

THE MEDICAL STAFF

BYLAWS

OF

NORTH SHORE UNIVERSITY HOSPITAL

As Amended through September 30, 2021.

TABLE OF CONTENTS

PREAMBLE 1

DEFINITIONS 3

ARTICLE I NAME..... 6

ARTICLE II PURPOSES 6

ARTICLE III MEMBERSHIP ON THE MEDICAL STAFF 7

 Section 3.1 NATURE OF MEDICAL STAFF MEMBERSHIP 7

 Section 3.2 QUALIFICATIONS FOR MEMBERSHIP 7

 Section 3.3 PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT 8

 Section 3.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERS 9

 Section 3.5 ETHICS 12

 Section 3.6 TERMS OF APPOINTMENTS 12

 Section 3.7 CLINICAL PRIVILEGES 12

 Section 3.8 ORGAN PROCUREMENT ORGANIZATION EXEMPTION 15

 Section 3.9 COMMUNICATION OF BYLAWS AND REVISIONS
 TO THESE BYLAWS 15

 Section 3.10 MEDICAL STAFF CREDENTIALS AND QUALITY FILES 15

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF 16

 Section 4.1 THE ACTIVE STAFF..... 16

 Section 4.2 THE PRECEPTEE STAFF 18

 Section 4.3 THE TELEHEALTH STAFF 19

 Section 4.4 HONORARY STATUS 21

ARTICLE V DEPARTMENTS OF THE MEDICAL STAFF..... 21

 Section 5.1 CLINICAL DEPARTMENTS 21

 Section 5.2 DEPARTMENT CHAIRS 22

 Section 5.3 DEPARTMENT MEETINGS/COMMUNICATION..... 25

 Section 5.4 EMERITUS TITLE..... 26

ARTICLE VI MEDICAL BOARD AND COMMITTEES 26

 Section 6.1 THE MEDICAL BOARD AND ITS OFFICERS..... 26

 Section 6.2 STANDING COMMITTEES OF THE MEDICAL BOARD 30

 Section 6.3 MEDICAL BOARD AND COMMITTEE MEETINGS 38

 Section 6.4 OTHER COMMITTEES..... 38

ARTICLE VII COMMITTEE ON QUALITY 39

ARTICLE VIII CORRECTIVE ACTION FOR MEDICAL STAFF MEMBERS.....	39
Section 8.1	CORRECTIVE ACTION PROCESS DEFINED 39
Section 8.2	SUMMARY ACTION PROCEEDINGS..... 44
Section 8.3	AUTOMATIC TERMINATION OF MEDICAL STAFF MEMBERSHIP. 45
Section 8.4	AUTOMATIC SUSPENSION OF MEDICAL STAFF MEMBERSHIP 45
Section 8.5	DUTY OF COOPERATION..... 46
ARTICLE IX THE POSTGRADUATE TRAINEE STAFF	46
Section 9.1	NATURE OF POSTGRADUATE TRAINEE STAFF MEMBERSHIP 46
Section 9.2	RESIDENT/FELLOW MANUAL..... 46
Section 9.3	THE CORPORATION’S BYLAWS 47
ARTICLE X THE ALLIED HEALTH PROFESSIONAL STAFF.....	47
Section 10.1	NATURE OF ALLIED HEALTH PROFESSIONAL STAFF MEMBERSHIP 47
Section 10.2	TEMPORARY AND VISITING PRO TEM PRIVILEGES 48
Section 10.3	CORRECTIVE ACTION FOR ALLIED HEALTH PROFESSIONAL STAFF MEMBERS 49
Section 10.4	THE CORPORATION’S BYLAWS 50
ARTICLE XI IMPAIRED MEMBERS OF THE MEDICAL STAFF AND ALLIED HEALTH PROFESSIONAL STAFF.....	50
Section 11.1	INVESTIGATION OF POSSIBLE IMPAIRMENT 50
Section 11.2	REMEDIAL ACTION/VOLUNTARY REMEDIES 50
Section 11.3	REQUEST FOR, OR SUMMARY, CORRECTIVE ACTION..... 51
Section 11.4	CONFIDENTIALITY 51
ARTICLE XII OPERATIONAL COMMITTEES.....	51
ARTICLE XIII OFFICERS OF THE MEDICAL STAFF SOCIETY	52
Section 13.1	OFFICERS 52
Section 13.2	QUALIFICATIONS FOR OFFICE 52
Section 13.3	TERMS OF OFFICE..... 53
Section 13.4	CONDUCT OF ELECTIONS..... 54
Section 13.5	DUTIES OF OFFICERS OF THE MEDICAL STAFF 55
Section 13.6	RESIGNATION OR REMOVAL OF OFFICERS OF THE MEDICAL STAFF 58
Section 13.7	MEDICAL STAFF ADVISORY BOARD 59
Section 13.8	MEETINGS..... 59

ARTICLE XIV SYOSSET CAMPUS PROVISIONS.....	60
Section 14.1 CLINICAL DEPARTMENTS AT THE SYOSSET CAMPUS	60
Section 14.2 SELECTION OF DEPARTMENT DIRECTORS AT THE SYOSSET CAMPUS	60
Section 14.3 STANDING COMMITTEES OF THE SYOSSET CAMPUS.....	61
ARTICLE XV IMMUNITY FROM LIABILITY	68
ARTICLE XVI RULES AND REGULATIONS & ASSOCIATED POLICIES.....	69
Section 16.1 ADOPTION AND AMENDMENT	69
Section 16.2 NOTICE OF ADOPTION.....	69
ARTICLE XVII REVIEW AND AMENDMENTS.....	70
Section 17.1 BIENNIAL REVIEW.....	70
Section 17.2 PROPOSED AMENDMENTS	70
Section 17.3 NOTIFICATION AND ADOPTION OF PROPOSED AMENDMENTS...	71
Section 17.4 NOTICE OF ADOPTION.....	72
ARTICLE XVIII CONFLICT MANAGEMENT PROCESS.....	72
ARTICLE XIX ADOPTION	74

PREAMBLE

North Shore University Hospital (the “Hospital”) is a voluntary hospital established as a New York not-for-profit corporation licensed under the laws of the State of New York. The Hospital includes the Manhasset Campus and the Syosset Campus (each, a “Campus”). The Hospital is part of Northwell Health (“Northwell”), the mission of which is to improve the health of the communities its healthcare institutions serve with a commitment to providing the highest quality clinical care; educating the current and future generations of health care professionals; searching for new advances in medicine through the conduct of biomedical research; promoting health education; and caring for the entire community regardless of ability to pay.

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

- To ensure that all patients admitted to or treated in any of the facilities, campuses, departments or services of the Hospital shall receive the best possible care, irrespective of their race, color, creed, religion, gender, national origin, sexual orientation, veteran’s status, marital status, age, disability, or ability to pay for such care.
- To provide reliable and valid measures for the continuous evaluation of the overall quality of care provided to all patients of the Hospital and to make recommendations thereon to the Board of Trustees so that all patients admitted or treated at any of the facilities, departments or services of the Hospital receive safe, high quality care.
- To ensure a high level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges to practice in the Hospital and the regular review and evaluation of the activities of all individuals granted clinical privileges in the Hospital.
- To provide education and maintain the highest scientific and educational standards in cooperation with the Hospital’s affiliated medical school(s) and to ensure an optimum atmosphere for continuous progress in professional knowledge and skill of all members of the Medical Staff and those allied health practitioners affiliated with the Medical Staff.
- To initiate and maintain rules and regulations for the governance of the Medical Staff.
- To discuss issues concerning the patients, Medical Staff and the Hospital with the Board of Trustees, the Chief Executive Officer (“CEO”) and the Executive Directors, through authorized representatives and structures of the Medical Staff, such as the Medical Board and the Committee on Quality.
- To stimulate and foster approved clinical and laboratory research by members of the Medical Staff and to assist in providing funds therefor.
- To support programs associated with community public health needs.

- To conduct all of the above activities with an overriding concern for the patient and the recognition of his or her dignity as a human being.
- To render other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.

It is recognized that the Medical Staff of the Hospital shares responsibility for the quality of patient care and performance improvement at the Hospital and must accept and discharge that responsibility, subject to the ultimate authority of the Board of Trustees of the Hospital Corporation (“Corporation”), and that the cooperative efforts of the Board of Trustees, the CEO, the Executive Directors, the Chief Medical Officer, the Medical Directors and the Medical Staff are necessary to fulfill the Hospital’s obligations to its patients.

In order to further the aims and purposes of the Hospital, therefore, the practitioners practicing at the Hospital have organized themselves into a Medical Staff in conformity with these Bylaws, and the Rules and Regulations, which are subject to and shall not conflict with the Bylaws of the Hospital Corporation.

DEFINITIONS

ACADEMIC YEAR – as used in these Bylaws shall mean the period from July 1st to June 30th, inclusive.

ADMINISTRATIVE OFFICE OF THE MEDICAL STAFF SOCIETY– The Administrative Office of the Medical Staff Society provides administrative support to the Officers of the Medical Staff in the performance of their duties and responsibilities as described in these Bylaws and to members of the Medical Staff in Medical Staff Society administrative matters.

BOARD OF TRUSTEES – shall mean the governing body of the Hospital Corporation, which includes the governing body of any entity to which governing body decision-making authority is delegated by the Corporation.

CAMPUS: MANHASSET & SYOSSET – shall mean the two current campuses of the Hospital. The Manhasset Campus is located at 300 Community Drive, Manhasset, NY 11030, and the Syosset Campus is located at 221 Jericho Turnpike, Syosset, NY 11791.

CHIEF ACADEMIC OFFICER – shall mean the individual appointed by the CEO who is responsible for the activities related to the affiliated medical school(s) and for the educational programs of the Hospital, including its postgraduate trainee staff, medical students and the continuing medical education of the Medical Staff.

CHIEF EXECUTIVE OFFICER (“CEO”) – shall mean the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of the Hospital. The CEO is the CEO of Northwell Health and of the Hospital.

CLINICAL PRIVILEGES – shall mean the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, surgical, etc., services to patients of the Hospital.

CORPORATION – shall mean the Hospital Corporation licensed under Article 28 of the New York Public Health Law.

DESIGNEE – shall mean the person designated to act on another’s behalf. Where Designee is a defined term, the designation shall require the following additional requirements. The person making the designation shall notify the Chair of the Committee/Subcommittee of their Designee in writing no less than annually. Such notice shall, at a minimum, specify the duration of such designation and the subject matter of such authority to act on the principal’s behalf. Such Designee shall not further designate another person to act on his or her behalf. In the event that a Designee cannot act on the principal’s behalf at any given time, the principal shall be responsible for providing notice of an alternate Designee as described herein or act his or herself. A person may only assign a Designee in relation to Medical Board and Credentialing activities.

EXECUTIVE DIRECTOR – shall mean the individual appointed by the CEO who is responsible for the administration of the day-to-day operations of the Hospital. There shall be an Executive Director at and responsible for each Campus. Unless a specific Campus is identified, references in these Bylaws to the Executive Director shall mean such individual at either or both Campuses, as applicable.

MEDICAL BOARD – shall mean the Executive Committee of the Medical Staff as further defined in Article VI of these Bylaws.

MEDICAL DIRECTOR – shall mean a physician qualified for membership on the Medical Staff, who shall be responsible for the day-to-day medical activities and directing the Organized Medical Staff of the Hospital in accordance with these Bylaws and applicable state and Federal laws and regulations. There shall be a Medical Director at and responsible for each Campus. Each Medical Director shall be appointed by and accountable to the Board of Trustees, upon the recommendation of the Executive Director of the respective Campus. Unless a specific Campus is identified, references in these Bylaws to the Medical Director shall mean such individual at either or both Campuses, as applicable.

MEDICAL STAFF – shall mean that organized body of physicians, dentists and podiatrists duly licensed and registered by the State of New York, and appointed by the Board of Trustees in accordance with these Bylaws and the Hospital's Corporate Bylaws, who have clinical privileges at the Hospital's inpatient and/or ambulatory care facilities. Members of the Medical Staff shall be considered part of an organized health care arrangement with the Hospital (as that term is defined in 42 CFR 160.103) when exercising their clinical privileges in the Hospital. The Medical Staff shall also mean the Organized Medical Staff as such term is defined in The Joint Commission's Comprehensive Accreditation Manual for Hospitals. The Organized Medical Staff also may be referred to as the Medical Staff Society.

MEDICAL STAFF SERVICES CENTRAL OFFICE – the Medical Staff Services Central Office, among other things, receives applications for Medical Staff membership and clinical privileges by practitioners wishing to be members of the Hospital's Medical Staff. The Medical Staff Services Central Office processes the application along with making all appropriate inquiries, and forwards completed applications to the Chairs of the Clinical Departments, the Credentials Committee, Medical Board, and the Board of Trustees for their review and approval.

NORTHWELL – shall mean Northwell Healthcare, Inc.

NORTHWELL CHIEF MEDICAL OFFICER – shall mean the person appointed by the CEO who has administrative oversight over all the clinical programs and related activities (not day-to-day medical activities) of each of the Northwell Hospitals, as defined below.

NORTHWELL CHIEF OPERATING OFFICER – shall mean the person appointed by the CEO who is responsible for the overall operational and administrative issues of the Northwell Hospitals, as defined below. In addition, at its discretion, the Board of Trustees may elect the Chief Operating Officer as an officer of the Corporation.

NORTHWELL CHIEF QUALITY OFFICER – shall mean the person appointed by the CEO who has administrative oversight over all of the aspects of the Hospital’s Quality Management program.

NORTHWELL HOSPITAL – shall mean a hospital in the Northwell network whose sole voting member is Northwell Health, Inc. or Northwell Healthcare, Inc.

VOLUNTARY MEDICAL STAFF – Members of the Medical Staff who maintain a private clinical practice independent of the Hospital.

VOTING MEMBER OF THE MEDICAL STAFF – shall mean a member of the Active Staff (except visiting pro tem appointees and members of the Special Services Staff) as to whom: (i) all Medical Staff dues have been paid in full; (ii) the member is not under automatic suspension pursuant to Section 8.4, first paragraph, of these Bylaws; and (iii) his or her medical staff appointment is not currently suspended or terminated; *provided*, however, that a suspension of a member’s medical staff appointment pending an investigation shall not preclude a member from being a Voting Member of the Medical Staff.

ARTICLE I
NAME

The name of this organization shall be the “Medical Staff of North Shore University Hospital” (hereinafter the “Medical Staff”).

ARTICLE II
PURPOSES

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

To ensure that all patients admitted to or treated in any of the facilities, Departments or services of the Hospital shall receive the best possible care, regardless of their race, color, creed, religion, gender, national origin, sexual orientation, veteran’s status, marital status, age, disability, or their ability to pay for such care.

To provide reliable and valid measures for the continuous evaluation and improvement of the overall quality of care provided to all patients of the Hospital and to make recommendations thereon to the Board of Trustees so that all patients admitted or treated at any of the facilities, Departments or services of the Hospital receive a safe and high quality of care.

To ensure a high level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges to practice in the Hospital and the regular review and evaluation of the activities of all practitioners granted clinical privileges in the Hospital.

To provide education and maintain the highest scientific and educational standards in cooperation with the Hospital’s affiliated medical school(s) and to ensure an optimum atmosphere for continuous progress in professional knowledge and skill of all members of the Medical Staff and those allied health practitioners affiliated with the Medical Staff.

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

To discuss issues concerning the patients, Medical Staff and the Hospital with the Board of Trustees, the Chief Executive Officer and Executive Directors, through authorized representatives and structures of the Medical Staff, such as the Medical Board, and the Committee on Quality.

To stimulate and foster approved clinical and laboratory research by members of the Medical Staff.

To support programs associated with community public health needs.

To conduct all of the above activities with an overriding concern for the patient and the recognition of his or her dignity as a human being.

To render such other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.

ARTICLE III

MEMBERSHIP ON THE MEDICAL STAFF

Section 3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

A. Membership on the Medical Staff is a privilege that shall be extended only to practitioners who upon application can demonstrate practical and academic competence and good character, and who continuously meet the qualifications, standards and requirements of the Hospital's Corporate Bylaws and of these Bylaws and the Rules and Regulations. Gender, race, creed, age, sexual orientation, disability, national origin or any other legally impermissible basis shall not be used in making decisions regarding the granting or denying of privileges or appointment to the Medical Staff. Appointments and reappointments to the Medical Staff shall be made by the Board of Trustees following recommendation by the Medical Board as provided in these Bylaws and the Rules and Regulations. In addition, in the absence of a conflict, members of the Medical Staff who are eligible for a faculty appointment to the affiliated medical school(s) shall accept such appointment if offered.

B. No practitioners shall be entitled to membership on the Medical Staff or to clinical privileges at the Hospital merely by virtue of the fact that they are licensed to practice their profession, or that they are members of or certified by any professional organization, or that they have or have had professional privileges at other hospitals.

C. Medical Staff members who, by virtue of their practice patterns, practice at one of the Campuses of the Hospital, but desire to exercise the same privileges at the other Campus of the Hospital, shall request an extension of their privileges in accordance with procedures established by the Medical Staff Services Central Office.

D. Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging process of the Hospital.

Section 3.2 QUALIFICATIONS FOR MEMBERSHIP

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

A. Be practitioners who can demonstrate acceptable levels and quality of education and who have graduated from an approved educational institution;

B. Have completed acceptable levels and quality of training in the discipline in which they are applying;

- C. Be board certified or board eligible as further prescribed in the Medical Staff Rules and Regulations;
- D. Unless granted a specific waiver by the Department Chair for a limited license or limited permit, as allowed by law, or unless applying only for Honorary status, possess unrestricted and duly registered licenses to practice their professions in the State of New York; and
- E. Unless granted a specific waiver by the Department Chair and approval by the Medical Board, not be involuntarily excluded as a participant in good standing in the Medicaid and Medicare programs.
- F. Such additional requirements as are set forth in the Medical Staff Rules and Regulations.

Section 3.3 PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Subsection 3.3.1 APPLICATION FOR APPOINTMENT/REAPPOINTMENT. Each application for membership on the Medical Staff will follow the procedure for appointments and reappointments as set forth by the Hospital. The Department Chair shall determine clinical privileges at each Hospital Campus. Each application shall be presented in a form satisfactory to the Board of Trustees and shall include all information deemed by the Board of Trustees to be necessary and appropriate to determine the practitioner's qualifications for Medical Staff membership, which the practitioner shall verify to be complete, true and correct. Such information shall include not less than the required information set forth in these Bylaws and in the Medical Staff Rules and Regulations.

Subsection 3.3.2 REVIEW OF APPLICATION AND RECOMMENDATION. Upon the written request of a practitioner, the Medical Staff Services Central Office shall provide to the practitioner an initial appointment application for Medical Staff membership and clinical privileges. The Medical Staff Services Central Office shall send applications for reappointment to Medical Staff members in advance of the expiration of their current appointment. An application shall be deemed completed by the applicant when it includes all required supporting data and documentation, except data and information that must be obtained directly from outside primary sources, as set forth in Subsection 3.3.1 of these Bylaws and in the Medical Staff Rules and Regulations. Completed applications shall be submitted by the applicant to the Medical Staff Services Central Office, and thereafter shall be processed and reviewed by the Medical Staff Services Central Office, the Department Chair or his/her Designee¹, the Credentials Committee and the Medical Board in accordance with the procedures described in these Bylaws and in the Medical Staff Rules and Regulations. If the Medical Board's recommendation is adverse to the applicant as to initial appointment or reappointment to the Medical Staff, or as to the extent of clinical privileges recommended, then the applicant shall be entitled to a hearing with respect thereto in accordance with Article VIII of these Bylaws and the Medical Staff Rules and Regulations. An adverse recommendation by the Medical Board shall be final and shall be transmitted to the Board of Trustees only if the applicant does not request a hearing within the time period specified for doing so or otherwise waives his or her right to a hearing.

¹ References in these Bylaws and Medical Staff Rules and Regulations to the "Department Chair" shall mean the "Department Director" on the Syosset Campus.

