

**MEDICAL STAFF BYLAWS
OF
NEWYORK-PRESBYTERIAN
HOSPITAL**

*Effective Date
July 13, 2022*

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ADOPTION

- (a) These Medical Staff Bylaws are adopted and made effective upon approval of the Board of Trustees, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges at NewYork-Presbyterian Hospital shall be taken under and pursuant to the requirements of these Bylaws.
- (b) The present Rules and Regulations of the Medical Staff are readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

Adopted by the Medical Board of NewYork-Presbyterian Hospital on _____.

(Signature on File)

President, Medical Board

Approved by the Board of Trustees of NewYork-Presbyterian Hospital on _____.

(Signature on File)

Corporate Secretary

PREAMBLE

NewYork-Presbyterian Hospital (the “Hospital”) is a voluntary Hospital established as a New York not-for-profit corporation licensed under the laws of the State of New York. It is the result of a merger between The Society of the New York Hospital and The Presbyterian Hospital in the City of New York which was completed on December 31, 1997. The Hospital includes the NewYork-Presbyterian/Weill Cornell Medical Center Campus consisting of the former The New York Hospital and the following additional sites: the New-York Presbyterian Westchester Behavioral Health Center, the NewYork-Presbyterian Lower Manhattan Hospital, and the NewYork-Presbyterian Brooklyn Methodist Hospital¹, and the NewYork-Presbyterian/Columbia University Irving Medical Center Campus consisting of the former The Presbyterian Hospital in the City of New York and the following additional sites: the NewYork-Presbyterian Allen Hospital, the NewYork-Presbyterian Lawrence Hospital and NewYork-Presbyterian Morgan Stanley Children’s Hospital.

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

- deliver one level of high quality, comprehensive care through the adoption of uniform standards, and best clinical and administrative practices;
- expand accessibility to this care to a broader population and geographic region;
- demonstrate clinical excellence and improve performance when indicated, through quality measurement and performance improvement activities;
- educate and train physicians, biomedical scientists, and other health care personnel to achieve leadership status in patient care, teaching, and research;
- contribute to conquering human disease and alleviate suffering and pain with the most current biomedical technology;
- continue to address the special needs of the poor and underserved population in a responsible and compassionate manner; and
- appropriately allocate financial resources in the most prudent and effective manner.

It is recognized that the Medical Staff of the Hospital shares responsibility for the quality of patient care at the Hospital and must accept and discharge that responsibility, subject to the ultimate authority of the Board of Trustees of the Hospital Corporation (“Corporation”), and that the cooperative efforts of the Board

¹ As of the effective date of the merger of NewYork-Presbyterian Brooklyn Methodist Hospital into NewYork-Presbyterian Hospital.

of Trustees, the President and Chief Executive Officer of the Hospital, the Medical Board and other such leaders of the Medical Staff are necessary to fulfill the Hospital's obligations to its patients.

In order to further the aims and purposes of the Hospital, the Physicians, Podiatrists, and Dentists practicing at the Hospital have organized themselves into the Organized Medical Staff in conformity with these Bylaws, Rules and Regulations which are subject to, and shall not conflict with the Bylaws of the Hospital Corporation and the applicable provisions of the Agreement between The Society of the New York Hospital and Cornell University, dated June 14, 1927, as amended and supplemented (the "Society/Cornell Agreement"), and the Alliance Agreement between the Trustees of Columbia University and The Presbyterian Hospital in the City of New York, dated February 10, 1921, as amended ("Presbyterian/Columbia Agreement").

ARTICLE I
DEFINITIONS

Unless otherwise indicated, the capitalized terms used in the Medical Staff Bylaws and Medical Staff Manuals are defined in the Medical Staff Glossary.

ARTICLE II
NAME

The name of this organization shall be the "Medical Staff of NewYork-Presbyterian Hospital" (hereinafter referred to as the "Medical Staff").

ARTICLE III
PURPOSES

The purposes of these Bylaws and of the Medical Staff shall be:

To ensure that all patients treated at the Hospital receive quality care;

To ensure professional performance on the part of the Medical Staff Members and other Practitioners granted clinical privileges at the Hospital through an ongoing review and evaluation of each practitioner's

performance and by the active participation of Practitioners in committee, Clinical Service and individual review, evaluation and education functions as provided for in these Bylaws, Medical Staff Manuals, Rules and Regulations and the establishment of objective standards of care and conduct to be followed by all Practitioners granted privileges at the Hospital;

To ensure continued development and maintenance of high standards in programs of education, research and preventative medicine;

To maintain an association with Columbia University's Vagelos College of Physicians and Surgeons and Weill Cornell Medical College of Cornell University and their standards of excellence in the education and training of those engaged in the study of medicine and its fields of specialty;

To provide a means whereby matters of a medico-administrative nature may be discussed by the Medical Staff with the Board of Trustees and the Senior Leadership Team of the Hospital;

To maintain, among other documents, rules and regulations, manuals, and policies for the conduct and governance of the Medical Staff;

To establish a framework by which the Medical Staff will provide leadership in organization performance improvement activities; and

To create a framework within which the members of the Medical Staff can act with a reasonable degree of freedom and confidence.

ARTICLE IV

MEMBERSHIP ON THE MEDICAL STAFF

SECTION 4.1 NATURE OF MEDICAL STAFF MEMBERSHIP AND THE ORGANIZED MEDICAL STAFF

Subsection 4.1.1 Medical Staff.

Membership on the Medical Staff is a privilege that shall be extended only to licensed independent Practitioners and other Practitioners privileged through the processes set forth in these Bylaws and in the

Medical Staff Credentials Manual. Such Practitioners must demonstrate practical and academic competence and good character, have a faculty appointment or an appointment to the instructional staff of Columbia University's Vagelos College of Physicians and Surgeons or College of Dental Medicine, and/or a faculty appointment at Weill Cornell Medical College of Cornell University, and shall continuously meet the qualifications, standards and requirements of the Hospital's Corporate Bylaws and of these Bylaws, Rules and Regulations. Gender, gender-identity, gender expression, race, creed, age, sexual orientation, disability, religion, national origin or any other legally impermissible basis shall not be used in making decisions regarding the granting or denying of privileges or appointment to the Medical Staff. Appointments and reappointments to the Medical Staff shall be made by the Board of Trustees following recommendations by the Medical Board as provided in these Bylaws, the Medical Staff Credentials Manual, and Rules and Regulations. Notwithstanding the foregoing or any other provision regarding appointments and reappointments to the medical staff in these Bylaws, the Medical Staff Credentials Manual, Rules and Regulations, and policies, the requirement for an appointment to the instructional staff or a faculty appointment as set forth above shall be waived for members on the medical staff of NewYork-Presbyterian Brooklyn Methodist Hospital ("NYPBM") in good standing on the effective date of the merger of NYPBM into the Hospital provided that the clinical privileges granted to such members are specific to the NYPBM site after the effective date of the merger.

Any meeting of the Medical Staff shall be held upon written notice with an agenda sent in advance.

Individuals will first apply for appointment and credentialing for specific privileges for the Campus at which they hold their primary faculty appointment ("Primary Campus"), in accordance with these Bylaws and the Medical Staff Credentials Manual. They may be credentialed for specific privileges at the other Hospital Campus (i.e., other than the one where they hold their primary faculty appointment) in accordance with these Bylaws and the Medical Staff Credentials Manual.

Subsection 4.1.2 The Organized Medical Staff.

The Organized Medical Staff is a self-governing entity accountable to the Board of Trustees that operates under the Medical Staff Bylaws developed and adopted by the Organized Medical Staff and approved by the Board of Trustees, and the Medical Staff Professionalism Manual and the Medical Staff Credentials Manual. The Organized Medical Staff is comprised of physicians, podiatrists and dentists appointed to the

medical staff categories as listed in these Bylaws. All members of the Organized Medical Staff are eligible to vote.

SECTION 4.2 QUALIFICATIONS FOR MEMBERSHIP

Subsection 4.2.1 Requirements.

Applicants for appointment and reappointment to the Medical Staff must satisfy the following requirements. They must:

a). Possess an appointment to the instructional staff of Columbia University Vagelos College of Physicians and Surgeons or Columbia University College of Dental Medicine and/or a faculty appointment at Weill Cornell Medical College of Cornell University, except as provided for in Section 4.1.1 of these Bylaws.

b). Demonstrate acceptable levels and quality of education and have graduated from approved educational institutions.

c). Possess a valid, uncensored and unsanctioned license to practice their profession in the State of New York, unless granted a specific waiver by the Service Chief for a limited license, or for a licensure disciplinary sanction as allowed by law and as approved by the Medical Board.

d). Not be excluded as a participant in good standing in Federal Reimbursement Programs (this does not include voluntary non-participation); and,

e). Be certified by, or in compliance with the certification process of the American Board in the appropriate specialty area. In individual cases as it deems appropriate, the Medical Board, by a majority vote of those present, may waive this requirement, upon recommendation of the Service Chief, based on equivalent experience.

