WYCKOFF HEIGHTS MEDICAL CENTER

BYLAWS

OF THE MEDICAL STAFF

EFFECTIVE DATE REFERS TO JANUARY 1, 2006

Approved by Medical Board: 9/17/2019
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Approved by Board of Trustees: 10/17/2019

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BYLAWS, RULES AND REGULATIONS
OF THE MEDICAL STAFF OF
WYCKOFF HEIGHTS MEDICAL CENTER

Note: The male pronoun has been used in this document. This usage is not meant to exclude or be discriminatory to female practitioners. The Pronoun “she” can be substituted for “he” in any part of this document. Chair refers to Chair of the department.

PREAMBLE

WHEREAS, Wyckoff Heights Medical Center is a not-for-profit corporation organized under the laws of the State of New York: and

WHEREAS, its purpose is to serve as a general hospital providing patient care in a safe environment, education and research: and

WHEREAS, the Medical Staff is responsible for the quality of medical care given in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Board of Trustees: and

WHEREAS, the best interests of the patients are protected by a cooperative effort of the Medical Staff, the President of Hospital and Board of Trustees to fulfill their obligations to the patients.

Therefore, the physicians, dentists and podiatrists practicing at Wyckoff Heights Medical Center hereby organize themselves into a Medical Staff in conformity with these Bylaws.

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Article I
Name

The name of this organization shall be “the Medical Staff of Wyckoff Heights Medical Center,” (hereinafter the “Medical Staff ”).

Article II
Purposes

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

1. To serve as the primary means for accountability to the Board of Trustees for the quality and appropriateness of the professional performance and ethical conduct of Medical Staff members.

2. To strive toward assuring that patient care in the Medical Center is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and resources locally available, regardless of patients' race, creed, color, age, national origin, gender, sexual orientation, or ability to pay.

3. To strive toward assuring that a high level of professional performance is maintained by all practitioners authorized to practice in the Medical Center, through the appropriate delineation of clinical privileges that each practitioner may exercise in the Medical Center, and through an ongoing review and evaluation of each practitioner's performance in the Medical Center.

4. To ensure continued development and maintenance of high standards of education and research programs.

5. To initiate and maintain rules and regulations for the conduct and governance of the Medical Staff.

6. 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 Administration of the Medical Center; and,

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

Article III
Membership

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege that shall be extended only to Physicians, Dentists and Doctors of Podiatric Medicine licensed in New York State. No Physician, Dentist or Podiatrist shall be entitled to membership on the Medical Staff or to the exercise of the particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed in New York State.

Appointments and reappointments to the Medical Staff shall be made by the Board of Trustees following recommendation by the Medical Board as provided in these Bylaws, Rules and Regulations. Sex, race, creed, age, sexual orientation, (disability) handicap, national origin or other considerations not impacting the applicant's ability to discharge the privileges for which the practitioner has applied, shall not be used in making decisions regarding the granting or denying of membership and clinical privileges.

Section 2. Qualifications for Membership

Eligibility for Medical Staff membership shall be limited to Physicians, Dentists, and Doctors of Podiatric Medicine who have licenses to practice their professions in the State of New York. Applicants for Medical Staff membership have the burden to document their

1. background,
2. relevant experience and training,
3. and current competence,
4. physical and mental fitness,
5. adherence to the ethics of their profession,
6. sufficient medical care activities to assure familiarity with the Medical Center's policies, procedures and practices to provide assurance that the instruction given to the Medical Student and Resident staff is in keeping with current standards of good and accepted medical practice,
7. and their ability to work with and be supervised by others, with sufficient adequacy to assure the Medical Board and the Board of Trustees that all patients treated by them in the Medical Center will be given professional care consistent with the prevailing standards of medical practice and conduct in their area of practice; that they will cooperate fully and with sustained interest in the overall functions, activities and responsibilities of the Medical Center, and that they will afford all patients all rights guaranteed by applicable statute or regulation and these Bylaws, Rules and Regulations. These qualifications, criteria and performance standards are designed to assure the Board of Trustees and the Medical Staff that Medical Center patients will receive the highest quality of care.

Professional and ethical criteria applied uniformly to all medical staff applicants or members, shall constitute the basis for granting medical staff membership and clinical privileges. No physician, dentist or podiatrist shall be entitled to membership on the Medical Staff, or to clinical privileges at the Medical Center merely by virtue of possessing a license to practice the profession in this, or any other State, or that he is a member of or certified by any professional organization, or he has or has had professional privileges at other hospitals or health facilities.

The process of appointment will be the same for applicants holding or proposed for administrative positions at the Medical Center. The process of appointment will be the same for applicants and for practitioners with or proposed contracts or agreements executed between them and the Medical Center.

Except those physicians, dentists and podiatrists who are members of the Active Medical Staff as of the effective date of these Bylaws, appointment to the Medical Staff shall be limited to physicians, dentists and podiatrists certified by one or more United States or Canadian certifying bodies, or who are board qualified or eligible and those physicians, dentists and podiatrists without board certification, who, upon the recommendation of the Medical Board, and with the approval of the Board of Trustees, are deemed to possess such equivalent training and experience in the area of their specialty as to warrant membership on the Medical Staff.

In considering appointment and reappointment to the Medical Staff, the appropriate bodies thereof shall give consideration, but shall not be limited to the following factors:

1. That the practitioner's professional competence, moral standards, ethical stature and character meet acceptable standards.

2. That the practitioner shall practice a discipline that is consistent with the mission, purposes and resources of the Medical Center, and for which the Medical Center has a current and/or projected need.

3. That the practitioner meets all of the necessary qualifications for both the category of staff membership and for the clinical privileges requested.

All medical staff members shall participate in relevant continuing education as required by the appropriate Departmental Chair.

Continued membership to the Medical Staff of Wyckoff Heights Medical Center is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who:

1. Abide by these Bylaws, Rules and Regulations, the Corporate Bylaws of the Medical Center, and all Medical Center and departmental policies, rules and regulations;

2. Afford patients all rights guaranteed by applicable statute or regulation, Hospital policies, or these Bylaws, Rules and Regulations;

3. Demonstrate the ability to work cooperatively and professionally with the Medical Center, its professional staff and medical staff, and who refrain from disruptive behavior which has, or could interfere with patient care or the efficient operation of the Medical Center and its medical staff;

4. Conform to the terms/conditions of contracts executed between the individual practitioner and the Medical Center.

Section 3. Ethics and Ethical Relationships

Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to strictly abide by the generally accepted principles of ethics within the profession. Inherent in each practitioner's acceptance of appointment to the Medical Staff is the pledge:

1. to provide for the continuous care for his or her patients;

2. to abide by Federal, State and local statutory or administrative law pertaining to professional fees;

3. to only delegate responsibility for the care of hospitalized patients to a practitioner who is qualified;

4. to inform the patient of any delegation of care.

Section 4. Conditions and Duration of Appointment and Reappointment

To ensure that the practitioner is free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of clinical privileges requested, each practitioner, upon initial affiliation with the Medical Center is required to submit a physician's statement attesting to the member's physical and mental competence based on a physical examination and recorded medical history and supply any additional health related information requested by the Medical Board and, thereafter, as frequently as necessary, but no less than annually, provide documentation of a physician's reassessment of his or her health status.

Appointment to the Attending, Consulting and House Physician staffs shall also be conditional upon the applicant's having submitted evidence of professional liability coverage by a licensed carrier or approved self insurance program in at least the minimum amount established by the Board of Trustees, and upon the maintenance of membership. If approved by the applicant's Clinical Department Chair, the applicant may obtain coverage from a federally chartered risk retention group.

Failure by the applicant to maintain continuous professional liability insurance coverage shall, in and of itself, constitute termination/ suspension of the clinical privileges of the appointment or reappointment of the practitioner. Such a termination/suspension shall continue in effect until such time as the Medical Center is presented with new evidence of professional liability coverage.

The Board of Trustees shall make initial appointments and reappointments and grant initial, renewed or revised clinical privileges pursuant to these Bylaws. The Board of Trustees shall act on appointments, reappointments, and clinical privileges based on recommendations of the Medical Board, as provided in these Bylaws. Initial appointment to the Medical Staff, except the Consulting Staff, shall be provisional for one year. Each newly appointed Medical Staff member will be assigned to a clinical department where his or her performance and clinical competence shall be observed and evaluated by the Chair of the department or designee.

Reappointments shall be made for a period of not more than two years. The medical staff year commences on July 1 and ends on June 30 each year.

Every application for staff appointment shall be signed by the applicant, and shall contain the applicant's specific acknowledgment of each medical staff member's obligations to provide continuous care/and or supervision of care to his or her patients; to abide by the Medical Staff Bylaws, Rules and Regulations and to fulfill departmental responsibilities as delineated by the Departmental Chair.

Section 5. Continuing Medical Education

It shall be a condition for continued staff membership that all Medical Staff members participate in relevant programs of continuing medical education, whether hospital-sponsored or extra-hospital. Such participation should be consistent with guidelines established by the respective disciplines, adopted by the Medical Board and shall be documented in the practitioner's reapplication.

Section 6. Procedure for Appointment and Reappointment

Applicants for Attending Medical Staff appointment and reappointment shall provide the Medical Center the following information:

1. Evidence of current, unrestricted New York State licensure, relevant training and experience, and current competence;

2. Any loss of his or her membership in a professional organization or any loss of staff privileges at another hospital or health facility;

3. Relating to involvement in any previously successful or current challenges to state licensure or federal registration (narcotic license); or the voluntary surrender of such licensure or registration; or any reports filed with the New York State Health Department's Office of Professional Medical Conduct /New York State Education Department's Office of Professional Discipline. They shall make the findings and/or disciplinary actions related to professional misconduct available to the Medical Center. A waiver by the practitioner of any confidentiality provisions is required;

4. Any settled or pending malpractice litigation, and judgments or settlements of malpractice actions and the findings of any such or actions. A waiver by the practitioner of any confidentiality provisions;

5. The name of all hospitals or medical facilities with which the practitioner was associated, employed, privileged, or practiced; in situations where the association was discontinued and the reasons for the discontinuation;

6. Verification by the practitioner that the information provided is true and accurate. The Medical Center shall request from other hospitals with which the practitioner had been previously associated (for at least the last ten years) information regarding pending professional misconduct proceedings or pending malpractice actions, judgments or settlements of malpractice actions, findings and/or disciplinary actions related to professional misconduct.

The Medical Center shall also query the National Data Bank.

All of the aforementioned information and documentation shall be maintained by the Medical Center in the practitioner's credentials file.

Section 7. Application for Appointment and Reappointment

All applications for appointment to the Medical Staff shall be in writing, signed by the applicant and submitted on the form recommended by the Medical Board and approved by the Board of Trustees. The application shall require detailed information concerning the applicant's professional qualifications.

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

Applications for Appointment:

1. Shall include the name of at least two peers, one of whom shall be the Chair, Director, Program Director (or similar title) in another hospital, who have had experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and ethical character. Under special circumstances defined by the Credentials Committee in consultation with the Chief Medical Officer, the two required peer recommendations may be obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

2. Shall require information as to whether the applicant's membership status and/or clinical privileges have ever voluntarily or involuntarily terminated, suspended, reduced, or not renewed at any other hospital or institution;

3. Shall require information as to whether his membership in local, state, or national professional medical societies, or his license to practice any profession in any jurisdiction, has ever voluntarily or involuntarily been suspended or terminated, and, if so, the reason for it.

4. Releases from liability all representatives of the Medical Center and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials;

5. Releases from liability all individuals and organizations who provide information to the Medical Center in good faith and without malice, concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

The Credentials Office shall forward the completed application packet to the Department Chair who will interview the candidate and then propose the acceptable candidate to the Credentials Committee for a vote.

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

After collecting the references and other materials deemed pertinent, the Chair, or his designee, shall submit the application and all supporting materials to the Credentials Committee for evaluation and recommendations.

1. The completed application shall be processed by the Medical Staff and acted upon by the Board of Trustees.

2. By applying for appointment to the Medical Staff, each applicant

    a. agrees to appear for any interviews requested;

    b. authorizes all prior facilities with which the applicant has been associated, or any entity or individual who may have knowledge of the applicant's current competence, character and ethical qualifications to release such information to Wyckoff Heights Medical Center;

    c. consents to the Medical Center's right to inspect any and all documents that may be material to the evaluation of the applicant's qualifications if the applicant has a record of disciplinary action taken against him/her relating to competency at another hospital or health facility or a significant number of medical malpractice cases pending;

3. The application form shall include a statement that the applicant:

    a. Has read the Bylaws, Rules and Regulations of the Medical Staff, and agrees to be bound by the terms thereof if granted membership and/or clinical privileges in all matters relating to the consideration of the application.

    b. Agrees to comply with the Medical Center's policies which apply to activities as a Medical Staff member and are consistent with the Medical Staff Bylaws, Rules and Regulations.

    c. Certifies that information given in or attached to the application is accurate and that any misrepresentation, misstatement or omission from the application shall, of itself alone, constitute cause for automatic rejection of the application resulting in denial of appointment or re-appointment and clinical privileges.

Section 8. Appointment Process

After receipt of the completed application for membership, the Credentials Committee shall submit a written report of its recommendations as to Membership and Clinical Privileges to the Medical Board.

Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the practitioner, and shall determine through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department in which clinical privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him.

1. Every department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report.

2. The Credentials Committee shall submit its report to the Medical Board with a recommendation that the practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

3. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Board shall determine whether to recommend to the Board of Trustees that the practitioner be appointed to the Medical Staff, rejected, or that his application be deferred for further consideration. All medical staff appointment decisions must also recommend specific clinical privileges to be granted. These may be qualified by probationary conditions relating to such clinical privileges.

4. When the recommendation of the Medical Board is to defer the application for further consideration, it shall be forwarded by the Medical Board President to the Credentials Committee Chair with a specific request for further investigation or evaluation. The Credentials Committee shall consider the request for further review by the Medical Board at the Credentials Committee's next scheduled meeting. It shall re-submit the application for reconsideration by the Medical Board immediately upon addressing any request made by the Medical Board which shall not be later than thrifty days following the Medical Board's request for reevaluation of the application. Upon re-submission of the application by the Credentials Committee to the Medical Board the Medical Board must vote to either recommend the applicant for appointment with specific clinical privileges or reject the application.

5. When the recommendation of the Medical Board is favorable to the practitioner, the President of the Medical Board or designee shall submit it to the Board of Trustees for consideration at its next regular meeting.

6. When the recommendation of the Medical Board is adverse to the practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Trustees until after the practitioner has exercised, or has been deemed to have waived, the right to a hearing as provided in Article VII of these Bylaws.

7. If, after the Medical Board has considered the report and recommendation of the hearing committee and the hearing record, the Medical Board's reconsidered recommendation is favorable to the practitioner, it shall be processed, in accordance with subparagraph e. of this section. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner, by certified mail, return receipt requested.

8. At its next regular meeting after receipt of a favorable recommendation, the Board of Trustees shall act on the matter. If the Board of Trustees is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him of such adverse action by certified mail, return receipt requested. Such adverse action shall be held in abeyance until the practitioner has exercised, or has been deemed to have waived, his rights under Article VII of these Bylaws, and until there has been compliance with subparagraph 1 of this section. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

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

10. Whenever the Board of Trustees' decision will be contrary to the recommendation of the Medical Board, the Board of Trustees shall submit the matter to a review committee for review and recommendation and shall consider such recommendation before making its decision final.

11. When the Board of Trustees decision is final, it shall send notice of such decision through the Chief Executive Officer to the Medical Board and Chair of the Department concerned, and by certified mail to the practitioner.

