i) the President of the Staff and not more than three (3) additional members of the Medical Executive Committee appointed by the President of the Staff, (ii) not more than four (4) members of the Board appointed by the Chairperson of the Board, and (iii) the Chief Executive Officer and the Chief Medical Officer. A request by the Medical Executive Committee for a joint conference committee shall be delivered to the Chairperson of the Board, with a copy to the Chief Executive Officer, and a request by the Board for a joint conference committee shall be delivered to the President of the Staff, with a copy to the Chief Executive Officer. The request shall include a reasonably detailed explanation of the

substance of the matter or matters to be discussed by the joint conference committee. The Chief Executive Officer shall use diligent efforts to schedule a meeting of the joint conference committee within 30 days of receipt of the request or as soon thereafter as is possible. The Chief Executive Officer shall notify all participants of the date, time and location of the joint conference, which shall be held at the Hospital or another location within 15 miles of the Hospital. The participants in the joint conference committee may, by mutual agreement, schedule additional meetings. Discussion at meetings of the joint conference committee shall be limited to the topics identified in the request for the joint conference, unless the President of the Staff and the Chairperson of the Board agree to expand the scope of the discussion to include additional topics. Any actions or recommendations of the joint conference committee shall be purely advisory.

ARTICLE I

MEMBERSHIP

Section 1. ***Requirement of Membership***. No practitioner, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a member of the Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Staff or the granting of temporary privileges shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

Section 2. ***Goals and Objectives of the Hospital***. One of the primary factors in evaluating an application for initial membership or for reappointment to the Staff is the extent to which the approval of the application would advance and promote the goals, needs and objectives of the Hospital and Staff in serving the best interests of the patient community. Among the goals, needs and objectives of the Hospital to be considered are:

a. the provision of both general and special medical services, particularly those not otherwise available either in the Hospital or in the area served by the Hospital,

b. the efficient, effective, and appropriate utilization of the Hospital's resources, including but not limited to:

(1) the preservation of the relationship between the facilities available and the number of practitioners requiring access to such facilities which will allow the most effective patient care and teaching. Such facilities include the number of hospital beds, operating rooms and special equipment or treatment areas;

(2) compliance with public and private statutes, regulations, rules, procedures and policies governing utilization of Hospital resources; and

(3) maintaining the highest quality of patient care.

Section 3. ***Effect of Other Affiliations***. No person shall be entitled to membership on the Staff merely because that person holds a certain degree, is licensed to practice in this State, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility, or was ever previously a member of the Staff.

Section 4. ***Non-discrimination.*** The Hospital will not discriminate in granting Staff membership or clinical privileges based upon gender, race, age, color, creed, national origin, sexual orientation or disability.

Section 5. ***Acknowledgment by Applicants for Initial Appointment and Reappointment***. By applying for appointment or reappointment to the Staff, the applicant acknowledges responsibility to first review these Bylaws and rules and regulations of the Staff, agrees to accept and to follow the procedures set forth in the Bylaws, rules and regulations and policies of the Staff with respect to the processing and review of other applications, and agrees that throughout any period of membership he or she will comply with the responsibilities of Staff membership and with these Bylaws and the rules and regulations and policies of the Staff and of the Hospital as they exist and as they may be modified from time to time. Appointment to the Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

Section 6. ***Applicant's Burden for Initial Appointment and Reappointment***. In connection with all applications for appointment or reappointment, the applicant shall have the burden of producing the information required for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges being requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information.

Section 7. ***Annual Health Assessment***. As a condition of continued membership on the Staff, each Staff member must annually complete and return a medical self-evaluation assessment on a form acceptable to the Hospital. Such form shall include, but not be limited to, information concerning any health impairment which may pose a potential risk to patients or other personnel in the Hospital, or which may interfere with the Staff member's ability to perform his or her duties.

Section 8. ***Patient Safety & Quality Improvement Committee of the Board***. The Board has delegated to its Safety and Quality Improvement Committee the Board's responsibility for all appointments and reappointments to the Staff, the granting of clinical privileges to such appointees, and the modification, limitation, suspension, termination or other corrective action with respect to clinical privileges or membership on the Staff; provided, however, that any action regarding the appointment or reappointment of members of the Staff or the granting of clinical privileges or corrective action involving a member of the Staff that is not approved by a supermajority vote of at least seventy-five percent (75%) of Safety and Quality Improvement Committee members present where a quorum exists shall be referred to the Board for final action; and further provided that the Board, in its discretion,

may cancel any exercise of such delegation and assume authority and responsibility for such action at any time and from time to time.

Section 9. ***Authorized Leave of Absence***.

a. A member of the Staff who wishes to take an authorized leave of absence from the Staff must submit a written request to the Chief Executive Officer. The request must state the reason for the leave and the beginning and ending dates of the leave, which shall not exceed two years. Any absence from the Staff and patient care responsibilities of longer than 60 days shall require a request for a leave of absence and if not requested, may at the discretion of the Hospital's Chief Executive Officer be treated as such whether a request was received or not.

b. The Chief Executive Officer shall have the authority to make determinations in connection with requests for leaves of absence. In reviewing the request the Chief Executive Officer shall consider the reasonableness of the request and whether the best interests of the Hospital would be served by granting the request. The Chief Executive Officer may consult the President, the Chief Medical Officer and others and shall use best efforts to make a determination within 30 days of the receipt of a complete written request, including such supporting information as may be requested from the Staff member.

c. If the request is granted, the member shall not be required, during the period of the authorized absence, to attend meetings that the member is otherwise required to attend under these Bylaws. During the period of the leave the member shall not exercise any clinical privileges at the Hospital. Malpractice insurance coverage is not required during the leave of absence if the practitioner's insurance is of the "occurrence" type. For "claims made" policies, such coverage must be continued or a "tail" policy must be provided to cover any claims that might be asserted with respect to incidents occurring prior to the leave of absence.

d. A denial of a request for a leave of absence shall entitle the Staff member to a hearing as provided for in Part III of these Bylaws.

e. At least 30 days prior to the expiration of the leave of absence, the Staff member must request reinstatement of privileges by submitting a written notice to that effect to the Chief Executive Officer. The Staff member requesting reinstatement bears the burden of providing any information and documentation sufficient to demonstrate current competence and all other applicable qualifications. The member shall provide any other information requested by the Chief Executive Officer, including a report from the member's physician describing whether the member is capable of safely resuming a hospital practice, a summary of all professional activities undertaken by the member during the leave of absence, and the execution of any and all releases that may be necessary to cause third parties, including the member's physician and other health care providers, to respond to any requests for information or clarification.

f. The Chief Executive Officer may approve reinstatement to either the same or a different Staff category and may limit or modify the clinical privileges to be extended to the member upon reinstatement or impose conditions for the member's practice deemed reasonably necessary for patient safety or the effective operation of the Hospital. A decision under this Section to deny reinstatement or to deny reinstatement to the same Staff category and/or with the same clinical privileges shall entitle the Staff member to a hearing as provided for in Part III of these Bylaws.

g. Failure, without good cause, to timely request reinstatement shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Part III of these Bylaws for the sole purpose of determining whether the failure to request reinstatement was unavoidable. A request for Staff membership and privileges subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

h. A Staff member who is on an approved leave of absence must apply for reappointment to the Staff in accordance with Part II, Article III of these Bylaws if the term of the member's current appointment will expire during the approved leave of absence period. All of the terms and conditions of these Bylaws applicable to applications for reappointment shall apply.

Section 10. ***Reporting Professional Misconduct.*** Every member of the Staff shall report to the State Board for Professional Medical Conduct any information he or she has which reasonably appears to show that a physician is guilty of professional misconduct.

Section 11. ***Medical Malpractice Liability Insurance***.

a. All members of the Staff, except Community-Based Staff and Emeritus Staff, shall be required to carry and keep in full force and effect medical malpractice liability insurance coverage which is adequate in its terms and amount in view of the member's particular specialty or area of practice, provided that in no event shall any Staff member, other than Emeritus Staff, carry less than $1.3 million/$3.9 million, except that dentists, other than oral surgeons, may carry not less than $100,000/$300,000. The terms and amount of such coverage shall be disclosed at the request of the Chief Executive Officer or the Board.

b. Each Staff member required to carry medical malpractice insurance under this Section shall immediately notify the Chief Executive Officer of any cancellation, limitation, or modification of the terms and type of medical malpractice insurance coverage.