SECTION 4.3 RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

Subsection 4.3.1 Every member of the Medical Staff shall:

a). Provide evidence of a physical examination and recorded medical history attesting to the member's physical and mental competence in accordance with New York State Health Regulations, Section 405.3, and Hospital policy and supply any additional health-related information requested by the medical Board and/or the Hospital; provide a reassessment of health status as frequently as necessary, but no less than annually to ensure that the member is free from health impairments which could pose potential risk to patients or personnel or which may interfere with the performance of the Medical Staff member's duties and responsibilities; comply with Workforce Health and Safety Requirements;

b). Cooperate with sustained interest in the overall functions and activities of the Hospital;

c). Render high quality professional care fully consistent with prevailing standards of medical practice and conduct in the Medical Staff member's specialty, sub-specialty, or area of practice;

d). Afford patients all rights guaranteed by applicable law, statute or regulation and the Hospital Patients' Bill of Rights and those set forth in these Bylaws, the Medical Staff Credentials Manual, the Medical Staff Professionalism Manual, Rules and Regulations and to cooperate fully with patients' legally authorized representatives who may inquire as to the enforcement of these rights in a particular case;

e). Cooperate and participate in the Hospital's quality and patient safety program, peer review process, risk management program, claims and malpractice prevention programs, legal compliance program and carry out committee activities as may be assigned;

f). Abide by all applicable laws, rules and regulations of the State of New York and city and local municipalities within the State of New York, and of the Federal Government and The Joint Commission Standards; these Medical Staff Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, rules and regulations and the Hospital's Corporate Bylaws; and all Hospital and Clinical Service policies, rules and regulations as they are amended from time to time;

g). Provide for continuance care for the member's patients;

h). Not be required to give advice or participate in any induced termination of pregnancy;

- i). Carry professional liability insurance covering the member's practice and duties at the Hospital with at least the minimum limits, not less, than those set by the Board of Trustees;
- j). Participate in continuing educational activities and attend Clinical Service meetings as mandated by the respective Service Chief;
- k). Participate in Clinical Service and Medical Staff committee reviews and evaluation functions;
- l). Immediately self-report to the respective Service Chief and/or the Hospital President and Chief Executive Officer and/or their respective designees of any health or other impairment that the Medical Staff member may have that might interfere with performance of the member's duties, or might pose a potential health risk to patients or personnel;
- m). Immediately notify the respective Service Chief of any reasonable suspicion that any other healthcare practitioner may have of any health or other impairment that might interfere with performance of that healthcare practitioner's duties or might pose a potential health risk to patients or personnel;
- n). Continuously meet performance standards promulgated by their respective Service Chief;
- o). Refrain from rebating a portion of a fee, or receiving other inducements in exchange for patient referrals;
- p). Inform patients as to the identity of an operating surgeon or any other member of the Medical Staff providing treatment or service;
- q). Refrain from delegating responsibility for the diagnosis or care of patients to another member of the Medical Staff or any other person who is not qualified to undertake this responsibility;
- r). Participate in the education and supervision of and the Graduate Staff and any other Practitioners as required and in accordance with applicable laws and Hospital policies;
- s). Perform on each patient for whom the Medical Staff member as the practitioner of record, a complete history and physical examination in accordance with State and Federal law and in compliance with

The Joint Commission requirements, as well as in accordance with Hospital Rules and Regulations, and Appendix A of these Bylaws.

t). Prepare and complete in a timely manner, the medical and other required records for all patients the Medical Staff member admits, or for whom the member in any way provides care for in the Hospital, as provided in these Medical Staff Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, Rules and Regulations and other applicable legal mandates, policies, rules or regulations;

u). Immediately notify the President and Chief Executive Officer of the Hospital or designee, or the Service Chief upon the occurrence of any of the events enumerated below:

(1) any challenge to, investigation of, official action regarding a voluntary or involuntary relinquishment of the Medical Staff Member's licensure or registration or status as a provider under any governmental or other third-party payer program; (2) any complaint or report about the Medical Staff Member made to or by or any investigation of the Medical Staff Member by any federal, state or local government or professional licensing or disciplinary agency, foreign or domestic, including, but not limited to, the New York State Office of Professional Medical Conduct, Office of Health Systems Management of the New York State Department of Health, Bureau of Controlled Substances, Department of Education, Department of Mental Hygiene, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities or Commission on Quality of Care for the Mentally Disabled, State Board of Regents, the Medical Society of the State of New York, the New York State Osteopathic Medical Society, the New York Academy of Medicine, county medical societies, and any predecessor or successor of any of these agencies and any investigation relating thereto; (3) any previous or pending voluntary or involuntary termination, limitation, suspension, resignation or other discontinuation of the applicant's medical staff membership, clinical privileges or employment of any kind at any hospital or medical facility or organization or denial of any application therefor; (4) any criminal investigation, pending action, settlement or conviction under state or federal law; (5) any and all information relating to findings pertinent to violations of patients' rights as set forth in any applicable statute, regulation, or standard; and furthermore, an acknowledgment that the applicant will inform the Medical Staff Administration on a timely basis of facts germane to these areas of inquiry that arise during the application process and any term of appointment;

v). Seek appropriate consultations, when necessary, in accordance with sound medical practice in the member's specialty, sub-specialty, or area of practice;

w). Conform to accepted principles of professional and medical ethics, including but not limited to the Hospital's Code of Conduct, Respect Credo, Principles of Behavior, and the Medical Staff Professionalism Manual.

SECTION 4.4 TERMS OF APPOINTMENTS

Procedures for Terms of Appointments to the Medical Staff are set forth in the Medical Staff Credentials Manual.

SECTION 4.5 PROCEDURES FOR APPOINTMENTS

Procedures for Medical Staff Appointments are set forth in the Medical Staff Credentials Manual.

SECTION 4.6 PROCEDURES FOR REAPPOINTMENT

Procedures for Medical Staff Reappointment are set forth in the Medical Staff Credentials Manual.

SECTION 4.7 MEDICAL BOARD STEERING COMMITTEE REVIEW AND RECOMMENDATIONS FOR APPOINTMENTS AND REAPPOINTMENTS

Procedures for Medical Board Steering Committee Review and Recommendations are set forth in the Medical Staff Credentials Manual.

SECTION 4.8 BOARD OF TRUSTEES ACTIONS WITH REGARD TO APPOINTMENTS AND REAPPOINTMENTS

Procedures for Board of Trustees Actions with regard to appointments and reappointments are set forth in the Medical Staff Credentials Manual.

SECTION 4.9 CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall consist of the following categories: Attending, Emeritus, Honorary, Consulting, and Affiliate.

Subsection 4.9.1 The Attending Staff.

The Attending Staff shall consist of those physicians, podiatrists and dentists who admit patients to the Hospital or who practice a Hospital-based medical specialty, and are continually active in the patient care, education, research and preventative medicine programs of the Hospital. The Attending Staff shall consist of physicians and dentists who have appointments as Attending, Associate Attending or Assistant Attending Physicians or Dentists. The Attending staff may include those physicians whose appointments and privileges are contingent upon or otherwise subject to an agreement between the Hospital and any other facility or organization. Attending Staff members shall perform such duties as may appropriately be assigned to them by their respective Service Chiefs in the patient care, education, research and preventative medicine programs of their respective Services, whether such duties are related to provision of services directly, inclusive of all modalities of care, including telemedicine. Attending Staff members shall also be responsible for managing the medical care of all patients for whom they are the primary attending physician (attending of record). Members of the Attending Staff shall be eligible to serve on the Medical Board and its committees and subcommittees and shall attend the Medical Staff meetings of their respective Services. The Attending Staff members who have admitting privileges shall admit patients only in accordance with the admitting policies of the Hospital and such members' clinical privileges as delineated and shall comply with all applicable laws, regulations, and Hospital policies relating to patient admissions and inpatient discharge review procedures.

Subsection 4.9.2 The Emeritus Staff.

The Emeritus Staff shall consist of former members of the Attending Staff who are no longer active in the Hospital and who had been members of the Attending Staff for ten (10) or more years. Members of the Emeritus Staff shall have the right to attend meetings of their respective services but shall not have the right to vote at those meetings and shall not have admitting or clinical privileges unless granted temporary or emergency privileges pursuant to these Bylaws and the Medical Staff Credentials Manual.

Subsection 4.9.3 The Honorary Staff.

The Honorary Staff shall consist of those certain members of the Emeritus Staff who are honored with such appointments by the Board of Trustees of the Hospital for their outstanding professional contributions to and interest in the Hospital, and other members of the medical profession whom the Board of Trustees wish to honor for their outstanding contributions to their profession.

Subsection 4.9.4 The Consulting Staff.

To be eligible for appointment to the Consultant Staff, an individual must meet the requirements set forth in these Bylaws, the Medical Staff Credentials Manual and the Medical Staff Professionalism Manual. Consultant Staff members may not admit patients to the Hospital, nor may they perform procedures. They may act as consultants. Each Consulting Staff member shall be assigned to a Clinical Service and shall perform only their specific delineated clinical privileges. Consulting Staff members shall have the same rights and responsibilities under these Bylaws that are applicable to members of the Attending Staff except Consulting Members 1) are not eligible to serve as voting members of Medical Board Committees; 2) are not eligible to hold office in the Medical Staff organization; and 3) are not required to attend clinical service and annual medical staff meetings.

Subsection 4.9.5 The Affiliate Staff.

The affiliate staff shall consist of physicians who meet the qualifications set forth in these Bylaws, the Medical Staff Credentials Manual and the Medical Staff Professionalism Manual. Affiliate Staff members may not admit patients to, or perform procedures at, the Hospital. Affiliate staff members may round on the patients they treat in their private practice when such patients are admitted to the Hospital. They may view such patients' hospital medical records but shall not document in the medical records. Members of the Affiliate Staff shall not be eligible to serve on the Medical Board or its committees or subcommittees; shall not be required to attend the medical staff meetings of their service and annual medical staff meetings; and shall not be granted clinical privileges.

Subsection 4.9.6 The House Physician.

House Physician staff may be appointed to clinical services for which care is not covered by postgraduate trainees. A House Physician shall have completed at least one year of graduate medical education in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) and must possess the licensure, character, training, experience, judgment and other competencies appropriate for the House Physician's delineated clinical privileges. The attending physicians of record for those patients covered by the House Physician staff remain responsible for their patients' care and such attending physicians must provide the necessary level of supervision over House Physicians. Each House Physician must a) demonstrate acceptable levels of quality education and have graduated from approved educational institutions; b) possess a valid, uncensored and unsanctioned license to practice in the State of New York, unless granted a specific waiver by the Service Chief for a limited license or for a licensure disciplinary sanction as allowed by law and as approved by the Medical Board; and c) not be excluded as a participant in good standing from any Federal reimbursement program (this does not include voluntary non-participation). Members of the House Physician staff shall not admit patients to the Hospital nor be eligible to serve on the Medical Board or its committees or subcommittees.