Section 8a. Application for Reappointment

1. At least ninety (90) days prior to the expiration of each medical staff appointee's term of appointment and expiration of clinical privileges, a reapplication form is sent to the candidate for reappointment.

2. Upon receipt of the completed reapplication form, the Credentials Department verifies the reapplication information, which includes malpractice history, disciplinary actions and performance data.

3. The completed reappointment package is forwarded to the Department Chair for evaluation. The recommendation of the Chair shall be made based upon criteria established by the department and approved by the Medical Board.

4. Based on the verified reapplication information, requested clinical privileges, and his knowledge of the practitioner's practice patterns and adherence to department requirements, the Department Chair evaluates the practitioner and presents recommendations for reappointment and re-privileging to the Credentials Committee.

5. The Credentials Committee reviews the reapplication summary information and recommendations of the Chair and forwards a report of its recommendations to the Medical Board.

6. The Medical Board reviews the recommendations of the Department Chair and the report of the Credentials Committee. The Medical Board then forwards its recommendations along with supporting information to the Board of Trustees.

7. The Board of Trustees reviews the Credentials Committee report regarding reappointment and the delineation of clinical privileges for consideration of re-appointment for the practitioner.

Section 9. Temporary Clinical Privileges

The President/CEO of the Medical Center authorizes the Chief Medical Officer to grant temporary clinical privileges on the recommendation of the President of the Medical Board in the following circumstances:

1. Urgent Staffing Needs: In order to maintain necessary and appropriate staffing levels temporary clinical privileges can be granted. After receipt of an application for staff appointment and clinical privileges, pending formal review of the complete credentials file, an appropriately licensed applicant may be granted temporary clinical privileges for an initial period of ninety days. The National Data Bank will be queried. Temporary clinical privileges may be granted only when the information supplied by the Chair reasonably supports a favorable determination regarding the practitioner's qualifications, competence and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements of Article III of these Bylaws regarding professional liability insurance.

   The practitioner must acknowledge that he has been given access to the Medical Staff Bylaws and that agrees to abide by the terms thereof in all matters relating to temporary clinical privileges. An extension of temporary clinical privileges may be granted upon the recommendation of the Departmental Chair concerned and the approval of the Credentials Committee. Temporary clinical privileges may not be granted for more than a total of 120 days.

   a. Termination of temporary clinical privileges: Upon the discovery of any information, or an occurrence, of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary clinical privileges granted, the Chief Medical Officer with the concurrence of the Chair of the Department concerned, may terminate any and all of the practitioner's privileges. In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the appropriate Department Chair. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

      A practitioner shall not be entitled to the procedural rights afforded by Article VII of these Bylaws because his request for temporary clinical privileges is refused or because all or any portion of his temporary clinical privileges are terminated or suspended.

2. Care of specific patient or special circumstances: Upon receipt of a written request for specific clinical privileges, an appropriately licensed physician, dentist or podiatrist of documented competence, compliant with the requirements of Article III of these Bylaws regarding professional liability insurance, who is not an applicant for staff membership, may be granted "one case" temporary clinical privileges.

3. Organ or tissue procurement organizations: The Medical Center shall exempt from the requirement to obtain Medical Staff privileges those practitioners from organ procurement organizations solely at the Medical Center in the retrieval of tissues and/or body parts for transportation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and the Health Code of New York State.

Section 10. Emergency Clinical Privileges

In case of emergency, any member of the Medical Staff, to the degree permitted by his license, shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm. Such emergency care may be provided by properly supervised members of the Resident Staff. For the purpose of this section, an “emergency” is defined as a condition in which serious harm would result to the patient, or, in which the life of the patient is in immediate danger, and any delay in administering treatment would add to that danger.

Section 11. Disaster Privileges

In the event of a Disaster, in which the Emergency Operations Manual has been activated, the CEO or Chief Medical Officer or the ranking Emergency Medicine attending physician on duty may grant disaster privileges after eligibility has been confirmed by a member of the Credentials Department or designee as per the Emergency Operations Manual. Eligibility will be determined upon presentation of a valid government issued photo ID (e.g. driver’s license or passport) and one or more of the following:

A current picture hospital I.D. card that clearly identifies their professional designation;

A current license to practice;

Primary source verification of licensure;

Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT),the Medical Reserve Corps (MRC),the Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP),or other recognized state or federal response organization or group;

Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a Federal, State or Municipal entity)

Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner’s identity and ability to act as a licensed independent practitioner during a disaster.

Furthermore,

1. The hospital is not required to grant privileges to all volunteers, decisions are made on a case-by case basis.

2. Issuance of temporary Hospital I.D. card is necessary.

3. Emergency privileges terminate with the emergency.

4. A roster of all volunteer practitioners and the cases they are involved in must be maintained.

5. Prior to implementing policy, there is a determination by the command center/CMO, that existing resources are not sufficient.

6. Applicants must provide the name of their primary hospital, with verification done if possible.

7. Pair the emergency practitioner with a credentialed practitioner on staff, in the same specialty, if possible.

8. Volunteers must wear identification as determined by the Emergency Operations Manual.

9. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours. If, due to extraordinary circumstances, primary source verification of licensure cannot be completed within 72 hours, the staff shall document what efforts were made, why it was not possible to complete the task within 72 hours, and the approximate timeframe for when verification can be expected.

Section 12. Expedited Credentialing

The Medical Staff Policy for Eligibility for “Expedited Credentialing” is applicable for those months the Board of Trustees does not convene as per the Corporate Bylaws.

Article IV
Categories of the Medical Staff

The Medical Staff shall be divided into six (6) categories. Each practitioner shall at the time of appointment to the Medical Staff be appointed to one of the foregoing categories:

1. Attending Staff
2. Consulting Staff
3. Emeritus Staff
4. Teaching Faculty
5. Clinical Affiliate Staff
6. House Officers
7. Advanced Practitioners

Section 1. Attending Staff

The Attending Staff shall consist of those physicians, dentists and podiatrists who admit patients to the Medical Center or who practice a hospital based medical specialty. Those physicians who are solely in a hospital based practice are subject to the provisions of Article III. If their position is suspended or terminated or if they resign, they are not entitled to due process provided in the bylaws and their staff membership and clinical privileges shall also be automatically terminated.

Attending Staff members shall perform such duties as may appropriately be assigned to them by their respective Departmental Chair in the patient care, research, and educational programs of their respective departments, whether such duties relate to inpatients, clinic patients or Emergency Department patients. Attending Staff members shall be responsible for managing the medical care of all patients for whom they are the primary attending physicians. Except for those practitioners who are members of the Attending Staff, as of January 1, 2000, appointment to the Attending Staff, shall be limited to:

1. Board certified practitioners;
2. Board eligible practitioners who are eligible for such certification, and complete such certification within five years of being appointed to the Attending Staff.
3. Those practitioners without such Board certification who are not actively working toward completion of such certification, if in the opinion of the Medical Board, and with the approval of the Board of Trustees, they possess such equivalent training and experience in the area of their specialties as to warrant membership in the Attending Staff.

Attending Staff members are expected to attend the staff meetings of their respective departments and the Medical Staff Society meetings. Attending Staff members in good standing with the Medical Staff Society are eligible to vote. Attending Staff members may be eligible to hold elected office in the Medical Staff Society and are eligible to serve on the Medical Board and its committees.

The Attending Staff members who have admitting privileges shall admit patients only in accordance with the admitting policies of the Medical Center and clinical privileges as delineated. They shall comply with all applicable rules, regulations, and Medical Center policies relating to patient admissions and inpatient/discharge review procedures.

Appointment to the Attending Staff and applicable rank shall be made, based upon recommendation of the Medical Board, with the approval of the Board of Trustees.

All new staff members shall serve a provisional period of one (1) year during which time they shall be supervised by the Departmental Chair or designee. The Board of Trustees may extend the provisional period for any new Medical Staff member upon recommendation of the Medical Board.

The following ranks are established for members of the Attending Staff:

1. Attending

2. Associate Attending

3. Assistant Attending

Ranks shall be assigned on the basis of experience, continuing education, length of tenure on the Medical Staff, teaching experience, and research and academic accomplishments.

Members of the Attending Staff may be appointed to the following administrative titles:

1. Chair of Department, Associate Director of Department, Assistant Director of Department

2. Director of Division

3. Program Director

The Departmental titles of Director, Associate Director, Assistant Director and Program Director are appointed by the Chair of the Department.

Section 2. Consulting Staff

The Consulting Staff shall consist of practitioners of widely recognized professional ability in the areas of their specialties who are eligible for membership of the Active Staff.

Members of the Consulting Staff shall not have admitting privileges, shall not be eligible to vote or hold office in the Medical Staff Society nor be required to attend Medical Staff Society or Departmental Meetings or to serve on committees. Consulting Staff members are eligible to be members of the Medical Board

Section 3. Emeritus Staff

Emeritus is an honorary title, which is given to former members of the Medical Staff retired from active practice, who had been members for ten or more years, or practitioners of outstanding reputation. Those practitioners deemed worthy shall be granted Emeritus Status by the Board of Trustees, upon recommendation of the Medical Board. Emeritus Staff members shall not be eligible to vote or hold office in the Medical Staff Society nor be required to attend staff meetings or to serve on committees. Membership on the Emeritus Staff shall be without clinical privileges to admit, attend patients or provide consultations. Emeritus Staff members are eligible to continue to be involved in the educational and research activities of the Medical Center. Emeritus Staff members are eligible to be members of the Medical Board

The Emeritus Staff shall have the right to be designated by any significant prior medical staff or faculty rank or title, provided such title is prefixed “emeritus”.

Section 4. Teaching Faculty

Physicians, dentists and podiatrists, or other qualified individuals, whose sole duties are to teach undergraduate trainees, post-graduate trainees, or staff, shall be eligible for appointment to the Teaching faculty. Such appointments shall be made on the recommendation, and shall be under the direction of the appropriate Department Chair and/or Program Director, with subsequent approval by the Credentials Committee, the Medical Board, and the Board of Trustees. Such appointments are for teaching purposes only. Appointees to the Teaching Faculty shall not be entitled to admitting privileges or clinical privileges, and shall have no patient responsibilities or any entitlement to the Due Process provided in these Bylaws.

Such appointees shall not be required to attend Departmental meetings. Teaching Faculty members in good standing with the Medical Staff Society are eligible to vote. They may serve on the Medical Board and serve on Medical Board committees.

The acceptance of membership on the Teaching Faculty Staff shall constitute an agreement by the member to abide by these Bylaws, Rules and Regulations and the Corporate Bylaws of Wyckoff Heights Medical Center.

Applicants to the Teaching Faculty staff shall provide, at a minimum, the following credentials: curriculum vitae, New York State license or certificate where appropriate, and additional credentials as deemed necessary and required by the Chair of the Department and the Credentials Committee.

Section 5. The Clinical Affiliate Staff

The Clinical Affiliate Staff shall consist of those qualified physicians, dentists and podiatrists who are pursuing an affiliation but not pursuing clinical privileges at Wyckoff Heights Medical Center. Such appointments shall be made on the recommendation of, and shall be under the direction of, the Chair. These appointments require approval by the Credentials Committee, the Medical Board and the Board of Trustees.

Members of the Clinical Affiliate Staff shall not have admitting privileges. Members of the Clinical Affiliate Staff may serve on the Medical Board and may serve on Medical Board committees upon the recommendation of the Department Chair and appointment by the President of the Medical Board. Members of the Clinical Affiliate Staff are not required to attend nor are eligible to hold office in the Medical Staff Society. Clinical Affiliate Staff members in good standing with the Medical Staff Society are eligible to vote.

The acceptance of membership on the Clinical Affiliate Staff shall constitute an agreement by the member to abide by these Bylaws, Rules and Regulations and the Corporate Bylaws of Wyckoff Heights Medical Center.

Section 6. House Officers

Physicians employed by the Medical Center whose main function is to provide patient care services as directed by the appropriate Departmental Chair. House Officers are not members of the Medical Staff. On all actions taken and care given to patients, the House Officer will record the findings and therapy in the medical record and notify the attending physician.

All House Officers must maintain a current, unrestricted limited permit to practice medicine in the State of New York at Wyckoff Heights Medical Center. The process of appointment as a House Physician will be in accord with Article III, Section 6. Such appointments and granting of clinical privileges shall be made on the recommendation of the appropriate Departmental Chair, with subsequent approval by the Credentials Committee, the Medical Board and the Board of Trustees. House Officers are not eligible to vote. These practitioners will not be granted admitting privileges. These practitioners shall abide by these Bylaws, Rules and Regulations, the Corporate Bylaws of the Medical Center and all Medical Center and departmental policies, rules and regulations.

Section 7. Advanced Practitioners

The Advanced Practitioners shall consist of Nurse Practitioners, Certified Nurse Midwives, Certified Midwives, and Certified Registered Nurse Anesthestists. Those providers who are solely employed by the hospital or a hospital owned PC are subject to the provisions of Article III. If their position is suspended or terminated or if they resign, they are not entitled to due process provided in the bylaws and their staff membership and clinical privileges shall also be automatically terminated.

Advanced Practitioners shall perform such duties as may appropriately be assigned to them by their respective Departmental Chair in the patient care, research, and educational programs of their respective departments, whether such duties relate to inpatients, clinic patients or Emergency Department patients.

Advanced Practitioners are expected to attend the staff meetings of their respective departments and the Medical Staff Society meetings. Advanced Practitioners in good standing with the Medical Staff Society are eligible to vote. Advanced Practitioners are eligible to serve on the Medical Board and its committees, however are not eligible to hold elected office.

The Advanced Practitioners who have admitting privileges shall admit patients only in accordance with the admitting policies of the Medical Center and clinical privileges as delineated. They shall comply with all applicable rules, regulations, and Medical Center policies relating to patient admissions and inpatient/discharge review procedures.

Appointment to the Advanced Practitioners shall be made, based upon recommendation of the Medical Board, with the approval of the Board of Trustees.

ARTICLE V
Allied Health Professional Staff

The Medical Center shall maintain an Allied Health Professional Staff to support the Medical Staff in carrying out the Medical Center's mission.

The Allied Health Professional Staff shall consist of the members of those allied health professions who may be authorized to practice their professions at the Medical Center including, but not limited to, physicians practicing with a limited permit, , psychologists, doctoral scientists, optometrists, physicians' assistants, specialists' assistants, registered dieticians, and clinical pharmacists.

The Allied Health Professional Staff members shall be appointed with specific authority and privileges by the Board of Trustees upon the recommendations of the Medical Board following evaluation of the qualifications of such applicants. Members of the Allied Health Professional Staff shall have completed acceptable courses of education and training and shall possess such licenses, certificates, or authorizations to practice their professions as the law may require. Privileges granted shall be within the scope of activity permitted under State law.

Members of the Allied Health Professional Staff shall be assigned to appropriate clinical departments And only the certified midwives are eligible for admitting privileges. All other members of the Allied Health Professional Staff shall practice only under the supervision of a member of the Medical Staff designated by the Department Chair concerned. Each department shall define in writing the duties and responsibilities of each category of the Allied Health Professional Staff performing patient care activities in that department. The Departmental Chair concerned is responsible for the determination of the qualifications and competence of the Allied Health Professional Staff assigned to the Department.

The Allied Health Professional Staff appointment and privileges are contingent upon appointment to or employment with the Medical Center and shall be automatically suspended or terminated, as appropriate, upon the suspension, termination, or resignation from that appointment or employment.

Allied Health Professional Staff members are not members of the Medical Staff and are not entitled to the due process procedure provided in these Bylaws. Acceptance of membership on the Allied Health Professional Staff shall constitute an agreement by the member to abide by the Rules and Regulations and the Corporate Bylaws of Wyckoff Heights Medical Center and to practice under the direct or indirect supervision of the Medical Staff. Members of the Allied Health Professional Staff shall be subject to the same appointment and reappointment process as members of the Medical Staff. Clinical privileges shall be granted in accordance with the provisions of Article VI of these bylaws.