ARTICLE II

INITIAL APPLICATION

Section 1. ***Eligibility***. Applicants for initial appointment shall have the burden of demonstrating their eligibility for Staff membership and clinical privileges on the basis of the following:

a. documenting their (1) current licensure, (2) adequate experience, education, and training, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided; (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Staff that they are professionally and ethically competent and able to perform the requested privileges, and that patients treated by them can reasonably expect to receive quality medical care;

b. are determined (1) to adhere to the ethics of their respective professions, continuous professional development, an understanding of and sensitivity to cultural differences, and responsible attitude toward patients and their profession; (2) to be able to work cooperatively with others so as to promote and not adversely affect patient care, including, but not limited to, possessing interpersonal and communication skills sufficient

to enable them to maintain professional relationships with patients, families and other members of health care teams; and (3) to be willing to participate in and properly discharge those responsibilities determined by the Staff;

c. are insured with medical malpractice insurance coverage or the appropriate professional malpractice insurance coverage, as the case may be, which is adequate in its terms and amount, as determined by the Board, in view of the applicant's particular specialty or area of practice; and

d. demonstrate that approval of their application would promote the goals and objectives of the Hospital.

Applicants who possess limited permits to practice their profession shall not be eligible for Staff membership.

Section 2. ***Application Fee***. The Staff may require the payment of a reasonable application fee to accompany, and as a condition to, all applications for Staff membership.

Section 3. ***Procedure for Credentialing Staff for Initial Appointment***.

a. The Credentials Department shall forward an application form and instructions to those individuals deemed eligible in accordance with Part II, Article II, of these Bylaws.

b. By applying for appointment to the Staff, each applicant:

(1) signifies his or her willingness to appear for interviews in regard to the application;

(2) authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(3) consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out the clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(4) releases from any liability, to the fullest extent permitted by law, all persons for their good faith acts performed in connection with investigating and evaluating the applicant;

(5) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(6) consents to the disclosure from other hospitals, medical associations, licensing boards, and other similar organizations any information regarding his or her professional or ethical standing that the Hospital or Staff may have, and releases the Staff and Hospital from liability for so doing to the fullest extent permitted by law;

(7) if a requirement then exists for Staff dues, acknowledges responsibility for timely payment;

(8) pledges to provide for continuous quality care for his or her patients; and

(9) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

c. The applicant shall have the burden of providing full information concerning any denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment of any association, employment, privileges or practice. The applicant shall have the further burden of providing the following documentation:

(1) a completed initial application form and signed consent form which includes the applicant's education or professional training, including dates of training, facility name and address, and Program Director name, health care affiliations, practice and/or work history, including dates and locations;

(2) the applicant's health, including the results of a physical examination completed within a year of the date of the application, documentation of immunity against rubella and if born after 1/1/1957, documentation of immunity against measles, and the results of PPD testing within the past year (unless previously tested positive);

(3) requested privileges utilizing the Hospital's Delineation of Privilege form(s);

(4) current DEA registration, if applicable to the individual's practice;

(5) malpractice claims, suits, judgments, pending or settled;

(6) insurance face sheet;

(7) an application fee, if one is required;

(8) documentation of completion of the New York State Mandatory Infection Control Training certification, unless the physician proves his exemption by New York State;

(9) all information required under Section 2805-K of the Public Health Law, and any other information required to be considered under Section 405.6 of the Commissioner's regulations;

(10) proof of Board Certification, qualification, eligibility, or admissibility if applicable;

(11) two letters of reference specifically addressed to the Hospital and any other hospitals within the St. Peter's Health Partners system to which the applicant is also applying; at least one must be from a peer in the applicant's specialty who has personal knowledge of the applicant's current clinical abilities, ethical character, health status and ability to work cooperatively. None of the individuals providing a letter of reference should be related to the applicant by family, and not more than one of the individuals providing a letter of reference may be a current or impending professional partnership/financial association;

(12) a valid photo identification issued by a state or federal agency (e.g., driver's license or passport); and

(13) any other information necessary to substantiate the application.

d. The application shall require the applicant to verify the content of the application under oath.

e. Upon receipt of the application and supporting documents as outlined above, the application shall be reviewed by the Hospital's designee and/or the Hospital's Credentials Department for completeness, accuracy and appropriate supporting information and/or documentation. The applicant shall be notified that the application has been received and advised of any outstanding information.

f. The Hospital's designee and/or the Credentials Department shall conduct the verification process for all required information, including but not limited to:

(1) primary source verification of training, health care affiliations, and New York State licensure;

(a) If primary source verification cannot be achieved (either as a result of a facility having closed or not responding to at least one request for information), the applicant will be so advised. The applicant shall have the burden of taking whatever measures are deemed appropriate to secure the required information. Such variances will be identified and brought to the attention of the department chief and the Credentials Committee for determination as to whether or not the lack of information constitutes a significant barrier in the consideration of the applicant's request for membership and privileges;

(2) National Practitioner Data Bank query;

(3) New York State Office of Professional Medical Conduct query;

(4) exclusion from participation in Federal health care programs query;

(5) professional liability insurance coverage/claims history; and

(6) any other verifications necessary to substantiate the application.

g. Applications for appointments to the Staff will be processed as received and shall be brought forth for consideration by the Medical Executive Committee within sixty (60) days after completion, as defined in Section 3(k). Final action will be taken as soon as reasonably practicable. Final action on such applications will not, however, necessarily be in chronological order.

h. The applicant shall be informed of the status of his/her application by the Hospital's designee and/or the Credentials Department throughout the process. Applicants who fail to respond to requests for required information shall receive a certified letter from the Hospital's designee or the Credentials Department informing them that their applications for membership on the Staff shall be deemed withdrawn if the applicant fails to provide information required to complete the application within 30 days measured from the time that the applicant is advised by the Hospital that his or her application is incomplete and that certain additional information is required. Individuals whose applications are withdrawn may reactivate their application within 60 days of the date of withdrawal. Requests after that date must proceed as outlined in Bylaws Part III, Article II.

i. When all information required under Section 3(c), (d) and (f) of this Article has been received, or if a preponderance of the information has been received sufficient for the

clinical chief to conduct a review of the application, the application and all supporting documentation shall be forwarded to the chief of each department(s) in which the applicant is seeking privileges. The department chief is encouraged, but not required, to conduct an interview (in person or by telephone) with the applicant. The department chief may delegate the conduct of an interview to a designee.

j. Thereafter, the department chief shall provide to the Credentials Committee his or her written recommendations for membership and privileges, as well as be prepared to report to the Credentials Committee the results of his or her review of the application and interview of the applicant. The department chief shall identify any additional information required to support requests for specific privileges or any other information necessary to proceed with a review of the application by the Credentials Committee.

k. An application is considered "complete" when

(1) the applicant has provided all information required under Bylaws Part II, Article II, Sections 3(c) and (d);

(2) the Credentials Department has received the information as outlined in Bylaws Part II, Article II, Section 3(f); and

(3) a review has been conducted in accordance with Bylaws Part II, Article II, Sections 3(i) and (j) and any additional information requested by the department chief under Bylaws Part II, Article II, Section 3(j) has been received.

l. An application may become incomplete if during the course of review by the Credentials Committee, Medical Executive Committee or the Board the need arises for new, additional or clarifying information.

m. After receiving the written recommendations of the department chief, the Credentials Committee shall evaluate the applicant's credentials and the chief's recommendations at its next scheduled meeting. The Committee shall then report its findings and recommendations to the Medical Executive Committee. Thereafter, the Medical Executive Committee shall make its recommendation to the Board for final action.

n. The Board's Safety and Quality Improvement Committee, on its own initiative or upon the written request of the Medical Executive Committee, may appoint a subcommittee of the Safety and Quality Improvement Committee for the purpose of meeting with representatives of the Medical Executive Committee (appointed by the President of the Staff) to discuss any application for appointment or reappointment, before it is presented to the full Safety and Quality Improvement Committee or Board for approval. Minutes of such meeting shall be made and become part of the application file, and shall be provided to the full Safety and Quality Improvement Committee or Board for consideration in connection with its review of the application. Such minutes shall be maintained as privileged peer review material.

o. If the Medical Executive Committee recommends disapproval of the application, or recommends a limitation of the clinical privileges that would usually be attendant to the appointment, the applicant is entitled to notice of that determination and a review thereof as provided in Bylaws Part III. An applicant who receives a final adverse determination with regard to his or her application for appointment or reappointment to the Staff shall not be eligible to reapply for membership for a period of two years, unless the Medical Executive Committee, in its sole discretion, elects to permit an earlier reapplication.

p. Notice of action taken by the Board shall be transmitted to the applicant by the Chief Executive Officer of the Hospital by mail. Notification of appointment shall include a

delineation of the clinical privileges assigned to the new member. Notices of disapproval of the application shall be transmitted in accordance with Bylaws Part III. Notices of the limitation of clinical privileges requested by the applicant or normally attendant to the appointment shall set forth the reason therefor.

