

# **Kenmore Mercy Hospital Medical Staff, Bylaws**

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## **PREAMBLE**

**WHEREAS**, it is the purpose of the Governing Body of this Hospital, through its Medical Staff and its President of the Hospital, to provide care and treatment to the sick and injured without regard to age, race, creed, color, sexual orientation, religion, marital status, sex, national origin or disability, to maintain and improve community health and to provide education and research.

**WHEREAS**, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital, subject to the ultimate authority of the Governing Body, in order to fulfill the Hospital's obligation to its patients. The Medical Staff has overall responsibility for establishing Medical Staff criteria, standards, policies and procedures for recommending clinical privileges to be granted to individual practitioners.

**THEREFORE**, the physicians, dentists, podiatrists and Allied Health Professionals practicing in this Hospital pursuant to clinical privileges granted by the Governing Body are hereby organized into a Medical Staff with Bylaws, Rules and Regulations; maintained in conformity with the standards of the New York State Hospital Code and the Joint Commission (JC).

**NOW THEREFORE**, be it enacted that all Bylaws of the Medical Staff heretofore enacted be canceled and revoked and that the following Medical Staff Bylaws be substituted.

# **ARTICLE ONE: NAME**

The name of this organization shall be the “Medical Staff of Kenmore Mercy Hospital, Kenmore, New York.”

# **ARTICLE TWO: PURPOSES AND RESPONSIBILITIES**

## **Section I: Purposes**

The purpose of the Medical Staff is to provide the formal organizational structure through which the responsibility, authority and accountability of each member is outlined, the process through which membership on the Medical Staff may be obtained by individual practitioners and the ways in which the obligations of Medical Staff membership may be fulfilled.

## **Section II: Responsibilities**

In order to fulfill the mission of the Hospital to provide care and treatment to the sick and injured, to maintain and improve community health and to provide education and research, it is the responsibility of the Medical Staff:

- A. To insure that all patients admitted to or treated in any of the facilities, departments, or services shall receive quality medical care commensurate with recognized current medical practices.
- B. To insure a high level of professional performance by all practitioners authorized to practice in the Hospital through the appropriate delineation of the current clinical privileges that each practitioner may exercise in the Hospital; and through an ongoing review and evaluation of the performance of each member of the Medical Staff in the Hospital.
- C. To provide for Medical Staff accountability to the Governing Body for the quality of care provided to patients.
- D. To provide a means for making recommendations to the Governing Body regarding granting, renewing and delineation of clinical privileges and to provide for procedural due process in the event of a recommendation adverse to a practitioner.
- E. To promote and maintain quality care by measuring, assessing and improving performance of the clinical practices within the Hospital.
- F. To promote and participate in activities designed for the general health of the community.
- G. To provide educational opportunities and to encourage advancements in professional knowledge and skill in order to maintain educational standards of all personnel and to encourage research.

- H. To provide a means to discuss issues concerning the Medical Staff and the Hospital with the Governing Body and/or the President of the Hospital.
- I. To provide a means through which the Medical Staff may participate in the Hospital's policy making and planning process and through which such policies and plans are communicated to the Medical Staff.
- J. To initiate, administer, recommend amendments to and enforce compliance with these Medical Staff Bylaws and Rules and Regulations for the self-governance of the Medical Staff.
- K. To exercise the authority granted by these Medical Staff Bylaws as necessary to adequately fulfill the foregoing responsibilities.

# **ARTICLE THREE: MEDICAL STAFF MEMBERSHIP**

## **Section I: Nature of Medical Staff Membership**

The Medical Staff shall be organized, and accountable, operating under Medical Staff Bylaws approved by the Governing Body, for the quality of the medical care provided to all patients. The Medical Staff shall establish objective standards of care and conduct to be followed by all practitioners granted clinical privileges at the Hospital, consistent with prevailing standards of medical and other licensed health care practitioner standards of practice and conduct which afford patients their rights in accordance with New York State laws, codes, rules and regulations.

Membership on the Medical Staff of the Hospital or the exercise of temporary clinical privileges is a privilege which shall be extended only to professionally competent physicians, dentists, podiatrists and Allied Health Professionals (AHP) certified and/or currently registered to practice independently in the State of New York who continually meet the qualifications, standards and requirements for appointment by the Governing Body, set forth in the Medical Staff Bylaws.