Subsection 3.3.3 BOARD OF TRUSTEES ACTION

A. The Board of Trustees may accept, reject or modify the recommendation of the Medical Board, or may refer the matter back to the Medical Board with a direction for further consideration.

B. The Executive Director shall give written notice of the final decision of the Board of Trustees to the practitioner. If the final decision of the Board of Trustees shall be to not appoint or reappoint a practitioner to the Medical Staff, or grant clinical privileges to the extent applied for, then the Executive Director shall inform the practitioner in writing of the reasons for the decision, which must relate to patient welfare, standards of patient care, the objectives of the Hospital or the character or competence of the applicant. Thereafter, the applicant shall be afforded an opportunity to appear before an appellate review committee of the Board of Trustees as provided in Article VIII of these Bylaws and the Medical Staff Rules and Regulations, unless the reason for the final decision was previously the subject of appellate review following a hearing on an adverse recommendation by the Medical Board, or the applicant waived his or her right to appellate review following such a hearing.

Section 3.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

Every member of the Medical Staff has responsibilities to the patient, to the Hospital, to the Department(s) in which he or she is a member, and to the Medical Staff.

Regarding the Patient, Medical Staff Members Shall:

1. Render the highest quality professional care fully consistent with prevailing standards of medical practice and conduct in his or her specialty, sub-specialty, or area of practice. The attending physician of record is responsible and accountable for coordination and implementation of the plan of care throughout the continuum. The attending of record will provide, as the accountable leader of the care team, the main line of communication to patients, their families and representatives, and the other members of the care team.

2. Care for patients at the Hospital regardless of their race, color, creed, religion, sex, sexual orientation, age, marital status, national origin, veteran's status, disability, or other category of legally impermissible discrimination, or the ability to pay for such care. Medical Staff members may not refuse to care for patients in the Hospital based on the patient's type of or lack of health insurance.

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

4. Provide for continuous care for his or her patients, provided that a physician may inform a patient that he or she refuses to give advice with respect to or participate in any induced termination of pregnancy.

5. Protect the privacy, confidentiality and security of patient information in accordance with the Hospital's Notice of Privacy Practices.
6. Where the appropriate diagnosis, treatment or therapy of a patient is subject to reasonable doubt, seek appropriate consultations in accordance with sound medical practice in his or her specialty, sub-specialty, or area of practice. Document in the medical record a well-defined plan of care that fully integrates all consultant recommendations into a unified care plan.
7. Maintain "primary ownership" of the patient unless there is an explicit and well-documented handoff of primary responsibility to another physician.
8. Not rebate a portion of a fee, or receive other inducements in exchange for patient referrals.
9. Documentation of a complete history and physical examination shall be completed and accessible within twenty-four (24) hours of admission to the Hospital. The history and physical examination are performed and documented by a physician, an oral-maxillofacial surgeon or other qualified licensed individual in accordance with law and Hospital policy. If a complete history and physical examination has been performed within thirty (30) days prior to admission, this requirement may be satisfied if a durable, legible copy of the documentation of this history and physical examination is placed in the patient's Hospital medical record at the time of, or prior to, any anticipated procedure, provided that an update to the patient's condition or a notation of no change has been recorded at the time of the admission or procedure. Other details associated with the recording of the history and physical examination are set forth in the Rules and Regulations of the Medical Staff.

Regarding the Hospital, Medical Staff Members Shall:

10. Cooperate fully and with sustained interest in the overall functions and activities of the Hospital, including, without limitation, serve on the Hospital's Operational Committees as may be requested by the Department Chair and/or Chair of the Medical Board.
11. Abide by all federal, state and local laws, rules and regulations; these Medical Staff Bylaws, the Medical Staff Rules and Regulations and the Hospital's Corporate Bylaws; and all Hospital and Department policies, rules and regulations, including, without limitation, those set forth in the Hospital's Notice of Privacy Practices, as they are amended from time to time.
12. Maintain ongoing evidence of his or her physical and mental competence and provide any additional health-related information requested by the Medical Board and/or the Hospital upon initial affiliation with the Hospital; he or she shall also provide a reassessment of his or her health status as frequently as necessary, but no less than annually, to ensure that he or she is free from health impairments which could pose potential risk to patients or personnel or which may interfere with the performance of duties. In the event of a health or other impairment, immediately notify the Hospital if any health or other impairment might interfere with performance of the Medical Staff member's duties or might pose a potential health risk to patients.

13. Cooperate with and participate in the Hospital's quality assurance and performance improvement program, risk management and malpractice prevention programs, legal compliance program and carry out committee activities as may be assigned.
14. Participate in relevant programs of continuing education as required by the appropriate Department Chair(s), and provide documentation thereof to the Chair(s) and/or the Chair(s) designee(s).
15. Maintain professional liability insurance covering his or her practice and duties at the Hospital naming the Hospital as a certificate holder, with an insurance company satisfactory to Northwell Health and with minimum limits not less than those set by the Board of Trustees, and satisfying such additional requirements as are set forth in the Medical Staff Rules and Regulations. The Medical Staff member shall use such insurance coverage in the event of a litigation that also names the Hospital and/or its employees as a defendant. The Medical Staff member shall immediately notify the Hospital and Department Chair of any change in the ability to maintain the necessary malpractice insurance.
16. Prepare and complete in a timely manner the medical record and other required records for all patients he or she admits or for whom he or she in any way provides care in the Hospital, as provided in these Medical Staff Bylaws and the Rules and Regulations and other applicable Hospital policies, rules and regulations.
17. Participate in the education and appropriate supervision of the Postgraduate Trainee Staff.
18. Safeguard the confidentiality of information learned or obtained from service on Hospital and Medical Board committees, including but not limited to peer review information and strategic information of the Hospital.
19. Provide emergency coverage for patients presenting to the Emergency Department, as assigned by the Department Chair.
20. Upon the occurrence or change in status of any matter identified in Section C, paragraph 1, of the Medical Staff Rules and Regulations, provide immediate written notification thereof to the member's Department Chair and the Medical Staff Services Central Office.

Regarding the Department, Medical Staff Members Shall:

21. Continuously meet all performance standards promulgated by the Department Chair.
22. Attend Department meetings and participate in continuing education activities according to Department guidelines.
23. Participate in Department and Medical Staff review and evaluation functions, and serve on departmental committees as may be requested by the Department Chair.

Regarding the Medical Staff, Medical Staff Members shall:

24. Perform staff, department, committee, and Hospital functions and assignments for which he or she is responsible by appointment, election or otherwise.
25. Pay mandatory Medical Staff Society dues by April 1st of each year as established by the Medical Staff Society Advisory Board pursuant to section 13.1 of Article XIII of these Bylaws. All Medical Staff Society dues not paid by April 1st of each year shall incur a late fee as established by the Medical Staff Advisory Board. A reappointment application shall be deemed incomplete when dues requirements are not satisfied and does not include all required supporting data and documentation. No dues are required to be paid by members of the Preceptee, Visiting Pro Tem, Special Services, Telehealth, and Honorary categories of the Medical Staff.
26. Provide current contact information (mail and electronic mail addresses, and telephone, cellular phone and pager numbers) to the Administrative Office of the Medical Staff Society and the Medical Staff Services Central Office, and update such information whenever it changes.
27. Serve on Medical Staff committees and on ad hoc hearing committees and perform other peer review activities as may be requested by the Department Chair and/or Chair of the Medical Board.

Section 3.5 ETHICS

The professional conduct of members of the Medical Staff shall conform to accepted principles of professional and medical ethics.

Section 3.6 TERMS OF APPOINTMENTS

All appointments to the Medical Staff shall be for periods not to exceed two (2) years. The Medical Staff appointment and clinical privileges of full-time employed practitioners in Clinical Departments that are comprised solely of full-time salaried physicians shall terminate immediately upon the termination of such practitioner's employment at the Hospital. During the initial appointment period, there shall be conferences between each member of the Attending Staff and his or her respective Department Chair for the purpose of reviewing the overall performance of the practitioner at the Hospital.

Section 3.7 CLINICAL PRIVILEGES

Subsection 3.7.1 LIMITATIONS ON CLINICAL PRIVILEGES. Appointment or reappointment to the Medical Staff shall entitle a practitioner to exercise only those clinical privileges granted to him or her by the Board of Trustees, except to the extent that a practitioner is granted temporary or emergency privileges as hereinafter provided.

Subsection 3.7.2 DELINEATION. Clinical privileges for each member of the Medical Staff shall be delineated in writing at the time of appointment, each reappointment, and when a revision of privileges in-between reappointment periods is recommended by the Chair in accordance with the method recommended by the Medical Board and approved by the Board of Trustees for the Clinical Department concerned, and shall be based on consideration of the practitioner's education, training, experience, demonstrated current competence, references, the objectives, plans and programs of the Hospital and such other relevant information as may be obtained. Members of the Attending Staff who seek privileges at a Campus other than the one where he or she holds his or her primary Medical Staff appointment shall follow the procedures set forth in these Bylaws.

Subsection 3.7.3 EMERGENCY PRIVILEGES. In the case of an emergency when a practitioner qualified by these Bylaws and the Rules and Regulations is not available, any licensed practitioner at the Hospital, regardless of his or her Department or extent of clinical privileges approved, shall be permitted and expected to do everything reasonably possible to save a patient from imminent serious harm or death. Such practitioner shall use every available resource of the Hospital, including calling for assistance as may be available.

Subsection 3.7.4 DISASTER PRIVILEGES. Disaster privileges may be granted when the Hospital's emergency management plan has been activated and the Hospital is unable to meet immediate patient care needs due to a national, State or local disaster or emergency. Such disasters and emergencies include, but are not limited to, unexpected events (whether human-made or natural or a combination of both) that result in a sudden, significantly changed or increased demand for the Hospital's services. Disaster privileges may be granted to a non-affiliated practitioner by the Executive Director or his/her authorized designee, which shall include the Medical Director and/or the Chair of the Medical Board, upon presentation of a valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current photo identification card from a health care organization that clearly identifies professional designation; or
- A current license to practice; or
- primary source verification of licensure; or
- identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals, (ESAR-VHP), or other recognized state or federal response organization or group; or
- 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); or
- Presentation by current administration or Medical Staff member(s) with personal knowledge regarding practitioner's identity and such individual's ability to act as a licensed independent practitioner.

A practitioner who is denied disaster privileges, or whose disaster privileges are subsequently revoked or restricted, shall not be entitled to the procedural rights set forth in Article VIII of these Bylaws.

The Hospital will ensure oversight of the professional performance of practitioners who are granted disaster privileges by any of the following: direct observation, mentoring or clinical review, as appropriate under the circumstances. Reassessment to determine whether such privileges should continue will occur within seventy-two (72) hours of granting disaster privileges.

The Hospital will provide appropriate identification badges for all practitioners who are granted disaster privileges.

Primary source verification of licensure of practitioners who receive disaster privileges begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours of granting disaster privileges. In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible thereafter. In this extraordinary circumstance, there must be documentation of *each* of the following:

- Why primary source verification could not be performed in the required time frame;
- Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
- Attempts to perform primary source verification as soon as possible.

Primary source verification of licensure certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.

These privileges will be in effect until the Executive Director or designee has deemed that the services of those practitioners granted disaster privileges are no longer needed for any reason. Upon termination of disaster privileges, the practitioner shall not be entitled to the procedural rights set forth in Article VIII of these Bylaws and the Medical Staff Rules and Regulations.

Subsection 3.7.5 EXPEDITED PRIVILEGES. The Hospital shall approve expedited appointments and reappointments to the Medical Staff in accordance with the Hospital's Expedited Privileges Policy and Procedure.

Subsection 3.7.6 CONTINUOUS PRACTICE REVIEW. Upon granting clinical privileges the Hospital shall perform focused professional practice evaluations and thereafter continuous review by way of ongoing professional practice evaluations of all privileged practitioners. The performance monitoring process shall be in accordance with Hospital policy and will include (i) criteria for conducting performance monitoring; (ii) a method for establishing a monitoring plan specific to the requested privilege; (iii) a method for determining the duration of

performance monitoring; and (iv) the circumstances under which monitoring by an external source is required. Focused professional practice evaluation will be consistently implemented in accordance with the criteria and requirement defined by Hospital policy. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege. The measures employed to resolve performance issues are defined and consistently implemented by Hospital.

Section 3.8 ORGAN PROCUREMENT ORGANIZATION EXEMPTION

As required by regulation, practitioners from outside organ procurement organizations designated by the Secretary of the United States Department of Health and Human Services and engaged at the Hospital solely in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to federal and state law shall be exempt from having to obtain a Medical Staff appointment or clinical privileges.

Section 3.9 COMMUNICATION OF BYLAWS AND REVISIONS TO THESE BYLAWS

The Medical Staff shall make these Bylaws and the Rules and Regulations and other policies of the Medical Staff available to individuals who have been appointed to the Medical Staff and/or granted clinical privileges. In addition, a copy shall be maintained in the Administrative Office of the Medical Staff Society and in the Medical Staff Services Central Office. The Hospital shall maintain an electronic copy on Northwell's internal website. The Medical Staff will notify such individuals by electronic mail of significant revisions to these Bylaws, the Rules and Regulations and other policies of the Medical Staff, if any, and such revised documents also shall be available in the Administrative Office of the Medical Staff Society, the Medical Staff Services Central Office, and on Northwell's internal website. Members of the Medical Staff shall be responsible for keeping informed of such revisions.

Section 3.10 MEDICAL STAFF CREDENTIALS AND QUALITY FILES

For each member of the Medical Staff and each person granted clinical privileges, the Hospital shall maintain separate, confidential credentials and quality files. These files shall contain all documentation relating to the practitioner, including his or her applications for appointment and reappointment, and pertaining to the quality of care rendered by him or her. The quality file shall be kept within the Clinical Department of the Medical Staff member.²

² On the Syosset Campus, the quality files shall be kept in the Quality Management Department.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall consist of the following categories: Active Staff, Preceptee Staff and Telehealth Staff. Each practitioner shall at the time of appointment to the Medical Staff be appointed to one of the foregoing categories.

Section 4.1 THE ACTIVE STAFF

The Active Staff shall consist of the Attending Staff, the Adjunct Staff, and the Special Services Staff. Except as provided hereafter, Voting Members of the Medical Staff shall have the right to participate in Medical Staff Society elections and to run for or hold office.

Subsection 4.1.1 THE ATTENDING STAFF. The Attending Staff shall consist of those physicians, dentists and podiatrists who admit patients to the Hospital or who practice a Hospital-based medical specialty, or are active in the patient care, education, research and preventive medicine programs of the Hospital as assigned by the Department Chair. The Attending Staff may include those practitioners whose appointments and privileges are contingent upon or otherwise subject to an agreement between the Hospital and any other facility or organization. Attending Staff members shall perform such duties as may appropriately be assigned to them by their respective Department Chairs in the patient care, education, research and preventive medicine programs of their respective Departments, whether such duties relate to inpatients, outpatients, or Emergency Department patients. Attending Staff members also shall be responsible for managing the medical care of all patients for whom they are the primary attending physician (physician of record). Members of the Attending Staff shall be eligible to serve on the Medical Board, shall attend the meetings of their respective Departments, and shall serve on Medical Staff, Medical Board, Operational, and Department committees, if requested to do so. Attending Staff members who have admitting privileges shall admit patients only in accordance with the admitting policies of the Hospital and such members' clinical privileges, as delineated, and shall comply with all applicable statutes, rules, regulations, and Hospital policies relating to patient admissions and inpatient discharge review procedures.

Subsection 4.1.1.1 TEMPORARY PRIVILEGES PENDING FINAL APPROVAL OF APPLICATION. Following approval by the Credentials Committee of a completed application for Medical Staff membership, and pending the recommendation of the Medical Board and final action by the Board of Trustees thereon, the Executive Director or his or her designee may, based upon the request of the Department Chair or his or her Designee to satisfy an important patient care need and, when applicable, in consultation with Northwell's Senior Vice President for Medical Affairs, grant temporary clinical privileges to an applicant. Temporary privileges shall also be based on verification of the following: (i) a current New York State license; (ii) relevant training or experience; (iii) current competence; (iv) ability to perform the privileges requested; (v) a query and evaluation of information obtained from the National Practitioner Data Bank; and (vi) no current or previously successful challenge to the applicant's licensure or registration. The grant of such privileges shall be upon such conditions as the Executive Director (or designee) at any time may in his or her discretion wish to impose, and shall

be exercised only under the supervision of the Department Chair concerned or his or her Designee. Temporary privileges on a completed application to the Medical Staff shall be granted for a period not to exceed one hundred and twenty (120) days. Such privileges may be revoked, reduced or restricted at will at any time by the Department Chair in whose Department the temporary privileges were granted, the Chair of the Medical Board, the Executive Director, or the Medical Director or his or her Designee. In such event, the practitioner shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws and the Medical Staff Rules and Regulations, and the patients of the practitioner shall be assigned to appropriate members of the Medical Staff by the responsible Department Chair or his or her Designee. The wishes of the patient shall be considered in the selection of the alternative practitioner. Practitioners with Temporary privileges are not eligible to vote or to hold office.

Subsection 4.1.1.2 VISITING PRO TEM PRIVILEGES. Under limited circumstances, practitioners who are needed to meet an important patient care need, including but not limited to clinical experts needed to proctor a member of the medical staff, individuals seeking focused training under the supervision of a member of the Medical Staff, and those who are requested by a patient (or another person authorized to consent on behalf of the patient) to provide clinical care, may be granted temporary privileges. All such practitioners shall be designated as *visiting pro tem*. Visiting pro tem appointments shall require the following documents: a request from the relevant department chair indicating the rationale for the appointment, approved by Northwell's Senior Vice President for Medical Affairs; a delineation of privileges completed by the applicant and approved by the department chair; a completed health assessment form; proof of malpractice insurance coverage that complies with the Bylaws; a current curriculum vitae that, for proctors, demonstrates that the applicant is a clinical expert; a DEA certificate if applicable to the privileges requested; evidence of infection control training compliant with New York State requirements; proof of current clinical competence evidenced by a minimum of one letter of reference from an authorized agent of the applicant's principal institution; and a copy of the current registration of the New York State license or, in such absence, the New York State Education Law regarding exemptions of such license shall apply and, in such instance, a copy of the out-of-state license shall be provided. The grant of *visiting pro tem* privileges shall be upon such conditions as the Executive Director (or designee) at any time may, in his or her discretion, wish to impose, and shall be exercised only under the supervision of the Department Chair concerned, or his or her Designee. The visiting pro tem appointee shall be under the appropriate level of supervision of the Chair of the Clinical Department or Designee. A *visiting pro tem* appointee shall not have the right to admit patients nor be the attending of record, or to vote, hold office, serve on committees or attend Medical Board or Medical Staff meetings. *Visiting pro tem* privileges shall be granted only for the period of time that the underlying rationale for such privileges justifies, and in any event not exceeding one hundred twenty (120) days. *Visiting pro tem* privileges may be terminated whenever, in the opinion of the Department Chair, the need or justification therefor no longer exists. Practitioners whose *visiting pro tem* privileges are so terminated, or whose request for such privileges is denied, shall not be entitled to the

procedural rights afforded by Article VIII of these Bylaws and the Medical Staff Rules and Regulations.

Subsection 4.1.2 THE ADJUNCT STAFF. The Adjunct Staff shall consist of those members of the Medical Staff who do not admit patients, but perform significant other services to the Hospital. Such members of the Adjunct Staff may not admit patients, but they may visit and review the charts of their patients when hospitalized. They may not render consultations or write orders concerning Hospital patients. Members of the Adjunct Staff shall have no other mandatory assigned duties in the Hospital except pursuant to specific provisions of the Corporate Bylaws of the Hospital, the Bylaws and the Rules and Regulations of the Medical Staff, and the policies and procedures of their respective Clinical Departments, as amended from time to time. Appointment to the Adjunct Staff shall be made in accordance with the provisions of Article III to these Bylaws and the Medical Staff Rules and Regulations. Adjunct Staff members shall serve on Medical Staff, Medical Board, Operational and Department Committees, if requested to do so, and as necessary in connection with the departmental quality assurance process and other clinical and administrative matters.