SECTION 4.10 GRADUATE STAFF

- (a) The Graduate Staff shall consist of the interns, residents and fellows who are graduates of approved schools of medicine, osteopathy, dentistry or podiatry and in training in the Hospital, eligible to practice in the Hospital in accordance with the provisions of the Education Law of the State of New York and the New York State Hospital Code.
- (b) Application for appointment to the Graduate Staff shall be conducted in accordance with the Medical Staff Credentials Manual and Graduate Medical Education policies and procedures.
- (c) The corrective action and hearing and appellate review procedures which apply to Graduate Staff members are set forth in the Office of Graduate Medical Education's Policies and Procedures. Accordingly, the Hearing and Appeal Procedures set forth in the Medical Staff Professionalism Manual shall not apply to Graduate Staff members. The Graduate Staff member procedures for corrective action and hearing and appellate review shall be subject to approval by the Graduate Medical Education Committee, and the revision of such policies and procedures shall not be subject to the Amendment procedures outlined in these Bylaws.

Graduate Staff members shall have the right to submit any grievance or concern regarding any non-Graduate Staff member of the Medical Staff or any other concern through their respective Program Director, the applicable Service Chief, Senior Leadership Team, or through any procedure applicable to the Hospital staff and employees.

ARTICLE V

PROFESSIONAL ASSOCIATE STAFF INCLUDING BUT NOT LIMITED TO ADVANCED PRACTICE PROVIDERS AND LICENSED INDEPENDENT PRACTITIONERS

SECTION 5.1. QUALIFICATIONS.

Professional Associate Staff include all Practitioners other than the Organized Medical Staff, including but not limited to Advanced Practice Providers and Licensed Independent Practitioners.

SECTION 5.2. ADVANCED PRACTICE PROVIDERS

Applications for Permission to Practice as an Advanced Practice Provider shall be submitted and processed in accordance with the Medical Staff Credentials Manual.

Subsection 5.2.1. Conditions of Practice.

- (a) Professional Associate Staff including but not limited to Advanced Practice Providers may function in the Hospital within the scope of their license and only so long as (i) they comply with applicable law and regulations pertaining to supervision, relationship, or collaboration by a Physician, provided the Physician is currently appointed to the Medical Staff, and (ii) they have a current, written agreement with the Physician if required by New York State law or other applicable law or regulation. In addition, should the Appointment or Clinical Privileges of the Physician be revoked or terminated, the Advanced Practice Provider's Permission to Practice at the Hospital and Clinical Privileges shall be placed in Time Out Pending Review for failure to meet threshold eligibility requirements pursuant to the Bylaws and the Medical Staff Manuals (unless replaced by another approved Physician on the Medical Staff).
- (b) As a condition of Clinical Privileges, an Advanced Practice Provider must provide the Hospital with a copy of any written agreement that may be required by the state, as well as Notice of any revisions or modifications that are made to any such agreements between them. This

Notice must be provided to Medical Staff Administration within three (3) days of any such change.

SECTION 5.3. LICENSED INDEPENDENT PRACTITIONERS

Applications for Permission to Practice for Licensed Independent Practitioners shall be submitted and processed in the same manner as outlined in the Medical Staff Credentials Policy.

ARTICLE VI

CLINICAL SERVICES OF THE HOSPITAL

SECTION 6.1 SERVICES

Subsection 6.1.1 Established Clinical Services

To promote the care and treatment of patients, the Board of Trustees may create such Clinical Services, as it from time to time deems advisable. Clinical Services so established include, but are not limited to, the following: Anesthesiology, Cardiothoracic Surgery, Oral and Maxillofacial Surgery, Dermatology, Emergency Medicine, Medicine, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Pediatrics, Psychiatry, Physical Medicine and Rehabilitation, Radiation Oncology, Radiology, Reproductive Medicine and Infertility, and Urology. The Service Chiefs may, from time to time, establish divisions within their Clinical Services with the approval of the President and Chief Executive Officer of the Hospital or designee. Each member of the Medical Staff shall be assigned to one of the Hospital's Clinical Services. Upon the recommendations of the Service Chiefs concerned, and the Medical Board and authorized by the Board of Trustees, a member of the Medical Staff may be assigned to and granted clinical privileges in more than one Service.

SECTION 6.2 SERVICE CHIEFS

Subsection 6.2.1 Appointments.

Chiefs of Clinical Services ("Service Chiefs") shall be appointed by the Board of Trustees. On each Campus, the Academic Clinical Chairs of the Medical School and the Campus Service Chiefs of the Hospital will be the same individual. The Academic Clinical Chairs and the Service Chiefs at the NewYork-

Presbyterian/Weill Cornell Medical Center Campus will be selected and appointed by the procedures currently in place on that Campus, and the Academic Clinical Chairs and Service Chiefs on the NewYork-Presbyterian/Columbia University Irving Medical Center Campus will be selected and appointed by the procedures currently in place on that campus. The requirement of Campus-specific Service Chiefs being the same person as the Academic Clinical Chair shall only apply to those Services in which there is an Academic Clinical Chair. Each Service Chief also shall be either Board Certified in that specialty or have affirmatively established comparable competence through the Credentialing process set forth in the Medical Staff Credentials Manual. Appointment of a physician as a Service Chief shall not affect the clinical privileges that individual is otherwise authorized to exercise at the Hospital. The Hospital Board of Trustees has the right to remove or suspend a Service Chief and a Medical School's respective governing Board has the right to remove or suspend an Academic Clinical Chair, but neither should happen without close consultation and thorough review of the circumstances between the Hospital and the involved Medical School.

Subsection 6.2.2. Duties.

A Service Chief shall have the following duties:

- a). Be accountable for all the clinical and administrative activities within the Service;
- b). Be responsible for the implementation of a program to continuously evaluate, monitor and improve the performance, quality and safety of care and services provide by the Service; including but not limited to creation, review and implementation of Service policies and procedures;
- c). Give guidance to the Medical Board on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding the Service, in order to maintain safe, high-quality patient care;
- d). Provide general supervision over the professional performance of the members of the Medical Staff assigned to the Service while exercising Hospital privileges including the treatment and care of patients, so that observance of the general rules, regulations and standards of professional care of the Hospital shall be maintained;

- e). Have the authority to order any practitioner in the Service to have a mandatory administrative consult to determine fitness to provide clinical services or to seek any corrective action, in accordance with these Bylaws, and the Medical Staff Professionalism Manual;
- f). Be responsible for enforcement within the Service of the Hospital's Corporate Bylaws, these Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, Rules and Regulations, and Hospital policies;
- g). Be responsible for implementation within the Service of actions taken by the Medical Board, including but not limited to Medical Board Policies and Procedures and the dissemination of same to members of the Medical Staff, and all other credentialed Practitioners covered by these Bylaws, the Medical Staff Professionalism Manual and the Medical Staff Credentials Manual;
- h). Make recommendations to the Medical Board concerning Medical Staff appointments, reappointments, staff qualifications and delineations of clinical privileges for the Service, and the criteria for same;
- i). Make recommendations to the Medical Board regarding appointments, reappointments, staff qualifications and delineation of clinical privileges for the Service and the criteria for same;
- j). Establish service level committees as may be necessary to review, evaluate and monitor the quality and appropriateness of patient care in the Service, all of which shall be in accordance with Rules and Regulations and Hospital policies and procedures for quality and patient safety and legal compliance. Such monitoring and evaluation must at least include:
- The identification and collection of information about important aspects of patient care provide in the clinical Service;
 - The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care;
 - 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.

- k). Be accountable for the administration of the Service through cooperation with the Senior Leadership Team of the Hospital including budgetary planning and space considerations, pertaining to the Service;
- l). Promulgate performance standards, approve and facilitate in-service training and continuing education for all Practitioners on their service;
- m). Integrate the Service into the primary functions of the Hospital and coordinate interdisciplinary activities;
- n). Be responsible for tracking the quality and patient safety performance improvement program reviews of members of the Service and determining what actions, if any, must be taken based on the reviews;
- o). Be responsible for the actions of the Service's Division Chiefs and, where applicable, Site Chiefs;
- p). Maintain all legal and regulatory requirements regarding work hour limitations, the delineation of privileges and adequate supervision of Graduate Staff are met within the Service;
- q). Coordinate and integrate interdepartmental and intradepartmental services.

SECTION 6.3 SITE CHIEFS

To the extent there is a Site Chief of a Hospital clinical department for a hospital Site, the following shall apply:

- a) The President and Chief Executive Officer of the Hospital, the Dean of Weill Cornell Medical College or Dean of Columbia University Vagelos College of Physicians and Surgeons, as applicable, and the responsible Service Chief shall agree on the individual selected to serve as a Site Chief.
- b) A Site Chief shall have a faculty appointment at either Weill Cornell Medical College or Columbia University Vagelos College of Physicians and Surgeons.
- c) A Site Chief shall be board certified in an appropriate specialty/subspecialty or have equivalent competency/experience as determined by the responsible Service Chief.

- d) A Site Chief shall report to the responsible Service Chief and will assist the Service Chief in carrying out the Service Chief's duties for the Site.
- e) A Site Chief shall work with the Chief Medical Officer or designee responsible for the Site with regard to Site-based operations issues such as quality, patient safety, performance improvement, and medical affairs.
- f) Appointment of a physician as a Site Chief shall not affect the clinical privileges that individual is otherwise authorized by the Hospital to exercise.
- g) The removal or suspension of a Site Chief will be effective only after consultation and close coordination between the Hospital and the involved medical school.

SECTION 6.4 CREDENTIALS FILES

Subsection 6.4.1 Responsibility

The Clinical Service Chief shall be responsible for ensuring that a credentials file is maintained in a confidential manner for every practitioner granted privileges by the Department. The practitioner's credentials file shall be separate and distinct from the employment and University faculty file and shall be maintained in a confidential manner in accordance with these Bylaws and the Medical Staff Credentials Manual.

The Clinical Service Chief shall maintain in a confidential manner materials relating to the following for each practitioner in the Department:

- (a). Quality assurance and performance reviews, if any;
- (b). Peer review matters, and disciplinary/corrective actions, if any;
- (c). Verification of identity by review of a valid picture identification issued by a State or Federal agency (for example: a driver's license or a Passport);
- (d). Completed Practitioner Profiles which shall be compiled from at least the following data sources, if applicable:
 - Morbidity and Mortality review
 - Tissue review

- Blood utilization review
- Infection control review
- Incident report review
- Utilization review
- Patient complaints
- Ethical issues
- Corrective actions/ disciplinary actions
- Liability claims data
- PRO quality review data
- Prescription review
- Safety committee review
- Surgical case review
- Medical case review
- Any medical care evaluations performed
- Continuing education programs and training
- Peer reviews
- Significant events

Subsection 6.4.2 Requests for Access.