No physician, dentist, podiatrist or Allied Health Professional shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice the profession in this or in any other state, or is a member of any professional organization, or is certified by any clinical board, or because he/she had, or presently has, staff membership or clinical privileges at another health care facility or in another practice setting.

Membership on the Medical Staff of the Hospital shall be extended and/or maintained taking into account patient needs, available hospital facilities, resources, and utilization standards in effect at the Hospital, as determined by the Medical Executive Committee and the Governing Body.

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, marital status, sexual orientation, disability or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, professional qualifications, the Hospital's objectives or the character and/or competency of the Applicant.

## **Section II:                   Qualifications and Performance Standards for Membership-Medical**

Each physician, dentist, podiatrist and Allied Health Professional certified to practice independently in the State of New York who seeks or enjoys Medical Staff membership must be able to:

1. Provide evidence of a valid New York State license to practice medicine, dentistry, podiatry or in the case of the Allied Health Professions, the appropriate license or certification.
2. Provide documentation of professional education, experience, background and training. An Applicant shall be a graduate of a School of Medicine approved by the Liaison Committee for Medical Education or the American Osteopathic Association conferring the degree of Doctor of Medicine or Doctor of Osteopathy or, for Allied Health Professionals, an appropriate degree from an approved school.
3. Show proof, upon applying for Medical Staff membership and clinical privileges, of having successfully completed an internship or residency approved by the Council of Medical Education of the American Medical Association or the American Osteopathic Association. Allied Health Professionals will show proof of appropriate training.
4. Demonstrate current clinical competence with sufficient adequacy to assure the Medical Staff and the Governing Body that patient care will be provided at a generally acceptable level.
5. Assure the Medical Staff and the Governing Body, with sufficient adequacy, that he/she meets the requirements of his/her respective requested clinical department(s) in order to be assigned to such department(s).
6. Provide evidence of professional liability insurance in the amounts required under these Medical Staff Bylaws.
7. Provide evidence of current, unlimited United States Drug Enforcement Agency registration, where applicable.
8. Demonstrate freedom from any physical or behavioral impairment, including alcohol or drug dependence, which may interfere with his/her ability to perform the procedures and essential functions of the position for which he/she is seeking clinical privileges, with or without reasonable accommodation.
9. Provide references documenting his/her strict adherence to the ethics of the profession, good reputation and moral character, ability to work



cooperatively with others and ability to participate in the discharge of Medical Staff responsibilities.

10. Document that he/she has fulfilled applicable requirements of the Immigration and Naturalization Services, where appropriate.

### **Section III:           Qualifications and Performance Standards for Membership-Dental**

Each dentist licensed to practice independently in the State of New York who seeks or enjoys Medical Staff membership must be able to:

1. Provide proof of all of the foregoing enumerated in Section II, above, and
2. Provide documentation of graduation from a Dental School approved by the Committee of Dental Accreditation conferring the degree of Doctor of Dental Surgery or Doctor of Dental Medicine.
3. Show proof of having successfully completed a minimum of one (1) year in-hospital training (internship or residency approved by the American Dental Association) and/or graduate training in his/her dental specialty field.
  - a. Oral Surgery applicants shall have three (3) years of formal training in their specialty.
  - b. Applicants shall seek clinical privileges in the field of his/her training.

Dentists appointed to the Medical Staff shall be responsible for the admission, management and discharge of dental patients, including all related written documentation. The admission history and physical examination for dental patients shall be completed by a dentist qualified to perform a history and physical examination or by another member of the Medical Staff so qualified. A dentist qualified to perform a history and physical examination shall mean a dentist who has successfully completed a postgraduate program of study incorporating training in physical diagnosis at least equivalent to that received by one who has successfully completed a postgraduate program of study in oral and maxillofacial surgery accredited by a nationally recognized body approved by the United States Education Department. The Medical Staff shall determine whether the Applicant is currently competent to conduct a complete history and physical examination to determine a patient's ability to undergo a proposed dental procedure and whether he/she is acting within the scope of his/her license.