Subsection 4.1.3 THE SPECIAL SERVICES STAFF. A qualified physician, dentist or podiatrist who is needed to provide special services, including but not limited to physicians retained by a third-party vendor under contract with the Hospital to provide such services, may be appointed to the Special Services Staff upon the recommendation of the Department Chair, and with the approval of the Medical Board and the Board of Trustees. A practitioner appointed to the Special Services Staff shall have all of the qualifications and fulfill all of the requirements for membership on the Medical Staff; his or her special service shall be limited and stipulated; he or she shall not have the right to vote, hold office, serve on committees or attend Medical Board or Medical Staff meetings; he or she shall be encouraged, but not required, to attend departmental and/or divisional meetings; and his or her appointment to the Special Services staff shall automatically terminate without any of the procedural rights set forth in Article VIII of these Bylaws and the Medical Staff Rules and Regulations when the contract with the third-party vendor terminates, or when the physician ceases for any reason either to be retained by such vendor or to provide services to the Hospital under such contract, or when the physician is notified that the Department Chair has determined that the need for that practitioner's special service(s) no longer exists.

Section 4.2 THE PRECEPTEE STAFF

The Preceptee Staff shall consist of those physicians, dentists and podiatrists who are pursuing one or more years of advanced training in their specialty/subspecialty field, under the supervision of a member of the Hospital's Attending Staff, pursuant to an agreement between the Preceptee and the Hospital. Every Preceptee shall act, at all times, under the supervision of a member of the Hospital's Attending Staff, who shall be responsible for evaluating the performance, competence, ethical and moral conduct of such individual. Membership in the Preceptee Staff shall be contingent upon the Preceptee's continued employment by the Hospital. In the event that such employment terminates for any reason, the membership on the Medical Staff of such individual, and such individual's right to exercise any clinical privileges granted, shall auto-

matically terminate, effective as of the termination of employment. In the event that a Preceptee's Medical Staff membership or right to exercise clinical privileges is terminated for any reason, including, but not limited to termination of his/her employment, such individual shall not be entitled to the procedural rights provided in Article VIII of these Bylaws and the Medical Staff Rules and Regulations. Members of the Preceptee Staff may admit and attend patients in the Hospital under the supervision of a member of the Attending Staff. They shall not have the right to vote, hold office, serve on committees or attend Medical Board or Medical Staff meetings.

Section 4.3 THE TELEHEALTH STAFF

Subsection 4.3.1 MEMBERSHIP. The Telehealth Staff shall consist of those physicians, dentists and podiatrists who (i) hold an appointment in the Attending Staff medical staff category at least at one other Northwell Hospital (ii) satisfy the credentialing and other requirements for membership on the Medical Staff and (iii) whose clinical privileges are limited to the provision of Telehealth Services ("Telehealth Privileges"). All capitalized terms as used herein shall have the definitions ascribed to them below, or in the relevant Northwell policy. For purposes of these Bylaws, "Distant Site" shall mean an entity that has entered into an agreement with Hospital to make available one (1) or more health care practitioners that are members of its clinical staff to Hospital for the purposes of providing Telehealth Services.

Subsection 4.3.2 RIGHTS AND RESPONSIBILITIES OF TELEHEALTH STAFF MEMBERS. A practitioner appointed to the Telehealth Staff shall have all of the qualifications and fulfill all of the requirements for membership on the Medical Staff, as set forth in Article III of these Bylaws, except that he/she:

(a) Shall not be the attending of record. While a member of the Telehealth Staff shall be entitled to treat patients within the limits of his/her assigned clinical privileges and write orders for such patients, a member of the Active Staff shall serve as the attending physician of record and be primarily responsible for the care of such patients.

(b) Shall not have the right to vote, hold office, serve on committees or attend Medical Board meetings at Hospital.

(c) Shall be exempt from the obligation to pay Medical Staff dues at Hospital.

Subsection 4.3.3 CREDENTIALING OF TELEHEALTH STAFF MEMBERS. Members of the Telehealth Staff shall be subject to credentialing, and the granting of privileges, by Hospital, as the Originating Site. Such credentialing and granting of privileges shall be accomplished by means of one of the following methods:

(a) Non-Reliance by the Hospital on Information From the Distant Site

Hospital may credential and grant privileges to the Telehealth Provider without reference to, and without reliance upon, the credentialing process undertaken at, or the privilege determination made by, the Distant Site. In such circumstances, the practitioner

seeking Telehealth Privileges as a member of the Telehealth Staff shall be required to undergo, and successfully complete, the processes for appointment to the Medical Staff of Hospital, and the granting of clinical privileges in connection with such appointment, as set forth in Article III of these Bylaws.

(b) Reliance by the Hospital on Credentialing and Verification Information, but Not the Privilege Decision, of the Distant Site

Hospital may credential and grant Telehealth Privileges to the Telehealth Provider by relying, in whole or in part, upon the credentialing and verification information obtained from the Distant Site, but *not* the privilege determination of the Distant Site. In such circumstances, responsibility for the granting of Telehealth Privileges to an applicant remains with Hospital.

Subsection 4.3.4 CORRECTIVE ACTION AND DUE PROCESS.

Subsection 4.3.4.1. Subject to the provisions of Subsection 4.3.4.2 below, in the event that (i) the recommendation of the Medical Board is adverse to the applicant as to initial appointment or reappointment to the Telehealth Staff, or as to the exercise of Telehealth Privileges; or (ii) a member of the Telehealth Staff is the subject of a request for corrective action, the affected practitioner shall be entitled to request a hearing with respect thereto, in accordance with Article VIII of these Bylaws and the Medical Staff Rules and Regulations and Section O of the Rules and Regulations of the Medical Staff, as the same may be amended from time to time.

Subsection 4.3.4.2 Notwithstanding the provisions of Subsection 4.3.4.1 above:

(a) If a practitioner's Telehealth Staff membership and Telehealth Privileges are granted by reason of the practitioner's having a contract with Hospital or with the Distant Site, or by reason of the practitioner's having been employed or engaged by a vendor or other third party under contract with Hospital or with the Distant Site, then:

(i) such Telehealth Staff membership and Telehealth Privileges are contingent on (a) the continuing validity and effectiveness of the practitioner's contract with Hospital or the Distant Site, and/or (b) the continuing employment or engagement by the practitioner with the vendor or other third party and the continuing validity and effectiveness of the contract between such vendor or other third party and Hospital or the Distant Site; and

(ii) the Telehealth Staff membership and Telehealth Privileges of the practitioner shall automatically terminate (a) upon the termination of the practitioner's contract with Hospital or the Distant Site, (b) when the practitioner, for any reason, ceases to be employed or engaged by the vendor or other third party under contract with Hospital or with the Distant Site, or (c) the termination of the contract between such vendor or other third party and Hospital or the Distant Site. Such contract with Hospital or third party vendor should provide the practitioner

notice of this automatic termination. Under such circumstances, the practitioner shall not be entitled to any of the procedural rights set forth in Article VIII of these Bylaws, or in Section O of the Rules and Regulations of the Medical Staff, as the case may be, as the same may be amended from time to time.

(b) If Hospital determines, for any reason, to discontinue serving as an Originating Site for the provision of Telehealth Services to patients at any of its Campuses or its ambulatory care facilities, then the Telehealth Staff membership and Telehealth Privileges of all Telehealth Staff members shall automatically terminate. Under such circumstances, Telehealth Staff members shall not be entitled to any of the procedural rights set forth in Article VIII of these Bylaws, or in Section O of the Rules and Regulations of the Medical Staff, as the case may be, as the same may be amended from time to time.

Section 4.4 HONORARY STATUS

Honorary Status shall be reserved for former members of the Active Staff who have retired from the practice of medicine, upon whom the Hospital wishes to bestow an honorific title in recognition of their years of service to the Hospital. Nominees for Honorary Status shall be presented by the Chair of their respective Department to the Medical Board for approval. If a nominee is not approved for Honorary Status, the hearing and appeal procedures set forth in Article VIII of these Bylaws shall not apply. Physicians who are granted Honorary Status are not members of the Medical Staff and, therefore, shall not have privileges to admit, care for or provide consultations respecting the care of Hospital patients, nor shall they be eligible for membership on the Medical Board, or to hold office or vote. Honorary Status does not carry any obligations to attend departmental meetings, carry malpractice insurance, or perform any other activities required of Active Staff members under these Bylaws. Physicians who are granted Honorary Status may participate in quality assurance and peer review activities only if they do so as a reviewer, evaluator or educator because their knowledge, expertise or experience would aid in the understanding of the subject matter under review. Physicians who are granted Honorary Status shall be subject to periodic review, as circumstances warrant, by the Department Chair who proposed the nominee. The Medical Board may rescind Honorary Status on its own initiative or based upon the Chair's report, and in such event the hearing and appeal procedures set forth in Article VIII of these Bylaws shall not apply.

ARTICLE V

DEPARTMENTS OF THE MEDICAL STAFF

Section 5.1 CLINICAL DEPARTMENTS

To promote the care and treatment of patients, the Board of Trustees may create such Clinical Departments as it from time to time deems advisable. The scope of services provided by each Clinical Department will be defined in writing and approved by the Medical Board. Each member of the Medical Staff shall be assigned to one of the Hospital's Clinical Departments. In exceptional circumstances, upon the recommendations of the Department Chairs concerned and

the Medical Board and authorized by the Board of Trustees, a member of the Medical Staff may be assigned to and granted clinical privileges in more than one Clinical Department.

The Clinical Departments so established at the Manhasset and Syosset Campuses are set forth in the Medical Staff Rules and Regulations.

Subsection 5.1.1 DIVISIONS. Divisions, as major sub-units of Departments, may be established or dissolved upon the recommendation of the Department Chair, pursuant to the approval of the Medical Board and the Board of Trustees. The establishment of a departmental Division shall be based upon some or all of the following criteria:

- A. Recognition by sub-specialty Board examination and certification (ABMS or AOA);
- B. Traditional recognition as a clinical sub-specialty;
- C. An organ system or scientific discipline, not limited to one (1) disease process; and
- D. Inclusion of all clinical functions traditionally incumbent upon a sub-specialty, including patient care, teaching and research activities.

Each Division shall have as its operational head a Chief, who shall be appointed by the Chair. The Division Chief shall report upon the operation of his/her Division, including any Sections within the Division, to the Department Chair.

Subsection 5.1.2 SECTIONS. Sections may be created or deleted as sub-units of a Division or of the Department at the discretion of the Department Chair. The head of the Section shall be called the Section Head and shall be appointed by the Department Chair and report to the Division Chief or the Department Chair, as appropriate.

Section 5.2 DEPARTMENT CHAIRS³

Subsection 5.2.1 APPOINTMENTS. Chairs of Clinical Departments (“Department Chairs”) shall be appointed by the Board of Trustees, be qualified by training, experience and administrative ability for the position, and meet any requirements for persons who shall be designated as a Departmental Chair by the Board of Trustees and as may be set forth in The Joint Commission’s standards and/or New York State Public Health Law, including certification by an appropriate specialty board (ABMS or AOA) or affirmatively established comparable competence through the credentialing process. Appointment of a physician or dentist as a Department Chair shall not affect the clinical privileges he or she is otherwise authorized to exercise at the Hospital, and the appointment shall be for that period as stated in the Department Chair’s employment agreement with the Hospital. Department Chairs also may appoint Vice Chairs and Associate Chairs, with the approval of the Medical Board.

³ References in these Bylaws to the “Department Chair” shall mean the “Department Director” on the Syosset Campus.

Subsection 5.2.2 SELECTION OF DEPARTMENT CHAIRS⁴

- A. The Northwell Chief Medical Officer will appoint an Ad Hoc Search Committee and serve as Chair of this Ad Hoc Search Committee or designate such Committee's Chair.
- B. The Ad Hoc Search Committee shall consist of at least the following individuals: three (3) Department Chairs selected by Northwell's Chief Medical Officer; the Executive Director; Northwell's Chief Academic Officer; two (2) other members of the Medical Staff below the rank of Chair, at least one of whom shall be a member of the Voluntary Medical Staff; and a physician/dentist faculty member of the affiliated medical school(s).
- C. The Ad Hoc Search Committee shall act independently or partner with an executive search firm to canvass the field for qualified candidates and present the names of qualified candidates to the CEO and Northwell's Physician-in-Chief. The CEO and Physician-in-Chief shall review the qualifications of the candidates and select one, whose application will be processed pursuant to the credentialing process. If the CEO and the Physician-in-Chief do not approve one of the Ad Hoc Search Committee's candidates, or if the approved candidate does not successfully complete the credentialing process, then the Search Committee shall commence its search again until another qualified candidate is found who does successfully complete the process.

Subsection 5.2.3 DUTIES. Among his or her duties, each Department Chair shall:

- A. Be accountable to the Medical Board, Executive Director and the CEO, Chief Medical Officer and Chief Operating Officer for all clinical and administrative activities within his or her Clinical Department; establish, together with the Medical Board and Hospital Administration, the type and scope of services required to meet the needs of patients in the Hospital;
- B. Give guidance to the Medical Board and Hospital Administration on the overall medical policies and procedures of the Hospital;
- C. Make specific recommendations to the Medical Board and Hospital Administration concerning his/her own Clinical Department, including those relating to criteria for clinical privileges relevant to the care provided in the Clinical Department; sufficient numbers of qualified and competent practitioners within the Clinical Department to provide patient care and administrative services, and the space and resources necessary or desirable for the operation of the Clinical Department;
- D. Make specific recommendations to the Medical Board as to the appointment, reappointment, qualification and delineation of clinical privileges, including the revision of such clinical privileges for each member of the Medical Staff within the Clinical Department, and ensure consistent representation of the Department on the Credentials Committee;

⁴ Department Directors at the Syosset Campus shall be selected as set forth in Article XIV ("Syosset Campus Provisions"), Section 14.2.

- E. Ensure that all legal and regulatory requirements regarding the delineation of privileges and adequate supervision of Postgraduate Trainee Staff are met at all times within his or her Clinical Department;
- F. Develop, implement and periodically review policies and procedures of the Clinical Department, as well as performance standards for members of the Medical Staff, that guide and support the provision of services in order to maintain and improve the quality of patient care and the proper functioning of the Department;
- G. Make specific recommendations to the Medical Board and/or the Credentials Committee regarding the appropriate method for delineating privileges in new and emerging disciplines, taking into consideration how practitioners will function in a multidisciplinary manner when needed to provide the best care to patients;
- H. Be responsible for the integration of the Clinical Department into the primary functions of the Hospital, and for the coordination and integration of interdepartmental and intra-departmental services affecting his or her Clinical Department;
- I. Be responsible for the implementation of a program to continuously evaluate, monitor and improve the quality of care and services provided by the Clinical Department by all appropriate means, and report regularly thereon to the Medical Board;
- J. Be responsible for continuing general supervision and surveillance of the professional performance in the Hospital of all individuals in the Clinical Department who have delineated clinical privileges, so that observance of the general rules, regulations and standards of professional care of the Hospital and the Medical Staff shall be maintained, and regularly report thereon to the Medical Board. As part of this surveillance, the Department Chair shall update on an ongoing basis and periodically review practitioner profiles, tracking the quality assurance and performance improvement program reviews of each member of his or her Clinical Department; and determine when actions must be taken based on these reviews;
- K. Appoint committees from among the members of the Active Staff in his or her Clinical Department to assist him or her in the performance of the duties described in Article III of these Bylaws, and such other committees as may be necessary or appropriate to evaluate and monitor the quality and appropriateness of patient care, including, without limitation, the Performance Improvement Coordinating Group, in accordance with the Hospital Quality Assessment and Improvement Plan and Corporate Compliance Plan;
- L. Be responsible for determining the qualifications and competence of personnel in the Department who are not licensed independent practitioners and who provide patient care services, and regularly report thereon to the Medical Board;
- M. Be responsible for the enforcement within his or her Clinical Department of the Hospital's Corporate Bylaws, the Hospital's administrative and other departmental policies and procedures, and these Medical Staff Bylaws and the Rules and Regulations; and for the

implementation within his or her Clinical Department of any actions taken by the Medical Board or the Board of Trustees;

N. Have the authority to order any practitioner in his or her Clinical Department to have a mandatory consultation or evaluation to determine fitness to provide clinical care;

O. Be responsible for the orientation and continuing education of all persons in the Clinical Department;

P. Assess and make recommendations to Hospital Administration concerning off-site resources for needed patient care activities not provided by the Clinical Department or the Hospital, provided that he or she must disclose any financial interest which he or a member of his family has in any such off-site resource in accordance with the Hospital's conflict of interest policies and Code of Ethical Conduct;

Q. Assist in the preparation of such reports, including, without limitation, budgetary planning, pertaining to his or her Clinical Department as may be required by the Medical Board, Hospital Administration, the Executive Director or the Board of Trustees; and

R. Be responsible for any other matter or activity, which federal, state or local law, or applicable accreditation standards designate as the responsibility of heads of Clinical Departments.

Section 5.3 DEPARTMENT MEETINGS/COMMUNICATION⁵

Each Clinical Department shall hold meetings no fewer than ten (10) times per year, such conferences, quality assurance and performance improvement program conferences, and other meetings as may be necessary to maintain an adequate review of the medical practice and medical records of the Department. The Chair of each Clinical Department which is subdivided into permanent recognized Divisions is authorized to permit such Divisions to meet separately, provided they hold not less than the same number of meetings for the same purposes as their Departments. Minutes of meetings of Departments and Divisions 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. Accurate attendance figures shall be kept by each Department. The Department Chair shall be responsible for communicating with the members of his or her Clinical Department respecting all clinical and administrative matters and may require attendance at departmental meetings as he or she deems appropriate or necessary to accomplish that purpose.

⁵ At the Syosset Campus each clinical Department shall hold meetings no fewer than four times per year and Divisions no fewer than two times per year.

Section 5.4 EMERITUS TITLE

Former Department Chairs and Division Chiefs who have provided extraordinary and distinguished service to the Hospital as a member of its Active Staff for a minimum of ten (10) years may be nominated by the Department Chair for the honorific title of Emeritus Chair or Emeritus Division Chief. Such nominations are subject to approval by the Medical Board and the Board of Trustees.

ARTICLE VI MEDICAL BOARD⁶ AND COMMITTEES

Section 6.1 THE MEDICAL BOARD AND ITS OFFICERS

Subsection 6.1.1 COMPOSITION. There shall be nineteen (19) voting members of the Medical Board consisting of the following: (a) the five (5) Officers of the Medical Staff Society, comprising the President, President-Elect, Immediate Past President, Secretary, and Treasurer; (b) three (3) “at-large” members of the Medical Staff from the Manhasset Campus and one (1) “at-large” member of the Medical Staff from the Syosset Campus, nominated as set forth in Subsection 6.2.2.6 below and elected as set forth in Article XIII of these Bylaws; (c) seven (7) chairs of clinical departments to be selected on a rotating basis by all current department chairs; (d) the two (2) Medical Directors from each of the Manhasset and Syosset Campuses; and (e) the Chair of the Medical Board, who is elected as set forth further in Subsection 6.1.3 herein, and who shall only vote to break a tie. The following are ex officio members of the Medical Board without vote: the Executive Directors from the Manhasset and Syosset Campuses; the Nurse Executive from the Manhasset Campus; the Chair of the Performance Improvement Coordinating Group (PICG) from the Manhasset Campus; and the Medical Director of Long Island Jewish Medical Center. If a current “at-large” member of the Medical Board is elected Chair in accordance with Subsection 6.1.3 below, then his/her former position on the Medical Board shall be filled in accordance with the provisions of Subsection 13.3.3 of Article XIII below.