All requests for access to credentials files maintained in accordance with these Bylaws and the Medical Staff Credentials Manual shall be presented to the Service Chief or designee who shall keep a record of requests made and granted. Unless otherwise stated, an individual permitted access under this section shall be afforded a reasonable opportunity to inspect the records, and to make notes regarding the requested files in the presence of the Service Chief or designee. In no case shall an individual be permitted to remove or make copies of any file without consulting Hospital Counsel.

Subsection 6.4.3 Access by Individuals Performing Official Functions

- (a). The Service Chief or designee may have access to all files as needed to fulfill their responsibilities in accordance with these Bylaws and State law and regulations.

- (b). The Senior Leadership Team of the Hospital and Hospital Counsel may have access to these files on an as needed basis, to enable them to perform their functions.
- (c). Representatives of regulatory or accreditation agencies may have access to files to the extent legally authorized. Hospital Counsel should be consulted prior to granting access.
- (d). An individual practitioner may review their credentials file in the presence of the Service Chief or designee, except the confidential letters of reference received during the initial appointment or any subsequent reappointment which may not be reviewed by the practitioner. The practitioner may not remove or photocopy any items from the credentials file but may add an explanatory note or other document to the file. The Service Chief may provide a copy of requested documents to practitioner upon approval by Hospital Counsel.
- (e). All subpoenas pertaining to credential files shall be referred to Hospital Counsel regarding appropriate response.
- (f). The Service Chief shall provide records that are requested by persons or organizations outside of this Hospital only upon approval by Hospital Counsel.

SECTION 6.5 SERVICE MEETINGS

Subsection 6.5.1 Frequency and Scope

Each Clinical Service shall hold meetings no fewer than six (6) times per year, as well as any such conferences, quality assurance and performance improvement program conferences, and other meetings as may be necessary to maintain an adequate review of the medical practice and medical records of the Service. The Service Chief of each Clinical Service which is subdivided into permanent recognized divisions is authorized to permit such divisions to meet separately, provided they hold not less than the same number of meetings for the same purpose as their Services. Minutes of the meetings of the Services and divisions shall include the following: persons in attendance; date and duration; identification of topics discussed including recommendations and actions pertaining to the Service; recommendations made; and actions taken. Each member of the Attending Staff should attend each regularly scheduled meeting of the Service or division, and

shall be required to attend not less than fifty percent (50%) of such meetings unless excused by the Service Chief for good cause. Each Service shall keep accurate attendance figures.

Subsection 6.5.2 Confidentiality of Service Meetings.

The meetings required herein shall be privileged and confidential in accordance with the New York State Public Health Law §2805-m.

ARTICLE VII
PRACTITIONER HEALTH

In accordance with legal mandates, the Hospital is required to ensure that all personnel will not assume duties unless free from health impairment which is of potential risk to the patient or other personnel, or which might interfere with the performance of duties. Personnel includes all employees, students, volunteers and members of the medical and other staff credentialed under these Bylaws and the Medical Staff Manuals. Health impairment may be due to one or more of the following: physical illness, mental illness or psychological disorder, injury, or substance abuse. Matters involving practitioner health issues and occurrences shall be handled in accordance with the Medical Staff Professionalism Manual and the Medical Staff Credentials Manual and other applicable policies and procedures. Practitioners have an ongoing obligation to cooperate with Workforce Health and Safety.

ARTICLE VIII
MEDICAL BOARD AND COMMITTEES

SECTION 8.1 THE MEDICAL BOARD AND ITS OFFICERS

Subsection 8.1.1 Composition.

The Medical Board shall consist of twenty-two (22) members. Each Campus shall be represented by ten (10) members of its Executive Committee and one (1) additional physician member of the Attending Medical Staff for a total of eleven (11) representatives serving on the Medical Board. Of the ten (10) members from each Campus Executive Committee, one shall be the immediate past President of the Medical Board. The remaining voting members of the Medical Board shall consist of: (i) The President of each Campus

Executive Committee, the Vice President of each Campus Executive Committee, (ii) the Chief of Medicine and the Chief of Surgery at each Campus; (iii) a representative physician or dentist chosen by each Campus' practitioner society or like entity (iv) a representative physician or dentist member on the active Attending Medical Staff selected by each Campus Executive Committee from its members and (v) a sufficient number elected from the remaining Service Chiefs to reach the final total representation from each campus of eleven (11).

In addition, the Hospital President and Chief Executive Officer, the Executive Vice President and Chief Operating Officer of the Hospital, and the Chief Medical Officer or their designees shall be on the Medical Board with a vote. The Deans of the Medical Schools, the Chief Operating Officers, the Chief Nursing Officer, Secretary of the Medical Board and Hospital Counsel shall attend ex-officio with vote if an active Member of the Medical Staff. Any member of the Medical Board may be represented at any meeting by an alternate designee. The alternate shall have the same voting rights as does the member being represented.

Subsection 8.1.2 Duties.

The Medical Board is empowered to act on behalf of the Medical Staff between meetings of the Medical Staff. In addition to such other duties as may be prescribed elsewhere in these Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, Rules and Regulations, it shall be the duty of the Medical Board to govern the Medical Staff, and to advise the Board of Trustees and the Hospital President and Chief Executive Officer or designee in matters relating to the welfare of the Hospital and the Medical Staff. The Medical Board shall make recommendations directly to the Board of Trustees for its approval, such recommendations pertaining to: the structure of the Medical Staff; planning for Clinical Services; the mechanism used to review credentials and to delineate clinical privileges for each eligible individual; the participation of the Medical Staff in organizational performance-improvement activities; the mechanism by which Medical Staff membership and clinical privileges may be terminated or limited, the mechanism for fair-hearing procedures; requirements for the medical care and treatment of patients in the Hospital, and programs of education, research and preventive medicine conducted at the Hospital; and the reports of the Campus Executive Committees, standing Committees, and Subcommittees of the Medical Board and such special Committees as may be appointed by the President of the Medical Board. The Medical Board shall also implement and report on the activities for monitoring

Subsection 8.1.3 Terms.

The President of the Medical Board holds a one-year term which shall occur in the second year of the two-year elected term as President of the Campus Executive Committee. The Vice President of the Medical Board holds a one-year term which shall occur in the first year of the two-year elected term as President of the Campus Executive Committee. When the President of the Medical Board is the President of one Campus Executive Committee, the Vice President of the Medical Board shall be the President of the other Campus Executive Committee. In an emergency when there is not sufficient time to call a meeting of the full Medical Board, the Presidents and Vice Presidents of each Campus Executive Committee shall exercise all the power of the Medical Board.

Each Member of the Medical Board as set forth in Subsection 8.1.1 (iii), (iv), and (v) shall be elected for a two year term. The Chiefs of Medicine and Surgery at each Campus shall be permanent Members of the Medical Board.

Subsection 8.1.4 Duties of the President of the Medical Board.

In addition to such others as may be specified in these Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual and Rules and Regulations, the duties of the President of the Medical Board shall be to:

- a). Act in coordination and cooperation with the Hospital President and Chief Executive Officer, the Executive Vice President and Chief Operating Officer of the Hospital, the Chief Medical Officer.

- b). Call and preside at meetings of the Medical Board;

- c). Represent the views, needs and issues of the Medical Board and the Medical Staff to the Board of Trustees and to the President and Chief Executive Officer of the Hospital or designee;

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

- e). Appoint the chairs and members (or delegate the appointment of members to the chairs) of all Standing Committees, Subcommittees and Ad-Hoc Committees of the Medical Board, and,

- f). As voting members of the Board of Trustees, the President and/or Vice President of the Medical Board shall submit to the Board of Trustees regular reports concerning the professional activities of the Medical Staff of the Hospital. The reports shall set forth the procedure for granting clinical privileges and the delineation of clinical privileges in connection with appointments and reappointments to the Medical Staff.

Subsection 8.1.5 Duties of the Vice President and the Role of Secretary.

The Vice President of the Medical Board shall assume the duties and responsibilities of the President of the Medical Board in the President's absence. In the event the Vice President also is unavailable, the Vice President of the Campus Executive Committee on which the President of the Medical Board sits shall assume such duties and responsibilities. If the President cannot fulfill the term of office, the Vice President will serve as President for the duration of that term. The Vice President shall also carry out specific tasks as assigned by the President of the Medical Board.

The Secretary shall cause to be kept accurate and complete minutes of all Medical Board meetings, and records of all appointments to the Medical Staff; call Medical Board meetings; attend to correspondence; and perform such other duties as ordinarily pertain to the office or as otherwise directed by the President or Vice President of the Medical Board.

Subsection 8.1.6 Resignations and Removal of Officers and Members.

Any officer or member of the Medical Board may resign at any time by giving written notice to the President of the Medical Board. Unless otherwise specified in the notice, the resignation shall take effect upon delivery. An officer or member of the Medical Board shall be removed upon a majority vote of the members of the Medical Board present at the meeting at which removal is discussed. The officer of the Medical Board who is not the subject of the request shall conduct the review and preside over the meeting.

SECTION 8.2 THE WEILL CORNELL CAMPUS AND THE COLUMBIA UNIVERSITY CAMPUS EXECUTIVE COMMITTEES OF THE MEDICAL BOARD.

Subsection 8.2.1 Composition.

Each Campus Executive Committee shall consist of the following standing members with vote: (i) Service Chief of each clinical department; (ii) President of the faculty practice organization; (iii) President of the Campus' practitioner society or like entity (iv) a representative physician or dentist member on the active Attending Medical Staff of the Campus who shall be elected at large for a two (2) year term, renewable two times for a total of six (6) years; (v) the President and Chief Executive Officer of the Hospital or designee; (vi) the Chief Medical Officer of the Hospital; (vii) the Chief Medical Officer for Medical and Professional Affairs; (viii) and such other member as the Medical Board may from time to time appoint.