Section 4. ***Terms of Appointment***. All initial appointments to the Staff shall be made by the Board, upon recommendation of the Medical Executive Committee, and shall be provisional (as provided in Bylaws Part II, Article IV, Section 7) until the first reappointment is approved by the Board. Thereafter, the Board may biennially (or at such shorter interval as it may impose in accordance with Bylaws Part II, Article III, Section 8) reappoint the members of the Staff by written notification, following the submission of a written application for reappointment, the recommendation of the chief of the department of which the applicant is a member and the Medical Executive Committee.

ARTICLE III

REAPPOINTMENT

Section 1. The Hospital will provide each member of the Staff with the appropriate application for reappointment and letter of instruction at least 120 days before the expiration of the member's current term of appointment. Failure of a Staff member to complete and submit such an application for reappointment and all required documentation at least 90 days prior to the expiration of his or her appointment shall be deemed a voluntary resignation of Staff membership upon the expiration of the appointment. Upon such voluntary resignation, the Staff member shall not be entitled to a hearing as provided in Bylaws Part III but thereafter may apply for Staff membership and privileges in the same manner as one seeking initial appointment.

Section 2. Prior to granting or renewing clinical privileges, the Hospital must request the following information:

a. From a physician, dentist or podiatrist:

(1) The name of any hospital or facility with or at which the applicant had or has any association, employment, privileges or practice;

(2) If such association, employment, privilege or practice has been discontinued, the reasons for the discontinuance;

(3) A list of any pending investigations, focused professional practice evaluations, professional misconduct proceedings, or any pending malpractice actions in this state, or in any other state, including the substance of the allegations in such proceedings or actions;

(4) The substance of the findings in such actions or proceedings; and

(5) A waiver by the applicant of any confidentiality provisions concerning the foregoing information.

b. From any other hospital or facility at which the applicant has privileges, was associated or was employed:

(1) Any pending investigations, focused professional practice evaluations, professional medical conduct proceedings or any pending medical malpractice actions in this State, or in any other State;

(2) Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this State or any other State; and

(3) Any information required to be reported by hospitals as an incident of possible professional misconduct pursuant to Section 2803-e of the New York Public Health Law.

Section 3. On the biennial reappointment application the Staff member shall indicate that he or she has complied with the requirements for continuing medical education (a) by meeting the requirements of a national specialty organization; or (b) by meeting the requirements of the Medical Society of the State of New York; or (c) by documentation of educational activities within the Hospital which shall be acceptable to the chief of the Staff member's department.

Section 4. Upon receipt of a reappointment application, the Hospital's designee and/or the Credentials Department shall conduct a process to verify the following information including, but not limited to, the Staff member's:

a. License to practice in New York State;

b. All information in accordance with Section 2805-k of the Public Health Law;

c. Eligibility to participate in Federal health care programs (i.e., exclusion screening); and

D. Any other information required to substantiate the application.

Section 5. The Hospital shall maintain a file with respect to the credentialing and clinical performance of each Staff member. In considering an individual's application for reappointment, the factors listed in Article II, Section 1 will be considered, as well as the individual's participation in the Hospital's continuing education activities. Such file shall contain the information required to be collected under these Bylaws prior to granting or renewing Staff membership or clinical privileges and documented results of performance and quality improvement activities, including the results of the Hospital's performance improvement, ongoing professional practice

evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified), and any focused professional practice evaluation. Such file shall be used in conjunction with the biennial re-evaluation and reappraisal of the Staff member's membership and clinical privileges. Such documented results shall compose the physician profile. The profile shall be updated at least 60 days before the expiration of a Staff member's current appointment. A Staff member shall have the right to examine his or her file at any reasonable time and upon reasonable notice.

Section 6. Reappointment applications shall be reviewed by the chief of each department in which the applicant is seeking renewal of Staff membership and/or clinical privileges. Applicants for reappointment shall be subject to review as part of the organization's performance improvement activities. The recommendation of the chief of the department shall contain an evaluation of the member's physical and emotional health, professional and clinical competence and compliance with the these Bylaws and the rules and regulations and policies of the Staff. Thereafter, the Board may reappoint the member to the Staff by written notification, following the recommendation of the department chief and the Medical Executive Committee.

Section 7. A contingency may be placed on a reappointment in the case of a hospital affiliation verification, or any other information which remains outstanding at the time the reappointment application is presented to the Board for final action, if the absence of such information is deemed by the department chief not to interfere with the recommendation for reappointment. The contingency will be removed upon satisfactory receipt of the required information.

Section 8. The grant of reappointment and renewed privileges may be conditioned upon a Staff member's compliance with certain specific conditions. These conditions may relate to behavior or to clinical issues (e.g., general consultation requirements, preceptoring, completion of CME requirements). Unless the conditions involve the matters set forth in Bylaws, Part III, Article V, the recommendation or imposition of such conditions does not entitle a member to request a hearing. In addition, reappointments may be recommended and approved for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may

be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing.

ARTICLE IV

CLINICAL PRIVILEGES

Section 1. ***Exercise of Privileges***.

a. Except as otherwise provided in these Bylaws, a Staff member providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges specifically granted. Such privileges and services must be within the scope of the Staff member's license and professional training, experience and capability, and shall be subject to the rules and regulations of the clinical department and the authority of the department chief and the Staff.

b. Notwithstanding the foregoing, those practitioners from outside organ procurement organizations designated by the Secretary of the U. S. Department of Health and Human Services engaged at the Hospital solely in the harvesting of tissues and/or other body parts for transportation, therapy, research or educational purposes pursuant to the federal Anatomical Gift Act and the requirements of Section 405.25, shall be exempt from the requirement to obtain clinical privileges.

Section 2. ***Delineation of Privileges in General***.

a. Each application for appointment and reappointment to the Staff must contain a request for the hospital-specific clinical privileges desired by the applicant. A Staff member may request additional clinical privileges at any time.

b. Requests for clinical privileges made by initial appointees and current members of the Staff shall be submitted in writing to the Credentials Department on the form(s) provided for that purpose. If the desired privilege is considered a new procedure or technique or is not currently offered at the Hospital, additional information may be required to assist in determining and establishing criteria for training, experience, and demonstrated competence and the review of such application shall be subject to the provisions of Section 8 of this Article.

c. Requests for clinical privileges shall be evaluated by the chief of the department to determine the applicant's eligibility for the requested clinical privileges. Such evaluation shall be made on the basis of the applicant's documented education, training, experience, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and the quality review and monitoring which the Staff deems appropriate, and the Hospital's ability to accommodate the request. Determinations concerning clinical privileges may also be based on pertinent information concerning clinical performance obtained from other sources, especially ongoing and focused professional practice evaluation conducted in other institutions and health care settings where the applicant exercises clinical privileges. Such evaluation shall also be conducted in accordance with written privileging criteria promulgated by each department and approved by the Chief Medical Officer.

d. If an initial appointee or current member of the Staff fails to supply the requested documentation of education, training, experience, or other documentation as requested, within 90 days of being requested to provide such documentation in support of the request for privileges, the request for the privilege(s) will be considered voluntarily withdrawn.

e. Requests for clinical privileges in a department other than the one in which the Staff member is currently assigned shall be evaluated by the appropriate department chief. In the course of evaluating the request for an additional appointment, the chief of each department in which the applicant is seeking privileges may review the applicant's credentials file and may also require an interview with the applicant. The chief shall provide to the Credentials Department his or her written recommendations for membership and privileges, as well as be prepared to report to the Credentials Committee the results of his or her review of the application and interview of the applicant. The chief shall document any additional information required to support requests for specific privileges or any other information necessary to proceed with a review of the application by the Credentials Committee.

f. After receipt of the written recommendation of the chief of the department, a request for clinical privileges made by an initial appointee or a request for additional clinical privileges made by a current member of the Staff shall be subject to review and approval in accordance with the procedures set forth in Bylaws Part II, Article II, Section 3(l) – (o).

Section 3. ***Temporary Clinical Privileges***. Temporary privileges may be granted under the following circumstances:

a. *Applications Awaiting Committee Review.* Temporary clinical privileges may be granted to a new applicant for Staff membership whose application, including delineation of privileges, is "complete" as defined in Bylaws Part II, Article II, Section 3(k) and has been recommended for approval by the Credentials Committee but is awaiting review by the Medical Executive Committee or the Board. Under such circumstances, temporary clinical privileges may be granted by the Chief Executive Officer of the Hospital (or his or her designee) upon the recommendations of the appropriate department chief and the President (or his or her designee). Temporary privileges may be granted under this paragraph (c) for an initial period not to exceed 90 days. Such privileges may be renewed for one additional 60-day period upon the recommendations of the appropriate department chief and the President (or his or her designee) and the approval of the Chief Executive Officer of the Hospital (or his or her designee).

b. *To Fulfill an Important Patient Care, Treatment, and Service Need*. Temporary clinical privileges may be granted to a practitioner to fulfill an important patient care, treatment, and service need. Such circumstances include the following:

(1) Where a shortage of Staff members possessing such privileges is impairing the Hospital's ability to meet patient needs; or

(2) Upon a showing of good cause, for the care of a specific patient (and if the applicant is licensed in another State or country but not in New York State, only for the purpose of providing a requested consultation to a member of the Staff); or

(3) Where a practitioner has been asked to teach, precept or mentor a member or members of the Staff or where the practitioner is visiting the Hospital to receive medical instruction; or

(4) Where a practitioner is serving as a *locum tenens* for a member of the Staff, and only to attend patients of the member for whom the *locum tenens* is providing coverage.