Subsection 6.1.2 DUTIES. In addition to such other duties as may be prescribed elsewhere in these Bylaws and in the Medical Staff Rules and Regulations, it shall be the duty of the Medical Board to govern the Medical Staff, and to advise the Board of Trustees, the Executive Directors and the CEO, Chief Medical Officer and Chief Operating Officer in matters relating to the welfare of the Hospital and the Medical Staff. The Medical Board also shall make recommendations to the Board of Trustees for its approval pertaining to: the structure of the Medical Staff; planning for Clinical Departments; the qualifications for appointment to the Medical Staff; the mechanism used to review credentials and to delineate individual clinical privileges; recommendations of individuals for Medical Staff membership; recommendations for delineated clinical privileges for each eligible individual; the participation of the Medical Staff in organizational performance-improvement activities; the mechanism by which Medical Staff

⁶ At the Syosset Campus, the Leadership Coordinating Council shall be directly responsible to the Medical Board, and through the Medical Board to the Board of Trustees of the Hospital, for the conduct of the medical affairs of the Syosset Campus and the relations with those Medical Staff members who primarily exercise their clinical privileges at the Syosset Campus. See Article XIV (“Syosset Campus Provisions”), Section 14.3.2.

membership and clinical privileges may be terminated or limited; the mechanism for fair-hearing procedures; requirements for the medical care and treatment of patients in the Hospital, and programs of education, research and preventive medicine conducted at the Hospital; and the reports of the standing committees and subcommittees of the Medical Board and such special committees as may be appointed by the Chair of the Medical Board. The Medical Board's duties also include coordinating medical staff involvement with Operational Committees (as defined in Article XII of these Bylaws and the Medical Staff Rules and Regulations), centralized Northwell committees and other committees that are not site-specific (e.g., the Institutional Review Board and Graduate Medical Education Committee), with respect to the recommendations and policies of such committees as they relate to the functions and responsibilities of the Medical Board; and providing oversight of local activities governed by such centralized or non-site-specific committees. To the extent permitted by applicable law and The Joint Commission's standards, the Medical Board is authorized to adopt, on behalf of the Medical Staff and subject to approval by the Board of Trustees, details concerning the foregoing matters, and to place such details in the Medical Staff Rules and Regulations or in Medical Staff policies. The Medical Staff may withdraw delegation of such authority by a vote conducted in accordance with the procedures set forth in Section 17.2.1 and Section 17.3 of Article XVI below.

The Medical Board also shall implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve care, and act on behalf of the organized Medical Staff between Medical Staff meetings. The actions of the Medical Board are subject to review and approval or disapproval by the Board of Trustees. Further, because of their responsibility for the overall Hospital operations, the Medical Board shall keep the Chief Executive Officer and Chief Medical Officer apprised of important issues that may arise at the Hospital.

The Medical Board's duties also include oversight of the Leadership Coordinating Council at the Syosset Campus in carrying out its functions as described in Article XIV of these Bylaws and/or in the Medical Staff Rules and Regulations.

Subsection 6.1.3 OFFICERS. The Officers of the Medical Board are the Chair and the Secretary. The Chair shall be elected by the voting members of the Medical Board as nominated by a committee consisting of the President, President-Elect and Immediate Past President of the Medical Staff; one Department Chair selected by the chairs; the Medical Director from the Manhasset Campus; and the Executive Director from the Manhasset Campus. To be eligible for nomination, the candidate for Chair must be a current or past member of the Medical Board. If a current member of the Medical Board is elected Chair, then his/her former position on the Medical Board shall be filled consistent with the provisions of Subsection 6.1.1 above. If a current officer of the Medical Staff is elected Chair, then his/her former position on the Medical Staff shall be filled in accordance with the provisions of Subsection 13.3.3 of Article XIII below. The Chair of the Medical Board shall serve a term of two years and may succeed himself for one additional two-year term, if elected. The Chair of the Medical Board shall be compensated for his service by a stipend, established and revised as necessary by the Stipend Committee, subject to review and approval by the Hospital to ensure compliance with any applicable regulatory requirements. The membership of the Stipend Committee shall include the Immediate Past President of the Medical Staff, Secretary of the Medical Staff and Treasurer of

the Medical Staff, one Department Chair selected by the chairs; the Medical Director from the Manhasset Campus; and the Executive Director from the Manhasset Campus. There must be at least four (4) members of the Stipend Committee to vote in favor of any proposed change in the stipend. Such compensation shall be paid one-half by the Medical Staff and one-half by the Hospital. If the Chair of the Medical Board is unable to preside at a meeting, the President of the Medical Staff shall preside and appoint any member of the Medical Staff Advisory Board to sit on the Medical Board as the proxy of the President of the Medical Staff at the given meeting. If the Chair of the Medical Board becomes unable to serve, then a special election consistent with this provision shall be held to replace him. The President of the Medical Staff shall be the Secretary of the Medical Board.

Subsection 6.1.3.1 DUTIES OF THE CHAIR OF THE MEDICAL BOARD.

In addition to such others as may be specified in these Bylaws, the duties of the Chair of the Medical Board shall be to:

- A. Act in coordination and cooperation with the Executive Directors and Medical Directors in all matters of mutual concern to the Hospital;
- B. Call and preside over meetings of the Medical Board and be responsible for the agendas thereof;
- C. Represent the views, needs and grievances of the Medical Board and the Medical Staff to the CEO, Executive Directors, Chief Medical Officer and Board of Trustees;
- D. Report on the policies of the Board of Trustees to the Medical Board and the Medical Staff;
- E. Report to the Board of Trustees on the performance of, and maintenance of quality with respect to, the Medical Staff's delegated responsibility to provide medical and dental care;
- F. In consultation with the President of the Medical Staff, appoint the chairs and members (or delegate the appointment of members to the chairs) of all standing committees, subcommittees and any other ad hoc committees of the Medical Board under this Article VI, unless such appointments are otherwise provided for herein;
- G. Appoint, jointly with the Executive Directors and in consultation with the President of the Medical Staff, the chairs and members (or delegate the appointment of members to the chairs) of the Operational Committees as defined in Article XII of these Bylaws and the Medical Staff Rules and Regulations, unless such appointments are otherwise provided for in these Bylaws and/or in the Medical Staff Rules and Regulations; and
- H. Submit to the Board of Trustees regular reports concerning the professional activities of the Medical Staff of the Hospital. The reports shall set forth the procedure

for granting clinical privileges and the delineation of clinical privileges in connection with appointments and reappointments to the Medical Staff.

Subsection 6.1.3.2 DUTIES OF THE SECRETARY. The Secretary shall also carry out specific tasks as assigned by the Chair of the Medical Board. The Secretary shall cause to be kept accurate and complete minutes of all Medical Board meetings, and records of all appointments to the Medical Staff; call Medical Board meetings; attend to correspondence; and perform such other duties as ordinarily pertain to the office or as otherwise directed by the Chair or Medical Board. In addition, the Secretary shall assume the duties and responsibilities of the Chair of the Medical Board in the Chair's absence.

Subsection 6.1.3.3 RESIGNATION OR REMOVAL OF OFFICERS. The Chair of the Medical Board may resign at any time by giving written notice to the Secretary of the Medical Board. Unless otherwise specified in the notice, the resignation shall take effect upon delivery, and acceptance of the resignation shall not be necessary to make it effective. The Chair of the Medical Board shall be removed for good cause, which shall include, but not be limited to (i) failure to carry out his or her duties as Chair, or (ii) conduct which adversely affects the reputation of the Hospital or the conduct of the Hospital's operations or affairs, upon a vote of two thirds of the members of the Medical Board present at the meeting in which removal is discussed. If at least five (5) members of the Medical Board believe that they have good cause, as set forth above, for the removal of the Chair, they shall present their request for removal in writing to the Medical Director of the Manhasset Campus and the President of the Medical Staff, who shall promptly inform the Chair. At the next regular meeting of the Medical Board or at a special meeting called for such purpose, held no fewer than fifteen (15) days after a copy of the request for removal is given or sent to the Chair, the Medical Board shall inquire into and take action on the request for removal. The President of the Medical Staff and the Medical Director of the Manhasset Campus shall preside over and conduct the review. The Chair, if he or she shall be present and request an appearance, shall be permitted to appear before the Medical Board and respond to the request, prior to a vote upon it by the Medical Board. Upon the resignation or removal of the Chair, his or her replacement shall be selected in accordance with the procedures set forth in Subsection 6.1.3 above. If the President-Elect of the Medical Staff resigns or is removed from such position, then he or she shall be deemed to have resigned as Secretary of the Medical Board, and shall be replaced by the new President-Elect of the Medical Staff.

Subsection 6.1.3.4 RESIGNATION OR REMOVAL OF MEMBERS OF THE MEDICAL BOARD. Except for ex officio members of the Medical Board, with or without vote, any member of the Medical Board may resign at any time upon written notice to the Chair of the Medical Board stating the effective date of such resignation. Except for ex officio members of the Medical Board, with or without vote, any member of the Medical Board may be removed upon good cause as determined in the reasonable discretion of the Medical Board, in accordance with the process set forth herein. Good cause shall include but not be limited to (i) failure to carry out his duties, or (ii) conduct that is detrimental to the Hospital's operations, affairs or interests, or that adversely

affects the Hospital's reputation in a material fashion. Any voting member of the Medical Board or any three or more voting members of the Medical Staff may bring a written concern regarding the service of a member of the Medical Board to the Chair of the Medical Board, or, if the concern relates to the Chair, to the President of the Medical Staff and the Medical Director of the Manhasset Campus, who shall notify the Medical Board. The Medical Board shall determine the appropriate level of inquiry and consideration to be given the matter. A member of the Medical Board may only be removed thereafter upon the affirmative vote of at least two thirds of the voting members of the Medical Board. The member whose removal is under consideration shall be permitted an opportunity to appear before the Medical Board prior to its vote on the matter. If an elected member of the Medical Board is so removed, a special election shall be held to replace him as set forth in Article XIII of these Bylaws.

Section 6.2 STANDING COMMITTEES OF THE MEDICAL BOARD

Subsection 6.2.1 CHARGE AND MEMBERSHIP OF STANDING COMMITTEES. The Standing Committees are charged with developing and recommending for Medical Board approval the policies and procedures governing the functions or practices for which the Committee is responsible.

The Chair of the Medical Board shall, after consultation with the President of the Medical Staff, appoint the Chairs of the Standing Committees and the members thereof, unless such appointments are otherwise provided for herein or in the Medical Staff Rules and Regulations. However, the Chair of the Medical Board may, at his or her discretion, delegate responsibility for appointment of committee members to the Committee Chairs. If these Bylaws or the Medical Staff Rules and Regulations designate an individual as the ex officio Chair of a committee, but such individual is unable or unwilling to serve in such role, then an alternate Chair shall be appointed by the Chair of the Medical Board after consultation with the President of the Medical Staff.

Subsection 6.2.2 THE INDIVIDUAL STANDING COMMITTEES⁷

The Standing Committees of the Medical Board are:

- The Bylaws Committee
- The Credentials Committee
- The Medical Ethics Committee
- The Medical Staff Affairs Committee
- The Medical Staff Nominating Committee
- The Performance Improvement Coordinating Group

In addition to the Standing Committees of the Medical Board, there are Operational Committees, as defined in Article XII of these Bylaws and the Medical Staff Rules and Regulations that require Medical Staff participation.

⁷ The Standing Committees of the Syosset Campus are set forth in Article XIV ("Syosset Campus Provisions"), Section 14.3.

Subsection 6.2.2.1 THE BYLAWS COMMITTEE

A. Membership

The Bylaws Committee shall consist of the Medical Directors of the Manhasset and Syosset Campuses, the Executive Director of the Manhasset Campus, the President of the Medical Staff, the President-Elect of the Medical Staff, and the Chair of the Medical Board. The President of the Medical Staff and the Chair of the Medical Board shall select four additional members of the committee. The following shall be ex officio members without vote: Northwell Chief Medical Officer or his/her designee; the Medical Director of Long Island Jewish Medical Center; and the Executive Director of the Syosset Campus.

B. Functions

The Bylaws Committee shall receive, review, evaluate, and offer recommendations regarding amendments to these Bylaws, which recommendations shall be submitted to the Medical Board for approval prior to being proposed to the Medical Staff. The Bylaws Committee also shall receive, review, evaluate, and offer recommendations regarding amendments to the Rules and Regulations of the Medical Staff, which shall be submitted to the Medical Board for approval.

C. Meetings

The Bylaws Committee shall meet at least bi-annually, and as many additional times as the Chair thereof may direct.

The Bylaws Committee shall meet conjointly with the Bylaws Committee for Long Island Jewish Medical Center.

Subsection 6.2.2.2 THE CREDENTIALS COMMITTEE

A. Membership

The Credentials Committee shall be comprised of the following, who shall be voting members: (i) Chairs of Clinical Departments, or their Designees, although the preceding clause shall not be construed to require that the Chairs of all Clinical Departments be members of the Committee; (ii) the Chair of the Medical Board; (iii) the Hospital's Medical Director and the Medical Director from the Syosset Campus; (iv) the Immediate Past President of the Medical Staff, who shall Chair the Committee; and (v) five (5) Chairs of Clinical Departments from the Syosset Campus, as may be appointed by the Chair of the Committee (in consultation and upon mutual agreement with the Medical Director and/or the Chair of the Medical Board).

B. Functions

The functions of the Credentials Committee shall be:

1. To review the completed applications of all applicants for membership and clinical privileges on the Medical Staff, who desire to practice at the Hospital in compliance with these Bylaws and the Medical Staff Rules and Regulations, including, but not limited to, interviewing such candidates, as it deems necessary or appropriate.
2. To make recommendations, as to each applicant to the Medical Board, regarding initial appointment, reappointment and delineation of clinical privileges, including specific consideration of the recommendations of the Chair of the Clinical Department in which the applicant requests privileges including recommendations by the Chair for the revision of privileges in between reappointment periods.
3. To provide a representative body for:
 - (i) Consultative review of delineating privileges in new and evolving areas of medical practice. In conjunction with the Medical Board, the Credentials Committee may appoint a subcommittee to bring special expertise to the process of delineating new privileges.
 - (ii) Consultative review of unusual credentialing and privileging cases at the time of initial appointment or reappointment of a practitioner to the Medical Staff.
4. Any such review or recommendation may not abridge or amend any action or procedure governed by the provisions of Article VIII or IX of these Bylaws.

C. Meetings

1. The Credentials Committee shall meet not less frequently than monthly and shall maintain a permanent record of its proceedings and activities, which shall be reported to the Medical Board.
2. All members of the Credentials Committee shall be permitted to participate in a meeting of the Committee by means of a conference telephone call or similar communication equipment allowing all persons participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence in person at the meeting.

Subsection 6.2.2.3 THE MEDICAL ETHICS COMMITTEE⁸

A. Membership

The membership of the Medical Ethics Committee shall be as set forth in the Medical Staff Rules and Regulations.

B. Functions

1. The Medical Ethics Committee shall consider the ethical issues related to clinical services, teaching, and research, and shall provide a forum for addressing such matters as:

- Decisions involving extraordinary treatments
- Withholding or withdrawing medical therapy
- End-of-life care decisions
- Research in and application of new therapies
- Disagreements regarding medical intervention
- Patients' rights conflicts
- Quality of life concerns
- Socioeconomic factors
- Practice and professional performance
- The health care professional and society

2. The Committee differs from other standing committees in that it addresses topical issues as they arise and functions at the service of the general community. Subcommittees may be established from time to time to address specific concerns, including pediatric matters, and shall regularly report into the Committee.

3. The Committee shall establish and oversee the Ethics Consult Service and shall review, as necessary, all clinical ethics consultations that are performed. The Committee shall aggregate and analyze the information generated by the Ethics Consult Service to improve the Service and to identify opportunities for institutional learning. The Committee shall organize and encourage educational programs that utilize existing forums such as departmental grand rounds and regularly scheduled conferences.

4. The Committee may utilize consultants when they can facilitate and enrich the activities of the Committee.

5. The Committee shall regularly review and monitor its activities with particular attention to participation and review by Hospital personnel as a measure of its effectiveness in furthering the mission of the Hospital.

⁸ The Syosset Campus has its own Medical Ethics Committee. See Article XIV ("Syosset Campus Provisions"), Section 14.3.3.

6. The Committee shall establish and monitor processes whereby the Hospital may effectively assist staff members, patients and their representatives to address decisions regarding care and treatment at the end of life, resolution of conflict in treatment decisions, and other clinical ethical matters. The Committee shall neither have the authority to make decisions with respect to the care and treatment of a particular patient nor assume the professional responsibility of the attending physician for the care and treatment of his/her patient.

7. The Committee shall appoint an Ethics Review Committee as required by the New York State Family Health Care Decision Act.

8. The Committee shall review the proceedings and actions of all departmental committees that discuss ethical issues.

C. Meetings

1. The Committee shall meet as often as necessary, but no less than six (6) times per year.

2. A permanent record of all proceedings and recommendations from the regularly scheduled meetings shall be maintained and forwarded to the Medical Board.

Subsection 6.2.2.4 THE MEDICAL STAFF AFFAIRS COMMITTEE
(“PHYSICIANS’ FORUM”)

A. Membership

The membership of the Medical Staff Affairs Committee shall be as set forth in the Medical Staff Rules and Regulations.

B. Functions

The Medical Staff Affairs Committee shall be responsible for reviewing, discussing and making recommendations to the President of the Medical Staff and the Medical Board on matters concerning Medical Staff activities, intra-Staff activities, and other aspects of the relationship between and among the Hospital, the Medical Board and the Medical Staff.

C. Meetings

This Committee shall meet at least bimonthly or upon the call of the President of the Medical Staff.

Subsection 6.2.2.5 THE MEDICAL STAFF NOMINATING COMMITTEE

A. Membership

The Medical Staff Nominating Committee shall consist of the President, President-Elect and Immediate Past President of the Medical Staff, two additional previous Presidents of the Medical Staff chosen by the Medical Staff Advisory Board, the Syosset at-large member of the Medical Board, and the Chair of the Medical Board. The Medical Director from the Manhasset Campus shall be an ex officio member, without vote.

B. Functions

The Medical Staff Nominating Committee shall identify a slate of candidates for the Officers of the Medical Staff Society (President-Elect, Secretary, and Treasurer) and for the four at-large members of the Medical Board to stand for election in accordance with Section 13.4 of Article XIII below. The Medical Staff Nominating Committee shall verify that all members of the slate meet the qualifications for office as set forth in Section 13.2 of Article XIII below. The Medical Staff Nominating Committee shall submit the full slate of candidates to the Administrative Office of the Medical Staff Society no later than October 1st of each year in which an election is to be held. The Administrative Office of the Medical Staff Society, in consultation with the Medical Staff Services Central Office, shall verify the qualifications of all candidates, including candidates from the field who are nominated by petition, verify the signatures on any such petitions, ensure the eligibility of all voters in any election, and verify the results of all elections.

C. Meetings

The Committee shall meet upon the call of the President of the Medical Staff.

Subsection 6.2.2.6 THE PERFORMANCE IMPROVEMENT COORDINATING GROUP⁹

A. Membership

The membership of the Performance Improvement Coordinating Group (“PICG”) shall be jointly appointed by the Chair of the Medical Board and the Executive Director, and shall include at least fifteen (15) physician members (including one (1) representative from each of the Clinical Departments and ambulatory facilities), the President-Elect of the Medical Staff, who shall be the Associate Chair of the committee, and a member of the Voluntary Medical Staff. Additional members shall include the Director of Patient Care Services and Care Coordinator, Administration, members from clinical or support services, the Risk Manager, the Safety Officer, Infection Control Practitioner, a member

⁹ The Syosset Campus has its own Performance Improvement Coordinating Group. See Article XIV (“Syosset Campus Provisions”), Section 14.3.5.

of the Postgraduate Trainee Staff and a member of Northwell's Department of Quality Management.