In addition, the Dean of the Medical School; the Associate Dean for Clinical Affairs; the Dean of the Nursing School; the Chief Operating Officers of the Hospital, the Chief Nursing Officer(s); Hospital Counsel; the Secretary of the Medical Board, and one representative from the House Staff who shall be peer selected and recommended by the Graduate Medical Education Committee, shall attend ex-officio with vote. Quorum: A majority of the total number of standing members shall constitute a quorum whenever any action is to be taken by vote of the Executive Committee.

Any member of the Executive Committee may be represented at a meeting by an alternate designee who shall have the same voting rights as does the member being represented.

Subsection 8.2.2 Duties.

In addition to such other duties as may be prescribed by the Medical Board or elsewhere in these Bylaws, the Medical Staff Credentials Manual and the Medical Staff Professionalism Manual, Rules and Regulations, it shall be the duty of the Executive Committees to govern the Medical Staff, and to advise the Medical Board in matters relating to the welfare of the Hospital and the Medical Staff. The Executive Committees also shall make recommendations to the Medical Board for its approval, regarding all other matters generally considered as pertaining to the Medical Staff identifying opportunities to improve care. The actions of the Executive Committees are subject to review and approval or disapproval by the Medical Board.

Subsection 8.2.3 _____ Terms.

The term of each non-elected member of the Executive Committees shall be indefinite and held because of title, not individual.

Subsection 8.2.4 _____ Officers.

Each Campus Executive Committee shall have a President and a President elect or Vice President and the Secretary of the Medical Board who shall also serve as Secretary for each Executive Committee.

The President and Vice President of each Campus Executive Committee shall hold a two (2) year term. Each July 1st, the President elect or Vice President of a campus shall be elected from that Executive Committee on an alternating basis, with the New York Weill Cornell Campus election in odd-numbered years and the Columbia Presbyterian Campus election in even-numbered years. The election will be held based on recommendations from the Campus Nominating Committee, which shall be comprised of the past President, current President and President elect of the Campus Executive Committee. The President elect or Vice President shall become President after completion of two-year term as President elect or Vice President.

In the first year of the President's term he or she shall be the Vice President of the Medical Board for one year. In the second year, he/she shall also be the President of the Medical Board for a one-year term. When the President of the Medical Board is the President of one Campus Executive Committee, the Vice President of the Medical Board shall be the President of the other Campus Executive Committee.

In an emergency when there is not sufficient time to call a meeting of the full Medical Board, the Presidents and Vice Presidents of each Campus Executive Committee shall exercise all the power of the Medical Board.

Subsection 8.2.5 Duties of the President.

In addition to such others as may be specified in these Bylaws, the Medical Staff Credentials Manual and the Medical Staff Professionalism Manual, Rules and Regulations, the duties of the President shall be to:

- a). Call and preside at meetings of the Executive Committee;
- b). Represent the views, needs and issues of the Executive Committee and the Medical Staff to the Medical Board;
- c). Report on the policies of the Medical Board and the Medical Staff, and report to the Medical Board on the performance of, and maintenance of quality with respect to, the Medical Staff's delegated responsibility to provide quality medical and dental care;
- d). As voting members of the Medical Board, the President /or Vice President of each campus shall submit to the Medical Board regular reports concerning the professional activities of the Medical Staff of the Hospital. The reports shall set forth the procedure for granting clinical privileges and the delineation of clinical privileges in connection with appointments and reappointments to the Medical Staff.

Subsection 8.2.6 Duties of the Vice President.

The Vice President shall assume the duties and responsibilities of the President in the President's absence. In the event the Vice President also is unavailable to hold a Committee meeting, the President shall designate a substitute President from among the voting members of the Committee who shall assume such duties and responsibilities for that Committee meeting. If the President cannot fulfill the term of office, the Vice President will serve as President for the duration of that term. The Vice President shall also carry out specific tasks as assigned by the President.

Subsection 8.2.7 Duties of the Secretary.

The Secretary shall cause to be kept accurate and complete minutes of all Executive Committee meetings, and records of all appointments to the Medical Staff; call meetings; attend to correspondence; and perform such other duties as ordinarily pertain to the office or as otherwise directed by the President or Vice President of the Executive Committee.

Subsection 8.2.8 Resignations and Removal of Officers.

Any officer may resign at any time by giving written notice to the President of the Executive Committee. Unless otherwise specified in the notice, the resignation shall take effect upon delivery. An officer of the Executive Committee shall be removed upon a majority vote of the members of the Committee present at the meeting in which removal is discussed. The officer of the Executive Committee who is not the subject of the request shall conduct the review and preside over the meeting.

SECTION 8.3 STANDING COMMITTEES OF THE MEDICAL BOARD

Subsection 8.3.1 Charge of Standing Committees.

The Standing Committees are charged with developing and recommending for Medical Board approval the policies and procedures governing the functions or practices for which the Committee is responsible. The Standing Committees shall delegate responsibility for implementing the policies and procedures to their Subcommittees. The Standing Committees shall act in an advisory and oversight capacity to their Subcommittees.

The Subcommittees are responsible for implementing and monitoring approved policies and procedures. Each of the Subcommittees shall report to its respective Standing Committee of the Medical Board.

The President of the Medical Board shall appoint the Chairs of the Standing Committees and the members thereof. However, except for the Campus Executive Committees, the President of the Medical Board may, at with discretion, delegate responsibility for appointment of committee members to the Committee Chairs. The Chair of each Standing Committee shall appoint the Chair and members of its Subcommittee(s).

The Standing Committees of the Medical Board are:

The Weill Cornell Campus and Columbia Campus Executive Committees
The Blood Bank/Transfusion Committee
The Credentials Committee
The Emergency Services Committee
The Ethics Committee
The Medication Management Committee
The Enterprise Formulary and Therapeutics Committee
The Graduate Medical Education Committee
The Human Rights and Research Committee
The Health Information Management Committee
The Infection Control Committee
The Medical Board Steering Committee
Quality & Patient Safety Committees
The Medical Leadership Planning Committee for Clinical Programs and Services
The Committee on Practitioner Health
The Medical Supplies and Equipment Standardization Committee
Professional Practice Evaluation Committee
Radiation Safety Committee

Unless otherwise stated, a motion shall be adopted by a majority vote of the voting members present at a Standing Committee or Subcommittee at the time of the vote.

Subsection 8.3.2 The Individual Standing Committees.

(a). The Weill Cornell Campus and Columbia University Campus Executive Committees of the Medical Board

It shall be the responsibility of the Campus Executive Committees to coordinate the existing activities and general policies of the Campus's Clinical Services; supervise implementation of policies and procedures adopted by the Medical Board; keep the Medical Board apprised concerning all matters pertaining to the health and well-being of patients and to make suggestions and recommendations to

improve such professional care and to enhance the services of the Hospital; oversee and ensure implementation and monitoring at each Campus level the responsibility of the Medical Staff under the Quality Assurance and Performance Improvement Program; and review reports submitted to them by the subcommittees of the Medical Board Standing Committees.

(b). The Blood Bank/Transfusion Committee

It shall be the responsibility of the Blood Bank/Transfusion Committee to monitor and regulate the activities of the Blood Bank in order to provide optimal and safe use of blood and blood products; establish standards for transfusion practices, including distribution, handling and administration to ensure appropriate use of blood and blood products; and review and evaluate quality control and transfusion appropriateness.

c). Credentials Committee

It shall be the responsibility of the Credentials Committees to receive applications and to review any such application meeting any of the following criteria: 1) all submitted applications for initial appointment to the medical staff; 2) reappointment applications where there is either a) a current or previously successful challenge to the applicant's licensure or registration; or b) an involuntary termination of medical staff membership at another institution; or c) an involuntary limitation, reduction, denial or loss of clinical privileges; or d) a focused peer review based on a quality of care concern; and 3) any application where a quality of care concern has been raised. Based on such reviews, the Credentials Committee shall make recommendations as to reappointment and delineated clinical privileges to the Steering Committee. If the recommendation to the Steering Committee differs from the Service Chief's recommendation, then the Credentials Committee shall inform the Steering Committee and the Service Chief and the reasons therefor.

(d). The Emergency Services Committee

It shall be the responsibility of the Emergency Services Committee to develop systems for delivery and coordination of patient care in Emergency Services and develop the policies and procedures to operationalize these systems; define the organizational structure of Professional Staff for the

Emergency Services; participate in planning for the Emergency Services; and develop, implement and monitor performance improvement and quality of care mechanisms.

(e). The Medication Management Committee

The Medication Management Committee shall consist of representatives of the Hospital's Clinical Services, the Directors of Pharmacy, and members of the nursing and pharmacy staffs. It shall provide oversight for medication management at NYPH and have the responsibility to develop policies, procedures, and guidelines which promote the safe and effective prescribing, distribution, administration, and monitoring of drugs to review quality assurance data and quality improvement processes to facilitate optimal prescribing, distribution, administration, and monitoring of drugs; to define, review, and where possible, recommend changes designed to prevent medication errors and significant adverse drug reactions; to make recommendations concerning the use and control of investigational drugs and research in the use of recognized drugs; to provide information to professional staff with respect to new drugs and preparations and significant findings concerning recognized drugs and preparations, including, but not limited to drug therapies, indications for use, dosages, routes of administration, drug interactions, side effects, cautions, and drug shortages; to provide information regarding and a means to comply with laws affecting the storage, use, and dispensing of drug.

(f). The Enterprise Formulary and Therapeutics Committee

The Enterprise Formulary and Therapeutics Committee shall consist of representatives of medical leadership, pharmacy leadership, and nursing leadership from NYP/WC, NYP/CUIMC, and a representative appointed by each regional hospital. This Committee shall be co-chaired by members from the Medical Staff of the Weill Cornell Campus and of the Columbia University Campus. The Subcommittees reporting to the Enterprise Formulary and Therapeutics Committee shall consist of representatives from the Hospital and Regional Hospitals' medical staff, nursing staff, pharmacy staff, and members from other relevant departments, as applicable.