Article VI
Clinical Privileges of Members of the Medical Staff and Allied Health Professional Staff

Section 1. Clinical Privileges

Applications for appointment or reappointment to the Medical and Allied Health Professional Staff must contain a request for the specific clinical privileges desired by the applicant. The applicant shall be required to cooperate fully in providing all necessary information and documentation.

1. Limitations on Clinical Privileges:

   Appointment or reappointment to the Medical Staff shall entitle the practitioner to exercise only those clinical privileges granted by the Board of Trustees, except to the extent that a practitioner is granted temporary or emergency privileges. Members of the Allied Health Professional Staff shall not engage in any professional activities at the Medical Center except under the supervision of a member of the Medical Staff designated by the Chair of the clinical department concerned. Clinical privileges granted to the Medical and Allied Health Professional Staff members shall be limited to those specified in the appointee's Notice of Appointment or Reappointment, as set forth in the records maintained by the Medical Center.

2. Delineation of Clinical Privileges:

   Clinical privileges for each member of the Medical Staff shall be delineated in writing at the time of appointment and reappointment in accordance with the procedures specified in these Bylaws.

   Periodic redetermination of clinical privileges (and change in same) shall be based upon the evaluation of care provided by the practitioner based on review of the records of patients treated by the practitioner, departmental committees which document the evaluation of the member's participation in the delivery of medical care, and a review of the practitioner's post-graduate continuing education. The review shall be accomplished through the combined efforts of the Quality Management Department, the responsible Chair and the Credentials Committee in accordance with the procedures specified in Article III.

Section 2. Clinical Privileges of Dentists and Oral and Maxillofacial Surgeons

Clinical privileges granted to Dentists and Oral and Maxillofacial Surgeons shall be based upon their training, experience, and demonstrated competence as provided for in these Bylaws. Surgical procedures performed shall be under the overall supervision of the Director of Oral Surgery or the Chair of the Department of Surgery.

A qualified physician shall perform the admission history and physical examination, and the medical assessment of patients. The dentist is responsible for the part of the history and physical examination related to dentistry. There shall be dual responsibility on the part of the physician and the dentist, each limited to his/her respective field. The management of a patient's medical problem or condition that may be present on admission or that might arise during hospitalization is the responsibility of a physician and, therefore, a consultation with a qualified physician is required. Said patients can only be discharged on the written orders of the physician. Qualified oral and maxillofacial surgeons can be privileged to perform a comprehensive admission history, physical examination and the medical assessment of patients. Prior to major high-risk procedures a consultation with a qualified physician shall be required.

Section 3. Clinical Privileges of Podiatrists

Podiatrists seeking appointment/reappointment shall specifically indicate the clinical privileges requested. These clinical privileges must be confined to the practice of podiatry as defined in the Education Law of the State of New York.

Applicants shall indicate membership in the appropriate National and/or Divisional Association and shall agree to conform to the requirements established by the American Podiatric Medical Association's

Code of Ethics. Podiatrists may be privileged to perform comprehensive history and physical examinations in conjunction with the provision of podiatric treatment as defined in the Education Law of the State of New York. Podiatrists are eligible to be granted admitting privileges. The admission history and physical examinations and medical assessment shall be performed by a physician. The management of a patient's medical problem or condition that may be present on admission or that might arise during hospitalization is the responsibility of a physician and, therefore, a consultation with a qualified physician is required. Said patients can only be discharged on the written orders of a physician. Podiatrists are eligible to be granted the clinical privilege of performing consultations at the request of staff physicians for inpatients, clinic patients and Emergency Department patients.

Section 4. Clinical Privileges of the Allied Health Professional Staff

The Allied Health Professional Staff shall be individually assigned to an appropriate Clinical Department, and shall carry out their activities subject to the rules, regulations, and policies of such Department.

The clinical privileges of Allied Health Professional Staff members shall be based upon the individual's training, experience, demonstrated competency, and scope of (if applicable) State licensure or certificate. Allied Health Professional Staff members may exercise judgment within their areas of competence providing that a member of the Medical Staff shall have the ultimate responsibility for patient care. Allied Health Professional Staff members may record reports and progress notes on patients' medical records and write orders to the extent set forth in these Bylaws, Rules and Regulations, within the limits established by their State license or certificate. Those Allied Health Professionals who are permitted to write orders require countersignature by supervisory or Attending Medical Staff members within twenty four hours.

Article VII
Corrective Action

Section 1. Medical Board Proceedings

Whenever the conduct or condition (professional or otherwise) of any member of the Medical Staff is considered to be inconsistent with the Medical Center's standards of patient care, patient welfare or the objectives of the Medical Center or if such conduct or condition reflects adversely on the Medical Center or the character or competence of such practitioner, or results in disruption of operations of the Medical Center, or if such practitioner shall refuse or neglect to comply with or observe any of these Bylaws, Rules and Regulations, or the Medical Center's Corporate Bylaws, a request for corrective action may be made with regard to such practitioner to the Medical Board by the Board of Trustees, the President of the Medical Center, or any member of the Medical Staff. Such a request for corrective action shall be in writing, shall set forth the facts upon which it is based, and shall be sent to the President of the Medical Board. Anonymous complaints will not be addressed under these bylaws but will be referred to the Corporate Compliance Department.

Upon receipt of such a request for corrective action, the President of the Medical Board shall consult with the respective Department Chair and conduct a preliminary review to determine if corrective action is required or if the matter can be handled on the departmental level. It shall be in the discretion of the President of the Medical Board as to the manner in which this preliminary review is to be conducted.

If the preliminary review indicates that corrective action is required, the President of the Medical Board shall appoint an ad hoc committee consisting of not less than three (3) and not more than five (5) members of the Medical Staff to investigate the matter. As soon as practicable after it has been decided corrective action is required, the involved practitioner shall be informed, in writing (by personal delivery, FedEx or certified mail) that a request for corrective action has been requested and of the reasons for such request.

The ad hoc committee shall conduct an investigation, including any interviews and review of documents, as it deems appropriate under the circumstances, but the involved Medical Staff member shall have the opportunity for an interview before the ad hoc committee. At such an interview, the involved practitioner shall be informed of the general nature of the request for corrective action, and shall be invited to discuss, explain, or refute the facts upon which it is based. This interview shall not constitute a hearing and shall be preliminary in nature.

Upon completion of its investigation, the ad hoc committee shall submit a report of its findings and recommendations to the President of the Medical Board.

Within thirty (30) days of receipt, the Medical Board shall consider the ad hoc committee's report and take action on the request for corrective action.

The action the Medical Board may take on such a request for corrective action shall include all or part of the following: to reject or modify it; issue a warning or reprimand; impose terms of probation or a requirement for consultation or treatment; recommend termination, restriction or suspension of the practitioner's clinical privileges; recommend that the Medical Staff membership of the practitioner be terminated or suspended; or recommend or take any other action that is appropriate under the circumstances.

Any recommendation by the Medical Board for reduction, revocation, or suspension of clinical privileges, or for the termination or suspension of the practitioner's Medical Staff membership shall entitle the practitioner to a hearing and appellate review as provided in Article VIII of these Bylaws. Any other recommendation for corrective action shall be final and shall not entitle the practitioner to a hearing or appellate review, and shall be implemented as soon as practicable under the circumstances.

The practitioner shall be given written notice (by personal delivery, FedEx or certified mail) of the Medical Board's action on the request for corrective action, as well as notice of any right to hearing and appellate review the practitioner may have under these Bylaws.

Section 2. Summary Suspension

Summary suspension is indicated whenever conduct of a Medical Staff member is such as to create an immediate threat to the health, safety and welfare of patients, staff or others within the Medical Center; and/or any Medical Staff member has failed to carry out professional responsibilities as set forth in these Bylaws, Rules and Regulations, the Corporate Bylaws of the Medical Center, or any applicable departmental rules and regulations so as to create a significant adverse effect on patient care. The President/CEO of the Medical Center or a designee, the Chief Medical Officer, the respective Department Chair and the Board of Trustees, or its designee, shall have the authority to summarily suspend all or part of the clinical privileges of a Medical staff member. Such a suspension becomes effective immediately and shall be confirmed within twenty-four (24) hours in writing to the practitioner (by personal delivery, FedEx or certified mail). Such writing shall also give the practitioner notice that he has the right to a hearing and appellate review under Article VIII of these Bylaws.

Section 3. Automatic Suspension of Membership and Clinical Privileges

The Medical Staff membership and clinical privileges of a practitioner shall be terminated automatically upon the practitioner becoming subject to the suspension or termination of the practitioner's professional license. It shall be the duty of a practitioner who becomes subject to such an action to report that fact to his/her Department Chair, who in turn, shall notify the Chief Medical Officer and the President/CEO of the Medical Center.

A practitioner's privileges shall automatically be suspended upon the practitioner's failure to maintain adequate and satisfactory professional liability insurance, or upon his failure to provide documentation of adequate and satisfactory professional liability insurance, as required by these Bylaws, Rules and Regulations. The suspension will terminate upon the Chief Medical Officer's determination that the practitioner is in compliance with the requirements of the Medical Center and these Bylaws, Rules and Regulations regarding maintenance of adequate and satisfactory professional liability insurance.

A practitioner's Medical Staff membership and clinical privileges shall automatically terminate upon the termination of a contract between the Medical Center and any other facility or organization pursuant to which the practitioner has been granted privileges at the Medical Center and appointment to the Staff.

A practitioner's Medical Staff membership and clinical privileges shall automatically terminate upon the practitioner becoming subject to the suspension or revocation of the Controlled Substance Registration DEA number or being excluded or suspended from the Medicare or Medicaid Programs.

An automatic suspension of admitting and clinical privileges may be imposed if the practitioner refuses to comply with the Medical Center's policy and procedures relating to medical records. A staff member receiving three or more such automatic suspensions within a 12 month period, or one suspension lasting longer than 120 days, shall be subject to disciplinary action up to and including termination of Medical Staff membership and clinical privileges.

The Medical Staff membership and clinical privileges of a practitioner shall automatically be terminated if the practitioner is convicted of a felony. If a member of the Medical Staff is convicted of a felony, he/she shall be barred or discharged from employment at Wyckoff Heights Medical Center. If a convicted felon has served the prescribed sentence and there are no restrictions on the practitioner's license to provide patient care, nor any limitations on the practitioner's right to care and/or bill for any segment of the population (imposed by an agency of local, state, or federal government), then, on a case-by-case basis, consideration may be given to credentialing that practitioner as a member of the Staff and/or as an employee of the Medical Center.

Automatic suspension of Medical Staff membership and clinical privileges under this Section 3 shall not entitle the practitioner to a hearing or appellate review under these Bylaws.

Section 4. Physician Impairment

The Medical Staff and Administration of the Medical Center believe that in most instances the conditions related to impairment are treatable illnesses and that the focus of an impaired program is to help impaired health practitioners recognize any impairing condition that might exist, receive rehabilitative services and return to or remain in active work status with appropriate monitoring in place.

The term "impaired professional" is used to describe the practitioner who may be prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. In some contexts, impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. Clearly, such a situation places the professional and the Medical Center at risk and may pose an actual or potential risk to the health and safety of our patients.

All employees and medical staff members are strongly encouraged to relay concerns about physicians who may be suffering from conditions leading to impairment. It is the policy of the Medical Center that referrals of impaired physicians are made to the President of the Medical Board, the Medical Staff Health Committee or directly to the Committee for Physicians' Health (C.P.H.) of the Medical Society of the State of New York, One Commerce Plaza, 99 Washington Ave. Suite 1111, Albany, New York 12210, (518) 436-4723. The Medical Staff Health Committee, in conjunction with the C.P.H., will arrange for assessment, treatment, support, and monitoring to facilitate recovery and appropriate return to work.

Cases referred to the Medical Staff Health Committee will be handled in the following manner:

1. The Committee may ask the referral source to have others who may have relevant information confidentially contact a member of the committee. The committee does not conduct formal investigations but rather serves as the recipient of information from concerned colleagues and other sources.

2. It is the policy of the Committee not to disclose the source of referrals to the physician in question.

3. The Committee will collect whatever information is readily available concerning the problem and will contact the Committee for Physicians' Health of the Medical Society of the State of New York.

4. The Medical Staff Health Committee, where appropriate may do the following:

    a. Encourage the physician to seek assessment and/or treatment services in conjunction with the Committee for Physicians' Health.

    b. Notify the President/CEO, the Chief Medical Officer, the appropriate Departmental Chair, and the President of the Medical Staff Society if the impaired practitioner has either: Entered into a recovery agreement with the Committee for Physicians' Health and the Medical Staff Health Committee; or failed to successfully engage in an appropriate assessment/treatment/recovery program as recommended by the Committee for Physicians' Health.

    c. Maintain and document the physicians' cooperation with treatment and recovery activities in conjunction with the Committee for Physicians' Health.

    d. Make efforts to assist the physician to continue in his or her professional duties to the extent that the practitioner is considered able to do by the Medical Staff Health Committee and the Committee for Physicians' Health.

    e. Write an agreement for monitored recovery, which refers to the Committee for Physicians' Health agreement and periodic notification of recovery status.

f. In cases where the physician has discontinued or limited work, aid him or her to return to work as soon as possible with the approval and cooperation of both the Medical Staff Health Committee and the Committee for Physicians' Health.

5. The Medical Staff Health Committee will be responsible for monitoring the effectiveness of the impaired Physicians' treatment plan in conjunction with the Committee for Physicians' Health. When the Medical Staff Health Committee considers with physician to be able to re-enter practice and knows the physician is enrolled and actively participating in the Committee for Physicians' Health's monitored recovery plan, appropriate medical staff individuals may be informed. Members of the Medical Staff Health Committee may provide monitoring services if requested by C.P.H.

   If the physician is unable to demonstrate involvement in a recovery process, violates the agreement with the Committee for Physicians' Health or with the Hospital, or relapses in a manner that places a patient at risk, the Medical Staff Health Committee will so notify the Department Chair who will refer the case to the Medical Board for corrective action in accordance with the Medical Staff Bylaws. Having done so, the committee will remain available to assist in a recovery plan if the physician agrees to participate. Any further action against the physician will be responsibility of the Medical Board in accordance with the Medical Staff Bylaws.

* Depending upon the facts of the case, the Medical Staff Health Committee may be required to cause a report to be submitted to the BPMC if it receives information that reasonably shows a physician is guilty of professional misconduct as defined by state law. The Committee should consult legal counsel for guidance.

Section 5. Alternate Medical Coverage

Immediately upon any termination, limitation or suspension of a practitioner's Medical Staff membership or any termination, limitation or suspension of his clinical privileges the President of the Medical Board, the Chief Medical Officer, the respective Department Chair and the President/CEO of the Medical Center shall each have authority to arrange for alternate medical coverage for the practitioner's patients still hospitalized. The wishes of the patients concerned shall be considered in the selection of an alternate practitioner.

ARTICLE VIII
Due Process for Hearing and Appellate Professional Review Actions

Section 1. Right To A Review Hearing

Unless otherwise provided by these bylaws, whenever a medical staff member is entitled to a hearing under these Bylaws, such hearing shall be conducted by a Hearing committee appointed by the Board of Trustees. Said committee shall be comprised of five members of the Medical Staff, recommended by the Chief Medical Officer. The majority of the committee members must be peers of the affected physician. In this instance, "peer" refers to an appropriately trained and licensed physician in a practice similar to, but not necessarily identical to, that of the affected physician. The Chair of the Board of Trustees shall appoint one member as the Chair of the Committee. In order to exercise the right to a hearing under this article, the involved Medical Staff member must make a request for a hearing in writing within thirty (30) days of receipt of the notice of corrective action pursuant to Article VII. Such request for a hearing shall be sent to the President of the Medical Board. The failure of the Medical Staff member to request such hearing shall constitute a waiver of the right to such a hearing and to any further Board of Trustees' review to which the practitioner might otherwise be entitled under these bylaws. Rights afforded under this Article pertain to Medical Staff privileges and appointments only and are not applicable to Medical Center employment decisions.