Under such circumstances, temporary clinical privileges may be granted by the Chief Executive Officer of the Hospital (or his or her designee) upon the recommendation of the appropriate department chief or the Chief Medical Officer and the President (or his or her designee), after confirmation of the following:

(1) Current and valid license to practice medicine, dentistry or podiatry (as applicable) in New York State or in another State or country;

(2) Current professional liability insurance coverage in the same amounts and terms as required for Staff members;

(3) Current competence of the applicant, verified by contacting at least one professional peer of the applicant;

(4) Query to the National Practitioner Data Bank;

(5) Eligibility to participate in Federal health care programs (i.e., exclusion screening);

(6) Statement from the applicant outlining the reason for such temporary privileges; and

(7) Where the applicant will be involved in teaching, precepting, mentoring or receiving instruction, a statement from the Staff member who will be responsible for supervising the applicant, attesting to this supervisory responsibility.

Temporary privileges may be granted under this paragraph (b) for an initial period not to exceed 90 days, or in the case of a *locum tenens*, 120 days. Such privileges may be renewed for one additional 60-day period upon the recommendation of the appropriate department chief and President (or his or her designee) and the approval of the Chief Executive Officer of the Hospital (or his or her designee).

c. *Delineation of Privileges.* Requests for temporary clinical privileges must include the hospital-specific privileges which are included in the request and approval, if granted.

Section 4. ***Emergency Privileges and Disaster Privileges***.

a. *Emergency*. In the case of an emergency, any member of the Staff, to the degree permitted by his or her license and regardless of department, Staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of any person or to save a person from serious harm. The member shall make every reasonable effort to communicate promptly with the department chief concerning the need for emergency care and assistance by members of the Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the responsible Staff member with respect to further care of the patient at the Hospital.

b. *Disaster Privileges.* In the event the Hospital's emergency management plan has been activated and the Hospital is unable to meet immediate patient needs, practitioners who are not members of the Staff may provide clinical services, to the degree permitted by the

practitioner's license and authorized by the chief of the department to which the practitioner is assigned. Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation.

(1) The following information must be provided, preferably to the Credentials Department, before the practitioner may be granted privileges:

(A) A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport); and

(B) Current and valid license to practice in New York State; or a current hospital picture ID card that clearly identifies professional designation; or primary source verification of the license; or identification indicating that the practitioner is a member of a disaster medical assistance team (DMAT), medical reserve corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organizations or groups engaged in pre-event credentialing; or identification indicating that the practitioner has been granted authority by a federal, state or municipal entity to render patient care in disaster circumstances; or identification by current Hospital staff or Staff member(s) with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster.

(2) Information, such as a certificate of current professional liability insurance coverage in the same amounts and terms as required for Staff members, list of current hospital affiliations where the practitioner holds active staff privileges, and a query to the National Practitioner Data Bank, are not required but may be obtained if time allows.

After the above information has been received (and verified to the extent reasonably possible under the circumstances), disaster privileges may be granted by the Chief Executive Officer of the Hospital (or his or her formal designee).

As soon as the immediate situation is under control, the verification and privileging process for practitioners granted disaster privileges will proceed in accordance with Part II, Article IV, Section 3.b of these Bylaws or Section 6 of the Allied Health Professional Staff Policy, as applicable. Primary source verification of licensure shall be completed within 72 hours from the time the practitioner presents to the Hospital, except when extraordinary circumstances (such as no means of communication or a lack of resources) make it impossible, in which extraordinary circumstances primary source verification shall be completed as soon as possible.

Within 72 hours after the practitioner presents to the Hospital, the Chief Executive Officer of the Hospital (or his or her formal designee), in consultation with the chief of the department to which the practitioner has been assigned, will determine whether to continue the disaster privileges initially granted based on the primary source verification and other information regarding the professional practice of the practitioner obtained through such time.

The Hospital shall issue to each practitioner granted disaster privileges a picture ID tag that identifies the practitioner by name and professional designation and as having "disaster privileges." The practitioner shall wear the ID tag at all times while within the Hospital.

Section 5. ***General Conditions***.

a. If granted temporary or disaster privileges, the practitioner shall act under the general supervision of the chief of the department to which the practitioner has been assigned or, in the case of a practitioner granted temporary privileges in connection with teaching, precepting or mentoring or to receive instruction, a member of the Staff in the department to which the practitioner has been assigned. The practitioner shall ensure that the supervising practitioner, or his designee, is kept closely informed as to the practitioner's activities within the Hospital. The department chief shall meet with a practitioner granted disaster privileges on each of the first two days disaster privilege are granted and on a weekly basis thereafter, for the purpose of overseeing the professional performance of the practitioner. Such meetings may include direct observation of the practitioner's performance, mentoring, clinical records review, and other means of oversight as the department chief determines necessary to assess the practitioner's performance.

b. Temporary privileges shall automatically terminate at the end of the period designated under the applicable provision of Section 3 of this Article, unless earlier terminated by the President, the Medical Executive Committee or the Board. Disaster privileges shall automatically terminate upon the termination of the disaster or earlier at the direction of the Chief Executive Officer (or his designee).

c. A person shall not be entitled to the procedural rights afforded by Bylaws Part III, Article V or Section 13 of the Allied Health Professional Staff Policy because a request for temporary or disaster privileges is refused or because all or any portion of temporary or disaster privileges are terminated or suspended.

d. All persons requesting or receiving temporary or disaster privileges shall be bound by the Bylaws and rules and regulations of the Staff.

Section 6. ***Telemedicine Privileges.***

a. The Medical Executive Committee must approve each use of telemedicine technology in connection with any services offered at the Hospital. The chief of the department in which the telemedicine technology will be utilized will present the request to the Medical Executive Committee at one of its regularly scheduled meetings for consideration and approval. The Medical Executive Committee may adopt appropriate standards and requirements for the use of telemedicine technology, addressing such matters as security of information transmission, maintenance of medical records confidentiality, and minimum technological requirements.

b. Examples of telemedicine technology services that may be requested and approved in accordance with this Section include, but are not limited to: radiology and other diagnostic imaging services, including coronary and other angiograms; transmission of other digital data for diagnosis and interpretation, such as electrocardiograms, electroencephalograms, sonograms, and echocardiograms; and consultative services provided over a video link.

c. Practitioners who wish to utilize approved telemedicine technology will apply for privileges specifically authorizing such use, in accordance with the credentialing and privileging processes outlined in these Bylaws or the Allied Health Professional Staff Policy, as applicable. All practitioners granted telemedicine privileges are subject to the Bylaws, rules, regulations and policies of the Staff and the Hospital in the same manner as any other practitioner granted privileges.

Section 7. ***Provisional Status.***

a. Initial appointment to the Staff (regardless of the Staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

b. During the provisional period, the member's exercise of the relevant clinical privileges will be evaluated by the chief of the department in which the member has clinical privileges and/or by a physician(s) designated by the Credentials Committee. This focused professional practice evaluation may include chart review, monitoring of the individual's practice patterns, preceptoring, external review and information obtained from other physicians and Hospital employees and other hospitals or facilities with which the member is affiliated. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

c. The duration of the provisional period for initial appointment and privileges will be not less than 12 nor more than 24 months (which period may overlap the initial appointment period and the first reappointment period), as recommended by the Credentials Committee. The duration of the provisional period for all other initial grants of privileges will be as recommended by the Credentials Committee but shall not be longer than 24 months.

d. During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the department chief and/or by other designated physicians.

e. A new member of the Staff shall be deemed to have voluntarily resigned his or her appointment and privileges at the end of the provisional period if that new member fails, during the provisional period, to participate in the required number of cases. No hearing or appeal rights shall apply in such situation.

f. If a member of the Staff who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases, the member shall be deemed to have automatically resigned such additional clinical privileges at the end of the provisional period. No hearing or appeal rights shall apply in such situation.

g. When, based on the evaluation performed during or with reference to the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct or failure to cooperate with monitoring and review conditions (other than simply failing to participate in a required number of cases), the member shall be entitled to a hearing and appeal in accordance with Bylaws Part III, Article V.