It shall be the responsibility of the Enterprise Formulary and Therapeutics Committee and its Subcommittees to maintain a current Enterprise Formulary of accepted drugs for use at NewYork-Presbyterian Hospital which meets patients' needs and provides quality pharmaceuticals at reasonable costs; to evaluate clinical data regarding drugs; to develop policies, procedures, and guidelines which promote the safe and effective

prescribing, distribution, administration, and monitoring of drugs to review quality assurance data and quality improvement processes to facilitate optimal prescribing, distribution, administration, and monitoring of drugs; to define, review, and where possible, recommend changes to prevent medication errors and significant adverse drug reactions; to make recommendations concerning the use and control of investigational drugs and research in the use of recognized drugs; to provide information to professional staff with respect to new drugs and preparations and significant findings concerning recognized drugs and preparations, including, but not limited to drug therapies, indications for use, dosages, routes of administration, drug interactions, side effects, cautions, and drug shortages; to provide information regarding and a means to comply with laws affecting the storage, use, and dispensing of drugs. This Committee may, as it sees fit, create a Subcommittee with a focus on Sedation and Analgesia, or any other relevant Subcommittees.

(g). The Ethics Committee

It shall be the responsibility of the Ethics Committee to assist the Medical Board in the development, review and refinement of policies relating to ethical responsibilities and hospital legal responsibilities concerning bio-ethical issues, so as to maintain high ethical standards of patient care and clinical practice; and to enhance and oversee ethics case consultation and education among the medical and health care staff concerning bio-ethical issues.

(h). The Graduate Medical Education Committee

The responsibility of the Graduate Medical Education Committee shall be to act in an advisory capacity to the Administration and the Medical Board on all aspects of graduate medical education; oversee all residency programs sponsored by the Hospital; establish and implement institutional policies for Graduate Staff selection, evaluation, promotion, dismissal and medical education; establish and maintain appropriate liaison with residency program directors and with the administration of other institutions participating in programs sponsored by the Hospital; review all residency programs in relation to their compliance with the institutional policies and requirements of the ACGME Residency Review Committees, and all other applicable federal, State and local statutes, rules and regulations; accrediting agencies; ensure appropriate and equitable funding for resident positions, including benefits and support Services; establish and implement institutional policies and procedures for the discipline and the adjudication of complaints and grievances relevant to the graduate medical education programs; and ensure regular review of ethical, socioeconomic, medical/legal and cost containment issues that affect graduate medical education.

(i). The Human Rights and Research Committee

It shall be the responsibility of the Human Rights and Research Committee to review, approve and conduct continuing review of all biomedical research pertaining to human subjects in accordance with the Institutional Review Boards for each Campus and applicable law. Such review ensures that: risks to subjects are minimized, risks to subjects are reasonable in relation to anticipated benefits, selection of subjects is equitable, informed consent is obtained from each subject or legally authorized representative; and privacy of subjects is protected, and confidentiality of data maintained.

(j). The Health Information Management Committee

It shall be the responsibility of the Medical Information Management Committee to provide advice and support to the Hospital, including the Medical Records Department, in determining information-management processes which provide for the collection and use of patient-specific data and information to: facilitate patient care; serve as financial and legal records; aid in clinical research; support decision analysis; guide professional and organizational performance improvement and facilitate the medical records review process, especially with respect to the completeness, timeliness and clinical pertinence of the medical record entries so as to ensure that the medical records contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health providers.

(k). The Infection Control Committee

It shall be the responsibility of the Infection Control Committee to assist in the development of a Hospital-wide infection control program and maintain surveillance of the program; assist in the development and implementation of a preventive and corrective action program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques; review practices concerning use of equipment, sterilization and procedures as they impact on infection control, and assess the effectiveness of the Hospital's Infection Control Program, with particular attention to the system of reporting infections among patients and personnel.

(l). The Medical Board Steering Committee

The Steering Committee shall be comprised of the President and Vice President of each Campus Executive Committee, the Past President of the Medical Board, the Chief Medical Officer, the Chief Medical Officer of Medical and Professional Affairs, and legal counsel for the Medical Board.

The Medical Board authorizes its Steering Committee to review and consider applicants for appointment or reappointment to the Medical, Graduate staff and other Practitioners credentialed in accordance with these Bylaws and the Medical Staff Credentials Manual, and by a majority vote of those present, make a recommendation to the Medical Board as to the appointment or reappointment of each applicant.

In addition, the Medical Board authorizes its Steering Committee to review and consider proposed amendments to these Bylaws, the Medical Staff Manuals and Rules and Regulations as well as policies and procedures and administrative matters and by a majority vote of those present, take action or make a recommendation to the Medical Board.

Whenever the Medical Board Steering Committee takes action on a matter, it shall report such action to the Medical Board at its next regular or special meeting. The Medical Board may ratify, modify, or rescind the action taken by the Steering Committee; or it may defer taking action and/or remand the matter to the Steering Committee or other committee for further review.

The Steering Committee may refer any matter before it for vote to the Medical Board for consideration and recommendation. The Steering Committee shall also be responsible for: 1) developing the Agenda for the regular and special Medical Board meetings; 2) reviewing the reports, minutes, and presentations from the Campus Executive Committees; and 3) at the Medical Board's request, reviewing communications addressed to the Medical Board from all other sources and to highlight and prioritize issues for Medical Board attention.

(m). Quality and Patient Safety Committees

It shall be the responsibility of the Quality and Patient Safety Committees to direct the quality assurance/performance improvement activities of the Clinical Services; recommend pertinent clinical indicators to be used at both campuses; review findings of indicator monitoring on a monthly basis;

follow up with individual Services on any trends noted and forward issues to the Campus Executive Committees of the Medical Board; review in detail the reports of untoward events and significant New York State Department of Health (NYSDOH) cases at each monthly meeting of the Committee; present monthly trending of NYSDOH cases; forward reports to both Campus Executive Committees of the Medical Board for their review; review annual improvement summaries from each of the Clinical Services, as well as Nursing; and review reports of appropriate performance improvement teams upon their completion.

(n). The Medical Leadership Planning Committee for Clinical Programs and Services

It shall be the responsibility of the Medical Leadership Planning Committee for Clinical Programs and Services to provide a clinical forum for collaborating with Hospital leadership in planning the Hospital's Clinical Services and health care programs; assess, develop and recommend clinical and patient care services and programs based on the Hospital's mission and goals, as well as identified patient and community needs, consistent with available resources; serve as a resource to the Hospital Leadership, the Medical Board, the Board of Trustees and other Hospital leadership in evaluating the impact of contemplated new services on system-wide patient care, as well as system-wide clinical and ancillary departments; and provide clinical expertise and assistance in developing the Hospital's Strategic Plan.

(o). The Committee on Practitioner Health

The Committee on Practitioner Health ("CPH") shall be chaired by the Hospital's Chief Medical Officer or designee, and shall consist of the Psychiatrist-in-Chief as applicable at relevant Campus or designee, and an ad-hoc physician member appointed by the Chief-of-Service of the practitioner involved subject to confirmation by the Medical Board President or designee approval. The Chief Medical Officer may make other ad hoc appointments to the CPH when it is deemed necessary to appropriately consider a particular case.

Upon receipt of the report from the Service Chief, the CPH shall review it, make such additional inquiries as may be deemed necessary, including an audit of the practitioner's performance and practices, if appropriate, and may interview the practitioner concerning these issues. If upon completion of its inquiry, the CPH reaches a finding by majority vote that there is reasonable cause to

believe that the practitioner is impaired, it shall forward the report, the results of its inquiry and its findings and recommendations to the respective Service Chief and to the President of the Medical Board. The CPH may also work collaboratively with the Event Management Team pursuant to the procedures set forth in the Medical Staff Professionalism Manual and in these Bylaws as needed.

(p). The Medical Supplies and Equipment Standardization Committee

It shall be the responsibility of the Standardization Committee to study, review and make recommendations regarding the standardization of supplies and equipment throughout the Hospital; establish appropriate standards for equipment and supplies; recommend procedures and equipment which will provide the greatest possible economy of operation consistent with high standards of performance and patient care; and in collaboration with the Clinical Technology Committee, recommend acquisition of new clinical equipment.

(q). The Professional Practice Evaluation Committee

The Professional Practice Evaluation Committee shall be comprised of the President and Vice President of each Campus Executive Committee, the Chief Medical Officer and/or Chief Medical Officer of Medical and Professional Affairs. The Medical Board authorizes the Professional Practice Evaluation Committee to review findings related to practitioner performance that result from Professional Practice Evaluations and make recommendations to the Medical Board for corrective action as indicated.

(r). The Radiation Safety Committee

The Radiation Safety Committee of the Hospital is authorized to evaluate proposals for, and maintain surveillance over, all uses of radioactive material within the institution, as well as to evaluate and oversee any administration of radioactive materials, regardless of whether the administration is for research or clinical treatments. The Committee also oversees all aspects of usage of such radiation producing devices with attention to potential exposure of patients, visitors, employees, and medical staff.

SECTION 8.4 MEDICAL BOARD AND COMMITTEE MEETINGS

Subsection 8.4.1. Medical Board Meetings.

The Medical Board shall meet monthly a minimum of ten (10) times per year, and shall submit a report on each such meeting to the Secretary of the Board of Trustees. The site of each such meeting will alternate between the two Campuses on a monthly basis. Alternatively, the meeting may be teleconferenced. If such meetings are teleconferenced, at least one meeting annually must be in person. Any action taken by the Medical Board shall require a majority vote of those present. A majority of the voting members of the Medical Board present at a meeting shall constitute a quorum.

Subsection 8.4.2 Standing Committee Meetings.

Each Standing Committee and Subcommittee of the Medical Board shall hold not fewer than four (4) meetings each year. Minutes of each meeting shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed; recommendations made; and actions taken. Copies of such minutes shall be forwarded to, and maintained by, the Medical Staff Office. Standing Committees shall present their recommendations to create, revise, or discontinue policies and procedures to the Campus Executive Committees.

SECTION 8.5 AD-HOC COMMITTEES

Unless otherwise expressly provided elsewhere in these Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, Rules and Regulations, an Ad-Hoc Committee may be appointed by the President of the Medical Board in such number and of such composition as the Medical Board may deem necessary or desirable to properly carry out the duties of the Medical Board and the Medical Staff. Such committees shall confine their activities to the purposes for which they were appointed, should report to and make recommendation to the Medical Board.