Dental patients with medical comorbidities or complications present upon admission or arising during hospitalization shall be referred to an appropriate member of the Medical Staff for consultation and/or management. The dentist shall perform only the functions which he/she is legally authorized by the State of New York to perform.

## **Section IV:           Qualifications and Performance Standards for Membership-Podiatric**

Each podiatrist licensed to practice independently in the State of New York who seeks or enjoys Medical Staff membership must be able to:

1.     Provide proof of all of the foregoing enumerated in Section II, above, and
2.     Provide documentation of graduation from an approved Podiatric Medical School conferring the degree of Doctor of Podiatric Medicine.
3.     Show proof of having a minimum of one (1) year in-hospital training and/or board certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics.

Podiatric patients with medical comorbidities or complications present upon admission or arising during hospitalization shall be referred to appropriate Medical Staff for consultation and/or management. The podiatrist shall perform only the functions which he/she is legally authorized by the State of New York to perform.

## **Section V:           Basic Responsibilities of Individual Medical Staff Members**

### **A.     PATIENT CARE RESPONSIBILITIES**

Each member of the Medical Staff, regardless of assigned staff category, and each practitioner granted temporary clinical privileges shall:

1.     Provide patients with care which meets generally acceptable standards of professional practice and efficiency.
2.     Prepare and complete, in a timely manner, medical and other required records for all patients administered to or in any way cared for in the Hospital by such member.
3.     Provide for continuous care and supervision of patients and refrain from delegating the responsibility for diagnosis and/or treatment of hospitalized patients to a practitioner who is not qualified to undertake the responsibility or who is not adequately monitored.
4.     Have on file with the Medical Staff Office the name of the Medical Staff member or members providing coverage in their absence. Any changes in such coverage shall be promptly reported. The covering physician shall have the same responsibilities as the staff member. The patient must be made aware of any arrangement for prolonged or permanent alternate care coverage and this must be documented in the medical record.

5. Actively participate in the Quality Review and Performance Improvement activities required of the Medical Staff and facility.
6. Practice within a reasonable distance from the Hospital to assure the provision of continuity of patient care.
7. Accept on-call service roster and accept consultation assignments as required under the Medical Staff Bylaws, Rules and Regulations and Departmental Rules and Regulations, as applicable to the specialty.
8. Accept all service patients when assigned to Medical Staff service, as applicable.

**B. PROFESSIONAL RESPONSIBILITIES**

Each member of the Medical Staff, regardless of assigned staff category shall:

1. Abide by the Medical Staff Bylaws and all other adopted standards, rules and regulations and other lawful policies and procedures of the Hospital and Medical Staff.
2. Discharge such staff departmental, service, committee, Medical Staff and Hospital functions for which he/she is responsible by staff status, assignment, appointment, election or otherwise, as may be required under the Medical Staff Bylaws and Rules and Regulations. The Rules and Regulations are attached to these Medical Staff Bylaws as Appendix A and are incorporated by reference throughout the Medical Staff Bylaws.
3. Satisfy requirements concerning attendance at Medical Staff meetings and specific department meetings.
4. Satisfy requirements for Continuing Medical Education as shall be required in connection with his/her continued good standing as a duly licensed professional in the State of New York and/or as shall be required in connection with Hospital policies regarding Continuing Medical Education for its professional staff.
5. Accept teaching assignments as applicable to Department, specialty and Medical Staff category.
6. Discharge such other responsibilities as may be required by the Medical Staff subject to the approval of the Governing Body.
7. Pay the yearly dues in the amounts established by the Medical Executive Committee.

### C. NOTIFICATION RESPONSIBILITIES

Each member of the Medical Staff, regardless of assigned staff category, and each practitioner granted temporary clinical privileges shall:

1. Notify the President of the Hospital in a timely manner if any of the following events occur: (a) the revocation, limitation or suspension of his/her professional license or United States Drug Enforcement Agency registration, or the imposition of terms of probation or limitation of practice by any state; (b) his/her involuntary loss of Medical Staff membership or clinical privileges at any hospital or other health care institution; (c) the cancellation of his/her professional liability insurance coverage.
2. Notify the President of the Hospital in a timely manner of receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient at the Hospital.
  3. Notify the President of the Hospital in a timely manner of any physical and/or mental impairment rendering the practitioner unable to discharge his/her duties.