Section 8. ***Clinical Privileges for New Procedures.***

a. Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure (collectively, a "new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established. An individual seeking clinical privileges for a new procedure shall have the burden of providing all information that the Credentials Committee, Medical Executive Committee or Board may consider relevant to making such determination and formulating such criteria. The Medical Executive Committee or the Chief Medical Officer may also initiate review of a new procedure under this Section, in which case the Credentials Committee

with the support of the Chief Medical Officer, shall gather the information necessary to make its recommendations.

b. The Credentials Committee will make a preliminary recommendation to the Medical Executive Committee as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

c. If the Credentials Committee recommends that the new procedure be offered and the Medical Executive Committee concurs in that recommendation, the Credentials Committee shall then develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

Section 9. ***Clinical Privileges That Cross Specialty Lines.***

a. Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the applicant's eligibility to request the clinical privileges in question.

b. The Credentials Committee will conduct research and consult with experts, including those on the Staff (e.g., department chiefs, individuals on the Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

c. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the extent of monitoring and supervision that should occur if privileges would be granted;

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and

(5) the impact, if any, on emergency call responsibilities.

d. The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

Section 10. ***Voluntary Relinquishment of Privileges.***

a. A Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the department chief specifying the clinical privilege(s) to be relinquished and the reasons for the request. The department chief will make a recommendation to the Medical Executive Committee.

b. The department chief will report to the Medical Executive Committee as to whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call rotation. The Medical Executive Committee may request a meeting with the member involved. The Medical Executive Committee will make a recommendation to the Board.

c. The Board will make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. The Board's decision will be reported in writing by the Chief Executive Officer to the member, the Medical Executive Committee, and the applicable department chief. If the Board permits the relinquishment of privileges, it will specify the effective date of the relinquishment.

d. Failure of a member to request relinquishment of clinical privileges as set forth above will result in the member being maintained on the call schedule without any change to his or her call responsibilities.

e. Members must maintain competency for the core privileges in their specialty. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage or to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.

f. Notwithstanding the preceding provisions of this Section, a member may resign his or her appointment to the Staff and all privileges at any time upon not less than 90 days notice to the member's department chief and the Chief Medical Officer. If a member resigns his or her appointment, the member may not reapply for appointment to the Staff for a period of two years, unless permission to apply sooner is granted by the Medical Executive Committee. Nothing herein shall permit resignation by an employee of the Hospital in contravention of the terms of the employee's employment.

ARTICLE V

HISTORY & PHYSICAL EXAMINATIONS

Section 1. ***When Required***. A history and physical examination (H&P) shall be performed in all cases within 24 hours after inpatient admission, or in the case of outpatient surgery or invasive procedure, within 24 hours after admission but before the surgery or procedure. If a H&P has been performed within 30 days prior to inpatient admission, or outpatient surgery or invasive procedure, a reassessment that includes the following elements must be performed by a practitioner privileged by the Hospital to perform H&P and documented in an update note, in order to attest to the adequacy and appropriateness of the previous assessment:

a. Any changes in the patient's health status or any pre-existing conditions must be clearly documented and evaluated and a physical examination must be performed to update any

components of the patient's medical status that may have changed since the prior H&P or to address any areas where more current data are needed. This documentation must be made regardless of whether there are any changes in the patient's status.

b. For surgical care, the reassessment must document and address any contraindication to surgery or anesthesia.

c. The information documented should confirm that the necessity for the inpatient care or procedure is still present and that the H&P is still current, appropriate to the patient and to the inpatient admission, surgery or procedure.

Section 2. ***Content and Scope.*** The content and scope of the H&P will be specified, according to the setting (inpatient, non-inpatient), the level of care/treatment and/or the service, in policies approved by the Medical Executive Committee.

Section 3. ***Documentation of the H&P.*** The H&P, including all reassessments, must be documented in the patient's medical record within 24 hours after admission or, in the case of surgery or other invasive procedure, prior to the surgery or procedure. When a H&P is not recorded before the time stated for operation, the operation shall be canceled unless the attending surgeon states in writing that such a delay would be detrimental to the patient. Any H&P, including all reassessments, in the patient's chart written by a physician assistant, specialist assistant, or House Staff must be cosigned by the responsible Staff member (or if the responsible Staff member is a dentist who does not have H&P privileges, by a physician member of the Active or Courtesy Staff) within a time frame designated in policies and procedures approved by the Medical Executive Committee.

Section 4. ***Who May Perform H&P.*** The following practitioners may write or dictate H&P if they have privileges to perform H&P:

- physicians;
- dentists;
- physician's assistants;
- specialist's assistants;
- nurse practitioners;
- midwives;
- House Staff; and
- podiatrists.

Section 5. ***Use of Externally Generated H&P.*** A H&P that has been performed by a practitioner who is not privileged by the Hospital to do so can be utilized under the following circumstances:

a. The H&P was performed within 30 days before the inpatient admission, outpatient surgery or invasive procedure.

b. A practitioner who has privileges to perform a H&P hereunder reviews the H&P document, performs and documents a reassessment as provided in Section 1(a) within 24 hours after an inpatient admission, or in the case of outpatient surgery or invasive procedure, within 24 hours after admission but before the surgery or procedure, and signs and dates the previously provided H&P as an attestation to its adequacy and appropriateness.

ARTICLE I
COLLEGIAL INTERVENTION

Section 1. ***Collegial Intervention***. These Bylaws encourage the use of progressive steps by Staff leaders (Officers, appropriate department chief or committee chair) and Hospital management, beginning with collegial and educational efforts, to address questions relating to a Staff member's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Staff member to resolve questions that have been raised. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Staff members and pursuing counseling, education, and related steps, such as the following:

a. advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
b. preceptoring, monitoring, consultation, and letters of guidance; and
c. sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist members of the Staff to conform their practices to appropriate norms.

The Chief Medical Officer and the Staff member's department chair will determine whether it is appropriate to include documentation of collegial intervention efforts in a Staff member's quality assurance file. If documentation of collegial efforts is included in a Staff member's file, the member will have an opportunity to review it and respond in writing. The response will be maintained in that member's file along with the original documentation.

Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Staff leaders and Hospital management. The Chief Medical Officer and department chief, in conjunction with the Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). They may also direct these matters to the Medical Executive Committee for further action as provided in Section 2 of this Article.

Section 2. ***Procedure for Other Questions Involving Staff Members***. Whenever a serious concern or question has been raised, or where collegial intervention efforts (if attempted) have not resolved an issue, regarding: (1) the clinical competence or clinical practice of any Staff member; (2) the care or treatment of a patient or patients or management of a case by any Staff member; (3) the known or suspected violation by a Staff member of applicable ethical standards or the Bylaws, policies, rules or regulations of the Hospital or the Staff including, but

not limited to, the Hospital's quality improvement, risk management or utilization review programs; or (4) behavior or conduct on the part of any Staff member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or the Staff, including the inability of the Staff member to work harmoniously with others, the President, department chief, Chair of the Credentials Committee, Chief Medical Officer or Chief Executive Officer may make sufficient inquiry to determine whether the concern or question raised is credible, after which it shall be submitted in writing to the Medical Executive Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Hospital and the Staff member concerned, they may, but are not required to, discuss the matter with the affected Staff member.

ARTICLE II

INVESTIGATIONS

Section 1. ***Initiation of Investigation***.

a. When a serious concern or question involving clinical competence or behavior/conduct has been referred to the Medical Executive Committee, that committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the code of conduct policy or the physician practitioner health policy), or to proceed in another manner. Prior to making this determination, the Medical Executive Committee may, but is not required to, discuss the matter with the Staff member concerned. The Medical Executive Committee may also, by formal resolution, initiate an investigation on its own motion.

b. If the Board or the Board's Safety and Quality Improvement Committee (the "SQI Committee") wishes to begin such an investigation, it shall formally resolve to do so, but either may delegate the actual investigation.

c. Within 10 days after the initiation of an investigation by the Medical Executive Committee, the Board or the SQI, the President shall inform the Staff member that an investigation has begun. Such notification shall be given by certified or registered mail.

d. The President shall promptly notify the Chief Executive Officer in writing of all requests for investigations and shall keep the Chief Executive Officer fully informed of all action taken in connection therewith.

e. The Chief Executive Officer shall promptly notify the SQI Committee chair and the Board chair of the authorization of any investigation by the Medical Executive Committee that may lead to an adverse determination and grounds for a hearing, as defined in Section 2 of Article V.

Section 2. ***Investigating Body***. Once a determination has been made to begin an investigation, the Medical Executive Committee may conduct the investigation itself, appoint an individual to conduct the investigation, or assign the task to any standing or ad hoc committee of the Staff. Partners, associates, or relatives of the Staff member being investigated shall not participate in any committee conducting the investigation. The committee may

include individuals not on the Staff. Whenever the questions raised relate to the clinical competence of the Staff member under review, the committee shall include a peer of the Staff member to the extent reasonably available.