SECTION 8.6 DUTY OF COOPERATION

As set forth in these Bylaws, the Medical Staff Credentials Manual and in the Medical Staff Professionalism Manual, it shall be the duty of each practitioner to cooperate fully with quality assurance and peer review proceedings. Failure or refusal of a practitioner to do so shall be cause for suspension, summary

or otherwise, termination or limitation of all or part of their clinical privileges and /or appointment. Furthermore, by accepting membership each practitioner thereby agrees to take no action against the Hospital or any representatives of the Hospital or against any person supplying information or evidence thereto, for acts performed or statements made in good faith and without malice in connection with any proceedings provided for in these Medical Staff Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, and Rules and Regulations.

ARTICLE IX

BASIC STEPS AND DETAILS ASSOCIATED WITH CREDENTIALING AND PROFESSIONALISM

The details associated with the following Basic Steps are contained in the Medical Staff Credentials Manual and/or the Medical Staff Professionalism Manual in a more expansive form.

SECTION 9.1 QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for Appointment or Reappointment or for the grant of Clinical Privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested as set forth in the Medical Staff Credentials Manual.

SECTION 9.2 PROCESS FOR PRIVILEGING

Requests for Clinical Privileges are provided to the applicable Service Chief, who reviews the individual's education, training, and experience and prepares a form provided by Medical Staff Administration stating whether the individual meets all qualifications. The Credentials Committee then reviews the Service Chief's assessment, the application, and all supporting materials and makes a recommendation to the Medical Board. The Medical Board may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Board to grant Clinical Privileges is favorable, it is forwarded to the Board of Trustees for final action. If the recommendation of the Medical Board is unfavorable, the individual is notified by the President and Chief Executive Officer of the Hospital or designee of the right to request a hearing.

SECTION 9.3 PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable Service Chief, who reviews the individual's education, training, and experience and prepares a form provided by Medical Staff Administration stating whether the individual meets all qualifications. The Credentials Committee then reviews the Service Chief's assessment, the application, and all supporting materials and makes a recommendation to the Medical Board. The Medical Board may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Board to grant Appointment or Reappointment is favorable, it is forwarded to the Board of Trustees for final action. If the recommendation of the Medical Board is unfavorable, the individual is notified by the President and Chief Executive Officer of the Hospital or designee of the right to request a hearing.

SECTION 9.4. DISASTER PRIVILEGING

When the disaster plan has been implemented, a modified credentialing process may be utilized to grant Disaster Privileges after verification of the volunteer's identity and licensure in accordance with the Medical Staff Credentials Manual.

SECTION 9.5 INDICATIONS AND PROCESS FOR ADMINISTRATIVE TIME OUT AND TIME OUT PENDING REVIEW

Subsection 9.5.1 Administrative Time Out.

- (1) Appointment and Clinical Privileges may be placed in Administrative Time Out ("ATO") if an individual:
 - (a) fails to fulfill administrative duties, including but not limited to the following:
 - (i) completing mandatory training, educational, and orientation requirements;
 - (ii) attending a special meeting with the Service Chief, the Medical Board President, the CMO, and/or with a standing or ad hoc committee of the Medical Staff or Medical Board when requested;
 - (iii) obtaining any immunizations, vaccinations, and/or screening tests required by Hospital policy.

- (2) An Administrative Time Out shall take effect immediately upon Special Notice and shall continue until the matter is resolved pursuant to the Medical Staff Professionalism Manual and the Practitioner is reinstated, if applicable.

Subsection 9.5.2 Time Out Pending Review.

- (1) Appointment and Clinical Privileges may be placed in Time Out Pending Review (“TOPR”) if an individual:
 - (a). fails to satisfy any of the threshold eligibility criteria as set forth in the Medical Staff Credentials Manual (except for board certification requirements which shall be assessed at the time of Reappointment), including but not limited to the following occurrences:
 - (i) Licensure and Registration: Expiration, or a Practitioner’s license being placed on probationary status.
 - (ii) Controlled Substance Authorization and Registration: Revocation, expiration, suspension or the placement of restrictions on a Practitioner’s DEA controlled substance authorization.
 - (iii) Insurance Coverage: Termination or lapse of a Practitioner’s professional liability insurance coverage or other action causing resulting in the coverage provided not being acceptable to the Hospital, or resulting in the coverage falling below the minimum required by the Hospital, or cease to be in effect, in whole or in part.
 - (iv) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs. (Voluntary non-participation in such programs does not trigger Time Out Pending Review under these Bylaws or the Medical Staff Professionalism Manual).
 - (v) Criminal Activity: Subject of criminal charges or arrested for or indicted for a felony or a misdemeanor including but not limited to (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; (vi) violence against

another; (vii) the practitioner-patient relationship, (viii) sexual misconduct or sexual harassment. (DUIs will be reviewed in accordance with the Medical Staff Professionalism Manual.)

- (vi) failure to support the orderly operation of the Hospital and the Medical Staff, including but not limited to failure to follow clinical protocols or exhibiting unprofessional and/or inappropriate conduct.
 - (vii) failure to act in accordance with Hospital Bylaws and all Hospital policies, including, but not limited to, the Code of Conduct and Respect Credo; and
 - (viii) demonstrating concerning behavior in the workplace and/or in patient care settings that is unprofessional, unsafe, inappropriate or disruptive to Hospital operations.
- (2) Time Out Pending Review shall take effect immediately upon Special Notice and shall continue until the matter is resolved pursuant to the Medical Staff Professionalism Manual and the Practitioner is reinstated, if applicable.

SECTION 9.6 AUTOMATIC RESIGNATION

Subsection 9.6.1 Grounds for Automatic Resignation.

- (1) A Practitioner shall be deemed to have automatically resigned the Practitioner's Appointment and Clinical Privileges for any of the circumstances set forth below in Subsection 9.6.1 (2) – (11). Any Practitioner who is the subject of an Automatic Resignation shall not have the right to the procedural rights under the Medical Staff Professionalism Manual; rather, the procedures described in this Section shall be deemed fair to the Practitioner under the circumstances.
- (2) Automatic Resignation is triggered upon the practitioner becoming subject to one or more of the following:
- a. Suspension, revocation, the placement of restrictions on a practitioner's professional license or termination of a practitioner's professional license;
 - b. Termination, dismissal or resignation as a member of the instructional staff of Vagelos College of Physicians and Surgeons or Columbia University College of Dental medicine and/or a faculty appointment at Weill Cornell Medical College of Cornell University;

- c. The termination of a contract between the Hospital and any other facility or organization pursuant to which the practitioner has been granted privileges at the Hospital and appointed to the Medical Staff of the Hospital; or,
 - d. The collaborating physician's privileges relevant to the practitioner's privileges or practice are terminated.
- (3) For failure to disclose that the practitioner was previously terminated or resigned from the Hospital when applying for appointment to the Medical Staff shall result in automatic resignation regardless of when this information is identified by the Hospital and shall not entitle practitioner to review or due process.
 - (4) For failure to immediately notify the President and Chief Executive Officer of the Hospital or designee when any voluntary or involuntary action, including but not limited to sanction, suspension (including a stayed suspension), limitation, revocation, or monetary penalty is taken by any state licensure board, health insurance program or other regulatory agency, such as the Department of Health, Drug Enforcement Agency (DEA), the Bureau of Controlled Substances, Department of Education, Department of Mental Hygiene, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities or commission on Quality of Care for the Mentally Disabled, State Board of Regents.
 - (5) For failure to notify the President and Chief Executive Officer of the Hospital or designee upon the voluntary or involuntary termination, limitation, suspension, resignation, or other discontinuation of the applicant's medical staff membership, clinical privileges or employment of any kind at any hospital or medical facility or organization or denial of any application, therefore.
 - (6) For failure to notify the President and Chief Executive Officer of the Hospital or designee of failure to maintain professional liability insurance.
 - (7) For failure to notify the President and Chief Executive Officer of the Hospital or designee of conviction, plea of guilty or of no contest to any felony or the occurrence of a conviction, plea of guilty or of no contest to any felony.
 - (8) For failure to notify the President and Chief Executive Officer of the Hospital or designee of conviction, plea or guilty or plea of no contest to any misdemeanor.
 - (9) Administrative Time Out- Upon failure of the practitioner to complete the administrative responsibilities in a time frame as set forth in the Medical Staff Professionalism Manual. The foregoing does not create any procedural rights on behalf of the affected practitioner.

- (10) The practitioner's employment with the Hospital or with a New York-Presbyterian Medical Group terminates.
- (11) The practitioner is employed by a Medical Staff Member and the employer's Medical Staff appointment is terminated, or the employer's clinical privileges are curtailed to the extent that the practitioner's services are no longer necessary or permissible to assist the employer.

SECTION 9.7 INDICATIONS AND PROCESS FOR SUMMARY SUSPENSIONS

- (1) The Executive Committee of the Board of Trustees, the Medical Board, the President of the Medical Board, the President and Chief Executive Officer of the Hospital, the Executive Vice President and Chief Operating Officer of the Hospital, the Chief Medical Officer, the Chief Medical Officer for Medical and Professional Affairs, and Service Chief each shall have the authority, whenever action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations, or when an institutional title or faculty appointment has been suspended by either Columbia University's Vagelos College of Physicians and Surgeons or by Weill Cornell Medical College of Cornell University, to summarily suspend all or any portion of the Clinical Privileges or Clinical Title or Administrative Title granted by the Hospital to a Practitioner.
- (2) Such suspension is effective immediately and will remain in effect unless it is withdrawn in accordance with the Medical Staff Professionalism Manual.
- (3) The Practitioner shall be provided a written notification stating the facts upon which the Practitioner's summary suspension was based.
- (4) All further proceedings shall be in accordance with the Medical Staff Professionalism Manual.

SECTION 9.8 INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information, a Practitioner may be recommended for suspension or revocation of Appointment or Clinical Privileges based on concerns about, including but not limited to: (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, the Medical Staff Professionalism Manual, the Medical Staff Credentials Manual, Rules and Regulations, or policies of the Hospital or the Medical Staff; or

(d) conduct that is considered lower than the standards of the Medical Staff Professionalism Manual or is disruptive to the orderly operation of the Hospital or its Medical Staff.