Any Medical or surgical condition, other than childbirth, which carries a period of disability or inability to perform his/her duties for longer than two (2) weeks, will require a communication from the treating physician of record specifying the recommended restrictions, if any, before returning to the Medical Staff

4. Notify the President of the Hospital and Corporate Compliance Officer immediately if any of the following events occur: (a) he/she is notified that he/she may be, will be or is listed as excluded, suspended or otherwise ineligible for participation in any federal or state health care program, or if; (b) he/she is a member of a group which is notified that they may be, will be or are listed as excluded, suspended or otherwise ineligible for participation in any federal or state health care program.
5. Notify the President of the Hospital and Corporate Compliance Officer immediately if any of the following events occur: (a) he/she is the subject of or is a member of a group which is the subject of an investigation commenced by any governmental agency or other entity; (b) he/she is the subject of or is a member of a group which is subject of an enforcement action taken by any governmental agency or other entity; (c) he/she becomes aware of an investigation commenced against an individual, group or other entity affiliated or doing business with Hospital by any governmental agency or other entity; (d) he/she becomes aware of an enforcement action taken against an individual, group or other entity affiliated or doing business with Hospital by any governmental agency or other entity.

#### D. ETHICAL STANDARDS

Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association and/or American College of Surgeons and/or by the Code of Ethics of the American Dental and/or Podiatric Association, as well as the current Ethical and Religious Directives for Catholic Health Care Services and/or any other pertinent code of ethics which is applicable. The standards of the Joint Commission shall also govern the professional conduct of the Medical Staff. In the event of conflict the Medical Staff shall conduct themselves in a professional, ethical manner, consistent with the policies of the Hospital as established and interpreted by the Governing Body from time to time, with reference to a particular situation.

All members of the Medical Staff shall pledge that they will not receive from nor pay to another physician, either directly or indirectly, any part of a fee received for professional services. On the contrary, it shall be agreed that all fees shall be collected and retained by the individual in accordance with the value of services rendered by him/her to the patient. Hospital based specialists, who have a contractual arrangement with the Hospital, may accept a method of payment for their services through the collection facilities of the Hospital.

#### **Section VI: Participation in Quality Assurance and Medical Malpractice Prevention**

The Medical Staff shall establish mechanisms to monitor the ongoing performance in delivering patient care of practitioners granted clinical privileges at the Hospital, including monitoring of practitioner compliance with the Bylaws of the Medical Staff and pertinent Hospital policies and procedures.

The Medical Staff shall work with and relate to other practitioners, residents, students, Allied Health Professionals and members of professional review organizations and accreditation bodies in a manner appropriate for maintaining Hospital governance appropriate for the provision of quality patient care and that is non-disruptive to Hospital operations.

The Medical Staff actively participates and exercises professional leadership in measuring, assessing, and improving the performance of the organization by actively participating in the Quality Review and Performance Improvement activities required of the Medical Staff and facility. Medical Staff leadership actively participates in assessing and improving the quality of care delivered within the organization, including interactions between individual staff members and their clinical departments and/or patients and/or the overall organization.

# **ARTICLE FOUR: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

## **Section I: Pre-Application Form and Process**

### **A. INTRODUCTION**

An Application for medical staff appointment and clinical privileges should be sent only to Applicants who, according to these Medical Staff Bylaws, are eligible for appointment to the Medical Staff. In order to determine whether a potential Applicant has met threshold criteria set forth by the Hospital with respect to the granting of professional staff membership and clinical privileges, or whether a potential Applicant is applying for clinical privileges in a professional practice area that the Hospital, with the approval of the Medical Executive Committee and of the Governing Body, has closed to new grants of clinical privileges, the Hospital shall obtain and review the Pre-Application form in accordance with the Pre-Application process. The Pre-Application process places an appropriate burden on potential Applicants to satisfy certain minimum pre-conditions and to submit accurate and complete applications.

The Pre-Application process allows the Hospital to pre-screen potential Applicants not meeting the minimum requirements of training and education and potential Applicants seeking clinical privileges in areas where the Hospital cannot accommodate additional membership, without extending any hearing and appeal rights to the potential Applicant. The Pre-Application process benefits the ineligible potential Applicant as such determinations are not reportable to the Office of Professional Medical Conduct or the National Practitioner Data Bank.