Section 3. ***Investigation.***

a. The individual or committee conducting the investigation ("investigating body") shall have the authority to review relevant documents and to interview individuals. The investigating body shall also have available to it the full resources of the Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant may be used whenever a determination is made by the Chief Executive Officer or Chief Medical Officer and the investigating body that:
   (1) the clinical expertise needed to conduct the review is not available on the Staff; or
   (2) the Staff member under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Staff who might otherwise be consulted; or
   (3) the individuals with the necessary clinical expertise on the Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

b. The investigating body may require a physical and/or mental examination of the Staff member being investigated by a health care professional(s) acceptable to the investigating body. The Staff member being investigated shall execute a release allowing (i) the investigating body (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating body.

c. The Staff member shall be given an opportunity to meet with the investigating body before the investigating body makes its report. Prior to this meeting, the Staff member shall be informed of the general questions being investigated. At the meeting, the Staff member shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating body and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The Staff member being investigated shall not have the right to be represented by legal counsel at this meeting.

d. The investigating body shall make a reasonable effort to complete the investigation and issue its report to the Medical Executive Committee within 60 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating body shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for a Staff member to have an investigation completed within such time periods. In the event the investigating body is unable to complete the investigation and issue its report within these time frames, it shall inform the Medical Executive Committee and the Staff member of the reasons for the delay and the approximate date on which it expects to complete the investigation.

e. At the conclusion of the investigation, the investigating body shall prepare a written report to the Medical Executive Committee setting forth the findings, conclusions, and recommendations of the investigating body.

f. In making its recommendations, the investigating body shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the Staff member, recognizing that fairness does not require

that the Staff member agree with the recommendation. Specifically, the investigating body may consider:

(1) relevant literature and clinical practice guidelines, as appropriate;
(2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
(3) any information or explanations provided by the Staff member under review; and
(4) any other relevant information.

Section 4. ***Medical Executive Committee Action***. As soon as is practicable after the conclusion of the investigative process, if any, but in any event within 90 days after receipt of the request for the investigation, unless deferred in accordance with Section 5 of this Article, the Medical Executive Committee shall act upon the investigating body's recommendation. Such action may include, without limitation, recommending the following disposition to the SQI Committee:

a. Determination that no action is justified.

b. Modification of the proposed recommendation.

c. Letter of admonition, letter of reprimand, or warning.

d. Terms of probation or individual requirements of consultation.

e. Reduction or revocation of clinical privileges.

f. Suspension of clinical privileges until completion of specific conditions or requirements.

g. Reduction of Staff membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

h. Suspension of Staff membership until completion of specific conditions or requirements.

i. Revocation of Staff membership.

j. Other actions appropriate to the facts which prompted the request for an investigation.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing a precautionary suspension or restriction at any time, in the exercise of its discretion, pursuant to the provisions of Article III.

Section 5. ***Deferral***. If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 4 above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within 30 days of the deferral.

Section 6. ***Other Action***.

a. If the Medical Executive Committee's recommendation is that no action be taken, such recommendation, with supporting documentation, shall be transmitted to the SQI Committee. The SQI Committee need not accept such recommendation and may elect to take any action which it deems appropriate under the circumstances.

b. If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a Staff member or if it would involve the imposition of terms of probation or individual requirements of consultation, or a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical/Dental Staff membership, the Medical Executive Committee shall provide the member with a copy of the investigating body's report and, at the member's request, grant him or her an interview as provided in Section 7 of this Article. If, following the requested interview, the Medical Executive Committee's final recommendation to the SQI Committee is an admonition, reprimand or warning or any other action that does not constitute grounds for a hearing as set forth in Section 3 of Article V, and if the SQI Committee accepts such recommendation, such acceptance of the recommendation shall be conclusive and notice of the final decision shall be given to the Chief Executive Officer, Medical Executive Committee, the chief of the department in which the member exercises clinical privileges, the Chief Medical Officer and the Staff member.

c. If following the requested interview, the Medical Executive Committee's final recommendation to the SQI Committee constitutes grounds for a hearing as set forth in Section 2 of Article V, notice of such recommendation shall be given to the SQI Committee and the Board chair. The SQI Committee has the right to request reconsideration of the matter by the Medical Executive Committee. If no reconsideration is requested or if the Medical Executive Committee's final recommendation after reconsideration still constitutes grounds for a hearing as set forth in Section 2 of Article V, the Staff member shall be afforded the procedural rights set forth in Article V.

d. Whether the Medical Executive Committee's recommendation is no action be taken or an adverse action be taken, the SQI Committee has the right to ask the Medical Executive Committee to reconsider the matter before final action is taken by the Medical Executive Committee.

e. Notwithstanding any contrary provision of this Section 6, if any action by the SQI Committee taken pursuant to this Section was upon a vote of less than 75% of the SQI Committee members present when a quorum exists, the matter shall be referred to the for Board for action in lieu of action by the SQI Committee.

Section 7. ***Interviews***. Interviews shall neither constitute nor be deemed a "hearing," as described in Article V; shall be preliminary in nature; and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the Staff member's request, to grant the Staff member an interview only when so specified in these Bylaws. In all other cases and when the Medical Executive Committee or the SQI Committee or the Board has before it an adverse recommendation, as defined in Article V, it may, but shall not be required to, furnish the Staff member an interview. In the event an interview is granted, the member shall be informed of the general nature of the circumstance leading to such recommendation

and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE III

PRECAUTIONARY SUSPENSION OR RESTRICTION

Section 1. ***Criteria for Initiation***. Whenever the conduct of a member of the Staff requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital, the chief of any department in which the member exercises privileges, the Chief Medical Officer or the Chief Executive Officer shall have the authority to (1) suspend or restrict all or any portion of the member's clinical privileges, or (2) afford the member an opportunity to voluntarily refrain from exercising privileges pending an investigation.

Section 2. ***Imposition of Suspension or Restriction***. A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the Staff member to request a hearing. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction. A precautionary suspension or restriction shall become effective immediately upon imposition, and notice of such suspension or restriction shall be promptly given in writing by the individual imposing it to the Medical Executive Committee, the Chief Medical Officer, and the Chief Executive Officer. The precautionary suspension or restriction shall remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee. Within three days of the imposition of the suspension or restriction, the President shall provide the Staff member in question with written notice of the precautionary suspension or restriction. The notice shall include a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any), shall inform the member that he or she has the right to demand a hearing with respect to the determination within 30 days after receipt of the notice, and shall include a summary of the member's rights in the hearing as provided under Section 3 of this Article and Article V.

Section 3. ***Medical Executive Committee Procedure***. The imposition of a precautionary suspension or restriction shall constitute a request for an investigation and the procedures set forth in Article II shall be followed. The Staff member whose clinical privileges have been summarily suspended or restricted shall be entitled to request in accordance with Article V, Section 5 that the Medical Executive Committee hold a hearing on the matter within 14 days of receipt of the member's request for a hearing. The Medical Executive Committee shall serve as the Hearing Panel for purposes of Article V, notwithstanding any contrary provision thereof, and the requirement of a pre-hearing conference shall not apply. At the hearing, the member may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances. The Medical Executive Committee shall determine whether the precautionary suspension or restriction should be continued, modified, or terminated, and it shall give the Staff member written notice of its decision. If, as a result of such hearing (if requested), the Medical Executive Committee does not recommend immediate termination of the summary suspension or restriction, the Staff member shall be entitled to request an appellate hearing by the SQI Committee in accordance with Section 21 of Article V, but the terms of the precautionary suspension or restriction as sustained or modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the SQI Committee, or by the Board in the event the matter is referred to the Board pursuant to Section 25 of Article V.

Section 4. ***Care of Patients***. Immediately upon the imposition of a precautionary suspension or restriction, the department chief or President shall assign to another member with appropriate clinical privileges responsibility for care of the suspended Staff member's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician. All Staff members have a duty to cooperate in ensuring that patients are adequately covered.

ARTICLE IV

AUTOMATIC SUSPENSION OR TERMINATION

Section 1. ***Grounds for Automatic Suspension or Termination***. In the following instances, the member's privileges or Staff membership shall be automatically suspended, revoked, limited, modified or terminated. Where such action is taken pursuant to this Section 1, such action shall be final, without a right to a hearing or to further review, except where a bona fide dispute exists as to whether the following circumstances have occurred:

a. *License.*

(1) *Revocation or Expiration*: Whenever a member's license to practice in New York State is revoked or has expired, his or her Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated.

(2) *Restriction*: Whenever a member's license to practice in New York State is limited or restricted, those clinical privileges which are within the scope of said limitation or restriction shall be immediately and automatically restricted effective upon, and for at least the term of, the restriction.

(3) *Suspension*: Whenever a member's license to practice in New York State is suspended, his or her Staff membership and clinical privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.