B. Functions

The Performance Improvement Coordinating Group shall:

1. Function in a multi-disciplinary capacity, providing leadership and guidance in the Hospital's organizational performance improvement activities, medical staff professional review, health information management, utilization management, infection control, ambulatory care, risk management, Hospital safety program, special care nutritional support, and pharmacy and therapeutics functions thereby implementing a unified program that improves organizational performance by establishing multi-disciplinary teams to design, measure, assess and improve the organizational functions identified by The Joint Commission (and any other applicable accrediting and certifying boards and bodies).

2. Oversee, coordinate and prioritize quality assurance and performance improvement activities by, among other things, approving and administering an annual Hospital-wide Performance Improvement Plan by:

- Promoting and assisting, where needed, in the development of the methodology for the plan by focusing on its design, implementation, measurement methodology, means of assessment and improvement, and
- Assisting in coordinating the dimensions of performance with patient care and organizational functions.
- Reappraising the Hospital's quality assurance, quality management, performance improvement, risk management and safety programs for their effectiveness and the degree to which they integrate and coordinate their efforts and apply to all departments, services and practitioners of the Hospital.

3. Receive and analyze reports from each Hospital department/service (as appropriate) regarding all Hospital activities concerned with quality, utilization and risk management, integrate and, coordinate such activities to the degree possible, and recommend additional activities, and modification of existing activities as needed, as well as combination of activities, when appropriate, from all interdepartmental performance improvement committees which report to the Performance Improvement Coordinating Group and to the Medical Board.

4. Assure the use of information gathered regarding problems identified in the revision of Hospital policies and procedures.

5. Promote and assist, where needed, in the development of multi-disciplinary standards of care for all patient activities with particular reference to existing rules and regulations of the professional staffs.

6. Establish procedures for effective utilization of Hospital services and a mechanism for the provision of discharge planning by identifying utilization related problems, including the appropriateness and medical necessity of admissions, continued stays and support services, delays in the provision of support services, as well as length of stay norms.

7. Identify general areas of potential risk in all clinical aspects of patient care and safety, including at a minimum, all areas of concern identified in Part 405.6 of the New York State Hospital Code, establish corrective action plans therefor, and monitor the outcomes of such plans in order to reduce malpractice claims and the probability of harm to patients.

8. Receive, evaluate and coordinate reports of all improvement team activities and share information related to outcome and performance concerning all quality management and performance improvement activities.

9. Coordinate and oversee all functions identified in Part 405.6 of the New York State Hospital Code to be coordinated and overseen by this Committee.

10. Identify areas for the Tissue Committee to complete focus reviews of procedures, and review the reports of such reviews by the Tissue Committee.

11. Meet in an executive session comprised of physician and nursing members of the Performance Improvement Coordinating Group to review adverse patient outcomes and sentinel events.

12. Send representatives to, and receive reports from, committees comprised of representatives of the Hospital and other Northwell Hospitals in order to identify, share, develop, and improve best practices for patient care at the Hospital. Administrative support for, and coordination of all such committee's activities shall be provided by Northwell's Department of Quality Management and coordinated with the Hospital's Department of Quality Management.

C. Meetings

The Performance Improvement Coordinating Group shall meet monthly, not less frequently than ten (10) times per year.

D. Reports

1. The Performance Improvement Coordinating Group shall report monthly to the Medical Board and Executive Director from the Manhasset Campus. Reports shall include the status of current performance improvement activities.

2. The Performance Improvement Coordinating Group shall report at least quarterly through the Medical Board to the Committee on Quality of the Board of Trustees. Reports shall include:

- The status of organization performance improvement activities undertaken during the reporting period; and
- Pertinent findings and recommendations of quality management and performance improvement activities throughout the Hospital.

Section 6.3 MEDICAL BOARD AND COMMITTEE MEETINGS

Subsection 6.3.1 MEDICAL BOARD MEETINGS. The Medical Board shall meet regularly once each month and shall submit a report on each such meeting to the Secretary of the Board of Trustees. Any action taken by the Medical Board shall require a majority vote of those present. A majority of voting members of the Medical Board present at a meeting shall constitute a quorum. The Medical Board shall honor a request for a closed ballot vote made by fifteen percent (15%) of the voting members present at the meeting.

Subsection 6.3.2 STANDING COMMITTEE MEETINGS. Unless otherwise expressly provided elsewhere in these Bylaws, each standing committee and subcommittee of the Medical Board shall hold not fewer than four (4) meetings each year. Minutes of each meeting shall be kept and shall include the following: persons in attendance; date and duration of meeting; identification of topics discussed; recommendations made; and actions taken. Copies of such minutes and of all committee and subcommittee reports and recommendations shall be forwarded by each committee to the Medical Board.

Subsection 6.3.3 SPECIAL MEETINGS. The Chair of the Medical Board and the Chairs of the standing committees and subcommittees of the Medical Board, respectively, may call special meetings of their respective committee upon such notice as may be practicable under the circumstances.

Section 6.4 OTHER COMMITTEES

Unless otherwise expressly provided elsewhere in these Bylaws, other special committees may be appointed by the Chair of the Medical Board in such number and of such composition as the Medical Board may deem necessary or desirable to properly carry out the duties of the Medical Board and the Medical Staff. Such committees shall confine their activities to the purposes for which they were appointed, shall report to the Medical Board, and shall have only such power of action as is specifically granted by the Medical Board.

ARTICLE VII

COMMITTEE ON QUALITY

The Committee on Quality will serve as a liaison between the Corporation's Medical Board and the Board of Trustees. Quality information, which includes the results of measures that evaluate clinical performance of the Corporation, generated by Medical Board committees, such as the Performance Improvement Coordinating Group, may be presented to the Committee on Quality for review to better understand how the Corporation meets accepted standards of practice. The Committee on Quality also may review analyses of sentinel events in order to understand how these incidents can be prevented in the future, to communicate lessons learned and for establishing best practices. Medical staff credentialing matters, such as appointments and reappointments, approved by the Corporation's Medical Board that are presented to the Board of Trustees or its Executive Committee may be presented through the Committee on Quality, together with the recommendation of the Committee on Quality thereon with regard to approval. The Committee on Quality will meet not less than ten times per year, and will be comprised of members of the Board of Trustees and senior leadership representing administration, nursing and the Medical Staff.

ARTICLE VIII

CORRECTIVE ACTION FOR MEDICAL STAFF MEMBERS

Section 8.1 CORRECTIVE ACTION PROCESS DEFINED

These Bylaws set forth the bases for taking corrective action against a practitioner and the basic hearing and appeal procedures available to a practitioner who is subject to corrective action. The details relating to such procedures are set forth in the Medical Staff Rules and Regulations.

Subsection 8.1.1 A request for corrective action may be made with regard to any practitioner who is a member of the Medical Staff whenever the conduct or condition, professional or otherwise, of such Medical Staff member is considered to be inconsistent with the Hospital's standards of patient care, patient welfare or the objectives of the Hospital; if such conduct or condition reflects adversely on the Hospital or the practitioner; or results in disruption of Hospital operations. A request for corrective action also may be made with regard to any Medical Staff member who fails to comply with any of these Bylaws; the Medical Staff Rules and Regulations; the Corporate Bylaws, rules, regulations or policies; or the policies of his or her Clinical Department.

A. Such request for corrective action shall be made to the Chair of the Medical Board by any Trustee or Officer of the Corporation, the Executive Director, the Department Chair, or any member of the Medical Board, provided that a request for corrective action regarding the Chair of the Medical Board shall be made to the Medical Director. Such request for corrective action shall be in writing and shall set forth the facts upon which it is based. Subject to the provisions for summary suspension set forth in these Bylaws and in the Medical Staff Rules and

Regulations, any request for corrective action by the Chair of the Department in which the practitioner holds clinical privileges shall be based upon a prior investigation.

B. If a request for corrective action is made by any person other than the practitioner's Department Chair, upon receipt of the request for corrective action, the Chair of the Medical Board shall refer the matter back to the practitioner's Department Chair for him or her to conduct a departmental investigation of the issues that gave rise to the request for corrective action, unless such an investigation has already been conducted. In the event that a request for corrective action is made regarding a Department Chair, the investigation of the matter shall be conducted by the Medical Director.

C. No person filing a request for corrective action in an individual capacity shall sit on any committee reviewing the request under this Article VIII.

D. The Chair of the Medical Board shall ensure that a copy of such request for corrective action shall be sent to the practitioner about whom it is filed as soon as may be practicable under the circumstances. The copy of the request for corrective action sent to the affected practitioner shall be accompanied by a copy of this Article VIII.

E. Whenever any provision of this Article VIII requires that notice or any other communication be sent to the affected practitioner or to the parties to a hearing held pursuant to this Section 8.1, or to their legal counsel, such notice or communication shall be sent by overnight delivery service or personal delivery, and/or by such other prompt and reliable means as may be specified in the Medical Staff Rules and Regulations.

Subsection 8.1.2 CORRECTIVE ACTION: GENERAL RULES

A. A request for corrective action may include, without limitation, one or more of the following actions:

- (i) A written warning or reprimand, or letter of admonition;
- (ii) Time-limited terms of probation requiring monitoring of the practitioner, which may be extended or modified, or result in different corrective action, based on events during the period of probation;
- (iii) A requirement of remedial activity, such as further clinical training, study or education;
- (iv) Suspension pending medical or psychiatric consultation/evaluation by a physician or other health care provider acceptable to the Department Chair;
- (v) Reduction, suspension, restriction or termination of some or all clinical privileges pending investigation;

- (vi) Reduction, suspension, restriction or revocation of some or all clinical privileges;
- (vii) Continuation, modification or expansion of a previously imposed corrective action;
- (viii) A requirement for clinical supervision or consultation with respect to care or categories of care, or co-privileges with another practitioner;
- (ix) Suspension or termination of Medical Staff membership; and/or
- (x) Other specific sanctions as appropriate in the circumstances.

B. Whenever corrective action must be taken immediately in the interests of patient care or to prevent imminent or further disruption of Hospital operations, the Department Chair, the Chair of the Medical Board, the Chief Medical Officer, the Medical Director, and the Executive Director, each shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges granted by the Hospital to a member of the Medical Staff (hereinafter referred to as “summary action”). Such summary action also may be imposed pending an investigation to determine whether grounds exist for immediate action; such an investigation shall not exceed a period of fourteen (14) days without the practitioner’s consent. The practitioner shall be given notice of such summary action in accordance with Subsection 8.1.1(E) above. Such summary action shall become effective immediately upon imposition.

C. Except as specifically provided otherwise elsewhere in these Bylaws and the Medical Staff Rules and Regulations, any corrective action recommended pursuant to Subsection 8.1.2(A)(vi) through (x) above shall entitle the Medical Staff member to the procedural rights, including but not limited to a hearing before a Hearing Committee and review by an Appellate Review Committee of the Board of Trustees, as set forth this Article VIII and in the Medical Staff Rules and Regulations. In the event of a summary suspension of a practitioner’s clinical privileges and/or Medical Staff membership pursuant to Subsection 8.1.2(B) above, the procedures set forth in Section 8.2 below and in the Medical Staff Rules and Regulations shall apply. If a corrective action is upheld by final action by the Board of Trustees, it may be reportable to the Office of Professional Medical Conduct in the New York State Department of Health, as set forth in the Public Health Law, to the Office of Professional Discipline in the New York State Education Department, and to the National Practitioner Data Bank.

Subsection 8.1.3 **RIGHT TO HEARING.** Any practitioner who has received notice of a request for corrective action as set forth in Subsection 8.1.2(A)(vii) through (xi) above is entitled to a hearing before a Hearing Committee pursuant to the procedures set forth in this Article VIII and in the Medical Staff Rules and Regulations. The notice, provided to the practitioner by the Chair of the Medical Board, shall state: the particular action taken or proposed to be taken against the practitioner; the reasons for the action; that the practitioner has the right to request a hearing on the action; the time limit within which the practitioner may request the hearing; and a summary of the practitioner’s rights at the hearing under this Section. In addition, any practitioner who has received notice in accordance with Article III of these Bylaws of an adverse recommendation with respect to appointment or reappointment to the Medical Staff or to

a restriction and/or reduction of the practitioner's clinical privileges (hereafter referred to as an adverse appointment recommendation), is entitled to a hearing in accordance with the procedures set forth in this Article VIII. In the event the practitioner elects to not have a hearing or does not respond to the notice, the Medical Board shall act on the request for corrective action or the adverse appointment recommendation at its next regular meeting.

Subsection 8.1.4 SCHEDULING AND NOTICE OF HEARING. The Chair of the Medical Board (or Designee) shall schedule the hearing and shall notify the practitioner of the time, date and place of the hearing and the names of the Hearing Committee members and any witnesses expected to testify. Except as set forth below, the date of the hearing shall be no less than thirty (30) and no more than sixty (60) days from the date of receipt by the practitioner of the notice of the scheduling of the hearing, unless the practitioner makes a written request to the Chair of the Medical Board to schedule the Hearing for a later date.

If a request for a hearing is received from a practitioner whose clinical privileges have been summarily restricted or suspended in accordance with these Bylaws, the hearing may, upon the written request by the practitioner to the Chair of the Medical Board, be scheduled for a date earlier than 30 days from the date of receipt by the practitioner of such notice. However, the hearing shall not be scheduled for a date earlier than fifteen (15) days from the receipt by the Chair of the Medical Board of the practitioner's request for an expedited hearing. Postponement of the hearing beyond the hearing date shall be granted only with the approval of the Chair of the Hearing Committee.

Subsection 8.1.5 COMPOSITION AND SELECTION OF THE HEARING COMMITTEE. The hearing shall be conducted by a Hearing Committee, consisting of five (5) voting members. Three (3) members shall be members of the Medical Board and two (2) members shall be members of the Active Staff, at least one of whom shall be a member of the Voluntary Medical Staff, all selected by the Chair of the Medical Board. One member of the Hearing Committee shall be designated as its Chair by the Chair of the Medical Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Hearing Committee so long as that person did not take part in any process leading to the request for corrective action or adverse appointment recommendation. Members of the Medical Board or Active Staff who are direct economic competitors of the practitioner shall not sit on the Hearing Committee. If for any reason the Chair of the Medical Board is unable to select a Hearing Committee satisfying the above requirements, then the Chair may, with the consent of and in consultation with the President of the Medical Staff and the Medical Director, select one or more individuals from outside the Hospital to serve on the Hearing Committee.

Subsection 8.1.6 CONDUCT OF THE HEARING. The practitioner must be present at the hearing, and both parties shall have the right to be represented by counsel, to present relevant evidence, to cross-examine witnesses, to receive a written basis for the Hearing Committee's recommendation, to receive a copy of the record of the proceedings, and such other rights and obligations as more fully set forth in the Medical Staff Rules and Regulations. It shall be the obligation of counsel for the party who requested the corrective action or made the adverse appointment recommendation to first present the reasons supporting the request or adverse appointment recommendation. In order to reverse the recommendation, the affected

practitioner shall have the obligation to persuade the Hearing Committee, by clear and convincing evidence, that the reasons supporting the request for corrective action or adverse appointment recommendation lack any factual basis or that such basis, or any action based thereon, is either arbitrary, unreasonable or not in compliance with applicable law. Failure without good cause of the practitioner to appear at the hearing shall constitute a waiver of his or her rights under these Bylaws. The Hearing Committee shall determine if the reason a practitioner fails to appear at the Hearing is good cause.

Subsection 8.1.7 RECOMMENDATION OF HEARING COMMITTEE; RATIFICATION BY MEDICAL BOARD. Within fourteen (14) days of the completion of the hearing, the Hearing Committee shall issue a recommendation, by majority vote of the Hearing Committee, either upholding the request for corrective action or the adverse appointment recommendation, or terminating or modifying such request or adverse appointment recommendation. The Hearing Committee's recommendation shall then be submitted to the Medical Board for its ratification. Members of the Medical Board who also served on the Hearing Committee may vote on the Hearing Committee's recommendation. Neither the affected practitioner, nor his or her representative, may attend the Medical Board meeting at which the Hearing Committee's recommendation is being presented for ratification. Upon its ratification by majority vote of those present at the meeting, the Chair of the Medical Board (or Designee) shall forward copies of its decision to the Secretary of the Board of Trustees and to the parties or their counsel. In the event the Medical Board does not ratify the Hearing Committee's recommendation, the Medical Board may, by majority vote of those present, issue its own decision or request that the Hearing Committee either clarify its recommendation or re-review the Hearing record in light of Medical Board's concerns.

Subsection 8.1.8 RIGHT OF APPEAL. If the Medical Board ratifies an adverse recommendation of the Hearing Committee or renders its own decision restricting, suspending or terminating the practitioner's clinical privileges or Medical Staff membership, then the affected practitioner may request an appellate review before an Appellate Review Committee of the Board of Trustees. The party that requested the corrective action or made the adverse appointment recommendation shall also have the right to request an appellate review of a decision of the Medical Board that is adverse to it. A request for appellate review shall be made by written notice to the Board of Trustees, with a copy to the other party, and must be received within ten (10) days after receipt of the adverse decision of the Medical Board. The request shall identify the grounds for the appeal and include a clear and concise statement of the reasons in support of the appeal. If a request for appellate review is not made within such period, the action of the Medical Board shall be final, with no further notice or proceeding required, except that the Medical Board's decision shall be forwarded to the Board of Trustees for final action. Upon final action, the Board of Trustees shall forward copies of its decision to the Medical Board and to the parties or their counsel.

Subsection 8.1.9 APPEAL PROCESS. The party appealing shall submit a written statement setting forth in full the grounds for appeal and the reasons in support of the appeal, and thereafter the opposing party shall submit a responsive statement. Such statements shall be submitted in accordance with the procedures set forth in the Medical Staff Rules and Regulations. The decision of the Medical Board shall not be set aside unless it could not reasonably have been

made considering the burden of proof of the practitioner as set forth in Subsection 8.1.6 above and the facts and circumstances of the case.

Subsection 8.1.10 DECISION OF APPELLATE REVIEW COMMITTEE; RATIFICATION BY THE BOARD OF TRUSTEES. Within thirty (30) days after the conclusion of the appellate review, the Appellate Review Committee, through majority vote, shall render its decision in the matter, in writing. The Appellate Review Committee may affirm, modify, or reverse the decision of the Medical Board or remand the matter to the Medical Board for reconsideration. The Appellate Review Committee shall then submit its decision to the Board of Trustees for final action, and the members shall recuse themselves from any consideration of the matter by the Board of Trustees. Upon final action, the Board of Trustees shall forward copies of its decision to the Medical Board and to the parties or their counsel.

No practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter that has been the subject of adverse action or recommendation. All proceedings under this Article VIII shall be considered confidential to the maximum extent permitted by law and subject to the reasonable needs of the Board of Trustees and other persons who may be authorized from time to time by the Board of Trustees to review the proceedings.

Section 8.2 SUMMARY ACTION PROCEEDINGS

Subsection 8.2.1 SUMMARY ACTION REVIEW COMMITTEE. Except when imposed pending an investigation as described in Subsection 8.1.2(B) above, within five (5) days of the imposition of summary action, a summary action review committee shall be convened by the Chair of the Medical Board as an advisory group to the individual who imposed the summary suspension or restriction. The summary action review committee shall consist of the Medical Director, or Designee in his or her absence; a Department Chair, who did not impose the summary action, selected by the Medical Director; and the President of the Medical Staff or, in his or her absence, the next most senior officer of the Medical Staff.¹⁰ Unless the committee, upon reviewing the facts and circumstances of the matter that gave rise to the summary action, recommends, by a unanimous vote, that it be terminated, the summary action shall remain in effect. If the summary action is imposed pending an investigation, a summary action review committee shall be convened as described above only after the investigation has been completed and a determination has been made that there is a need for immediate action.

Subsection 8.2.2 All further proceedings with respect to the summary action, including the hearing procedures to be afforded the affected practitioner, shall be in accordance with the provisions of Section 8.1 of these Bylaws and the Medical Staff Rules and Regulations.

¹⁰ When summary action is taken at the Syosset Campus, the Syosset at-large member of the Medical Board, or his/her Designee, shall serve on the summary action review committee in lieu of the President of the Medical Staff.