### **B. PROCESS**

A person seeking membership on the Medical Staff must submit a written request to the Hospital to apply. Such requests are forwarded to the Medical Staff Office and upon receipt thereof, a Pre-Application Form is sent to the potential Applicant. Under special circumstances, the submission of the pre-application form and process may be waived upon written concurrence of the Chair of the Department where the clinical privileges if granted will be exercised. Rev. 2/18/09

When the completed Pre-Application Form is received by the Hospital, the information on the Pre-Application Form is reviewed by the appropriate Department Chair, according to established criteria, regarding minimum requirements of training, education and ability to accommodate. The review by the Chair should be accomplished within sixty (60) days of receipt by the Hospital.

If the Pre-Application Form is incomplete, the Hospital notifies the potential Applicant and provides the potential Applicant thirty (30) days to complete the Pre-Application and/or remedy any defect. If the potential Applicant is rejected based upon the

established criteria regarding training, education and ability to accommodate, the potential Applicant is so notified.

If the Pre-Application Form is complete and the Hospital has determined that the minimum requirement for training, education and ability to accommodate have been met by the potential Applicant, the Hospital forwards the Pre-Application Form to the System Verification Office (SVO) of the Catholic Health System, which sends the potential Applicant the Catholic Health System Application for Medical Staff Membership credentialing packet. The potential Applicant is instructed to return the completed application and credentialing packet to the SVO and upon the SVO's receipt of Applicant's completed application and credentialing packet, it is processed in accordance with the following sections of these Medical Staff Bylaws.

## **Section II: Application for Appointment**

### **A. INTRODUCTION**

The Hospital must maintain a Quality Assurance medical, dental and podiatric malpractice prevention program and must conduct investigations prior to granting or renewing Medical Staff membership and clinical privileges. All substantive decision-making must be retained by appropriate Hospital representatives and duly constituted Hospital committees. The Hospital may delegate the administrative and technical aspects of the credentialing process to an affiliated independent contractor for purposes of administrative convenience and economy.

The Hospital, as a member of the Catholic Health System (CHS), has entered into an Administrative Services Agreement with the System Verification Office (SVO) of the Catholic Health System and has appointed CHS as its exclusive agent to provide administrative, technical and verification services through its SVO to the Hospital in connection with the credentialing and recredentialing of physicians, dentists, podiatrists and Allied Health Professionals (Applicants) seeking to obtain or renew professional Medical Staff membership and clinical privileges at the Hospital. The Administrative Services Agreement shall be available, on file, in the Administrative and/or Medical Staff Offices of the Hospital and incorporated by reference herein.

The Hospital reserves to the Governing Body and any duly authorized committees thereof and to the Medical Staff any and all rights and obligations to determine whether an Applicant shall be appointed or re-appointed to the Hospital's Medical Staff. All such decisions by the Hospital are made in accordance with the requirements contained in these Medical Staff Bylaws and according to statutory and regulatory authority.

The SVO will retain such confidential information that it may receive in carrying out its relationship with the Hospital in a fiduciary capacity for the sole benefit of the Hospital. It will not disclose any confidential information which it acquires in the performance of its duties and responsibilities except as authorized in the Agreement and as more fully set

out in the Agreement. “Confidential Information” is defined as any and all information protected from disclosure by the New York Public Health Law.

#### B. PROCESSING THE APPLICATION

Once the Pre-Application Form has been completed and the Hospital has determined that the minimum requirements for training, education and ability to accommodate have been met by the potential Applicant, the Hospital forwards the Pre-Application Form to the SVO of the CHS. The Catholic Health System Application for Medical Staff Membership credentialing packet, including request for clinical privileges forms, is forwarded to the Applicant. Information contained in the application shall be maintained as confidential, as further defined in these Medical Staff Bylaws. A blank sample copy of the Application for Appointment to the Medical Staff as periodically revised and updated, shall be available, on file, in the Administrative and/or Medical Staff Office of the Hospital.