(4) *Probation*: Whenever a member is placed on probation by the applicable licensing authority, his or her applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation, effective upon, and for at least the term of, the probation.

b. *Drug Enforcement Administration*.

(1) *Revocation or Expiration*: Whenever a member's DEA certificate is revoked or has expired, he or she shall immediately and automatically be divested of his or her right to prescribe medications covered by the certificate. Upon subsequent presentation of a current, valid DEA certificate to the Credentials Department, the member's right to prescribe medications covered by the certificate shall be automatically reinstated.

(2) *Suspension*: Whenever a member's DEA certificate is suspended, he or she shall be divested, at a minimum, of his or her right to prescribe medications covered by the certificate effective upon, and for at least the term of, the suspension.

(3) *Probation*: Whenever a member's DEA certificate is subject to an order of probation, his or her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

c. *Participation in Government Programs*. For the Federal or State government's exclusion of the member from participation in Medicare, State health care programs (including Medicaid), or other Federal non-procurement programs based on the authority contained in sections 1128 and 1156 of the Social Security Act, Staff membership and clinical privileges shall be automatically suspended and shall remain so suspended until the member provides satisfactory evidence to the Chief Medical Officer that he or she has secured reinstatement of such participation.

d. *Medical Records*. Whenever a member fails to complete and sign medical records within the time limits set forth in the rules and regulations or policies of the Staff and the number of consecutive days when one or more records are delinquent reaches 30, all such member's clinical privileges will be automatically suspended upon receipt of written notice therof from the Chief Medical Officer or his or her designee. The automatic suspension shall terminate upon the member's completion of the delinquent records.

e. *Malpractice Insurance*. For failure to maintain the required amount of professional liability insurance, Staff membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the

member provides satisfactory evidence to the Chief Medical Officer that he or she has secured professional liability coverage in the required amount.

f. *Failure to Pay Dues*. A Staff member who is required to pay annual dues and fails to do so by May 1 of each year shall be deemed to have voluntarily resigned his or her Staff membership.

g. *Mandated Vaccinations and Tests.* Immediately upon a member's failure to be vaccinated or tested in accordance with federal, state or local laws or regulations or the standards of Accreditation Organizations applicable to the member or the Hospital, Staff membership and clinical privileges shall be automatically suspended and shall remain so suspended until the member provides satisfactory evidence to the Chief Medical Officer that he or she has been vaccinated or tested as required.

h. *Prohibited Financial Relationship.* Whenever the Chief Executive Officer or his or her designee determines and informs a Staff member that a financial relationship between the Hospital and such Staff member (or his or her immediate family member) may be or have been prohibited by Section 1877 of the Social Security Act or the regulations promulgated thereunder (42 CFR §411.350 *et seq.*) (collectively, the "Stark Law") and that the period of such possible noncompliance has not ended, the Staff member's membership and clinical privileges shall be automatically suspended. The suspension shall continue until the Chief Executive Officer or his or her designee determines either that there is or was no financial relationship prohibited by the Stark Law or that the period of noncompliance (as defined by the Stark Law) with respect to such financial relationship has ended. All such determinations shall be made in good faith, be based on competent legal advice, and be made as expeditiously as reasonably possible.

Section 2. ***Notice of Automatic Suspension***. Whenever a member's privileges are automatically suspended, in whole or in part, notice of such suspension shall be given to the member, the President, the member's department chief, the Chief Medical Officer. Giving such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the member's patients, whose treatment by such member is terminated by the automatic suspension, shall be assigned to another Staff member by the chief of the department or President.

Section 3. ***Reinstatement***. A Staff member whose privileges and membership have been automatically suspended may request reinstatement by submitting information sufficient to document their eligibility to resume their membership and clinical privileges. The Chief Medical Officer may authorize reinstatement following automatic suspension, but a determination by the Chief Medical Officer to deny reinstatement shall not entitle the Staff member to a hearing as provided for in Article V. Failure, without good cause, to request reinstatement within one year of the automatic suspension shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of membership, privileges, and prerogatives, and shall not entitle the member to a hearing as provided for under Article V. A request for Staff membership subsequently received from a member so terminated

shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE V

HEARINGS AND APPELLATE REVIEW

Section 1. ***Exhaustion of Remedies***. If any adverse determination, as described in Section 2 of this Article, is taken or recommended, the applicant or Staff member, as the case may be, must exhaust the remedies afforded under these Bylaws before resorting to legal action.

Section 2. ***Grounds for Hearing***. Any one or more of the following adverse actions or recommended adverse actions shall constitute an "adverse determination" and provide grounds for a hearing:

a. denial of Staff membership;
b. denial of Staff reappointment;
c. denial of requested advancement in Staff membership status;
d. demotion to lower category of Staff membership;
e. precautionary suspension or restriction of Staff membership or clinical privileges during the pendency of corrective action and hearing;
f. expulsion from the Staff;
g. denial, reduction or termination of clinical privileges, except such action taken with respect to temporary privileges;
h. involuntary imposition of significant prior consultation or monitoring requirements in connection with the treatment of patients, other than those which are generally applied during provisional status; and
i. denial of a request for or extension of a leave of absence of up to one year, and denial of a timely request for reinstatement or reappointment following a leave of absence.

No other recommendations shall entitle the Staff member to a hearing. If the SQI Committee or the Board makes an adverse determination without having received a recommendation of an adverse determination from the Medical Executive Committee, the member is also be entitled to request a hearing. For ease of use, this Article refers to recommendations of adverse determinations made by the Medical Executive Committee. When a hearing is triggered by an adverse recommendation made by the SQI Committee or the Board, any reference in this Article to "the Medical Executive Committee" shall be interpreted as a reference to "the SQI Committe" or "the Board" as applicable.

Section 3. ***Actions Not Grounds for Hearing***. None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the applicant or Staff member shall be entitled to submit a written explanation to be placed into his or her file:

a. issuance of a letter of guidance, counsel, warning, or reprimand;

b. termination of temporary privileges;

c. automatic suspension of appointment or privileges;

d. imposition of a requirement for additional training or continuing education;

e. determination that an application is incomplete; or

f. determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

Section 4. ***Notice of Adverse Determination***.

a. After the making of an adverse determination which gives rise to a hearing as set forth in Section 2 of this Article, the Medical Executive Committee shall promptly notify the Staff member and the Chief Executive Officer, in writing, of such adverse determination. Such notice shall be transmitted to the member by registered mail, return receipt requested, and shall state the reasons for the determination and the substance of any charges made against the member. The notice shall also inform the member that he or she has the right to demand a hearing with respect to the determination within 30 days after the receipt of the notice and shall contain a summary of the member's rights in the hearing, as provided in this Article.

b. The Chief Executive Officer shall promptly notify the SQI Committee chair and the Board chair of the adverse determination by the Medical Executive Committee.

c. This Section shall not apply to a precautionary suspension or restriction, notice of which shall be given in accordance with Section 2 of Article III.

Section 5. ***Request for a Hearing***. The Staff member may request a hearing within 30 days of the receipt of the notice provided under Section 4 of this Article. Such demand shall be made in writing, addressed to the President, and transmitted by mail. Failure to request a hearing within the said 30-day period shall be deemed: (a) a waiver by the member of his or her right to a hearing and any appeal therefrom; and (b) acceptance of the adverse determination. The President shall promptly notify the Chief Medical Officer, the Chief Executive Officer, the SQI Committee chair and the Board chair of the receipt of any request for a hearing.

Section 6. ***Notice of Hearing***. Within 10 days of the receipt of a request for a hearing, the President shall notify the Staff member who requested the hearing, by registered mail, return receipt requested, of:

a. the date, time and place of the hearing.

b. the names of the Presiding Officer and the members of the Hearing Panel, if known; and

c. a statement of the specific reasons for the recommendation, including a list of patient records (if applicable).

The hearing shall be scheduled no sooner than 30, and no later than 90, days after the mailing of the notice of

hearing as provided in this section, provided that any Staff member who is under precautionary suspension shall be entitled to a hearing within 14 days after such mailing.

Section 7. ***Hearing Panel***.

a. The hearing shall be held before the Hearing Panel. The Hearing Panel shall consist of five individuals as designated by the President. Such designation shall include appointment of a chair, who shall serve as the Presiding Officer.

b. The Hearing Panel may include any combination of Staff members, provided the member has not actively participated in the matter at any previous level. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Hearing Panel.

c. The Hearing Panel may not include (i) any member of the Medical Executive Committee, (ii) any other member of the Staff who has actively participated in the matter at issue, (iii) any Staff member who is in direct economic competition with the individual, or (iv) any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.

d. Within 10 days of receiving notice of the hearing required by Section 6 of this Article, the member who requested the hearing may object to any member of the Hearing Panel by providing a written notice of objection, including the basis for the objection, to the President. The President shall be given a reasonable opportunity to comment and may seek the opinion of the Presiding Officer as to the validity of the objection. The President shall rule on the objection and if objection is sustained, shall appoint a substitute member(s) to the Hearing Panel. The President shall give written notice of his or her ruling and the name of the substitute(s), if any, to the member who requested the hearing and the Chief Executive Officer.