Section 8.3 AUTOMATIC TERMINATION OF MEDICAL STAFF MEMBERSHIP

A. Notwithstanding any other provisions of these Bylaws, the Medical Staff membership of a practitioner shall be terminated automatically, without any of the procedural rights set forth in this Article VIII, upon the termination of the practitioner's professional license. It shall be the duty of a practitioner who becomes subject to such a sanction or whose license has lapsed to report that fact in writing to his or her Department Chair, the Medical Director and to the Executive Director immediately. Upon removal of the sanction, the practitioner may reapply for Medical Staff membership and clinical privileges in accordance with these Bylaws.

B. Notwithstanding any other provisions of these Bylaws, where a practitioner has been appointed to the Medical Staff and granted clinical privileges at the Hospital pursuant to a contract between the Hospital and any other facility, organization or vendor, the Medical Staff membership and privileges of such practitioner shall automatically terminate, without the procedural rights set forth in this Article VIII, upon the termination of such contract; or if the practitioner ceases to be employed by such other facility, organization or vendor; or if such other facility, organization or vendor ceases to assign the practitioner to provide services to the Hospital. Such Medical Staff member may at that time re-apply for Medical Staff membership and clinical privileges. Upon recommendation of the Department Chair, the Medical Board may waive the foregoing automatic termination requirement.

Section 8.4 AUTOMATIC SUSPENSION OF MEDICAL STAFF MEMBERSHIP

A practitioner's Medical Staff membership shall automatically be suspended without any of the procedural rights set forth in Article VIII, upon (i) an action by New York State suspending a practitioner's license to practice his or her profession or the failure of the practitioner to re-register for his or her license, (ii) upon the practitioner's failure to maintain adequate and satisfactory professional liability insurance, or upon his or her failure to provide documentation of adequate and satisfactory professional liability insurance, as required by these Bylaws and the Rules and Regulations, (iii) upon failure to provide the Medical Staff Services Central Office with any and all documentation required by law, such as proof of infection control training or health status, (iv) upon exclusion from the Medicare or Medicaid programs, or (v) failure to maintain a DEA license if the exercise of privileges requires a DEA license as determined by the Department Chair. The suspension may terminate upon the determination by the Medical Director or Chair of the Medical Board that the practitioner is in compliance with the requirements of the Hospital and these Bylaws and the Rules and Regulations regarding maintenance of a professional license in full force and effect, or adequate and satisfactory professional liability insurance, or upon reinstatement as a Medicare and/or Medicaid provider, as applicable.

In addition, a temporary suspension, in the form of a withdrawal of a Medical Staff member's clinical privileges, shall be imposed automatically for failure to complete medical records as specified in these Bylaws or the Rules and Regulations or other Medical Board or Hospital policies or procedures. Such temporary suspension shall be effective until the medical records are completed.

Section 8.5 DUTY OF COOPERATION

It shall be the duty of each practitioner to cooperate fully with all proceedings in which he or she is involved. Failure or refusal of a practitioner at any time to do so shall be cause for suspension, summary or otherwise, termination, or limitation of all or part of his or her clinical privileges and Medical Staff membership. Furthermore, by accepting membership on the Medical Staff each practitioner thereby agrees that he or she will take no action against the Hospital or any representatives of the Hospital or its Medical, Postgraduate Trainee or Nursing Staff, or against any person supplying information or evidence thereto, for acts performed or statements made in good faith and without malice in connection with any proceedings provided for in these Medical Staff Bylaws.

ARTICLE IX THE POSTGRADUATE TRAINEE STAFF

Section 9.1 NATURE OF POSTGRADUATE TRAINEE STAFF MEMBERSHIP

The Postgraduate Trainee Staff shall consist of the residents and clinical fellows in training at the Hospital in such numbers as may be approved from time to time and appointed annually by the Board of Trustees upon recommendations of the Department Chairs concerned and the Medical Board. Members of the Postgraduate Trainee Staff must be graduates of schools of medicine, dentistry, osteopathy or podiatry that are recognized by the Hospital and shall be limited in their practice in accordance with the provisions of the Education Law of the State of New York and other applicable statutes and regulations. The professional responsibilities, duties and assignments of each member of the Postgraduate Trainee Staff shall be as prescribed by his or her Department Chair and Program Director who shall ensure that the specific treatments and procedures each Postgraduate Trainee Staff member is authorized to provide and is delineated in writing, meets the Hospital's standard of care and that the supervision required to perform those treatments and procedures is specified. Acceptance of membership on the Postgraduate Trainee Staff shall constitute the Postgraduate Trainee Staff member's agreement to abide by these Bylaws, the Medical Staff Rules and Regulations, and the provisions of the Resident/Fellow Manual.

Section 9.2 RESIDENT/FELLOW MANUAL

The process and procedures governing remedial and corrective action relating to members of the Postgraduate Trainee Staff shall be set forth in the Resident/Fellow Manual established and maintained by the Chief Academic Officer. The Resident/Fellow Manual also may include such additional provisions relating to the responsibilities and duties of the Postgraduate Trainee Staff as the Chief Academic Officer may deem appropriate. The provisions of the Resident/Fellow Manual shall be subject to the approval of Northwell's Graduate Medical Education Committee. In the event of a conflict between the provisions of the Resident/Fellow Manual or any agreement with the Hospital and these Bylaws or the Medical

Staff Rules and Regulations, these Bylaws or the Rules and Regulations, as applicable, shall control.

Section 9.3 THE CORPORATION'S BYLAWS

Nothing contained herein or in the Resident/Fellow Manual shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the Corporate Bylaws of the Hospital or elsewhere in these Bylaws or in the Medical Staff Rules and Regulations.

ARTICLE X **THE ALLIED HEALTH PROFESSIONAL STAFF**

Section 10.1 NATURE OF ALLIED HEALTH PROFESSIONAL STAFF MEMBERSHIP

The Allied Health Professional Staff shall consist of the members of those allied health professions, who hold an advanced degree and are registered and/or licensed and/or certified, as applicable, pursuant to the New York State Education Law. Such Allied Health Professional Staff may be authorized from time to time to practice their professions at the Hospital, including, but not limited to:

- psychologists,
- research scientists, as defined by the Medical Board
- certified registered nurse anesthetists,
- physician assistants,
- nurse practitioners,
- nurse midwives,
- optometrists,
- orthotists,
- prosthetists, and
- Such individuals who are not involved in direct patient care activities, and others who may be accorded the ability to practice their profession at the Hospital, as defined by the Medical Board.

Subsection 10.1.1 CLINICAL PRIVILEGES. Allied Health Professional Staff members shall have their privileges reviewed every two years by the Board of Trustees, upon the recommendations of the Department Chairs concerned, and the Medical Board following evaluation thereby of the qualifications of such practitioners and only after all required inquiries have been made. Members of the Allied Health Professional Staff shall have completed acceptable courses of education and training and shall possess such licenses and authorizations to practice their professions as the law may require. Members of the Allied Health Professional Staff shall be assigned to appropriate Clinical Departments, and when required by regulation, law, The Joint Commission's standards, or Hospital policy shall practice only under the supervision of and/or in collaboration with a physician member of the Medical Staff designated in writing by the relevant Department Chair or his or her Designee. Each Department shall

define in writing the duties and responsibilities of each category of Allied Health Professional performing patient care activities in that Department.

If privileges and membership on the Allied Health Professional Staff are granted in conjunction with the member's employment (or an application for, or offer of employment) by the Hospital, or a vendor or other third-party providing professional services to the Hospital, then such privileges and membership are contingent upon the member's continued employment by the Hospital, vendor or other third-party, and, if the member is employed by such a vendor or other third-party, upon the vendor's continued provision of services to the Hospital. The Allied Health Professional Staff member's appointment and privileges, and any subsequent reappointment, shall immediately terminate if for any reason (a) the member fails to become or cease to be employed by the Hospital, vendor or other third-party; or (b) the vendor or other third-party ceases to provide services to the Hospital; or (c) the vendor or other third-party ceases to assign the member to provide services to the Hospital. Under such circumstances, the member will not be entitled to the procedural rights set forth in Sections 10.3 and 10.4 of these Bylaws. Such Allied Health Professional Staff member may at that time re-apply for clinical privileges. Upon recommendation of the Department Chair, the Medical Board may waive the foregoing automatic termination requirement.

The Telehealth Allied Health Professional Staff shall consist of those members of the Allied Health Professional Staff, permitted by Applicable Law and Authorities, who are only providing Telehealth Services ("Telehealth Allied Health Professional Staff"). Members of the Telehealth Allied Health Professional Staff shall be subject to credentialing, and the granting of privileges, by Hospital, as the Originating Site. Such credentialing and granting of privileges may be accomplished by means of one of the following methods: (a) Hospital may credential and grant privileges to the Telehealth Allied Health Professional Staff member in accordance with the process identified above in this Subsection 10.1.1 of these Bylaws; or (b) Hospital may credential and grant privileges to the Telehealth Allied Health Professional Staff member by relying, in whole or in part, upon the credentialing and verification information obtained from the Distant Site, but not the privilege determination of the Distant Site. In such circumstances, responsibility for the granting of Telehealth Privileges to an applicant remains with Hospital.

Section 10.2 TEMPORARY AND VISITING PRO TEM PRIVILEGES

Subsection 10.2.1 TEMPORARY PRIVILEGES PENDING FINAL APPROVAL OF APPLICATION. Following approval by the Credentials Committee of a completed application for Allied Health Professional Staff membership, and pending the recommendation of the Medical Board and final action by the Board of Trustees thereon, the Executive Director or his or her designee may, based upon the request of the Department Chair or his or her Designee to satisfy an important patient care need, grant temporary clinical privileges to an applicant. Temporary privileges shall also be based on verification of the following: (i) a current New York State license; (ii) relevant training or experience; (iii) current competence; (iv) ability to perform the privileges requested; and (v) no current or previously successful challenge to the applicant's licensure or registration. The grant of such privileges shall be upon such conditions as the Executive Director (or designee) at any time may in his or her discretion wish to impose, and shall be exercised only under the supervision of the Department Chair or his or her Designee.

Temporary privileges on a completed application to the Allied Health Professional Staff shall be granted for a period not to exceed one hundred and twenty (120) days. Such privileges may be revoked, reduced or restricted at will at any time by the Department Chair in whose Department the temporary privileges were granted, or his/her Designee, the Chair of the Medical Board, the Executive Director, or the Medical Director or his or her Designee. In such event, the practitioner shall not be entitled to the procedural rights afforded by Sections 10.3 and 10.4 below, and the patients of the practitioner shall be assigned to other members of the Allied Health Professional Staff or members of the Medical Staff by the responsible Department Chair or his or her Designee.

Subsection 10.2.2 VISITING PRO TEM PRIVILEGES. Under limited circumstances, allied health professionals who are needed to meet an important patient care need, including but not limited to individuals seeking focused training under the supervision of a member of the Allied Health Professional Staff or a member of the Medical Staff, may be granted temporary privileges. All such individuals shall be designated as *visiting pro tem*. Visiting pro tem appointments shall require the following documents: a request from the relevant department chair or his or her Designee indicating the rationale for the appointment; a delineation of privileges completed by the applicant and approved by the department chair or his or her Designee; a completed health assessment form; proof of malpractice insurance coverage that complies with the Bylaws; a current curriculum vitae; a DEA certificate if applicable to the privileges requested; evidence of infection control training compliant with New York State requirements; proof of current clinical competence evidenced by a minimum of one letter of reference from an authorized agent of the applicant's principal institution; and a copy of the current registration of the New York State license. The grant of visiting pro tem privileges shall be upon such conditions as the Executive Director (or designee) at any time may, in his or her discretion, wish to impose, and shall be exercised only under the supervision of the Department Chair concerned, or his or her Designee. The visiting pro tem appointee shall be under the appropriate level of supervision of the Chair of the Clinical Department or Designee. Visiting pro tem privileges shall be granted only for the period of time that the underlying rationale for such privileges justifies, and in any event not exceeding one hundred twenty (120) days. Visiting pro tem privileges may be terminated whenever, in the opinion of the Department Chair or his/her Designee, the need or justification therefor no longer exists. Practitioners whose visiting pro tem privileges are so terminated, or whose request for such privileges is denied, shall not be entitled to the procedural rights afforded by Sections 10.3 and 10.4 below.

Section 10.3 CORRECTIVE ACTION FOR ALLIED HEALTH PROFESSIONAL STAFF MEMBERS

The process and procedures governing corrective action relating to members of the Allied Health Professional Staff shall be as set forth in the Medical Staff Rules and Regulations.

Section 10.4 THE CORPORATION'S BYLAWS

Nothing contained herein shall be deemed to be to the exclusion of any further or different remedies or proceedings contained in the Corporate Bylaws of the Hospital or elsewhere in these Bylaws or in the Medical Staff Rules and Regulations.

ARTICLE XI

IMPAIRED MEMBERS OF THE MEDICAL STAFF AND ALLIED HEALTH PROFESSIONAL STAFF

Section 11.1 INVESTIGATION OF POSSIBLE IMPAIRMENT

When the Chair of a Department or his/her Designee obtains information indicating that a member of the Medical Staff or Allied Health Professional Staff in his or her Department has an impairment of physical or mental function that interferes, or is likely to interfere, with the Staff member's ability to provide care for his patients or otherwise meet the standards set forth in these Bylaws and the Rules and Regulations, the Chair shall promptly discuss with that practitioner the nature and cause of the perceived impairment. The Chair shall refer the matter to Hospital leadership, which must include the Medical Director, to determine the need for remedial action.

Section 11.2 REMEDIAL ACTION/VOLUNTARY REMEDIES

Remedies will depend upon the nature of the impairment, the nature of the practitioner's responsibilities, the practitioner's acknowledgment of the impairment and other relevant circumstances. Such remedies may include, without limitation, a leave of absence in order for the practitioner to seek the necessary medical or psychiatric care and assistance, either through existing programs of the Medical Society of the State of New York for impaired physicians and physician assistants, through other outside agencies authorized to participate in such activities, or through an alternative means of assistance which is satisfactory to the Department Chair. In addition to the foregoing, such remedies may include, without limitation, acceptance by the Department Chair of a voluntary reduction of the practitioner's clinical privileges, voluntary resignation from the Medical Staff or Allied Health Professional Staff, and/or voluntary resignation of employment. It shall be within the discretion of the Department Chair to take such remedial action as he or she deems necessary and appropriate in accordance with these Bylaws, including without limitation, the direct referral of a physician or physician assistant to the Committee for Physician Health of the Medical Society of the State of New York, and as such committee exists for the benefit and assistance of practitioners, there shall be no procedural rights afforded to a practitioner as a result of any such referral.

Section 11.3 REQUEST FOR, OR SUMMARY, CORRECTIVE ACTION

In the event that the affected practitioner fails to follow the recommendation of the Department Chair under the preceding paragraphs to address the perceived impairment, or if, for any other reason, the Department Chair deems it necessary, proceedings may be commenced under and in accordance with Article VIII, IX, or X of these Bylaws and the Medical Staff Rules and Regulations, in regard to Medical Staff and Allied Health Professional Staff members, respectively, including, without limitation, the summary suspension or restriction of clinical privileges. Where an employed practitioner is involved, the Department Chair may take action under and in accordance with any applicable policies and procedures of the Human Resources Department.

Section 11.4 CONFIDENTIALITY

The discussions and investigations by the Department Chair with respect to the suspected impairment of a practitioner shall be deemed confidential. However, in the event that the practitioner exercises his or her procedural rights under these Bylaws, or, with respect to Allied Health Professional Staff, under the policies and procedures of the Human Resources Department, the Department Chair may disclose the content of the discussions and investigations to any person or committee with the authority to investigate, hear or review the matter under these Bylaws, or, with respect to Allied Health Professional Staff, under the policies and procedures of the Human Resources Department.

ARTICLE XII

OPERATIONAL COMMITTEES

The Operational Committees are Hospital committees charged with developing and recommending policies and procedures governing various operational functions and practices. Each Campus may have its own Operational Committees. Each such Committee (i) is responsible to the Hospital administrator at its Campus with authority for the subject matter within the Committee's jurisdiction, and (ii) reports to the Medical Board with respect to those matters for which the Medical Board is responsible, except at the Syosset Campus, where each such Committee reports to the Leadership Coordinating Council. The individual Operational Committees and their areas of responsibility are as set forth in the Medical Staff Rules and Regulations.

The chairs and members of the Operational Committees at each Campus shall be appointed as set forth in Subsection 6.1.3.1(G) above and in the Medical Staff Rules and Regulations.

ARTICLE XIII

OFFICERS OF THE MEDICAL STAFF SOCIETY

Section 13.1 OFFICERS

The Officers of the Medical Staff Society are: President, President-Elect, Secretary, Treasurer and Immediate Past President. The Officers shall perform the duties set forth in this Article XIII, and in addition shall establish annual Medical Staff Society dues as are appropriate and necessary to meet the needs of the Medical Staff.

Section 13.2 QUALIFICATIONS FOR OFFICE

Subsection 13.2.1 Any candidate for President-Elect, Secretary or Treasurer of the Medical Staff Society, or for at-large member of the Medical Board, at the time of nomination and at all times during the term of office, shall (i) have been a voting member of the Active Staff for at least three years; (ii) have demonstrated participation in Medical Staff activities either by attendance at Medical Staff Advisory Board meetings or having served on other Medical Board or Hospital committees; (iii) have all Medical Staff dues paid in full; (iv) not be under automatic suspension pursuant to Section 8.4, first paragraph, of these Bylaws; and (v) not have his or her medical staff appointment nor any of his or her clinical privileges be currently suspended or terminated; *provided*, however, a suspension of a member's clinical privileges pursuant to Subsection 8.1.2(A)(v) of these Bylaws shall not preclude the member from being a Voting Member of the Medical Staff during the pendency of the investigation.

Subsection 13.2.2 Any candidate for the three at-large members of the Medical Board from the Manhasset Campus shall be a physician who practices principally at the Manhasset Campus. Any candidate for the Syosset at-large member of the Medical Board shall be a physician who practices principally at the Syosset Campus. A candidate for the Syosset at-large member may demonstrate his/her participation in Medical Staff activities, as required by Subsection 13.2.1 above, by attendance at Syosset Leadership Coordinating Council meetings or by having served on Syosset Campus Standing Committees or Operational Committees.

Subsection 13.2.3 Any candidate who runs for office or for at-large member of the Medical Board without having been nominated by the Medical Staff Nominating Committee pursuant to Section 6.2.2.6 of Article VI above, shall meet the qualifications in Subsections 13.2.1 and 13.2.2 of these Bylaws and, if a candidate for the office of Secretary, Treasurer or for one of the four at-large members of the Medical Board, also shall be supported by a petition with no fewer than twenty-five (25) signatures from Voting Members of the Medical Staff. Such a candidate running for the office of President-Elect shall be supported by a petition with no fewer than fifty (50) signatures from Voting Members of the Medical Staff.

Subsection 13.2.4 No Department Chair who is a voting member of the Medical Board may also serve as an Officer of the Medical Staff. If a voting Department Chair is elected as an Officer of the Medical Staff, he or she shall cease to be a voting Department Chair on the Medical Board, and another voting Department Chair shall be appointed in his place on the Medical Board in accordance with Subsection 6.1.1 of these Bylaws.

Subsection 13.2.5 Any candidate who does not meet the qualifications set forth herein shall be disqualified from running for or holding office.

Subsection 13.2.6 No individual may concurrently seek election or serve as more than one Officer of the Medical Staff, or as both an Officer and an at-large member of the Medical Board.

Subsection 13.2.7 No Officer of the Medical Staff may serve concurrently as Chair of the Medical Board.

Section 13.3 TERMS OF OFFICE

Subsection 13.3.1 The President-Elect shall serve a two-year term and shall thereafter assume the office of President.