Section 2. Notice Of Hearing

As soon as practicable after receipt of a request for a hearing from a Medical Staff member, the Medical Center shall arrange and schedule such a hearing and shall, through the President of the Medical Center, notify the involved Medical Staff member of the place, time, and date of the hearing. Such notice shall also include the names of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Center. The hearing shall be scheduled for a date that is no later than forty five (45) days from the date of the receipt of the request for a hearing from the involved Medical Staff member. However if the involved Medical Staff member has been summarily suspended, such hearing shall be scheduled for a date that is no later than twenty (20) days from the receipt of the request.

Section 3. Conduct Of Hearing

1. A majority of the members of the Hearing Committee shall be present when a hearing takes place,

2. An accurate record of the hearing shall be kept, the mechanism of which shall be established by the Hearing Committee.

3. No hearing shall be conducted without the personal appearance of the involved Medical Staff member unless the practitioner waives such appearance or fails without good cause to appear for the hearing after appropriate notice. A medical staff member who fails to appear for an appropriately scheduled and noticed hearing shall thereby waive his right to any further review of the corrective action taken pursuant to these Bylaws.

4. Postponements of hearing beyond the time set forth in these bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall be in the sole discretion of the hearing committee and shall be for good cause shown.

5. The involved Medical Staff member shall have the right to be represented by an attorney at law at the hearing and appellate review, at his own expense. The Medical Center shall also have the right to be represented by an attorney at law at the hearing and appellate review. The Chair of the Hearing Committee shall preside over the hearing. The Chair shall act to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and that decorum is maintained. The Chair shall rule on the admissibility of evidence, which shall not be subject to formal rules of evidence, but rather shall afford liberal introduction of evidence in the interest of fairness. However, the involved Medical Staff member shall have no right to pre-hearing discovery.

6. The involved Medical Staff member and the Medical Center shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross examine any witness on any matter related to the issues of the hearing, to challenge any witness and to rebut any evidence.

7. The Hearing Committee may, without special notice, adjourn the hearing to call witnesses or for the purpose of obtaining new or additional evidence or consultation.

8. Upon conclusion of the presentation of oral and written evidence, including a written closing statement from the involved Medical Staff member and the Medical Center, the hearing shall be closed. The Hearing Committee may, thereafter, conduct its deliberations outside the presence of the parties.

9. Within sixty (60) days after the close of the hearing, the Hearing Committee shall make written report and recommendations and shall forward same, together with the hearing record and all other documentation to the Board of Trustees for consideration. The report may recommend confirmation, modification, or rejection of the corrective action recommended or taken pursuant to Article VII. The hearing committee shall also provide the involved practitioner with a copy of its written report and recommendations.

Section 4. Burden Of Proof

The Medical Center shall have the initial obligation to present evidence in support of the corrective action recommended or taken. Thereafter, the involved Medical Staff member shall have the burden of proving by clear and convincing evidence that the grounds for the corrective action recommended or taken lack any factual basis or that such basis for the conclusions drawn are either arbitrary, unreasonable or capricious.

Section 5. Post Hearing Procedure

The Board of Trustees shall consider the Hearing Committee's report and recommendations and shall either adopt, modify or reject them. If the decision of the Board of Trustees is adverse to the involved Medical Staff member, the practitioner shall have the right to appellate review before the Board of Trustee's decision becomes final.

Section 6. Appeal to the Board of Trustees

1. Within ten (10) days after receipt of notice by an involved applicant or Medical Staff member of an adverse decision after a hearing pursuant to this Article, such practitioner may, by written notice to the Board of Trustees, delivered to the President of the Medical Center, via certified mail, return receipt requested, request an appellate review by the Board of Trustees. The involved applicant or Medical Staff member may request an oral argument.

2. If such appellate review is not requested within ten (10) days, the involved applicant or Medical Staff member shall be deemed to have waived the right to such appellate review and to have accepted such adverse recommendation as provided in Sections 5 and 7 of this Article.

3. Within ten (10) days after receipt of such notice of request for appellate review, the Board of Trustees shall schedule a date for such review, and shall, by written notice sent through the President of the Medical Center, notify the involved applicant or Medical Staff member of the date so scheduled. The date of the appellate review shall not be less than thirty (30) days nor more than sixty (60) days, from the receipt of the notice of request for appellate review, except that when the Medical Staff member requesting the appellate review is under suspension, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than thirty days from the date of receipt of such notice.

4. The appellate review shall be conducted by the Board of Trustees or by a duly appointed Appellate Review Committee of the Board of Trustees composed of not fewer than three (3) members of the Board of Trustees.

5. The involved applicant or Medical Staff member shall have access to the report and record of the Hearing Committee. The involved practitioner shall be permitted to submit a written statement, specifying those factual and procedural matters with which the practitioner disagrees and the reasons for such disagreement. A statement may also be submitted by the Medical Center setting forth its position on the appeal. Such written statements shall be submitted to the Board of Trustees or its appointed Appellate Review Committee at least ten (10) days prior to the scheduled appellate review.

6. The Board of Trustees or its appointed Appellate Review Committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to Section 10 (e) for the purpose of determining whether the adverse decision against the involved applicant or staff member was justified and was not arbitrary or capricious.

7. There shall be no right to oral argument as part of the appellate review process, and it shall be within the sole discretion of the Board of Trustees or its appointed Appellate Review Committee to allow oral argument, if a request for such argument is made by the involved applicant or Medical Staff member or the Medical Center.

8. The Board of Trustees may affirm, modify or reverse its prior decision or refer the matter to the Medical Board for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Board arrange for a further hearing to resolve specific disputed issues.

9. If the appellate review is conducted by a committee of the Board of Trustees, such committee shall, within thirty (30) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Trustees affirm, modify or reverse its prior decision, or refer other matters back to the Medical Board for further review and recommendation, except if the applicant/Medical Staff member is presently under suspension which is then in effect, said report shall be made as soon as it may be reasonably made, but not more than twenty (20) days after the scheduled date of the appellate review. Such referral may include a request that the Medical Board arrange for further hearing to resolve specific disputed issues. As soon as practicable, but within thirty (30) days after receipt of such recommendation following referral, the Medical Board shall make its recommendation to the Board of Trustees.

10. The appellate review shall not be deemed to be concluded until all of the appropriate procedural steps provided in the Section VIII have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board of Trustees may be taken by a committee of the Board of Trustees duly authorized to act.

Section 7. Final Decision by the Board of Trustees

At the next regularly scheduled meeting of the Board of Trustees after the conclusion of appellate review, the Board of Trustees shall make its final decision in the matter and shall send notice thereof to the Medical Board and to the affected practitioner via certified mail, return receipt requested. This notice includes a statement representing the basis for the decision.

Article IX
Departments of the Medical Staff

Section 1. Clinical Departments and Divisions

The Clinical Departments and Divisions of the Medical Center include the:

1. Department of Anesthesiology
    a. Pain Management
2. Department of Dental Medicine
    a. General Dentistry
    b. Oral & Maxillofacial Surgery
    c. Periodontics
    d. Endodontics
    e. Prosthodontics
    f. Orthodontics
    g. Dental Anesthesia
    h. Pediatric Dentistry
4. Department of Emergency Medicine
5. Department of Medicine
    a. Allergy and Immunology
    b. Cardiology
    c. Dermatology
    d. Endocrinology and Metabolism
    e. Family Medicine
    f. Gastroenterology and Hepatology
    g. Geriatrics
    h. Hematology
    i. Infectious Disease
    j. General Internal Medicine
    k. Intensive Care

l. Oncology

m. Nephrology

n. Neurology

o. Physical Medicine and Rehabilitation

p. Pulmonary and Critical Care

q. Rheumatology

r. Complementary and Alternative Medicine

s. Psychiatry

6. Department of Obstetrics and Gynecology

a. Gynecologic Oncology

b. Perinatology

c. Uro-Gynecology

7. Department of Pathology and Laboratory Medicine

a. Anatomic Pathology

b. Clinical Pathology

8. Department of Pediatrics,

a. Neonatology

9. Department of Diagnostic Radiology

a. Nuclear Medicine

b. M.R.I.

c. Ultrasound

d. Interventional Radiology

e. Computed Tomography

10. Department of Radiation Oncology

a. Radiation Therapy

11. Department of Surgery,

a. Ambulatory Surgery

b. Thoracic and Cardiovascular Surgery

c. Head and Neck Surgery

d. General Surgery

e. Neurosurgery

f. Ophthalmology

g. Orthopedic Surgery

h. Otorhinolaryngology

i. Plastic Surgery

j. Peripheral Vascular Surgery

k. Urologic Surgery

l. Podiatric Surgery

m. Pediatric Surgery

The Medical Board shall assign each member of the Medical Staff to one of the Medical Center's clinical departments, based upon the recommendation of the Credentials Committee.

In exceptional circumstances, upon the recommendations of the Departmental Chair concerned and the Medical Board, a member of the Medical Staff, may be assigned to and granted clinical privileges in more than one department.

The Board of Trustees, upon the recommendation of the Medical Board, may establish new Departments and Divisions thereof, to promulgate new programs and services, or abolish or change existing Departments, Divisions, programs or services.

Section 2. Qualifications, Appointments and Tenure of Chair of Departments, and Directors of Divisions

All Departments shall be administered and under the authority of a Chair. A Director shall supervise divisions. The Board of Trustees shall appoint Chair of Departments and Directors of Divisions in accordance with the provisions of these Bylaws. Chair of Departments and Directors of Divisions shall be a member of the Medical Staff, in charge of a specific department or division. Appointment as a Departmental Chair or a Divisional Director shall be independent of Medical Staff membership and/or the clinical privileges the individual is granted to exercise at the Medical Center.

Chair of Departments and Directors of Divisions shall be individuals who:

1. Are eligible for membership to or are members of the Active Staff;

2. Hold or have held a faculty appointment in a medical school approved by the Liaison Council on Medical Education, the American Osteopathic Association, the American Podiatric Association, or a dental school approved by the American Dental Association;

3. Are technically among the most competent in their particular fields; have made significant contributions to their fields as manifested by work of high quality;

4. Have demonstrated teaching ability;

5. Are persons of high character and integrity;

6. Possess the necessary administrative ability;

7. Are Board-certified in the appropriate specialty area. The Board of Trustees may make an exception to Board certification for compelling reasons in the light of the candidate's outstanding equivalent qualifications as to training, experience, and demonstrated clinical, administrative, and educational ability as confirmed by the credentialing procedure of these Bylaws.

All candidates for the position of Chair of Departments must qualify for academic medical college appointment.

To fill a vacancy in the position of Chair of a Department an Ad Hoc Search Committee shall be called for by the Chairman of the Board of Trustees and chaired by the Chief Medical Officer. The Search Committee shall consist of:

1. Two members of the Board of Trustees, designated by the Chair of the Board of Trustees;

2. Two Medical Staff members of the Medical Board, designated by the President of the Medical Board;

3. The President/CEO of the Medical Center or his designee;

4. Two non Medical Board active staff members designated by the President of Medical Staff Society.

A quorum shall consist of a majority of the members of the Search Committee.

The Chairman shall be selected by the majority of members present with at least three (3) votes supporting the recommendation. The selection shall be by closed ballot. The Committee shall forward its recommendations for informational purposes to the Medical Staff and Medical Board. The Medical Board President will submit the recommendation to the Board of Trustees at the next scheduled meeting for consideration of appointment.

In the event that the candidate is not acceptable to the Board of Trustees, the Committee shall be reconvened, and this procedure shall be repeated as often as is necessary to secure an appointment by the Board of Trustees.

Section 3. Responsibilities of Departmental Chair

The responsibilities of Departmental Chair shall include, but not be limited to the:

1. accountability for all clinical and administrative activities within the Department;

2. implementation of a program to continuously assess and improve the performance of care and services provided by the Department that provides for the continuing surveillance and evaluation of the professional performance of the practitioners within the Department; preparation and submission of required reports to the Quality Management Committee and to the Medical Board;

3. participation in the development and implementation of Medical Center policies and procedures related to patient services provided by the Department; provide recommendations to the Medical Board related to the development of needed services or programs and for appropriate off-site sources for patient care services not provided by the Department or the Medical Center;

4. coordinate and integrate services provided by the various Divisions within the specific Department and with all other clinical Departments;

5. provide recommendations to the Credentials Committee of the Medical Board the criteria for clinical privileges consistent with the care provided in the Department; recommendations to the Credentials Committee of the Medical Board appointments, reappointments and clinical privileges for each practitioners of the Department;

6. responsible for the enforcement of the Medical Center's Bylaws and these Bylaws, Rules and Regulations within the Department;

7. for implementation within the Department of actions taken by the Medical Board;

8. appoint, from among the members of the practitioners in the Department, teams and/or committees for assisting in the performance improvement activities, review, evaluation and monitoring of the quality and appropriateness of patient care in the Department, which shall be in accordance with the Plan for Provision of Patient Care and the Plan for Improving Organization Performance;

9. participate in every phase of the administration of the Department through cooperation with the Administration of the Medical Center to ensure the integration of the Department into the primary functions of the Medical Center; including budgetary and strategic planning; recommendations for enough qualified and competent staff to provide care or service and for space and other resources required by the Department.

10. maintain quality control programs as appropriate;

11. organize and supervise the teaching and research programs within the Department; encourage and support efforts, where practical and feasible, to procure approved residency training programs and thereafter to maintain such approval; the orientation, in-service training and continuing education of all persons in the Department.

12. recommendation for the appointment (with subsequent approval of the Medical Board and Board of Trustees), of Directors of Divisions, Associate Directors, and Assistant Directors. Members of the Active Medical staff may be appointed with the administrative titles as follows: Associate Directors of Department, Assistant Directors of Department, and Directors of Division. Such appointments shall be independent of Medical Staff membership and the clinical privileges such practitioners have been authorized to exercise at the Medical Center.

Section 4. Responsibilities of Director of Divisions

Directors of Divisions shall be responsible to their Departmental Chair. The responsibilities of the Divisional Director shall include and not necessarily be limited to:

1. Provide guidance to the Departmental Chair on the overall medical policies of the Division and make recommendations regarding the Division to ensure quality patient care;

2. Assist the Departmental Chair in the review, evaluation and monitoring of the quality and appropriateness of patient care in the Division;

3. Promulgate criteria for the granting of clinical privileges in the Division;

4. Make recommendations to the Departmental Chair concerning Medical Staff appointments, reappointments and delineation of clinical privileges for the practitioners within the Division;

5. Responsibility for implementation within the Division of actions taken by the Departmental Chair.

Section 5. Departmental Meetings

Each Department shall schedule not less than nine monthly Departmental meetings per year. There may be such supplementary Departmental, Divisional, or committee meetings as the Chair shall deem necessary for peer review and analysis of the clinical work, medical records, and performance improvement activities of the Department.

The date, time and manner of notice of such meetings shall be determined by the respective Chair of the Departments. Minutes of Departmental meetings shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed, including Medical Board recommendations and actions pertaining to the Department; recommendations made; and actions taken.

Records of meetings of professional business shall be submitted, as scheduled, to the Medical Board. Records of meetings involving quality improvement shall be submitted, as scheduled, to the Quality Management meeting. Any Departmental problems/issues may be discussed at the Medical Board meetings at any meeting.