Section 8. ***Presiding Officer***. The chair of the Hearing Panel or his or her designee shall be the presiding officer at the hearing. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. Except as otherwise provided herein, the Presiding Officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

Section 9. ***Pre-Hearing Procedures***.

a. The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

b. Prior to receiving any confidential documents, the Staff member requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The Staff member must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

c. Upon receipt of the above agreement and representation, the Staff member requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the member's expense;

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

d. The Staff member shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Staff.

e. Evidence unrelated to the reasons for the recommendation or to the Staff member's qualifications for appointment or the relevant clinical privileges shall be excluded.

f. Neither the Staff member, nor any other person acting on behalf of the Staff member, may contact Hospital employees whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the Staff member once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the Staff member who requested a hearing.

Section 10. ***Pre-Hearing Conference***. The Presiding Officer will require the Staff member who requested the hearing, or a representative (who may be legal counsel), and the Medical Executive Committee, or a representative (who may be legal counsel), to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer will seek to resolve all outstanding procedural questions, including any objections to exhibits or witnesses. The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

Section 11. ***Provision of Information to the Hearing Panel***. The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.

Section 12. ***Failure to Appear or to Proceed***. Failure of the Staff member to appear or proceed at the hearing, without good cause, shall be deemed a waiver of the member's right to a hearing and any appeal therefrom, and an acceptance of the adverse determination which gave rise to the appeal.

Section 13. ***Burden of Going Forward and Burden of Proof***. The Medical Executive Committee or other proponent of the proposed adverse determination shall have the duty to first present evidence in support of its proposed action. Consistent with the burden on the Staff member who requested the hearing to demonstrate that he satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Medical Executive Committee unless it finds that the member who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

Section 14. ***Record of the Hearing***. All testimony at the hearing shall be under oath and a verbatim record of the proceedings shall be kept. The cost of the transcript shall be borne by the party requesting it.

Section 15. ***Adjournment***. Adjournments of the initial hearing date or of any adjourned date may be granted in the discretion of the Hearing Panel and only for good cause shown.

Section 16. ***Representation***. The hearings and appeals provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on professional conduct, professional competency, or character. At the hearing and any appeal, both the member requesting the hearing or appeal and the Medical Executive Committee shall have the right to be represented by legal counsel. In the event both the member and the Medical Executive Committee agree to proceed without legal counsel, the member shall be entitled to be accompanied by and represented at the hearing or in the appeal only by another member of the Staff, which member is not also a licensed attorney.

Section 17. ***Rights of the Parties***. Within reasonable limitations, as determined in the discretion of the Presiding Officer, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross- examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee or other proponent of the adverse determination and examined as if under cross- examination. No later than 10 days before the scheduled hearing, the Medical Executive Committee shall provide the member with a list of the witnesses (if any) that it expects to call at the hearing. No later than seven days before the hearing the member shall provide the Medical Executive Committee with a list of the witnesses (if any) that the member expects to call at the hearing. In the discretion of the Presiding Officer and for good cause, either party to the hearing may be allowed to call and

examine witnesses whose names are not so listed.

Section 18. ***Miscellaneous Rules***. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Panel may interrogate the witnesses or call additional witnesses, if it deems such action appropriate. Both sides shall be entitled to submit a written statement at the close of the hearing.

Section 19. ***Basis for Recommendation***. The recommendation of the Hearing Panel shall be based upon the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

Section 20. ***Recommendation of the Hearing Panel to the SQI Committee***. The recommendation of the Hearing Panel to the SQI Committee shall be decided on the basis of a majority vote of the three members sitting at the hearing. Within 30 days after the final adjournment of the hearing, the Hearing Panel shall forward a copy of its recommendation to the Staff member who requested the hearing by registered mail, return receipt requested. A copy of the recommendation shall also be forwarded to the President, the Chief Medical Officer and the Chief Executive Officer. The recommendation shall be in writing and shall state the grounds upon which it is based. The recommendation of the Hearing Panel may consider the subject of the appeal *de novo* and may affirm, modify, limit, amend, revise or otherwise effect the adverse determination as the Hearing Panel shall determine. The Hearing Panel's recommendation shall also include a statement that the Staff member has the right to appeal to the SQI Committee within 15 days after the receipt of the recommendation.

Section 21. ***Appeal to the SQI Committee***. Within 15 days after the receipt of the Hearing Panel's recommendation, either the Staff member who requested the hearing or the proponent of the adverse determination may appeal the recommendation to the SQI Committee by mailing to the chair of the SQI Committee, by registered mail, return receipt requested, a request for such appellate review together with a short statement outlining the basis for the appeal. Failure to request an appeal within the said 15-day period shall be deemed a waiver of the right to an appeal and an acceptance of the recommendation of the Hearing Panel. Within 10 days after the receipt of such a request, the chair of the SQI Committee shall, by registered mail, return receipt requested, inform the appellant of the time, date and place of the review of the Hearing Panel's determination. Such appellate hearing shall be held no

sooner than 10, and no later than 90, days after the mailing of such notice to the appellant, provided that a Staff member under precautionary suspension or restriction shall be entitled to an appellate hearing in accordance with Section 3 of Article III no later than 30 days after such mailing.

Section 22. ***Grounds for Appeal***. The only grounds for appeal shall be substantial non-compliance with the procedures required by the Bylaws or applicable law which has resulted in demonstrable prejudice to the appellant; or that the decision is not based upon substantial evidence and is without rational basis.

Section 23. ***Procedure on Appeal***.

a. The review of the Hearing Panel's decision shall be made by a subcommittee of the SQI Committee which shall consist of any four members of the SQI Committee as designated by the SQI Committee, and one member of the Staff, who need not be a member of the Board, provided that no member of the Medical Executive Committee or the Hearing Panel who is also a member of the Board may be so designated.

b. A chairman of the subcommittee of the SQI Committee shall be designated by the chair of the SQI Committee, and he or she shall preside at the appellate hearing.

c. The appellant shall have access to the record of the proceeding before the Hearing Panel, but any expense attendant to reproducing the record for the appellant shall be the responsibility of the appellant.

d. Both parties shall be given a reasonable opportunity to submit a written statement, and both shall be permitted oral argument if requested by the Staff member in his or her written demand for appellate review.

e. The subcommittee of the SQI Committee may limit the parties to oral argument or, in its discretion, may permit the calling of witnesses or the introduction of evidence if it appears that factual circumstances exist which should be brought to the SQI Committee's attention and which are not part of the record before the Hearing Panel. Any additional testimony taken or evidence introduced shall be in accordance with the procedures and rules set forth in Sections 13 and 14.

Section 24. ***Appellate Decision***. The recommendation of the subcommittee of the SQI Committee to the SQI Committee shall be made on the basis of a majority vote of the subcommittee members hearing the appeal. Within 30 days after the final adjournment of the appeal, the subcommittee shall inform the SQI Committee of its recommendation to affirm, modify, limit, amend, reverse, or otherwise effect the Hearing Panel's decision, or refer the matter back to the Hearing Panel for further review and recommendation within 30 days of such referral. In the case of a referral back to the Hearing Panel, the subcommittee of the SQI Committee shall make its recommendation of approval or disapproval within 30 days after the matter is returned from the Hearing Panel.

Section 25. ***Final Action by the SQI Committee or Board***. Within 30 days after receiving the recommendation of the subcommittee of the SQI Committee (or the Hearing Panel if no appeal to the SQI Committee was timely requested), the SQI Committee shall make its final decision and transmit it, together with a written statement of the basis for the decision, to the Staff member by registered mail, return receipt requested; provided, however, that if the decision of the SQI Committee is taken upon a vote of less than 75% of the SQI Committee members present when a quorum exists, the matter shall be referred to the full Board for a final decision, and the Board shall transmit its decision, together with a written statement of the basis for the decision, to the Staff member by registered mail, return receipt requested.

Section 26. ***Status Pending Appeal***. Until all of the hearing and appeal mechanisms have either been exhausted or waived, the Staff member will maintain the same status and privileges that were in effect prior to the initiation of the hearing and appeal process, subject to the terms and conditions of any precautionary suspension or restriction.

Section 27. ***Right to One Hearing and One Appeal***. No Staff member shall be entitled to more than one hearing and one appellate review on any matter. If the Board or SQI Committee denies initial appointment to the Staff or reappointment or revokes the appointment and/or clinical privileges of a current Staff member, that individual may not apply for Staff appointment or for those clinical privileges for a period of two years unless the Board or SQI Committee provides otherwise.