Subsection 13.3.2 The President shall serve a two-year term, and then shall become Immediate Past-President for a two-year term. The President shall receive an annual stipend for his service, the amount of which shall be established and revised as necessary by the Stipend Committee described in Subsection 6.1.3 of these Bylaws, subject to review and approval by the Hospital to ensure compliance with any applicable regulatory requirements. The stipend shall be paid one-half by the Medical Staff and one-half by the Hospital.

Subsection 13.3.3

(a) If the President becomes unavailable to serve two years, the President-Elect shall assume the President's office and a special election for a new President-Elect shall be held in accordance with Section 13.4 below.

(b) If the President-Elect becomes unavailable to serve two years, a special election for a new President-Elect shall be held in accordance with Section 13.4 below.

(c) In either of the circumstances described in paragraphs (a) and (b) above, the new President and the new President-Elect shall complete the balance of their predecessors' terms; *provided*, however, that if one year or less remains in their predecessors' terms, then the Chair of the Medical Board and the President of the Medical Staff may, in consultation with the Medical Staff Nominating Committee described in Subsection 6.2.2.6 of Article VI above, determine in the interests of continuity that each shall also serve an additional one-year term before an election is held.

(d) If either the Immediate Past President, the Secretary, the Treasurer, or one of the three at-large members of the Medical Board becomes unavailable to complete his/her term, then the Chair of the Medical Board and the President of the Medical Staff, in consultation with the Medical Staff Nominating Committee described in Subsection 6.2.2.6 of Article VI above, shall appoint an individual who previously held such position

to complete the balance of the term, or, if no such person is able or willing to complete the balance of the term, then they shall appoint any other individual who previously served on the Medical Board. If the Immediate Past President role is vacated due to appointment as Medical Board Chair, the President of the Medical Staff shall have the authority to appoint any preceding Past President to fill the Immediate Past President vacancy.

Subsection 13.3.4 The Secretary and Treasurer of the Medical Staff, and the at-large members of the Medical Board and the Medical Staff Advisory Board shall serve one-year terms. They may succeed themselves if re-elected. Beginning with the elections held in 2021, the Secretary and Treasurer of the Medical Staff, and the at-large members of the Medical Board and the Medical Staff Advisory Board shall serve two-year terms. They may succeed themselves if re-elected.

Section 13.4 CONDUCT OF ELECTIONS

Subsection 13.4.1 No later than October 15th of each year, in which an election is to be held, the Administrative Office of the Medical Staff Society shall announce the slate of nominees proposed by the Medical Staff Nominating Committee under Section 6.2.2.6 of Article VI above. Any candidates from the field who wish to petition the slate of nominees must inform the Administrative Office of the Medical Staff Society of their intention to run. The Administrative Office of the Medical Staff Society will determine if the petitioning member meets the requirements for candidacy as set forth in Section 13.2.3 above. The announcement shall be sent by electronic mail to all Voting Members of the Medical Staff to the primary electronic mail address on file with the Medical Staff Services Central Office. Candidates from the field shall have until October 31st to submit to the Administrative Office of the Medical Staff Society their petitions as required by Section 13.2.3 above. Candidates from the field for at-large member of the Medical Board must designate the campus at which they seek to serve as a representative. The Administrative Office of the Medical Staff Society shall verify qualifications of all candidates, including candidates from the field who have been nominated by petition, and also shall verify the signatures on any such petitions.

Subsection 13.4.2 No later than November 15, the Administrative Office of the Medical Staff Society shall notify any candidates who have been disqualified as determined in accordance with Subsection 13.4.1 above.

Subsection 13.4.3 On December 7, or on the next following business day if December 7 is a Saturday or Sunday, the Medical Staff Services Central Office shall collaborate with the Administrative Office of the Medical Staff Society to notify eligible members of the Active Staff that voting is open. Such announcement shall be sent by electronic mail to all Voting Members of the Medical Staff, to the primary electronic mail address on file with the Medical Staff Services Central Office. The Administrative Office of the Medical Staff Society shall conduct the election electronically by secret ballot. Polling shall be closed ten days after it is opened. The Administrative Office of the Medical Staff Society shall verify the results of the election, which shall be announced within twenty-four hours of the polls closing.

Subsection 13.4.4 All Officers of the Medical Staff shall take office as of January 1st in the year of their election.

Subsection 13.4.5 In any case where a special election is required, the same process and relative time periods specified in Subsections 13.4.1 through 13.4.3 above shall be followed to fill the vacant office as soon as possible. An Officer elected through a special election shall take office immediately upon verification of the election results.

Section 13.5 DUTIES OF OFFICERS OF THE MEDICAL STAFF

Subsection 13.5.1 President of the Medical Staff

The President shall:

- (a) Act as the chief executive officer of the Medical Staff and act in coordination with the Executive Director on issues of mutual concern;
- (b) Call, preside at and be responsible for the agenda of all meetings of the Medical Staff;
- (c) Serve as a voting member of the Medical Board and act as its Secretary;
- (d) Serve as an ex-officio member, without vote, of all Medical Board committees established under Subsection 6.2.2 of Article VI of these Bylaws;
- (e) Consult with the Chair of the Medical Board with regard to appointing committee chairs and committee members to all Medical Board committees established under Subsection 6.2.2 of Article VI of these Bylaws;
- (f) Together with the Medical Board and Hospital administration, enforce the Medical Staff Bylaws, Medical Staff Rules and Regulations, and associated Medical Staff policies, implement sanctions where these are imposed, and assure the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a member of the Medical Staff;
- (g) Serve on Summary Suspension Review Committees in accordance Article VIII, Subsection 8.2.2, of these Bylaws;
- (h) Participate with the Treasurer in developing the budget and preparing reports of expenditures as provided in Subsection 13.6.4 below;
- (i) Represent the views, policies, needs and grievances of the Medical Staff to the Executive Director and the Board of Trustees;

- (j) Report the decisions and policies of the Board of Trustees to the Medical Staff;
- (k) Provide day-to-day liaison on medical matters with the Executive Director and the Board of Trustees; and
- (l) Be the spokesman for the Medical Staff in its external professional and public relations, consistent with the expectation of confidentiality in all Hospital and Medical Staff matters.
- (m) Continuously meet the qualifications to hold office as described in Subsection 13.2.

Subsection 13.5.2 President-Elect of the Medical Staff

The President-Elect shall:

- (a) Serve as a voting member of the Medical Board;
- (b) Serve as a voting member of the Bylaws Committee;
- (c) Serve as Associate Chair of the Hospital PICG;
- (d) In the event of the removal, resignation or incapacity of the President of the Medical Staff, assume all the duties of the President, whereupon the office of President-Elect will be filled by special election; and
- (e) Perform such other duties as may be assigned by the President of the Medical Staff, the Medical Board or the Board of Trustees.
- (f) Continuously meet the qualifications to hold office as described in Subsection 13.2.

Subsection 13.5.3 Secretary of the Medical Staff

The Secretary shall:

- (a) Serve as a voting member of the Medical Board;
- (b) Keep accurate and complete minutes of all Medical Staff meetings;
- (c) Call meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as pertain to his office;
- (d) Perform such other duties as may be assigned by the President of the Medical Staff, the Medical Board or the Board of Trustees.

- (e) Continuously meet the qualifications to hold office as described in Subsection 13.2.

Subsection 13.5.4 Treasurer of the Medical Staff

The Treasurer shall:

- (a) Serve as a voting member of the Medical Board;
- (b) Collect Medical Staff dues and special assessments, and separately account for dues and assessments paid by Medical Staff members from the Syosset Campus;
- (c) Make disbursements authorized by the Officers of the Medical Staff and, where the disbursement is made from dues and assessments paid by Medical Staff members from the Syosset Campus, with the approval of the Chair of the Syosset Leadership Coordinating Council;
- (d) With the President of the Medical Staff, develop an annual budget and maintain a current account for all receipts and disbursements, such budget to separately identify, after consultation with and approval by the Chair of the Syosset Leadership Coordinating Council, expenditures to be made with respect to the Syosset Campus;
- (e) Prepare the aforesaid budget utilizing the same fiscal year as the Hospital, and then distribute the proposed budget as follows: (i) first to the Associate Executive Director for Finance of the Manhasset Campus, who shall have not less than seven (7) or more than fourteen (14) days to review and comment upon it; (ii) then to the following members of the Medical Board for approval by majority vote: the Officers of the Medical Staff, the four “at-large” members of the Medical Staff, and the Chair of the Medical Board; and (iii) then, when so approved, to the members of the Medical Staff and to the aforesaid Associate Executive Director for Finance not less than thirty (30) days prior to the start of the fiscal year;
- (f) After approval of the annual budget, submit to the Chair of the Medical Board and the aforesaid Associate Executive Director for Finance, for prior review and comment, any proposed non-budgeted expenditure in excess of \$5,000 and/or new category of expense;
- (g) With the President of the Medical Staff, prepare monthly reports of all receipts, disbursements and balances, such reports to be submitted monthly to the Medical Board and to the aforesaid Associate Executive Director for Finance, and upon request to the Board of Trustees; and

- (g) Assist in the preparation of an annual report by an independent third-party accounting firm retained by the Medical Staff; such report shall account for all receipts and disbursements during the prior fiscal year, and shall be submitted to the Medical Board, the aforesaid Associate Executive Director for Finance, and the Hospital's Board of Trustees.
- (h) Continuously meet the qualifications to hold office as described in Subsection 13.2.

In the event that either the Chair of the Medical Board or the aforesaid Associate Executive Director for Finance has a concern with respect to the proposed budget, any proposed non-budgeted expenditure in excess of \$5,000 and/or new category of expense after approval of the budget, or any receipt or disbursement identified in either monthly or annual report, he or she shall report such concern to the President of the Medical Staff and the Executive Director of the Manhasset Campus. Such concern must relate to the potential adverse effect of the expenditure on the Hospital's compliance with regulatory requirements, on the Hospital's reputation, or on Hospital operations. Thereafter, if such concern remains unresolved, then the matter shall be submitted to the Finance Committee of the Board of Trustees for resolution.

Subsection 13.5.5 Immediate Past-President of the Medical Staff

The Immediate Past-President shall:

- (a) Chair the Credentials Committee in consultation with the Medical Director from the Manhasset Campus for a two (2) year term;
- (b) Serve as a voting member of the Medical Board;
- (c) Perform such other duties as may be assigned by the President of the Medical Staff, the Medical Board, or the Board of Trustees.

Section 13.6 RESIGNATION OR REMOVAL OF OFFICERS OF THE MEDICAL STAFF

An Officer of the Medical Staff may resign at any time. Any Officer of the Medical Staff may be removed upon good cause which shall include, but not be limited to, (i) failure to carry out his or her duties, or (ii) conduct that is detrimental to the Hospital's operations, affairs or interests, or the operations, affairs or interests of the Medical Staff. Any member of the Medical Board or any three or more members of the Medical Staff may bring a concern regarding the service of a Medical Staff Officer to the President of the Medical Staff, or, if the concern relates to the President, to the Immediate Past President of the Medical Staff. The concern shall be brought to the voting members of the Medical Board who shall determine the appropriate level of inquiry and consideration to be given the matter. An Officer of the Medical Staff may only be removed thereafter upon the affirmative vote of at least two-thirds of the voting members of the Medical Board. The Officer whose removal is under consideration shall be permitted an

opportunity to appear before the Medical Board prior to its vote on the matter. If an Officer of the Medical Staff is so removed, a special election shall be held to replace him or her, except in the case of the removal of the President of the Medical Staff, in which case the President-Elect shall succeed to the position and a special election shall be held for a new President-Elect.

Section 13.7 MEDICAL STAFF ADVISORY BOARD

A. Membership.

This committee shall consist of the five Officers of the Medical Staff (Immediate Past President, President, President-Elect, Secretary and Treasurer), the four at-large members of the Medical Board, two preceding Past Presidents who remain voting members of the Active Staff and eight to ten members at large, three of whom shall be elected by the Medical Staff and the balance shall be selected by the Officers of the Medical Staff and the four at-large members of the Medical Board.

B. Functions.

1. The Medical Staff Advisory Board shall advise the Officers of the Medical Staff with respect to matters of interest to the Medical Staff.

2. The Medical Staff Advisory Board shall choose two previous Presidents of the Medical Staff, in addition to the Immediate Past President, to serve on the Medical Staff Nominating Committee described in Section 6.2.2.6 of Article VI above.

C. Meetings.

The Medical Staff Advisory Board shall meet monthly.

Section 13.8 MEETINGS

Subsection 13.8.1 Regular meetings of the Medical Staff shall take place at least once a year. The Annual Meeting of the Medical Staff shall be held in the spring of each year. Attendance will be recorded by the Secretary and/or Treasurer.

Subsection 13.8.2 The President of the Medical Staff or the Chair of the Medical Board may at any time file a written request with the Secretary of the Medical Staff that within fourteen (14) days of the filing of such request, a special meeting of the Medical Staff be called. Such a request also may be filed with the Secretary by the submission of a petition signed by at least fifty (50) voting members of the Medical Staff. The President shall designate the time and place of any such special meeting, which shall be held not more than forty-four (44) days after the filing of the request.

(a) Notice stating the place, day and hour of any special meeting of the Medical Staff shall be sent by electronic mail to each member of the Active Staff not less than fourteen (14) nor more than thirty (30) days before the date of such meeting, by or at

the direction of the President, with the support of the Administrative Office of the Medical Staff Society and the Medical Staff Services Central Office. Such notice shall be sent to each member of the Active Staff at his/her primary electronic mail address on file with the Medical Staff Services Central Office. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

(b) The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

ARTICLE XIV

SYOSSET CAMPUS PROVISIONS

Section 14.1 CLINICAL DEPARTMENTS AT THE SYOSSET CAMPUS

The Clinical Departments established on the Syosset Campus are set forth in the Medical Staff Rules and Regulations.

Section 14.2 SELECTION OF DEPARTMENT DIRECTORS AT THE SYOSSET CAMPUS

Department Directors on the Syosset Campus shall be selected as follows:

- A. An Ad Hoc Search Committee will be appointed.
- B. The Ad Hoc Search Committee shall consist of at least the following individuals: the Medical Director from the Syosset Campus; two (2) Department Directors; and two (2) other members of the Medical Staff (not from the Department for which the Search Committee is convened), all of whom shall be selected by the Medical Director from the Syosset Campus. Other members of the Committee shall include the Executive Director of the Syosset Campus and the Chair of the relevant academic department of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.
- C. The Ad Hoc Search Committee shall canvass the field for qualified candidates and present to the Board of Trustees or its designated committee the name of one (1) qualified candidate. The Board of Trustees (or its designated committee) shall review the qualifications of the candidate and, if approved, the candidate's application will be processed pursuant to the credentialing process. If the Board of Trustees or its designated committee does not approve the Ad Hoc Search Committee's candidate, or if the candidate does not successfully complete the application (credentialing) process, the Search Committee shall commence its search again until another qualified candidate is found who does successfully complete the process.

Section 14.3 STANDING COMMITTEES OF THE SYOSSET CAMPUS

The Standing Committees of the Syosset Campus are:

The Leadership Coordinating Council
The Medical Ethics Committee
The Medical Staff Health Committee (MSHC)
The Performance Improvement Coordinating Group

Unless specified hereafter in these Bylaws, the membership of the Standing Committees of the Syosset Campus and their Chairs shall be as set forth in the Medical Staff Rules and Regulations.

Subsection 14.3.1 LEADERSHIP COORDINATING COUNCIL

A. Membership

1. The Leadership Coordinating Council shall be appointed by and responsible to the Medical Board of the Hospital for the conduct of the medical affairs of the Syosset Campus. It shall be chaired by the Syosset Medical Director. One individual shall be chosen by the Leadership Coordinating Council to act as its secretary and to keep the minutes of its meetings.

2. The Leadership Coordinating Council shall consist of the following members, all of whom shall have the right to vote, together with the Department Directors of all additional Clinical Departments at the Syosset Campus established by authority of the Board of Trustees after the effective date of these Bylaws:

The Syosset Medical Director
The Senior Vice President, Medical Affairs for the Syosset Campus
The Directors of the Syosset Departments of:
Anesthesiology
Emergency Medicine
Gynecology
Laboratories-Pathology
Medicine
Orthopedic Surgery
Pediatrics
Psychiatry
Radiology
Surgery
The Executive Director of the Syosset Campus
The Nurse Executive of the Syosset Campus

In addition, the Leadership Coordinating Council shall include at least four (4) representatives of the Medical Staff who have evidenced a commitment to the activities of the Syosset Campus, such individuals to be chosen by the Medical Staff using a method designated by the Leadership Coordinating Council, and approved by the Medical Board.

3. The following individuals shall be members of the Leadership Coordinating Council without vote:

The Executive Director of the Manhasset Campus
Chair of the Performance Improvement Coordinating Group of the Syosset
Campus
Northwell Chief Quality Officer
Director of Quality Management of the Syosset Campus

4. The Leadership Coordinating Council and/or its Chair is empowered to invite such guests to the proceedings of the Leadership Coordinating Council as it or he deems appropriate, including, but not limited to, the chairmen of the medical boards of one or more of the other Northwell Hospitals.

B. Functions

The Leadership Coordinating Council shall be directly responsible to the Medical Board, and through the Medical Board to the Board of Trustees, of the Hospital for the conduct of the medical affairs of the Syosset Campus and the relations with those Medical Staff members who primarily exercise their clinical privileges at the Syosset Campus. Accordingly, with respect to the activities of the Syosset Campus, the Leadership Coordinating Council shall:

1. Receive, review, coordinate and act upon committee minutes and department reports for those divisions and committees, and sub-committees based at the Syosset Campus.

2. Review, coordinate and act upon all performance improvement, quality management, risk management and utilization review activities of the Syosset Campus.

3. Provide formal liaison with, and consider and recommend action to the Executive Director of the Syosset Campus, the CEO, the Chief Medical Officer, the Medical Board, the Committee on Quality and the Board of Trustees on matters of a medico-administrative nature arising out of the operations of the Syosset Campus, and implement and monitor action based on approved recommendations.

4. Be responsible for the effectiveness and coordination of all general policies and clinical activities of the Medical Staff at the Syosset Campus and its various Departments, divisions and sections, and represent those members of the Medical Staff with clinical privileges at the Syosset Campus in those Hospital deliberations which affect the discharge of Medical Staff responsibilities at the Syosset Campus.

5. Ensure that those members of the Medical Staff practicing at the Syosset Campus are kept informed concerning the accreditation program, the current accreditation status of the Hospital and of the factors influencing that status.

6. Provide formal procedures in accordance with these Bylaws for recommendations regarding the evaluation of Medical Staff applications and credentials, the appointment, promotion, reappointment, suspension or termination of Medical Staff members, assignment of clinical privileges, changes of status, grievances, medical supervision of any allied health practitioners and other subjects and conditions which the Board of Trustees shall deem appropriate relating to those practitioners who practice primarily at the Syosset Campus.

7. Ensure ethical conduct on the part of all members of the Medical Staff in their practice at the Syosset Campus and initiate such prescribed disciplinary measures as are indicated by, and in the manner as set forth, in these Bylaws.

8. In accordance with Subsection 6.2.2.6(B) of Article VI above, the Chair of the Leadership Coordinating Council shall identify one (1) candidate for the Syosset at-large member of the Medical Board, and shall forward such candidate's name to the Medical Staff Nominating Committee for inclusion in the slate of candidates to stand for election in accordance with Section 13.4 of Article XIII above.

C. Reporting

The Leadership Coordinating Council shall report to the Medical Board, and through it to the Committee on Quality to the Board of Trustees.

D. Meetings

1. The Leadership Coordinating Council shall meet at least ten times per year. Meetings shall be held at a time and place to be designated in a notice of meeting which shall also include the agenda.

2. Special Meetings may be called at any time by the Chair of the Leadership Coordinating Council or upon request of the Medical Board, Board of Trustees, or upon the written request of one member of the Leadership Coordinating Council. A notice containing the time, place and purpose of any such Special Meeting must be issued in writing at least three (3) days prior to the proposed meeting.