Each member of the Active Staff is encouraged to attend the regularly scheduled monthly departmental meetings. Each department shall set its own attendance requirements.

The Chair of each Department which is subdivided into permanent divisions is authorized to permit such divisions to meet separately, provided they hold not less than nine (9) monthly meetings per year for the purposes set forth above.

Article X
The Medical Board

Section 1. Composition

There shall be established a Medical Board which shall serve as the executive committee of the Medical Staff and shall be empowered to represent and to act on behalf of the medical staff between meetings of the medical staff. It shall be responsible to the Board of Trustees for the conduct of the medical affairs of the Medical Center. It shall consist of the following voting members:

1. The President of the Medical Board

2. The President-Elect of the Medical Board

3. The President of the Medical Staff Society

4. The immediate Past President of the Medical Staff Society

5. The President Elect of the Medical Staff Society

6. The Chair or Acting Chair of the Departments of Anesthesiology, Emergency Services, Dental Medicine, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Radiology, Radiation Oncology and Surgery. If the Chair is unable to attend the meeting, their designee may attend as a non-voting member.

7. The Chief Medical Officer

8. The Vice President for Medical Education

9. Two (2) representatives of the Medical Staff, elected biennially by the Medical Staff Society.

There shall be the following ex-officio, non-voting members:

1. The Chair of the Board of Trustees or designee.

2. The President/CEO of the Medical Center or designee.

3. Vice President of Nursing

4. Chief Operating Officer

5. Two (2) Resident staff volunteers recommended from Resident Staff Leadership. Said representatives may not participate in matters dealing with Chair/ Directors of Departments, collective bargaining issues, or other non-medical matters.

6. All VPs will be invited guests as deemed necessary by the President of the Medical Board.

When a Board Member fills more than one position on the Medical Board, he or she is entitled to only one vote.

Section 2. Officers of the Medical Board

The officers of the Medical Board shall be the President and President-Elect. Any voting member of the Medical Board in good standing shall be eligible to hold the offices. An ad hoc nominating committee consisting of three (3) members of the Medical Board shall be appointed by the President of the Medical Board, which committee shall report its slate at the November meeting of the Medical Board.

Elections shall be held at the December meeting, by closed ballot, provided a quorum is present. Any voting member of the Medical Board who cannot be present for the election may vote by proxy. Election of any officer is subject to confirmation by the Board of Trustees.

The term of officers of the Medical Board shall be for two (2) years.

In the absence of the President, the President Elect shall preside over the Medical Board meetings.

All voting members of the Medical Board must remain members in good standing of the Active Medical Staff during their tenure. Any officer of the Medical Board who loses his medical staff privileges shall automatically cease to be a member of the Medical Board. In the event that the President Elect assumes the Presidency due to a vacancy, he shall serve out the remainder of the term vacated, and then serve his term normally, as if there had been no vacancy.

An officer or member of the Medical Board shall be removed from office upon a majority vote of the members of the Medical Board. If at least three (3) members of the Medical Board or 20% of the voting members of the medical staff believe that there is good cause for removal they shall present their request for removal in writing to the President/CEO of the Medical Center, who shall inform the officer of the request. At the next regular meeting of the Medical Board, held not fewer than fifteen days after a copy of the request for removal is given or mailed to the officer or at a special meeting called for such purpose, the Medical Board shall inquire into and take action on the request for removal. The officer of the Medical Board who is not the subject of the request shall preside over and conduct the review. The officer, if he requests an appearance, shall be permitted to appear before the Medical Board and respond, prior to a vote by the Medical Board. If a Chair is removed his position should be filled by a replacement from his or her Department.

Section 3. Vacancies

A vacancy in the office of President shall be filled by the President Elect. In the event that the President Elect assumes the Presidency, he shall serve out the remainder of the term vacated, and then serve his term normally, as if there had been no vacancy. A vacancy in the office of President Elect shall be filled at a special election meeting of the Medical Board.

In the event that both offices should become vacant, the Chief Medical Officer shall assume the duties of an Interim President of the Medical Board for a period of time not to exceed two (2) months. During this time, the Interim President shall convene an ad-hoc nominating committee consisting of three (3) members of the Medical Board, who shall report their slate of nominations for President and President Elect at the next regularly scheduled Medical Board meeting. Elections will be held at a special election meeting of the Medical Board, by closed ballot, provided a quorum is present. Any voting member of the Medical Board who cannot be present for the election may vote by proxy. Election of any officer is subject to confirmation by the Board of Trustees. The elected officers shall serve out the remainder of the terms vacated, and then serve a term normally, as if there had been no vacancy.

Section 4. Duties and Responsibilities of the Medical Board

In addition to those specified in these Bylaws and in the Corporate Bylaws of Wyckoff Heights Medical Center, the duties and responsibilities of the Medical Board shall include:

1. Assuming responsibility for the effectiveness and coordination of all general policies and medical activities of the Medical Staff, and its various Departments and Divisions.

2. Receiving and acting on the reports of Medical Staff Society.

3. Providing formal liaison with and providing recommendations to the Board of Trustees in all matters of a medical/administrative nature.

4. Providing for the medical staff's accountability to the Board of Trustees for the medical care rendered to the patients in the Medical Center.

5. Reviewing the conduct of medical staff members to ensure professional and ethical conduct, and recommending and instituting corrective actions as indicated.

6. Keeping the medical staff informed of the accreditation status and approved teaching programs within the Medical Center.

7. Revising these Bylaws, Rules and Regulations when indicated as per Article X Section 4 and Article XIV.

8. Receiving and acting on the reports presented to the monthly meetings of the Medical Board by various standing and special Medical Board Committees and clinical departments and providing appropriate responses to such reports, including necessary decisions, recommendations and actions, forwarded, in turn, to the President/CEO of the Medical Center and the Board of Trustees.

9. Performing such other and additional duties as may be reasonably necessary to carry out the foregoing, as well as other duties and responsibilities as determined by the Board of Trustees.

10. The designation of Committee Chair shall be made by the President of the Medical Board in consultation with the Chief Medical Officer

Any duty or responsibility of the Medical Board may be removed by the organized Medical Staff by amending these Bylaws in accordance with Article XIII.

Section 5. Medical Board and Committee Meetings

The Medical Board shall meet once a month except for one month in the summer as determined by the President of the Medical Board. The President or President Elect of the Medical Board may call special meetings at any time on one (1) week's written notice. An emergency meeting may be called without delay upon notification of each member of the Medical Board. All members of the Medical Board shall attend all regular and special meetings, unless previously excused by the President of the Medical Board. Fifty percent (50%) plus one (1) member of the voting membership of the Medical Board and Medical Board Committee shall constitute a quorum. Except as otherwise provided by these Bylaws, an affirmative vote of at least a majority of the quorum present and voting shall be required for approval of actions taken or recommendations made by the Medical Board.

Robert's Rules of Order shall govern all deliberations of the Medical Board, except that in the event of a conflict, the Bylaws of the Medical Staff shall apply.

Minutes of each meeting of the Medical Board shall be maintained and shall include the following: the date and duration of the meeting; attendance; topics discussed; recommendations made; and actions taken. Such minutes shall be submitted for approval at the next meeting of the Medical Board. The Medical Board shall submit a report of all Medical Board meetings to the President/CEO of the Medical Center and to the Chair of the Board of Trustees.

Section 6. Meetings of the Medical Board

Committees of the Medical Board shall be Standing and Special (adhoc). Except as specified elsewhere in these Bylaws, Rules and Regulations, each standing committee shall meet at least quarterly and submit a report of each meeting to the Medical Board.. A quorum shall consist of fifty percent (50%) plus one (1) member of the voting membership of the committee.

Article XI
Committees of the Medical Board

The President of the Medical Board will appoint all Committee Chairs. All committee members shall be appointed by the Committee Chair with consultation and consent of The President of the Medical Board. All committees report to the Medical Board on a quarterly basis unless specified differently, All committees shall have attendance and minutes of the meetings. In an event of Emergency and Disaster the Chief Medical Officer should be notified, in his absence the President of the Medical Board should be notified. Ex-Oficio non-voting members may include the President/CEO and Chairperson of the Board of Trustees. Residents from any clinical department shall be invited to participate in any committee. Members of the medical staff and Medical Center personnel may be requested to report on specific issues to the Quality Management Committee when the Chair deems it advisable. Membership to a Committee may be expanded to meet future needs as designated by the President of the Medical Board.

Section 1. Standing Committees

There shall be the following Standing Committees:

1. Ambulatory Services Committee
2. Bio-Ethics Committee
    a. Palliative Care Committee
3. Bylaws Committee
4. Cancer Liaison Committee
5. Continuing Medical Education Committees
6. Credentials Committee
7. Critical Care Committee
8. Emergency Management Sub-Committee
9. Environment of Care Committee
10. Graduate Medical Education Committee
11. Health Information Management Committee
12. Infection Control Committee
13. Information Technology Committee
14. Institutional Review Board
15. Peri-Operative Services Committee
16. Pharmacy and Therapeutics Committee
17. Quality Management & Patient Safety Committee
18. Research and Grants Committees
19. Utilization Management Committee
20. Medical Staff Health Committee

Section 2. Duties and Membership of Committees

1. Quality Management & Patient Safety Committee

The Quality Management & Patient Safety Committee shall include the following members, each of whom shall be voting members of the committee: the Chief Medical Officer or designee, who shall act as Chair of the committee, the Clinical Departmental Chair or their designees, the President of the Medical Board and the Vice President of Medical Education.

Non-voting members include the Vice President for Regulatory Services, Vice President of Nursing, Vice President of Health Information Management, Vice President of Patient Safety, Chief Operating Officer, and theDirector of Case Management/Utilization Management. The duties of the Committee shall be to assess the effectiveness of the Medical Center's Plan for Provision of Patient Care and the Plan for Improving Organization Performance, which shall be evaluated at least annually, and revised when necessary. The Committee administers and coordinates the Plan for Improving Organization Performance that focuses on continuous quality improvement by assessing and improving those processes and systems that most effect patient outcomes. The committee will oversee all activities related to improving organizational performance, quality of care, and safety at the Medical Center pursuant to the Hospital-Wide Plan for Provision of Patient Care.

All reports and records of the committee are confidential and accessible only to the committee and other appropriate bodies. Reports on quality and risk management activities shall be transmitted to the Medical Board by the Chair of the Quality Management Committee or designee quarterly.

The President of the Medical Board should report the through submission of minutes the Quality Management and Patient Safety Committee activities, findings and recommendations to the Board of Trustees quarterly, or as often as it deems necessary. The Committee shall meet at least ten times a year and may be convened, if necessary at the discretion of the Chair.

2. Credentials Committee

The Credentials Committee shall consist of the Departmental Chairs (if unavailable, his/her designee), the Chief Medical Officer, the Chair of the Quality Management and Patient Safety Committee or designee, and the Vice President for Medical Education. The Vice President for Regulatory Services and the Director of Credentials are non-voting participants.

Subsequent to the recommendations by the Departmental Chair pertaining to Staff membership and clinical privileges, the Credentials Committee shall review and evaluate the completed application, credentials and all pertinent information of every applicant. If deemed necessary, the Committee may interview the applicant. The Committee shall submit recommendations to the Medical Board, relative to the candidate's membership, Departmental assignment and delineation of clinical privileges, pursuant to the provisions of Article III of these Bylaws and the Medical Center's policy. It shall review and evaluate periodically the qualifications of each member of the Medical and Allied Health Professional Staff in consideration of re-appointment, non-reappointment, increased or decreased clinical privileges, and shall submit recommendations to the Medical Board pursuant to the provisions of Article III of these Bylaws, and the Medical Center's policy. The chair of the Committee may invite to its proceedings as nonvoting participants Departmental Directors as it deems necessary. It shall review reports that are referred to it by the Medical Board. The Credentials Committee shall be an investigational and advisory body only. It shall have no power of censure. It shall meet monthly .

3. Bylaws Committee

The Bylaws Committee shall consist of the President of the Medical Board, who shall chair the Committee, Chief Medical Officer, and shall include at least three physicians appointed by the President of the Medical Board.

The functions of the Committee shall be to review and recommend revisions to these Bylaws, Rules and Regulations as necessary to reflect the policies and practices of the Medical Staff. If revisions are warranted, the Committee shall work to revise any or all parts of these Bylaws, Rules and Regulations, and shall make recommendations on amendments to the Medical Board.

The Committee shall meet at least quarterly to review these Bylaws, Rules and Regulations and shall report its findings to the Medical Board. If revisions to the Bylaws, Rules and Regulations are warranted, the Committee shall meet as often as necessary to accomplish its revisions.

4. Bio-Ethics Committee

The Committee shall have a wide range of members, including representation from among the following voting groups: community, administration, the medical staff, the clergy, the nursing staff, legal counsel, the patient advocate, risk management, the pharmacy, and Resident. A member of the Resident staff shall be recommended for membership by the Chairs of the clinical Departments. Before appointing a member, the Chair shall ascertain that individual's interest in medical ethics as well as his/her willingness to contribute the necessary time for study and for meetings.

The purposes of the bio-ethics committee are as follows:

1. To provide a forum for interdisciplinary dialogue on ethical issues arising at the Medical Center.

2. To review and discuss medical-ethical literature for self-education and, to provide educational opportunities in the area of medical ethical questions for the Board of Trustees, the medical staff, personnel, patients and their families, and the community.

3. To review, develop and recommend Medical Center policies and procedures in the light of their medical-ethical appropriateness

4. To serve as a resource to those who wish to consult about medical ethical issues of patient care the committee will provide a consultation service.

Meetings shall be held quarterly and on an ad hoc basis as needed.

4(A). Palliative Care Committee

The Palliative Care Committee shall be a sub-committee of the Bio-Ethcs Committee and will establish and direct efforts to promote the development of the highest quality clinical palliative care services at the hospital and to meet or exceed regulatory, legal and best practice guidelines on end-of-life clinical care standards. As part of this effort, the Palliative Care Committee is responsible for the following, including the establishment of an Interdisciplinary Palliative Care team:

a. Overseeing clinical programs that relate to palliative and end-of-life care including but not limited to Palliative Care Program, the Hospice Program and hospital initiatives to improve pain management.

b. Improve communications about serious illness, end of life and pain management options between clinicians and patients and their families.

c. Monitor end-of-life clinical care practices through evaluation of data concerning pain and symptom control, use of advanced directives, patient and family satisfaction, and utilization of hospital resources and other data as decided by the Committee, and reporting such data through the Bio-Ethics Committee.

d. Make recommendations regarding appropriate changes in palliative patient care policies and procedures through the Chief Medical Officer.

e. Recommend topics for staff education to the Medical Board and to Hospital administration.

The Palliative Care Committee will consist of the Director of Division of Oncology, Director of the Pulmonary and Critical Care Division, Chair of Anesthesiology and/or Director of Pain Management Division, Hospital Chaplain, Chair of Pediatrics, AVP of Care Coordination, Director of Nursing CCU/ICU, General Counsel, and a representative from MJHS Hospice Program service.

The Palliative Care Committee shall meet at least quarterly.

5. The Institutional Review Board

The Committee shall consist of the following voting members : Chairperson or designee from the medical staff. Other members include those representatives from bio-ethics committee, clergy, legal counsel and other persons as may be deemed necessary or desirable by the Medical Board to enable it to best accomplish its duties. The duties of the Committee shall be to review, evaluate and pass on the propriety and safety of each research project and investigation involving human subjects proposed for implementation at the Medical Center.

The Committee shall adopt policy and procedures acceptable to the Medical Board to ensure that no such research or investigations shall be undertaken at the Medical Center unless the rights of the subject have been fully protected and, in particular, that the subject (and family when applicable) is fully and completely knowledgeable so that an appropriate informed consent can be obtained; that it has been determined that the subject will not be placed at medical, psychological or social risk; and that such project or investigation complies with all applicable laws and regulations.