SECTION 9.9 HEARING AND APPEAL PROCESS, INCLUDING
PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS
AND THE COMPOSITION OF THE HEARING COMMITTEE

- (1) The date of the hearing shall be noticed, scheduled and held in accordance with the Medical Staff Professionalism Manual.
- (2) The Hearing Committee will consist of voting members of the Medical Board or voting members of the Leadership Team as selected by the President of the Medical Board.
- (3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply. The Hearing Committee may permit the presentation of evidence and witnesses subject to such restrictions and limitations as it may impose and as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
- (4) A stenographic reporter will be present to make a record of the hearing.
- (5) The affected individual and the Medical Board may request an appeal of the recommendations of the Hearing Committee to the Board of Trustees.

ARTICLE X

RULES AND REGULATIONS OF THE MEDICAL STAFF
AND RELATED MEDICAL STAFF GOVERNANCE DOCUMENTS

- (1) Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges at the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.
- (2) In addition to the Medical Staff Bylaws and Rules and Regulations, there shall be policies, and procedures and manuals that shall be applicable to all Medical Staff Members and other Practitioners who have been granted Appointment, Reappointment, and/or Clinical Privileges. All Medical Staff policies and, procedures, and manuals shall be considered an integral part of

the Medical Staff Bylaws. These additional documents include, but are not limited to, the Medical Staff Glossary, the Medical Staff Credentials Manual, and the Medical Staff Professionalism Manual.

- (3) Particular Rules and Regulations may be amended in accordance with the process outlined in these Medical Staff Bylaws.

ARTICLE XI

AMENDMENTS TO BYLAWS; MEDICAL STAFF DOCUMENTS; CONFLICT MANAGEMENT

SECTION 11.1 MEDICAL STAFF BYLAWS

- (1) Amendments to these Bylaws may be proposed by a petition signed by at least 25% of the Voting Medical Staff Members, or by the Medical Board.
- (2) In the discretion of the Medical Board, amendments to the Bylaws shall be presented to the Voting Staff in one of the following two ways:
 - (a) Amendments Subject to Vote at a Meeting: The Medical Board shall report on the proposed amendments either favorably or unfavorably, in a communication to the Medical Staff, or at a special meeting of the Medical Staff called for such purpose. The proposed amendments may be voted upon if Notice has been provided at least fourteen (14) days prior to the vote. To be adopted, a quorum, as defined in these Bylaws, of the Voting Medical Staff Members must be present, and the amendment must receive a majority of the votes cast.
 - (b) Amendments Subject to Vote via Written or Electronic Ballot: The Medical Board shall present proposed amendments to the Voting Staff by written or electronic ballot, to be returned to Medical Staff Administration by the date indicated on the ballot, which date shall be at least fourteen (14) days after the proposed amendment was provided to the Voting Medical Staff Members. Along with the proposed amendments, the Medical Board shall provide a written recommendation on the amendments either favorably or unfavorably. To be adopted, the amendment must receive a majority of the votes cast. A quorum for purposes of such a vote shall be the number of responses returned to Medical Staff Administration by the date indicated.
- (3) The Medical Board shall have the power to adopt clarifications and technical, non-substantive amendments to these Bylaws that are needed because of reorganization, renumbering, renaming of titles or positions, punctuation, spelling, or errors in grammar or expression.
- (4) All amendments shall be reviewed by the Board of Trustees. Such amendments are effective only after approval by the Board of Trustees.
- (5) If the Board of Trustees has determined not to accept a recommendation submitted to it by the Medical Board or the Voting Medical Staff Members, the Medical Board may request a conference between the officers of the Board of Trustees and the Medical Board Executive Committee. Such conference shall be for the purpose of further communicating the Medical

Board's rationale for its contemplated action. Such a conference will be scheduled by the President and Chief Executive Officer of the Hospital or designee.

- (6) Neither the Medical Board, the Medical Staff, nor the Board of Trustees, may unilaterally amend these Bylaws.

SECTION 11.2 AMENDMENTS TO OTHER MEDICAL STAFF DOCUMENTS

- (1) An amendment to the Medical Staff Glossary, the Medical Staff Credentials Manual, the Medical Staff Professionalism Manual, Medical Staff Policies, and the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Board present and voting at any meeting of the Medical Board where a quorum exists. Notice of all proposed amendments to these documents shall be provided to the members of the Medical Board fourteen (14) days prior to the Medical Board meeting when the vote is to take place when reasonably practicable. Any member of the Medical Board may submit written comments on the amendments to the Medical Board.
- (2) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Board.
- (3) Amendments to Medical Staff policies may also be proposed by a petition signed by at least twenty-five (25) members of the Voting Medical Staff Members. Any such proposed amendments will be reviewed by the Medical Board, which may comment on the amendments before they are forwarded to the Board of Trustees for its final action.
- (4) In cases of a documented need for an urgent amendment to the Rules and Regulations that is necessary to comply with law or regulation, the Medical Board may provisionally adopt, and the Board of Trustees may provisionally approve, such an amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Board. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Board, the provisional amendment will stand. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the Medical Board will be implemented. If necessary, a revised amendment will then be submitted to the Member for action.
- (5) Adoption of and changes to the Medical Staff Credentials Manual, the Medical Staff Professionalism Manual, and other Medical Staff policies will become effective only when approved by the Board of Trustees.

SECTION 11.3 CONFLICT MANAGEMENT PROCESS

- (1) When there is a conflict between the Medical Staff and the Medical Board with regard to:
 - (a) proposed amendments to the Medical Staff Rules and Regulations,
 - (b) a new policy proposed or adopted by the Medical Board, or
 - (c) proposed amendments to an existing policy/manual that is under the authority of the Medical Board,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 25% of the Voting Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

- (2) If the differences cannot be resolved, the Medical Board shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Voting Staff, to the Board of Trustees for final action.
- (3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual Medical Staff Members.
- (4) Nothing in this section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies/manuals directly to the Board of Trustees. Communication from Medical Staff Members to the Board of Trustees will be directed through the President and Chief Executive Officer of the Hospital or designee, who will forward the request for communication to the Board of Trustees. The Chair of the Board of Trustees will determine the manner and method of the Board's response to the Medical Staff Member(s).

ARTICLE XII

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board of Trustees, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws and the Medical Staff Manuals.

APPENDIX A
HISTORIES AND PHYSICALS

- (1) If a complete history and physical examination is completed within thirty (30) days prior to inpatient admission or registration of the patient, an update is required within twenty-four (24) hours after the patient physically arrives for admission or registration but prior to surgery or a procedure requiring anesthesia services. The history and physical may be handwritten or transcribed, but must always be entered and/or placed in the patient's medical record within twenty-four (24) hours after admission or registration, but in the case of a patient undergoing surgery or a procedure requiring anesthesia services, prior to the surgery or procedure requiring anesthesia services, whichever comes first. If the history and physical examination is recorded in the patient's medical record by an individual other than the practitioner of record, the history and physical examination shall be reviewed and countersigned by the Attending Practitioner.
- (2) The history and physical examination shall:
 - (a) Be in accordance with clinical service protocols, relevant State regulations, and shall be relevant and appropriate to the individual patient's needs, age and medical condition and shall include the following, if medically indicated:
 - (i) Chief complaint
 - (ii) History of present illness
 - (iii) Medications and allergies
 - (iv) Medical History
 - (v) Family History
 - (vi) Social History
 - (vii) Problems-focused physician examination
 - a) General physical exam of head, neck, chest, abdomen, extremities and skin along with auscultation of the heart and lungs
 - (b) Vital signs will include blood pressure, pulse, temperature, weight and height
 - (viii) Assessment or impression
 - (ix) Plan
 - (x) Any other information that the provider determines may be relevant given the context, nature, and purpose of the visit

- (b) Comply with Hospital policy with regard to identifying victims in each of the following situations:
 - (i) Child abuse or neglect
 - (ii) Rape or sexual abuse
 - (iii) Domestic abuse
 - (iv) Elder neglect or abuse
 - (c) Report all cases of abuse, neglect, or exploitation to appropriate agencies according to Hospital policy and relevant laws and regulations.
- (4) The update note must document an examination for any changes in the patient's condition since the history and physical examination was performed that might be significant for the planned course of treatment. If the appropriately credentialed Practitioner finds no change in the patient's condition, they may indicate in the patient's medical record that the history and physical examination was reviewed, the patient examined, and that "no change" has occurred in the patient's condition. Any changes in the patient's condition must be documented in the update note. The update note must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but in the case of a patient undergoing surgery or a procedure requiring anesthesia services, the update note must be placed in the patient's medical record prior to the surgery or procedure requiring anesthesia services.
- (5) Any history and physical completed greater than 30 days prior to inpatient admission or registration cannot be updated and a new history and physical must be completed.
- (6) A new history and physical or update to the history and physical is not required when the patient remains continuously hospitalized. If the patient has been discharged, then readmitted, there must be a valid history and physical (no greater than 30 days) and updated within 24 hours after re-admission/registration but prior to a surgical procedure or other procedure requiring anesthesia.
- (7) In Outpatient areas the following applies:
- (a) For patients seen in a hospital-based ambulatory clinic, the history and physical examination should include at a minimum:
 - (i) Chief complaint
 - (ii) History of present illness
 - (iii) Medications and allergies
 - (iv) Medical History
 - (v) Family History

- (vi) Social History
 - (vii) Problems-focused physician examination
 - a) General physical exam of head, neck, chest, abdomen, extremities and skin along with auscultation of the heart and lungs
 - (b) Vital signs will include blood pressure, pulse, temperature, weight and height
 - (viii) Assessment or impression
 - (ix) Plan
 - (x) Any other information that the provider determines may be relevant given the context, nature, and purpose of the visit
- (b) For patients undergoing outpatient/ambulatory procedures or outpatient/ ambulatory surgery, the history and physical examination should include, at a minimum, documentation of an appropriate history and physical work-up. This shall include a review of the patient's overall condition and identification of any potential medical, surgical and/or cardiac problems. The record should also include any other information that the provider determines may be relevant given the context, nature, and purpose of the visit.
- (i) When the history and physical is completed within thirty (30) days prior to in patient admission or registration of the patient, an update is required within twenty-four (24) hours after the patient physically arrives for admission or registration but prior to surgery or a procedure requiring anesthesia services.