A completed application shall require information which shall include, but not be limited to, the following information, documentation and copies where requested in the Application Form:

1. The Applicant’s alternate/covering physician(s), where applicable to clinical privileges requested. Alternate/covering physician(s) must be member(s) of the Medical Staff of this Hospital. In certain circumstances, this requirement may be waived where it is felt that there is a lack of physicians within that specialty to provide coverage. Rev. 10/20/10
2. The Applicant’s qualifications including, but not limited to, professional education, training and experience including the name of each institution attended, degrees granted, program(s) completed, dates attended and name of Program Director(s).
3. The Applicant’s specialty or sub-specialty Board certification, re-certification or current qualification status to sit for the examination.
4. The Applicant’s request for department/division and clinical privileges.
5. The Applicant’s peer references familiar with the applicant’s professional competence and character.
6. Evidence of the Applicant’s current New York State License, current DEA registration, ACLS/ATLS certification (if required) and certificate of completion of “Infection Control & Barrier Precautions” course and, if foreign medical graduate, ECFMG Number and Certificate.
7. Evidence of Applicant’s last two (2) years of CME credits, when applicable.



8. All of Applicant's affiliations since completion of postgraduate education, including the name of any hospital or facility with which the Applicant has had any association, employment, privileges or practice and if such association, employment, privileges or practice have been suspended, restricted, terminated, curtailed or not renewed, the reasons for such action.
9. The Applicant's proof of professional liability insurance coverage in the amounts required under these Medical Staff Bylaws.
10. The Applicant's professional liability history and experience including the names of present and past insurance carriers, both primary and excess. The substance of any pending or prior malpractice actions, as well as any judgments or settlements rendered in any professional liability cases.
11. Previous or currently pending professional disciplinary actions or licensure denials or limitations in this or any other state and the findings of any such proceedings or actions. Any voluntary relinquishment of license and the reasons for such relinquishment.
12. Previous or currently pending federal, state or local registration limitations or denials and the findings of any such proceedings or actions. Any voluntary relinquishment of registration and the reasons for such relinquishment.
13. Any voluntary or involuntary relinquishment of participation in any private, federal or state insurance program, including but not limited to Medicare and Medicaid.
14. Any information relative to findings that the Applicant has violated a patient's rights as set forth in the Patient's Bill of Rights under the State Hospital Code.
15. Any misdemeanor or felony charge(s), conviction(s) or entering of a plea of guilty to a crime in this or any other state.
16. Information concerning the Applicant's physical and mental condition, including alcohol or drug dependence or any behavioral impairment, which may interfere with the Applicant's ability to perform the procedures and the essential functions of the position for which the Applicant is seeking clinical privileges, with or without reasonable accommodation.
17. The Applicant's geographic proximity to the Hospital to provide service to Applicant's inpatients or on rotation with other Medical Staff members, where applicable to clinical privileges requested.

18. The Applicant's sponsoring physician, applicable for Allied Health Professional Staff Membership.

### **Section III: Effect of Application and Acknowledgement by Applicant to Abide by These Medical Staff Bylaws**

In addition to the foregoing requirements listed under Section II(B), a completed application shall contain the following Certifications, Authorizations and Waivers of Liability:

1. The Applicant's acknowledgement that any misstatements in, or omissions from, the application may constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff.
2. The Applicant's acknowledgement that his/her Medical Staff appointment and requested clinical privileges are conditional upon the satisfactory demonstration of his/her capability of exercising the requested clinical privileges safely and competently.
3. The Applicant's verification that the information provided in the application is true and accurate to the best of his/her knowledge and belief.
4. The Applicant's acknowledgement of his/her continuing responsibility to promptly notify the Hospital in the event that any of the information contained on the application changes.
5. The Applicant's acknowledgement of having received and read the Medical Staff Bylaws of this hospital, received and agreed to abide by the Standards of Behavior of the Catholic Health System and that he/she is familiar with the principles and standards of the JC, the guiding principles for Physician-Hospital relationships of the Medical Society of the State of New York and the principles of Ethics of the American Medical Association and the Ethical and Religious Directives for Catholic Health Care Services.
6. The Applicant agrees to be bound by the terms of the Medical Staff Bylaws, if granted Medical Staff membership and/or clinical privileges, in all matters relating to the consideration of the Applicant's Application for Appointment to the Medical Staff.
7. The Applicant pledges to provide for continuous care for the Applicant's patients and further agrees to abide by such Hospital and Medical Staff Rules and Regulations as may be from time to time enacted.
8. The Applicant pledges that, if granted Medical Staff membership and clinical privileges, he/she will not receive from or pay to another, either

directly or indirectly, any part of a fee received for professional services and he/she will maintain an ethical practice.