Each Clinical Department shall be responsible to the Committee for the supervision of research and investigations involving patients in the Department, and shall establish such rules, regulations and procedures for the Department as may be necessary to assure the safe and proper care, treatment and investigation of patients and, specifically, to ensure that appropriate informed consent is obtained.

The Committee shall meet on an ad hoc basis based on Research and Grants Committee recommendations.

6. Graduate Medical Education Committee

The Graduate Medical Education Committee shall be chaired by the Vice President of Medical Education (DME for AOA and DIO for ACGME) and shall consist of the following voting members: Departmental Chairs with Residencies, Chief Medical Officer, the Graduate Medical Education Residency Program Directors, the Administrative Director for Medical Education. Non voting members include the Education Coordinators, the Director of the Medical Library, and representation from Resident staff., , The Committee shall discuss and take action on medical and administrative issues as they relate to the function and activity of the residents, interns, fellows and medical students. The committee shall receive, review, evaluate and offer recommendations to the Medical Board on the Graduate Medical Education Program of the Medical Center, and specifically the training and activities of interns, residents, fellows and medical students associated with the

Medical Center. It shall act as an advisory committee in the selection and credentialing of House Staff and shall assist the Director of Medical Education (DME/DIO) to develop and implement a high quality educational program

The committee shall participate in mid-cycle residency program review. The Committee shall also participate in policy development, and intern, resident and medical student evaluations. It shall meet monthly and maintain minutes for review by accrediting agencies, which shall be submitted to the Medical Board.

7. Critical Care Committee

The Critical Care Committee shall consist of the following voting members: medical staff representatives from Cardiology, Infectious Disease, Medicine and Surgery. Non-voting members shall consist of VP of Nursing or designee, VP Regulatory Services, Nursing Staff of the Critical Care Units (patient care managers), the Director of Patient Care Services, as well as the Directors of Respiratory Therapy, Pathology, the Pharmacy, and the Food and Nutrition services.

The duties of the Committee shall be to review, monitor and formulate policies regarding patient care rendered in Critical Care Units to assess and take opportunities to improve the quality of care rendered.

The Critical Care Committee shall meet monthly.

8. Peri-Operative Services Committee

The Peri-Operative Services Committee shall consist of the following voting members: physician representatives from the Departments of General Surgery, OB/GYN, Anesthesia, Dental, Internal Medicine and the Chief Medical Officer. Non-voting members include: Chief Operating Officer, VP of Patient Safety and Satisfaction, Director of Ambulatory Surgery, ,Nursing Director of Peri-Operative Services, Admitting, Housekeeping, Chief Operating Officer and OR Scheduler.

The Peri-Operative Services Committee shall evaluate those professional matters relating to the efficient utilization of the operating rooms including: room utilization, scheduling of operations, staffing, ambulatory preparation, recovery room procedures, patient transport, selection of new apparatus, instruments, supplies and all pertinent clinical matters. The committee shall also evaluate and maintain Medical Center policies governing cleanliness, sterility and health measures as recommended by the Infection Control Committee. The committee shall meet Bimonthly and shall submit a report including recommendations and /or corrective action plans to the Medical Board.

9. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee voting members shall consist of physician representation from all clinical departments, Non-voting members should bea representative of the nursing staff and of the Infection Control Committee. The Director of Pharmacy shall be an ex-officio member of the committee without vote and shall act as Secretary of the Committee.

The Pharmacy and Therapeutics Committee shall develop and maintain a current Formulary of accepted pharmaceuticals for use in the Medical Center which shall be made available to all members of the Medical Staff for their guidance. The Formulary shall be reviewed at annually and updated as necessary to meet patient needs and assure quality pharmaceuticals at reasonable costs; serve as an advisory group to the Pharmacy Department and to the Medical Board in all matters relating to the choice of pharmaceuticals.

The Committee shall assist in the formulation of policies relating to the choice of drugs in the Medical Center, including their evaluation, selection, deletion, procurement, storage, distribution, use and safety procedures. The Pharmacy and Therapeutics Committee shall review, pursuant to Medical Center Policy, all drug reactions, perform antibiotic usage review, and ensure that the assessment includes a clinical review together with any statistical/prevalent study of antibiotic usage.

10. Infection Control Committee

The Infection Control Committee shall include the following voting members: Chaired by the Director of Infectious Disease as Chair, physician representation from all clinical departments, Director of Infection Control, the Chair of the Pathology, or their designee. Non-voting members shall consist of the Chief Operating Officer, VP of Nursing Nursing Director of Peri-Operative Services, physician representation from the Departments of Medicine, Surgery, Ob/Gyn, Family, Community and Preventative Medicine and Pediatrics, a representative of the Hematology Staff, Microbiology Laboratory, Pharmacy, Employee Health Service, Housekeeping, Food and Nutrition Services, and Engineering, .

The duties of the Committee shall be to assess the effectiveness of the Medical Center's Infection Control Program with particular attention to the system of reporting infections among patients and personnel; the maintenance of records of infections as a basis for the study of their sources and for recommendations regarding preventive and remedial measures; reviewing aseptic techniques employed in the treatment of all patients, and, if indicated, recommending methods to improve such techniques and their enforcement.

The Committee shall establish policy defining specific indications for isolation and to ensure that the quality of care and the use of monitoring and other special equipment, is not compromised in the case of any patient requiring isolation.

The Committee should participate in developing and revising reports for the collection and collation of data. The responsibility for reporting may be delegated, i.e., venereal disease will be reported by the Microbiology laboratory, but the Committee shall retain responsibility for coordinating the reporting function.

The Committee shall study antibiotic sensitivity/resistance trends, and provide the information to the medical board.

The Committee shall review, at least annually, and revise if necessary, policies and procedures pertaining to infection control. The Infection Control Committee has the authority to institute those actions it deems immediately necessary in order to act appropriately in the case of infectious hazards, in emergency situations, when danger to patients or personnel is considered to be present.

11. Cancer Liaison Committee

The Cancer Liaison Committee shall consist of the following voting members Cancer Liaison Physician and, physician representatives from Surgical Oncology, medical oncology, pathology, radiology, radiation oncology, gynecologic oncology and physical medicine and rehabilitation .Non-voting members include: the the Cancer Registrar who serves in coordinating. The Cancer Program, Chief Operating Officer and Nursing and Social Services representation. .

The Cancer Liaison Committee shall be concerned with the entire spectrum of care for patients with cancer seen at this institution. To achieve this the Cancer Liaison Committee is authorized, by virtue of its policy advisory function to:

1. ensure that patients have access to the consultative services in all major disciplines available at the Medical Center.

2. ensure that patient oriented educational programs, multi disciplinary conferences and other clinical activities include all major sites of cancer that are diagnosed and treated at Wyckoff Heights Medical Center.

3. ensure that the cancer rehabilitation and social services available are utilized.

4. monitor and evaluate patient care, either directly or by interaction with the Quality Management Committee. Liaison between the two committees will be provided by the Chair of the Cancer Liaison Committee.

5. actively supervise the Cancer Registry for quality control of abstracting, staging and reporting.

The committee shall meet at least quarterly.

12. Utilization Management Committee

The Utilization Management Committee shall be chaired by the Chief Medical Officer or designee and shall consist of the Chairmen or representatives of the Clinical Departments, the Vice President of Regulatory Services, the Chief Operating Officer, the Directors of Case Management/Utilization Management, Social Work Department, Health Information Management Services, Patient Access (Admitting)Department, representatives from the Nursing Department, CFO or designee and others designated by the President of the Medical Board. All stated members shall have voice and vote.

The duties of the Utilization Management Committee shall include the development and assessment of the effectiveness of the Medical Center's Utilization Management Plan, which shall be evaluated at least annually, and revised when necessary. The Utilization Management Committee shall ensure that the Utilization Management Plan complies with applicable federal and state statutes, rules and regulations, and with standards and regulations promulgated by accrediting organizations.

The Utilization Management Committee shall delineate the responsibilities and authority of personnel, including members of the medical staff, involved in the performance of utilization review activities. Only physician members of the Committee have the authority to deny unnecessary admissions/continued stays and to cite quality of care issues. A physician will not have review responsibilities of cases that he or she has had professional involvement.

The Utilization Management Committee also oversees the appropriateness and timeliness of the Discharge Planning Process. The Utilization Management Committee shall monitor on a sample or other basis, and receive reports relating to, admissions, duration of patient stays and professional services rendered with respect to the medical necessity thereof, and quality of care issues related to utilization and related matters for the purpose of promoting the most efficient utilization of available Medical Center's resources.

The Utilization Management Committee will meet at least quarterly. They will report findings, conclusions and recommendations quarterly to the Medical Board by the Chief Medical Officer or designee.

13. Health Information Management Committee

The Health Information Management Committee shall consist of the following voting members: representation from the Clinical Departments, Vice President of Health Information Management, representatives of the Patient Access Department and representatives from the Nursing Department. The Health Information Management Committee shall be responsible for reviewing medical records for their timely completion and the quality of documentation, and, when necessary, as medico-legal documents. Medical record review shall ensure that the records reflect the condition and progress of the patient, including the results of all tests and therapy given, and that safe transfer of medical staff responsibility is ensured if such become necessary. The Health Information Management Committee shall review submitted documentation regarding the addition, deletion or change in forms used in the medical record.

The committee shall meet at least ten (10) times per year. . Written reports shall be maintained and submitted to the Medical Board.

14. Environmental Care Committee

The Environmental Care Committee shall be chaired by the Director of Fire and Safety and shall consist of voting representation from Chief Operating Officer, Chair of Emergency Department or designee the Director of Fire and Safety, Bio-Medical Engineering, Environmental Services, Admitting, Engineering, Food and Nutrition Services, Information Technology, Laboratory, Nursing, Security, Pharmacy, Radiology, Infection Control, Respiratory Therapy, Risk Management, and, Central Supply. The duties of the Environmental Care Committee shall be to ensure the development, implementation, and assessment of a comprehensive safety and emergency preparedness program and to monitor and evaluate the Medical Center's safety practices in an effort to minimize safety hazards to patients, employees and visitors; to make recommendations to the Medical Board. . The Environmental Care Committee is responsible for the coordination of the Medical Center's Safety Management program that is designed to provide a physical environment free of hazards and manage staff activities to reduce the risk of human injury. The Safety Committee Chair collaborates with the appropriate Medical Center personnel to implement the Committee's recommendations and to monitor the effectiveness of change. The 7 sub-committees that report to the Environmental Care Committee are:

- Bio Med
- Emergency Management
- Fire Safety
- Hazmat
- Safety
- Security
- Utilities

The Environmental Care Committee, through the Director of Fire and Safety shall have the authority to take appropriate action when a hazardous condition exists that could result in personal injury to individuals or damage to equipment or buildings. The Environmental Care Committee shall meet monthly and shall report its activities and recommendations to the Medical Board quarterly.

15. Emergency Management Committee

The Emergency Management Committee shall include the following voting members: Emergency Department Chairperson who will serve as Chair of this committee, the Director of Fire and Safety and select members of the Safety Sub Committee of the Environment of Care Committee.

The duties of the Emergency Management Committee shall be to ensure the development, implementation, and assessment of a comprehensive safety and emergency preparedness program for dealing with internal and external disasters involving mass casualties who may come or be brought to the Medical Center; to make recommendations to the Medical Board with respect thereto and regarding the policies and procedures to be followed in the event of a disaster.

Meetings shall be related to the Committee's duties and will be held on a quarterly basis. Periodic simulated disaster plan rehearsals and/or fire drills shall be followed by performance evaluations by the Committee at its meetings to upgrade the disaster plan and ensure the Medical Center's emergency disaster preparedness program is effective.

The Committee shall ensure that fire drills are performed in accordance with the Life Safety Code currently accepted by the U.S. Department of Health and Human Services. There shall be at least one drill per month on rotating shifts. There shall be at least one drill per year for partial evacuation on each shift, for example, a boiler explosion, etc. There shall be one rehearsal of the plan for the influx of patients at least annually, for example, a natural disaster, etc.

16. Research and Grants Committee

The committee Chair shall be an active member of the medical staff. The voting members shall include all program directors or their designees. The committee shall also include a representative of the community and a member of the clergy.

The objectives of the Research and Grants Committee are:

1. To promote clinical research activities at Wyckoff Heights Medical Center.

2. To identify various government foundation or private grants for the faculty of Wyckoff Heights Medical Center.

3. To assist in the writing, preparation and submission of research grants.

4. To approve all research submissions before recommendation to the institutional Review Board regarding the academic and scientific merits of the research protocols.

5. To encourage residents and medical students to develop an interest in research and grant opportunities.

The functions of the Research Committee are:

1. To review and approve all research protocols before submission to the Institutional Review Board.

2. To encourage each Department to sponsor clinical research activity and to monitor the quality of research.

To review in an advisory role recommendations from pertinent clinical Chairs any papers, manuscripts, presentations and abstracts before submission for publication. The committee shall meet monthly

17. Continuing Medical Education Committee

The committee shall include the following voting members: Chair of all clinical departments, Chief Medical Officer and Director of Medical Education,

The following non-voting members shall include: Chief Operating Officer, VP of Nursing, Director of Pharmacy, and Director of Medical Library.

The function of the Committee shall be to recommend, organize, evaluate and approve programs in continuing medical education for the attending staff. These programs will be tailored to the needs of the Medical Center's physicians in an effort to maintain quality patient care and physician competency.

The functions of the Continuing Medical Education Committee shall be:

1. To create and cultivate an atmosphere of heightened interest in good medical practice improving the quality of patient care, and enhancing the knowledge gaps, skills and attitudes of the physician by exposure to programs incorporating new and innovative technology;

2. The Committee will identify areas of concern through the Quality Management and Patient Safety Committee, assessment questionnaires, and other resources, designing programs addressing areas of identified need;

3. The Committee will determine program effectiveness through objective means such as physician performance evaluations, and measurement of patient outcomes.

4. The practicing physician will be encouraged to fulfill the AMA and AOA requirements necessary to qualify for the CME recognition awards; and assist physicians in maintaining required CME credits for reappointment to the medical staff, Board certifications and licensure where applicable.

5. To approve CME programs.

The Committee will meet at least quarterly or as needed.

18. Ambulatory Services Committee

The committee shall include the following voting members: All Clinical Chairs or designee, Chief Medical Officer.

There shall be the following non voting members: the Vice President of Regulatory Services, Vice President of Ambulatory Care, Director of Managed Care and the manager of each of the off-site ambulatory care facilities.

The Ambulatory Services Committee will:

- Promote uniform delivery of Ambulatory Care
- Identify and recommend resolutions to clinical patient care concerns
- Review all Ambulatory Performance Improvement and Quality of Care activities and to recommend action
- Review all standards of Ambulatory Care

19. Information Technology Committee

The Committee shall consist of the following voting members: Chair or designee of the Clinical Departments. Chief Information officer; Chief Operating Officer, , and VP of Nursing.

The purpose of the Committee is to assist all departments in their IT decisions and to improve the processes used for selection of technology and technological equipment. To assess and define the needs of the present hospital data environment, and define policies and procedures for enterprise wide IT protocol regarding clinical and administrative processes

The committee is the approving body for all strategic technology decisions for the Hospital.

The Committee will meet monthly. .

20. Medical Staff Health Committee

The Committee shall consist of the President of the Medical Board and three (3) members of the Medical Staff appointed by the President of the Medical Board.

The term “impaired professional” is used to describe the practitioner who may be prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. In some contexts, impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. Clearly, such a situation places the professional and the Medical Center at risk and may pose an actual or potential risk to the health and safety of our patients.