3. Fifty percent (50%) plus one (1) member of the total voting membership of the Leadership Coordinating Council shall be necessary to constitute a quorum for the conduct of business.

4. The affirmative vote of at least a majority of the voting membership present at the meeting of the Leadership Coordinating Council shall be required for the approval of any actions taken or recommendations made by the Leadership Coordinating Council.

5. Robert's Rules of Order shall govern all deliberations of the Leadership Coordinating Council, except that such Rules of Order shall not conflict with or be inconsistent with the Bylaws of the Medical Staff or the Corporate Bylaws of the Hospital.

6. The Leadership Coordinating Council shall maintain complete minutes of all meetings, and such minutes shall be approved at the next meeting of the Leadership Coordinating Council. It shall transmit the reports of such proceedings to the Medical Board, the Executive Director of the Hospital and the Secretary of the Board of Trustees.

7. All members of the Leadership Coordinating Council shall attend all Regular and Special Meetings, unless previously excused by the Chair.

Subsection 14.3.2 MEDICAL ETHICS COMMITTEE

A. Membership

The membership of the Medical Ethics Committee at the Syosset Campus shall be as set forth in the Medical Staff Rules and Regulations.

B. Functions

1. The Medical Ethics Committee shall consider the ethical issues related to the clinical service, teaching, and research roles of the Hospital and shall provide a forum for discussion of ethical issues related to such matters as:

- Decisions involving extraordinary treatments
- Experimentation of new therapies
- Indications for medical intervention
- Patient preferences
- Quality of life
- Socioeconomic factors
- Practice and professional performance
- The Health Care professional and society

or other matters that may influence and condition the Hospital's goals and objectives. This Committee is to be differentiated from other established committees whose functions are to consider specific matters.

2. The Committee shall organize and encourage programs of an educational nature that utilize existing Hospital formats.

3. The Committee may utilize consultants when they can facilitate and enrich the activities of the Committee and the Hospital.

4. The Committee shall assist in the development of and monitor the use and effectiveness of a method to assist Hospital practitioners in decisions relative to care and

treatment at the end of life, for resolution of conflict in treatment decisions and other clinical ethical issues. Such method shall not authorize the Committee to make any decisions with respect to the care and treatment of a particular patient nor assume responsibility, which is rightfully the attending physician's obligation for the care and treatment of his/her patient.

C. Meetings

1. The Committee shall meet as often as necessary but no less than six (6) times per year. The Chairperson of the Committee may excuse a member from attending a regularly scheduled meeting.

2. A permanent record of all proceedings and recommendations from the regularly scheduled meetings shall be maintained.

Subsection 14.3.3 THE MEDICAL STAFF HEALTH COMMITTEE (MSHC)

A. Membership

The membership of the Medical Staff Health Committee at the Syosset Campus shall be as set forth in the Medical Staff Rules and Regulations.

B. Functions

The Medical Staff Health Committee shall:

1. Develop and periodically review policies and procedures related to the health of the Medical and Allied Health Professional Staffs, to ensure that such policies and procedures include mechanisms for (i) education of the Medical and Allied Health Professional Staff about illness and impairment recognition issues specific to such professionals; (ii) self-referral by professionals; (iii) referral of affected practitioners to appropriate professional internal or external resources for diagnosis and treatment; (iv) maintenance of confidentiality except as limited by law, ethical obligation or concerns about patient safety; (v) evaluation of the credibility of a complaint, allegation or concern; (vi) monitoring of the affected practitioner and patient safety throughout the rehabilitation process; and (vii) reporting to the Medical staff leadership instances in which a practitioner is providing unsafe treatment. The Committee shall report on such matters to the Leadership Coordinating Council.

2. Provide professional advice to and consultation with departmental chairpersons and Hospital administrative personnel, as necessary, on individual matters of practitioners' physical and mental health as it relates to the functions and duties of such practitioners, in accordance with such duly adopted policies and procedures.

3. Provide professional consultation and coordinate and monitor assistance and rehabilitation activities with respect to practitioner impairment including impairments related to physical and mental health and substance abuse or addiction, among such impaired practitioners, their Departmental Directors, and other Hospital administrative personnel as appropriate, and the

Committee for Physician's Health of the Medical Society of the State of New York and/or other outside agencies authorized to participate in such activities.

4. Through such activities, aid practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients, provided that if at any time during the diagnosis, treatment or rehabilitation phase of the process it is determined that the practitioner is unable to safely perform the privileges he or she has been granted, the Committee shall forward the matter to the Chair of the Leadership Coordinating Council for corrective action under Article VIII and X of these Bylaws.

C. Meetings

The Committee shall meet as often as necessary, but at least four times annually. A permanent record of all proceedings and recommendations shall be maintained. Where part or all of any such meeting pertains to an individual practitioner, such proceedings shall be deemed confidential and, except as provided in Article XI to these Bylaws, the records thereof shall be redacted from any reports to the Leadership Coordinating Council.

Subsection 14.3.4 THE PERFORMANCE IMPROVEMENT COORDINATING GROUP

A. Membership

The membership of the Performance Improvement Coordinating Group shall be as set forth in the Medical Staff Rules and Regulations.

B. Functions

The PICG shall:

1. Function in a multidisciplinary capacity, providing leadership and guidance in the Hospital's organizational performance improvement activities, medical staff professional review, health information management, utilization management, infection control, ambulatory care, risk management, Hospital safety program, special care nutritional support, and pharmacy and therapeutics functions, thereby implementing a unified program that improves organizational performance by establishing multidisciplinary teams to design, measure, assess and improve the organizational functions identified by The Joint Commission (and any other applicable accrediting and certifying boards and bodies).

2. Oversee, coordinate and prioritize quality assurance and performance improvement activities by, among other things, approving and administering an annual Hospital-wide Performance Improvement Plan by:

- Promoting and assisting, where needed, in the development of the methodology for the plan by focusing on its design, implementation, measurement methodology, means of assessment, and;

- Assisting in coordinating the dimensions of performance with patient care and organizational functions.
 - Reappraising the Hospital's quality assurance, quality management, performance improvement, risk management and safety programs for their effectiveness and the degree to which they integrate and coordinate their efforts and apply to all departments, services and practitioners of the Hospital.
3. Receive and analyze reports from each Hospital department/service (as appropriate) regarding all Hospital activities concerned with quality, utilization and risk management, integrate and coordinate such activities to the degree possible, and recommend additional activities and modification of existing activities as needed, as well as combination of activities, when appropriate, from all interdepartmental performance improvement committees which report to the Performance Improvement Coordinating Group and to the Medical Board.
 4. Assure the use of information gathered regarding problems identified in the revision of Hospital policies and procedures.
 5. Promote and assist, where needed, in the development of multidisciplinary standards of care for all patient activities, with particular reference to existing rules and regulations of the professional staffs.
 6. Establish procedures for effective utilization of Hospital services and a mechanism for the provision of discharge planning by identifying utilization related problems, including the appropriateness and medical necessity of admissions, continued stays and support services, delays in the provision of support services, as well as length of stay norms.
 7. Identify general areas of potential risk in all clinical aspects of patient care and safety, including at a minimum, all areas of concern identified in Part 405.6 of the New York State Hospital Code, establish corrective action plans therefor, and monitor the outcomes of such plans in order to reduce malpractice claims and the probability of harm to patients.
 8. Receive, evaluate and coordinate reports of all improvement team activities and share information related to outcome and performance concerning all quality management and performance improvement activities.
 9. Coordinate and oversee all functions identified in Part 405.6 of the New York State Hospital Code to be coordinated and overseen by this Committee.
 10. Meet in an executive session comprised of the clinical and other designated members of the Performance Improvement Coordinating Group to review adverse patient outcomes and sentinel events.

11. Send representatives to, and receive reports from, committees comprised of representatives of the Hospital and other Northwell Hospitals in order to identify, share, develop and improve best practices for patient care at the Hospital. Administrative support for, and coordination of all such Committee's activities, shall be provided by Northwell's Department of Quality Management and coordinated with the Hospital's Department of Quality Management.

C. Meetings

The Performance Improvement Coordinating Group shall meet monthly, not less frequently than ten (10) times per year.

D. Reports

1. The Performance Improvement Coordinating Group shall report monthly to the Executive Director of the Syosset Campus and the Leadership Coordinating Council. Reports shall include the status of current performance improvement activities.

2. The Performance Improvement Coordinating Group shall report at least quarterly through the Leadership Coordinating Council and the Medical Board to the Committee on Quality of the Board of Trustees. Reports shall include:

- The status of organization performance improvement activities undertaken during the reporting period, and;
- Pertinent findings and recommendations of quality management and performance improvement activities throughout the Hospital.

ARTICLE XV
IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for appointment to the Medical Staff and/or clinical privileges at the Hospital and continuation of any such appointment and/or privileges.

A. Any act, communication, report, recommendation, or disclosure, with respect to any practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and/or maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

B. Such privilege shall extend to members of the Hospital's Medical Staff and the Board of Trustees, the Medical Board, the Hospital Administration, employees and agents of the Hospital, and to third parties, who supply information to any of the foregoing authorities to receive, release, or act upon the same. For the purpose of this Article XV, the term "third parties" means

both individuals and organizations from whom information has been requested by an authorized representative of the Medical Board or the Medical Staff.

C. To the fullest extent permitted by law, there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure.

D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's activities including, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension and hearings thereon and any actions pursuant to Articles VIII, IX or X, (4) medical care evaluations, (5) utilization reviews, and (6) other Hospital, Department or committee activities related to quality patient care and professional conduct or other provisions of these Bylaws.

E. The acts, communications, reports, recommendations, and disclosures referred to in this Article XV may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might be relevant to the practitioner's appointment to the Medical Staff, his or her privileges, or patient care.

F. In furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases, waivers of liability, confidentiality statements or other documents in accordance with the tenor and import of this Article XV, immunizing individuals and organizations specified in paragraph XV(B), subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under federal, state and local statutes, rules and regulations.

ARTICLE XVI

RULES AND REGULATIONS & ASSOCIATED POLICIES

Section 16.1 ADOPTION AND AMENDMENT

The Medical Board shall adopt such Medical Staff Rules and Regulations and associated medical staff policies as may be necessary for the proper conduct of the work of the Medical Staff. Such Rules and Regulations and associated policies may be amended at any regular meeting of the Medical Board without prior notice or any special meeting in accordance with these Bylaws. Amendments shall become effective when approved by the Board of Trustees.

Section 16.2 NOTICE OF ADOPTION

Following approval by the Board of Trustees, the Administrative Office of the Medical Staff Society shall ensure that all members of the Medical Staff are promptly notified of amendments to the Rules and Regulations and associated Medical Staff policies, and copies thereof shall be available for review by members of the Medical Staff in the Administrative Office of the Medical Staff Society, the Medical Staff Services Central Office and on

Northwell's website. Members of the Medical Staff are obliged to keep informed of all amendments to the Rules and Regulations and Medical Staff policies.

ARTICLE XVII

REVIEW AND AMENDMENTS

Section 17.1 BIENNIAL REVIEW

These Bylaws shall be reviewed at least once in each two-year period by the Medical Board pursuant to recommendations from the Bylaws Committee or as otherwise set forth herein, to decide whether revision is appropriate to ensure that the Bylaws reflect the Hospital's current practices with respect to Medical Staff organization and functions and are consistent with applicable legal and other requirements.

Section 17.2 PROPOSED AMENDMENTS

Amendments to these Bylaws may be initiated by the Medical Staff, the Medical Board or the Board of Trustees in accordance with the following procedures.

Subsection 17.2.1 MEDICAL STAFF PROPOSED AMENDMENTS. The following procedures shall be used to propose a Bylaws amendment that does not originate with the Bylaws Committee of the Medical Board, including a proposal to withdraw any portion of the Medical Staff's delegation of authority to the Medical Board pursuant to Section 6.1.2 above:

- (a) A group of at least fifty (50) voting members of the Medical Staff may submit a petition proposing a Bylaws amendment to the Medical Board. The petition shall include a clear description of the proposed amendment and, if the petition seeks to withdraw any portion of the Medical Staff's delegation of authority to the Medical Board pursuant to Sections 6.1.2 above, it shall also specify those matters as to which such authority is to be withdrawn.
- (b) Subject to the provisions of paragraph (d) below, if the Medical Board deems the proposal to be appropriate, then it will be referred to the Bylaws Committee for further consideration. If recommended by the Bylaws Committee and thereafter approved by majority vote of the Medical Board, then the proposed Bylaw amendment shall be effective thereafter only when approved by the Medical Staff and the Board of Trustees in accordance with Section 17.3 below.
- (c) Subject to the provisions of paragraph (d) below, if the Medical Board does not delegate review to the Bylaws Committee, or if the Bylaws Committee does not recommend in favor of the amendment, or if following such favorable recommendation the Medical Board does not approve the amendment by majority vote, then the petitioners shall have the right thereafter to invoke the Conflict Management Process in Article XVIII of these Bylaws.

- (d) A petition proposing to withdraw any portion of the Medical Staff's delegation of authority to the Medical Board pursuant to Sections 6.1.2 above shall be referred to the Medical Board and the Bylaws Committee for their recommendations, but shall not be subject to approval by either the Medical Board or the Bylaws Committee. Instead, the Medical Board shall arrange for the proposed amendment to be submitted to the Medical Staff, together with the recommendations of the Medical Board and the Bylaws Committee, if any, for a vote in accordance with the procedures set forth in Section 17.3 below.

Subsection 17.2.2 **MEDICAL BOARD PROPOSED AMENDMENTS.** As a result of its biennial review or at any other time, the Medical Board may by majority vote propose a Bylaws amendment pursuant to recommendation by the Bylaws Committee. Any such proposed Bylaws amendment shall be effective only when approved by the Medical Staff and the Board of Trustees in accordance with Section 17.3 below.

Subsection 17.2.3 **UNILATERAL AMENDMENT BY THE BOARD OF TRUSTEES.** The Board of Trustees may unilaterally amend these Bylaws only if the amendment is necessary to conform them to applicable statutes, regulations, judicial decisions, or to ensure compliance with Joint Commission standards to maintain accreditation. Such unilateral amendment shall not require approval by the Medical Staff, but notice of such amendment shall be provided to the Medical Staff in accordance with Section 17.4 below, and thereafter the Conflict Management provisions set forth in Section 11.2(c) of the Hospital's Corporate Bylaws shall be available to the Medical Staff with regard to the amendment.

Section 17.3 **NOTIFICATION AND ADOPTION OF PROPOSED AMENDMENTS**

Subsection 17.3.1 **NOTIFICATION.** Notice of any proposed Bylaws amendment approved by the Medical Board shall be given to the members of the Medical Staff at least thirty (30) days prior to a vote for approval by the Medical Staff. The Administrative Office of the Medical Staff, in consultation with Medical Staff Services Central Office, shall be responsible for providing such notice and conducting the voting electronically by secret ballot. Notice shall be sent to each voting member at his/her primary electronic mail address on file with the Medical Staff Services Central Office. Voting shall be permitted over a period of ten (10) days. The Medical Board and/or the Bylaws Committee shall serve to educate the Medical Staff about the pros and cons of proposed Bylaws amendments.

Subsection 17.3.2 **ADOPTION.** Medical Staff Bylaws amendments shall be adopted when approved by a majority of those voting, provided that a total of at least two hundred (200) votes are cast by Medical Staff members who are eligible to vote. A Bylaws amendment so approved by the Medical Staff shall become effective only upon approval by the Board of Trustees. If the Board of Trustees does not approve a Bylaws amendment approved by the Medical Staff in accordance with these procedures, then the Conflict Management provisions set forth in Section 11.2(c) of the Hospital's Corporate Bylaws shall be available thereafter to the Medical Staff with regard to the amendment.

Section 17.4 NOTICE OF ADOPTION

Following approval by the Board of Trustees, the Administrative Office of the Medical Staff Society, supported by the Medical Staff Services Central Office, shall ensure that all members of the Medical Staff are promptly notified of amendments to these Bylaws. Such notice shall be sent to members at their primary electronic mail address on file with the Medical Staff Services Central Office. In addition, a copy of the Bylaws and any amendments thereto shall be available for review by members of the Medical Staff in the Administrative Office of the Medical Staff Society, the Medical Staff Services Central Office and on Northwell's website. Members of the Medical Staff are obliged to keep informed of all amendments to the Bylaws.

ARTICLE XVIII **CONFLICT MANAGEMENT PROCESS**

The following conflict management process shall be followed in the event of conflict between the Medical Board and the Medical Staff regarding a proposed or adopted Medical Staff Bylaw, Medical Staff Rule and Regulation, or associated Medical Staff policy, or other significant matter under the purview of the Medical Board. A written petition to trigger the conflict management process signed by at least fifty (50) voting members of the Medical Staff shall be submitted to the President of the Medical Staff. The petition shall include (a) a clear statement of the reason for the conflict and the terms of any alternative Bylaw, Rule and Regulation or associated policy, and (b) the designation of three (3) members of the Medical Staff as selected by the petitioners to serve as the petitioners' representatives.

Within one week after receipt of the petition, the President of the Medical Staff shall convene a meeting between the three (3) petitioners' representatives and three (3) physician voting members of the Medical Board as selected by the Chair of the Medical Board. The three (3) physician members of the Medical Board shall be members of the Medical Staff of the relevant Campus.

The representatives of the Medical Board and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve differences within thirty (30) days of their first meeting, in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Board and the safety and quality of patient care at the Hospital. Resolution of the matter shall require a majority vote of the three (3) representatives of the Medical Board and a majority vote of the three (3) petitioners' representatives. If such a resolution proposes a Medical Staff Bylaw that has not been previously submitted to the Medical Staff, such resolution shall follow the process outlined in Article XVII above.

If the parties' representatives are unable to reach a resolution, they may, by mutual agreement, utilize Northwell's Chief Medical Officer and/or other persons skilled in conflict management to assist in resolving their conflict. Differences that remain unresolved after the expiration of the above thirty-day period shall be submitted to the Board of Trustees for its consideration in making a final decision with respect to the proposed medical staff Bylaw, medical staff Rule and

Regulation, or associated medical staff policy, or other matter. The Board of Trustees shall determine the method by which unresolved conflicts are submitted to the Board.

At all times the participants in the conflict management process shall observe the following principles:

- Resolution of all conflicts shall be undertaken in a manner that promotes productive, collaborative, and effective teamwork, and in an atmosphere of mutual respect and understanding.
- Resolution of the conflict shall be consistent with the organization's mission, values, strategic objectives, policies and organizational ethics; shall protect patient safety and quality of care; and shall best serve the interests of the patient.
- All discussions regarding the issues that are the subject of the conflict shall be confined to internal communications, and the highest level of confidentiality shall be maintained with respect to such discussions and issues. Communication to the public with respect to the issues is not appropriate.

**ARTICLE XIX
ADOPTION**

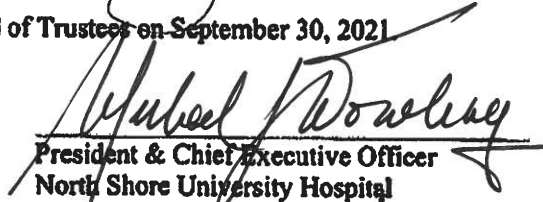
Subject to the provisions of the Hospital's Bylaws, these Bylaws of the Medical Staff shall become effective and shall replace any previous Bylaws of the Medical Staff after these shall have been adopted at a regular or special meeting of the Medical Board and approved by the Board of Trustees.

ADOPTED by the Medical Board on April 13, 2021.

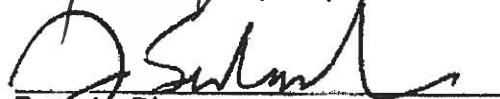


Chair of the Medical Board

APPROVED by the Board of Trustees on September 30, 2021




President & Chief Executive Officer
North Shore University Hospital



Executive Director
North Shore University Hospital



Assistant Secretary, Board of Trustees



Executive Director
Syosset Campus
North Shore University Hospital