The purpose of the Committee is to:

- Monitor and support any Medical Staff member currently impaired and participating in a program.
- Arrange for assessment, treatment, support, and monitoring for any Medical Staff member who voluntarily approaches the Committee for help. If this occurs before an incident, the Committee will determine if disciplinary action is necessary. If this occurs after an incident that put a patient, visitor, or other staff member at risk, the provider is subject to disciplinary action as per Article VII of these Medical Staff Bylaws.
- Review all referrals regarding the possible impairment of a Medical Staff member (See Article VII, Section 4). If the Committee determines a Medical Staff member is impaired, it will arrange for assessment, treatment, support and monitoring for the provider.
- Depending on the facts of a provider’s impairment, the Committee, in conjunction with legal counsel, shall report to the appropriate Board of Professional Conduct if they believe a provider is guilty of professional misconduct.
- Review all new appointment Medical Staff applications in which a provider reports impairment (past or present) before presentation to the Credentials Committee. The Committee can recommend appointment, not recommend appointment, or recommend appointment with monitoring. If monitoring is required, the Committee will design a provider specific monitoring plan which will be presented to the Credentials Committee with the provider’s application.
- Review and monitor all clinical activity for those providers automatically placed on focused evaluation due to indictment on felony charges.

When treatment and monitoring for a provider are recommended, the Committee shall work in conjunction with the Committee for Physicians’ Health (C.P.H.) of the Medical Society of the State of New York, One Commerce Plaza, 99 Washington Ave. Suite 1111, Albany, New York 12210, (518) 436-4723, to to facilitate recovery and appropriate return to work.

The Committee shall meet as needed to comply with monitoring needs.

Section 3. Categories, Appointment and Modification of Committees

Committees of the Medical Board shall be Standing and Special (ad-hoc). Except as specified elsewhere in these Bylaws, Rules and Regulations, each standing committee shall meet quarterly and submit a report to the Medical Board; appointment to all committees and the designation of Chair shall be made by the President of the Medical Board in consultation with the Chief Medical Officer and the President of the Medical Staff

Article XII
Rules and Regulations

Section 1. General Policies

In addition to the Rules and Regulations hereinafter set forth, any applicable Departmental Rules and Regulations, the New York State Hospital Code, and all federal, state, and local statutory and administrative law pertaining to hospitals and the practice of medicine, dentistry, podiatry, and the allied health professions shall also govern the Medical Staff.

Any staff member who willingly violates the following Rules and Regulations shall be subject to the provisions of Article VII Corrective Action.

Section 2. Admission and Discharge of Patients

1. Wyckoff Heights Medical Center may accept patients for care and treatment appropriate to an acute care general hospital except that it may elect to exclude a prospective patient when the capacity of the Medical Center has been reached as determined by the Administration of the Medical Center, or designee, or when the admission of a case would, in the opinion of the examining physician, and concurred by the Chairman of the Department or his designee, endanger other patients, e.g. communicable illness, acute psychiatric disturbance.

2. No patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated and unless admitted by a member of the Medical Staff with admitting privileges, and in accordance with admitting policies of the Medical Center. Practitioners admitting emergency cases shall be prepared to justify to the respective Department Chairman and the Medical Board that the said emergency admission was a bona-fide emergency.

   The term ‘bona-fide emergency’ may be applied only to those situations in which a delay in admitting the patient via the Admitting Office would pose a serious threat to the life of the patient. The medical record must clearly justify the patient being admitted on an emergency basis and such findings shall be recorded on the patient’s chart as soon as possible after admission.

3. A member of the Medical Staff will be responsible for the medical care of each patient in the Medical Center, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the patient’s condition to a referring practitioner and to the patient’s family. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility will be entered on the order sheet of the medical record.

4. Each clinical department shall submit, to the Medical Board, subject to approval by the Board of Trustees, the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.

5. All patients shall be attended by physicians, dentists, or podiatrists who are active members of the Medical Staff. Patient requiring admission who have no attending physician shall be assigned, with the knowledge (as much as feasible) of the patient, to members of the Medical Staff in the Department to which the illness of the patient indicates assignment.

6. Patients shall receive from the responsible practitioner information necessary to obtain an informed consent pursuant to Medical Center policy.

7. Any competent person who is eighteen (18) years of age or older, may give consent for medical, dental, podiatric health and Medical Center services, and require no other consent.

Parents of a child, if competent, may give consent, regardless of age.

Married individuals, if competent, may give consent, regardless of age.

8. Physicians in charge of inpatients shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm, as well as protection of other patients, Medical Center personnel, and visitors, from those who are a source of danger from any cause whatsoever.

9. Within twenty-four (24) hours before or after admission, every patient shall have a complete history and physical examination performed by a physician, nurse practitioner, certified midwife, or physician assistant. Oral and Maxillofacial surgeons can be privileged to perform complete admission history and physical examinations. Podiatrists can be privileged to perform comprehensive history and physical examinations in conjunction with the provision of podiatric treatment.

10. For inpatients, the medical history shall include:

    a. Present illness

    b. Past medical history

    c. Past surgical history

    d. Allergies

    e. Medication Reconciliation

    f. Review of Systems

    g. Family History

    The admission physical examination shall include:

    a. Cardiac

    b. Pulmonary

    c. General neurologic

    d. Affected area

    e. On women aged twenty-one (21) and over, unless medically contraindicated:

        i. A documented screening uterine cytology smear, unless performed within the previous three years

        ii. Palpation of the breast

    f. Within 24 hours after admission, a chest x-ray on all patients from the community in which the Commissioner of Health has determined there is a prevalence of tuberculosis, unless performed within the previous six months; and

    g. Examination for the presence of sickle cell hemoglobin on all patients over 6 months who are identifiable as susceptible to sickle cell anemia, unless recorded evidence is available that such tests have previously been performed.

11. For outpatients, the medical history shall include:

    a. Present illness

    b. Past medical history

    c. Allergies

    d. Medication Reconciliation

    e. Review of Systems

    The physical examination shall include:

    a. Cardiac

    b. Pulmonary

    c. General neurologic

    d. Affected area

12. Insofar as is practicable, the admitting physician shall request from persons applying for admission, information concerning signs or symptoms of recent exposure to communicable disease. Whenever there are positive findings, the practitioner shall take appropriate measures relative to isolation and care of the patient.

13. Each practitioner must assure timely, adequate professional care for his/her patients in the Medical Center, by being available or having available an eligible alternate practitioner with whom prior arrangements have been made.

14. It is incumbent upon every staff member to participate in the Discharge Planning Program, the Utilization Review Program, and all other legally mandated functions of the Medical Staff in relation to admission review, continued stay reviews, and medical care evaluation programs.

15. No persons admitted for medical care shall be transferred or discharged from the Medical Center without the approval of the responsible attending physician who shall determine that such removal is without hazard to the patient, or such removal is considered in the person's best interest despite the potential hazard of movement, or in the case of transfer, the appropriate medical facility has been given prior notification.

16. All discharges, when feasible, should be accomplished before 11:00 A.M. daily. Except when special circumstances exist, notice of discharge should be made at least one (1) day prior to the patient's discharge in order to permit preparation for it, e.g. patient's bill, discharge diet, etc. Patients are encouraged to have a responsible escort present upon discharge. At the time of discharge, the medical staff physician, when feasible, should complete the required final diagnosis, sign the patient's medical record, and ensure that same is otherwise complete.

17. No adult shall be detained in the Medical Center against his/her will, nor shall a minor under eighteen (18) years of age be detained against the will of his/her parents, legal guardian or custodian, except as authorized by law. This provision shall not be construed to preclude a patient to remain in the Medical Center in his/her own interest, for the protection of himself or others, pending prompt legal determination of his/her rights. If a presumptively competent patient insists that he/she be discharged against the advice of a member of the Medical Staff and efforts to dissuade him/her are unavailing, the patient (or patent, legal guardian or custodian) shall be required to sign the form entitled "Release for Leaving the Hospital Against Medical Advice". In the event of refusal to sign such form, this act shall be documented on the patient's chart. In no event should a patient be detained solely for non-payment of his/her hospital bill or physician's statement for medical services.

18. An unemancipated minor under eighteen (18) shall be discharged only in the custody of his/her parent(s), a member of his/her immediate family, or his/her legal guardian or custodian, unless the parent(s), guardian or custodian shall otherwise direct. In the case of a hospital death, the deceased shall be pronounced dead by the attending practitioner within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or his/her designee. If the attending practitioner is not on premises, it is the responsibility of the designated house officer to notify the responsible attending practitioner, and to record same in the hospital record.

19. The Department of Pathology no longer performs autopsies. If a family requests an autopsy, please call the laboratory for further information.

Section 3. Medical Records

1. The physician of record shall be responsible for the preparation and maintenance of a complete and legible medical record for each patient, the content of which shall be pertinent and current. A complete medical record is one which includes patient identification, data, complaints, history of present illness, personal and family history, physical examination, doctor's orders including dietary orders, special examinations and consultations, clinical laboratory and x-ray examinations, as well as other examinations, provisional or working diagnosis, treatment and medications given, surgical reports (including operative and anesthesia records, operations, treatment, gross and microscopic pathological findings), progress notes, and condition at discharge.

2. When the history and physical examination and/or hemoglobin or hematocrit, urinalysis, pre-anesthetic note, a required consultation report, signed operative informed consent are not recorded before the time stated for the operation, it shall be the responsibility of the anesthetist to so report and the operation shall be canceled unless the surgeon attending the patient states in writing that such delay would constitute a hazard to the patient.

3. The pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with special orders, as well as with the results of tests and treatment. Progress notes shall be written at least daily or more often if there is difficulty in diagnosis or management of the clinical problem.

4. Patients shall be discharged only on the written order of the physician attending the patient, or designee.

5. All clinical entries in the patient's medical record shall be accurately dated, timed, and signed.

6. Symbols and abbreviations may be used only when they have been approved by the Medical Board. The official record of such symbols and abbreviations is available in the Medical Record Department and the offices of the clinical departments.

7. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, dated, and signed by the responsible physician as soon after the discharge of the patient as possible.

8. Unless otherwise permitted by law, the written consent of the patient, his/her legal guardian or custodian, or representative is required for release of medical information to persons otherwise not authorized to receive this information.

9. Medical records may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with a court order, subpoena or statutes. All records are the property of the Medical Center and shall not be taken away without the permission of the President of the Medical Center or his designee. In the case of a readmission of a patient, all previous records shall be available for the use of the practitioner. This shall apply whether the patient is attended by the same practitioner or another. Unauthorized removal of charts from the Medical Center by staff members shall be grounds for suspension of Medical Staff privileges.

10. Nothing contained in a patient's medical record shall be removed from the chart. Alterations may not be made in the chart, but, instead, a fully explanatory new entry shall be made to correct or alter a previous entry.

11. Medical records must accompany the patient, e.g., from the Nursing Unit to the Operating Room, from the Operating Room to the Recovery Room, etc.

12. All of the patient's medical records, including progress notes, final diagnosis and clinical summary, shall be completed by the responsible practitioner at the time of discharge, either dictated or written legibly, but, in no event later than thirty (30) days following the date of such discharge. A complete medical record shall be defined as in Section 3.1 of Article XII. In the event that the record shall remain incomplete thirty (30) days after such discharge, the procedure set forth in the procedure set forth in Article VII, Section 3 of the Medical Staff Bylaws shall be followed.

13. Free access to all medical records of all patients shall be afforded to staff physicians, dentists and podiatrists in good standing for bona-fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

    Subject to the discretion of the President of the Medical Center or his designee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients, covering all periods during which they attended such patients in the Medical Center.

14. Entries in the Medical Record by House Staff or post-graduate trainees that require review and adoption by supervisory or attending Medical Staff members within 24 hours are:

    a. Admission history and physical examination

    b. Progress notes

    c. Consultation requests

    Adoption of the above sections of the medical records shall be affected by counter signature or the creation of a progress note by the supervisory or attending practitioner which acknowledges the content of the above medical record entries and either adopts or amends the instructions contained therein.

15. The discharge summary must be signed by the attending practitioner within thirty (30) days of its completion.

    Operative reports must be dictated immediately upon completion of the procedure.

    Medication Reconciliation needs to be completed immediately and provided to the patient at discharge.

    Attending Physicians shall sign all consultation requests within twenty-four (24) hours. Consultants must sign all consult opinions whether drafted by the consultant or his/her resident.

Section 4. General Conduct of Care

1. Orders

    All orders for treatment shall be in writing and signed on the Order Sheet. A verbal order shall be considered in writing if dictated to another member of the Medical Staff, or registered nurse, functioning within his/her sphere of competence and signed by the responsible practitioner.

    All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner, per his/her name. The responsible practitioner shall authenticate such orders within twenty-four (24) hours.

    The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written should not be carried out until rewritten or understood by the nurse. "STAT" orders shall be marked accordingly and the physician ordering the procedure shall sign the request and shall be available to receive the results.

    After notification is given to the attending physician, all previous orders are canceled automatically by transfer of the patient to another service, a Special Care Unit, or upon an order for an operation or delivery. After an operation, all preoperative orders are deemed automatically canceled and new postoperative orders must be written immediately after any surgical or obstetrical procedure.

2. Medication

The Medical Center Formulary must be used as a basis for orders for medication. A copy shall be kept available at each nurse's station. Except in clear emergency situations, drugs and medications not in the formulary will not be supplied. When a practitioner desires to order a necessary medication that is not in the formulary, he/she must personally consult the Chairman of his/her Department or a clinical member of the Pharmacy and Therapeutics Committee, and obtain special approval as a directive to the Director of the Pharmacy to obtain and supply the medication.

Except when a written order is given by the attending practitioner, patients are not permitted to bring medication into the Medical Center, and same will be confiscated by the Admitting Nurse, if brought in. Use of the metric system is encouraged in ordering and prescribing medication. The generic name of a medication as stated in the Medical Center Formulary should be used. The proprietary name should not be used.

When a staff member prescribes a medication by trade name, he/she does so with the clear understanding and agreement that the Medical Center's Director of the Pharmacy may dispense a generically and biologically equivalent drug. Medication shall not be ordered for an inpatient to take home except for an emergency order. The Anesthesiology Department is responsible for the ordering of pre-operative medication on all patients going to surgery except that the patient may be administered a local anesthetic by the operating surgeon. This includes narcotics, barbiturates and other related pre-anesthetic drugs. It does not include pre-operative orders that are not related to the anesthetic management of the patient. All problems concerning pre-anesthetic medication should be referred to the anesthesiologist.

After notification is given to the attending practitioner, all orders for narcotics, sedatives, hypnotics, tranquilizers, and other controlled drugs shall expire after seventy-two (72) hours unless previously cancelled in writing.

3. Investigational Drugs

Testing of investigational drugs must be approved by the Pharmacy and Therapeutics Committee and the Institutional Review Board.

Investigational drugs may be used only under the supervision of the principal on-site investigator and in accordance with all applicable regulation of the U.S. Food and Drug Administration, and in the case of grants or contracts with the Department of Health and Human Services, there shall be compliance with the current provisions of the Code of Federal Regulations (CFR) relating to any project or program involving the conduct of biomedical or behavioral research on human subjects. In the case of Medical Center sponsored research activities which are not federally funded, or are not subject to policies and regulations promulgated by any agency of the federal government for the protection of human subjects, the Institutional Review Board shall function in accordance with the Medical Staff Bylaws. A prior legal consent, in writing, in accordance with 45 CFR Part 46, as amended and successor provisions, shall be obtained from the patient or legal guardian, before the use of investigational drugs.

4. Surgical Services

The individual responsible for administering anesthesia, or, if anesthetic is not to be administered, the surgeon, shall, prior to commencing surgery, verify the patient's identity, the site or side of the body to be operated upon, and ascertain that a record of the following appears in the patient's chart:

a. **Inpatient Surgery Medical History and Physical Examination Requirements:**

Every surgical patient shall have a complete history and physical examination, signed by a physician which can be performed up to thirty (30) days prior to admission. A preoperative note written and signed by the operating surgeon must be entered on the day of surgery prior to the commencement of the procedure.

Ambulatory Surgery Medical History and Physical Examination Requirements:

Prior to ambulatory surgery each patient shall have a history and physical examination appropriate to the patient's physical condition and the surgical procedures to be performed. The history and physical examination shall be performed no more than thirty (30) days prior to the outpatient surgery. An appropriate assessment, including a physical examination of the patient to update the patient's current medical status, shall be completed within twenty-four (24) hours of registration or admission, but prior to surgery or procedure requiring anesthesia services. A preoperative note written and signed by the operating surgeon must be entered on the day of surgery prior to the commencement of the procedure.

b. A written, signed informed consent conforming to the requirements of the Medical Center Policy. Such consent shall be obtained prior to the operative procedure except in those situations where the patient's life is in jeopardy and signature cannot be obtained because of the patient's condition. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from a parent, guardian, or next-of-kin, these circumstances shall be fully explained in the medical record. In such cases, a consultation, if possible, before the emergency operative procedure is undertaken, may be desirable, if time permits.

c. Should a second operation be required during the patient's stay, a second consent, specifically worded, should be obtained. If two (2) or more procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

The surgeon shall be responsible that a record is maintained in the operating room suite for each operation performed, indicating compliance with the procedures established by the Medical Center to assure that foreign objects are not inadvertently left in the patient's abdominal or other cavities. The Medical Center's separate specific regulations for pre-operative prep and scrub techniques shall be strictly observed. All pre-operative orders are automatically cancelled upon operation and new post-operative orders must be written immediately.

The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. When major surgery is performed, there shall be an assisting physician in attendance who is capable of protecting the patient in the event of incapacity of the surgeon, until a qualified surgeon can be summoned.

All operations performed shall be fully described in the medical record by the operating surgeon or his designee, as soon as possible after surgery as is feasible. All parts and tissues, including teeth and all foreign bodies, removed during surgical and diagnostic procedures shall be delivered to the Department of Pathology. The Department of Pathology shall make such examination as it may consider necessary to arrive at a tissue diagnosis. A signed report of the Pathologist's findings shall be filed in the patient's chart.

The anesthesiologist shall have overall responsibility for patient supervision in the Recovery Room, subject to the post-operative orders of the patient's surgeon, who is responsible for being on call for any emergency complications. The anesthesiologist is responsible for determining when a patient is sufficiently recovered to permit transfer to his/her room and for ordering such transfer.

The surgeon is responsible for proper reporting of all wound infections, as well as any other infection of his patient, on the Medical Center form designated for that purpose.

Surgeons must be in the operating room and ready to commence with the operation at least fifteen (15) minutes prior to the scheduled time. The operating room shall not be held for longer than thirty (30) minutes after the scheduled time. The applicable Departmental Chairman or designee may cancel surgery if this rule is not followed. The surgical procedure shall be rescheduled for the next available time or at the end of the day's schedule.

5. Dental Patients

A patient admitted for dental care is the dual responsibility of a dentist and a physician member of the Medical Staff. The dentist's responsibilities shall include, but not be limited to:

a. A detailed dental history to justify hospital admission,

b. A detailed description of the examination of the oral cavity, and a preoperative diagnosis,

c. A complete operative report describing the findings and technique. In the case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth shall be sent to the Medical Center Pathologist for examination,

d. Progress notes as are pertinent to the oral condition,

e. Clinical resume or summary statement.

The responsibilities of the physician shall include, but shall not be limited to:

a. Medical history pertinent to the patient's general health,

b. A physical examination and assessment to determine the patient's condition prior to anesthesia and surgery,

c. Supervision of the patient's general health status while hospitalized. The discharge of the patient shall be on written order of the dentist member of the Medical Staff,

d. Qualified oral and maxillofacial surgeons can be privileged to perform a comprehensive admission history, physical examination, and the medical assessment of patients. Only prior to major high-risk procedures shall a consultation with a qualified physician be required.

6. Allied Health Professional Services

Members of the Allied Health Professional Staff shall be under the supervision of a physician member of the Medical Staff. The responsibilities of the Allied Health Professional Staff shall be:

a. To exercise judgment within their areas of expertise,

b. To participate directly in the management of patients under the supervision or direction of the Medical Staff,

c. To record reports and progress notes in patient records and write orders to the extent established for them by the Medical Board.

The responsibilities of the physician shall include, but not be limited to:

a. Medical history pertinent to the patient's general health,

b. Physical examination to determine the patient's condition prior to the procedure or treatment,

c. Supervision of the patient's general health status while hospitalized,

d. Discharge of the patient.

7. Consultations

Except in emergencies, consultation with another qualified practitioner member of the Medical Staff is required in the following situations, but shall not be limited thereto:

a. Unusually complicated situations where specific skills of other practitioners may be needed,

b. In instances in which patients exhibit suicidal tendencies or other severe psychiatric symptoms,

c. For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health,

d. Those situations specifically designated by the State Department of Health and incorporated in the Administrative Policy and Procedure relating to Consultations,

e. Or in the Regulations of the Clinical Departments or Special Care Units,

f. When the patient has a condition which has been excluded from the privileges granted and delineated to the attending physician of record.

The attending practitioner or designee, i.e. a Resident under the supervision of the attending practitioner, is responsible for requesting a consultation. A qualified Resident, supervised by a qualified member of the Medical Staff may answer a consultation request; countersignature within twenty-four (24) hours by the attending is required.

An acceptable consultation includes examination of the patient and the patient's record and a written opinion, signed by the consultant, which is made a part of the patient's record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the procedure.

A member of the Medical Staff, Board certified or eligible, shall be qualified to give an opinion in the field in which his opinion is sought. In general, only members of the Medical Staff shall serve as consulting physicians. However, in special situations, qualified physicians not on the Medical Staff of the Medical Center may be requested to visit a patient in the Hospital and advise the physician responsible for the care of the patient, as well as observe the course of treatment, provided the consultant has been granted temporary privileges pursuant to Article III, Section 9 of the Medical Staff Bylaws. The member of the Medical Staff requesting such a consultant shall first notify and obtain the permission of the Departmental Chairman concerned, and the Chief Medical Officer. Such permission must appear on the patient's record. The request for consultation and the consultation report itself shall be made on the Medical Center form for this purpose, and shall be incorporated into the medical record.

8. Use of Distinctive Osteopathic Approach in the Provision of Care

Osteopathic physicians shall subscribe to and utilize the distinctive osteopathic approach to the provision of care.

Section 5. Medical Examiners Cases

The physician of record, or his/her designee is responsible for recording in the progress notes, the data and title of direct contact with the Office of the Medical Examiner, the name of the Medical Examiner, or, in the case of the designee, who is authorizing disposition of a case, and a statement as to the disposition of the case, including the Medical Examiner number.

Section 6. Patient Care Regulations

Transfer of care of a patient from one member of the Medical Staff to another must be indicated on the medical record by a signed note certifying the consent of the accepting physicians. The Admitting Office shall be notified of such transfers.

The Medical Center requires that its staff members and personnel, in dealing with patients, take proper precautions to insure the correct identification of patients in order to prevent errors in the provision of services. A plastic band containing an insert with identifying information is placed on every patient, including newborns. In addition to checking the patient's identification by every standard method, it is also mandatory Medical Center routine to check the plastic band identification.

Patients shall not be exposed unnecessarily during examination, but shall be protected by screens, curtains or drapes. An order to raise side rails for a patient is a medical responsibility accomplished by entering an order. When side rails have been ordered raised, their removal is only accomplished by another written order. If the physician's order for side rails is refused by the patient, the patient must sign an appropriate release form.

An order to place a patient on the critical list is an alert to all pertinent sections of the staff, and also an official notice conveyed to the family. The order may permit waiving of the Medical Center's routine visiting hours and rules, unless specified otherwise in specialized areas. Such an order may be made and applied only to patients who have become critically ill.

Medical Staff members are expected to refer their patients who may need social service assistance to the Social Service Department. Whenever a practitioner has reasonable cause to suspect that a patient under eighteen (18) years of age is an abused or maltreated child (i.e. appears to have had severe physical or emotional injury inflicted upon him/her by other than accidental means), said practitioner shall report the matter to the Social Service Department for completion of such report and carrying out of such action as is required under the Social service Law of the State of New York.

It is the policy of the Medical Center that no patient shall be permitted to leave the Medical Center on pass, except in extraordinary circumstances (e.g. to attend the funeral of an immediate member of the family). Any such exception must be approved by Administration.

Section 7. Medical Center/Staff/Patient Relations

1. Members of the Medical Staff are to use their Medical Center titles in all research projects, publications or exhibits, etc.

2. Medical Center supplies and equipment are exclusively for the use of registered patients and are not to be removed from the Medical Center without Administrative approval.

3. Members of the Medical Staff are expected to cooperate with the Medical Center's Disaster Plan, and, in any emergency or local disaster requiring the presence of the staff.

4. Diagnosis or other clinical data should not be discussed in elevators, corridors, or any other public places where such conversation may be overheard.

5. The rules of the Medical Center in regard to "No Smoking" shall be observed by all.

6. Consistent with the Medical Center's policy of respect for the individuality and dignity of its patients, the members of the Medical Staff should familiarize themselves with, and be guided by the New York State Hospital Code entitled "Patients' Rights", a copy of which is available in the offices of the Patient Advocate and the clinical departments.

Section 8. Preoperative Medical Clearance/Evaluation

Preoperative medical evaluation by a physician is indicated and required for patients who have pre-existing medical conditions that are not well controlled, an existing medical condition that is evolving or unstable, or an acute process. Medical evaluation should include the patient's significant past history, existing co-morbidities (especially bleeding disorder, coronary, pulmonary, renal disease or allergies), physical examination, review of pertinent laboratory results and recommendations. The type of anesthesia shall be discussed by the anesthesiologist and the surgeon. The final decision on the type of anesthesia shall be determined by the anesthesiologist.

The ultimate decision to proceed with surgery will be made jointly by the attending surgeon and the anesthesiologist.

Section 9. Supervision of Post Graduate Trainees

Supervision of interns and residents shall be provided by attending physicians present in the hospital twenty-four (24) hours per day, seven (7) days per week pursuant to Administrative policy and procedure code 1.23.

All hospital in-patients shall be seen by a physician (resident, house staff, or attending) at least once per day, seven (7) days per week, and a note shall be created in the medical record documenting the nature of that physician's interaction with the patient.

- Admission history and physical examination
- Progress notes
- Consultation requests

Adoption of the medical record entries created by post graduate trainees by the supervising attending physician shall be reflected in the medical record by a daily note with attestation or an addendum with attestation to the post graduate trainee's note authored by the attending physician acknowledging the assessment and plan of the post graduate trainee and stating agreement with or exception to the plan. The addendum or attending note shall be timed and dated and shall be entered in the record within twenty-four (24) hours after a note is entered by the post graduate trainee.

A qualified resident, under the supervision of an attending practitioner, can request a consultation or can answer a consultation request. The requesting attending physician shall review and evaluate the resident's consultation request and document same with counter signature or a progress note in the chart within twenty-four (24) hours.

The postgraduate trainees will maintain a revised log which will reflect procedures done on a daily basis.

Daily conferences of postgraduate trainees shall be chaired by an assigned attending physician at all times.

Postgraduate trainees are required to use a stamp bearing their name and resident number beneath any signature in the medical record, so patient care can be properly monitored.

Section 10. Medical Students

Medical students may, to the extent allowed by applicable law and regulations, and with the approval of the patient's attending physician, take patient histories, perform complete physical examinations, and enter findings in the patient's medical record. All entries in a patient medical record by a medical student must be countersigned by an appropriately privileged physician within twenty-four (24) hours. Medical students may provide additional patient care services under the direct in-person supervision of an attending physician or authorized post-graduate trainee in accordance with New York State law. The attending physician or post-graduate trainee shall provide direct in-person supervision of the medical student's provision of patient care services at all times and ensure that the medical student renders appropriate patient care. In all patient care contacts, the patient shall be made aware that the provider is a medical student. All orders written by medical students must be approved and countersigned by a resident or attending physician prior to being implemented.

Article XIII
Amendments to Bylaws

Section 1. Proposal of Amendments

Amendments to these Bylaws may be proposed at any regular or special meeting of the Medical Board. Proposed amendments may originate from any voting member of the Medical Board, or from the Bylaws Committee. The proposed amendment shall be recorded in the Board's minutes, and, in a timely manner, referred to the Bylaws Committee.

The Bylaws Committee shall report its findings and recommendations to the Medical Board at its next regular meeting, the notice of which shall state that a proposed amendment to the Medical Staff Bylaws shall be acted upon, a copy of which may be obtained from the Secretary of the Medical Board. The quorum and voting requirements shall be a majority of the voting members of the Medical Board. The proposed amendment must then be presented to the organized Medical Staff at the next quarterly or special meeting of the Medical Staff Society for approval. A quorum shall be a majority of the voting members of the medical staff present. Their approval shall constitute an act of the Medical Staff.

Amendments may also be proposed upon written petition, of at least twenty percent (20%) of the members of the active staff, in good standing submitted to the President of the Medical Staff, who shall present the amendment at the next quarterly or special meeting of the Medical Staff Society.

A quorum shall be a majority of the voting members of the medical staff and the vote of a majority of the voting staff members present, if a quorum is present, shall constitute an act of the medical staff. If the proposed amendment is approved, it shall be presented by the President of the Medical Staff Society for consideration at the next regular or special meeting of the Medical Board. Medical Board action shall, thereafter, be in accordance with Article XIV Section 1a. If the Medical Board votes not to accept the proposed amendment, the organized Medical Staff may choose to present the proposed amendment directly to the Board of Trustees for consideration.

A copy of all proposed amendments shall be submitted to the Board of Trustees through the President/CEO of the Medical Center.

Any proposed amendments adopted by the Medical Board or the organized Medical Staff shall be effective when approved by the Board of Trustees.

Section 2. Adoption of Urgent Amendments

In the case of a documented need for an urgent Amendment to these Bylaws necessary to comply with law or regulation, the Medical Board may provisionally adopt and the Board of Trustees may provisionally approve the proposed amendment without prior notification of the Medical Staff. The Medical Board will immediately notify the organized Medical Staff of the provisional amendment. The organized Medical Staff will then review the amendment and submit comments to the Medical Board. If there is no conflict, the amendment stands. If the Medical Staff votes to revise the amendment, the policy for conflict management should be followed. If necessary, a revised amendment is then submitted to the Board of Trustees for approval.

The revised amendment shall be effective when approved by the Board of Trustees.

Article XIV
The Medical Staff Bylaws and the Bylaws of the Corporation and the Board of Trustees of Wyckoff Heights Medical Center

Section 1. Conformity of the Bylaws

The Medical Staff Bylaws shall conform with the Corporate Bylaws of the Medical Center and any provision in, or amendment to, the Corporate Bylaws inconsistent with the provisions of these Medical Staff Bylaws, Rules and Regulations shall be deemed to amend the latter to the extent necessary to conform to the Corporate Bylaws. In the event of a conflict or dispute regarding the referenced amendment, the same shall be resolved as set forth in the Medical Center conflict management policy.

Section 2. Interpretation

In cases of disputed interpretation of these Bylaws, the decision of the President/CEO of the Medical Center shall govern, until the Board of Trustees shall otherwise rule.