9. The Applicant signifies his/her willingness to appear for interviews in regard to his/her application.
10. The Applicant authorizes the Hospital, its Medical Staff and their representatives to consult with members of the administrative and professional staff of other hospitals and medical institutions with which the Applicant has been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on his/her professional qualifications, current competence, character and moral and ethical qualifications for Medical Staff membership.
11. The Applicant consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and current competence to carry out the clinical privileges he/she requests as well as his/her professional and moral and ethical qualifications for Medical Staff membership.
12. The Applicant releases from any liability all representatives of the Hospital, and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the Applicant and his/her credentials and qualifications, and releases from any liability, any and all individuals and organizations who provide information, including otherwise privileged or confidential information, to the Hospital in good faith and without malice concerning the Applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and delineation of clinical privileges.
13. The Applicant waives any confidentiality provision concerning the information to be provided to hospitals and other medical facilities pursuant to required legislation.
14. The Applicant authorizes and consents to the release of information, on request, by the Hospital or its Medical Staff to other hospitals, Medical Associations and other organizations concerned with provider performance and the quality and efficiency of patient care regarding any information relevant to such matters the Hospital and the Medical Staff may have concerning the Applicant, as long as such release of information is done in good faith and without malice and the Applicant releases from liability the Hospital and the Medical Staff for so doing.

15. The Applicant acknowledges the burden of producing adequate information for a proper evaluation of his/her current competence, character, ethics and other qualifications.
16. The Applicant acknowledges that Medical Staff membership is a privilege which may be withdrawn in accordance with the Hospital's Medical Staff Bylaws, Rules and Regulations and agrees, in the event of an adverse ruling made with respect to Medical Staff membership, status or clinical privileges, to exhaust the administrative remedies afforded by these Medical Staff Bylaws, Rules and Regulations before any other remedies are pursued.
17. The Applicant acknowledges his/her understanding that the Hospital has appointed the CHS SVO as its exclusive agent to provide administrative, technical and verification services in connection with the credentialing of physicians, dentists, podiatrists and Allied Health Professionals seeking to obtain professional Medical Staff membership and clinical privileges at the Hospital.

#### **Section IV: Procedures for Appointment and Reappointment**

##### **A. PROCEDURE**

Upon receipt of a completed application from the Applicant to the System Verification Office (SVO), with the applicable application fee and all required supporting documents, verifications are sent directly from the SVO or from an appropriate subcontractor of the SVO, to the professional schools, listed references, training institutions, hospital institution affiliations, previous employers and licensing agencies, by mail, telephone or on-line verification, as appropriate.

Queries to National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), American Medical Association (AMA) and the Educational Commission for Foreign Medical Graduates (ECFMG), if applicable, are processed on-line at appropriate web-sites. The SVO, or an appropriate subcontractor of the SVO, obtains New York State License and Office of Professional Medical Conduct (OPMC) status, on-line, at appropriate sites, as well as the Federation of State Boards to verify out of state Medical Board Licenses. The SVO, or an appropriate subcontractor of the SVO, reviews the Medicare/Medicaid Cumulative Sanctions Reports (CSR's) by querying the NPDB or by obtaining a Sanctions Exclusions Report, published by the Office of the Inspector General (OIG), via Internet site. When necessary, during the appointment process, the foregoing information may be obtained and/or verified by the Hospital Medical Staff Office.

1. If application fee is not received at the time application is submitted, a letter is immediately sent to Applicant noting that the application process will not be implemented until the check is received.

Upon receipt of a completed application with applicable application fee, the Applicant is notified that the application has been received, is informed that there is a ninety (90) day time frame to complete the process, that the time frame has been initiated, and is informed of any outstanding documents. A copy of this letter is forwarded to the Medical Staff Office of the Hospital. The Medical Staff Office will then forward a copy to the respective Department Chair, where applicable. The Applicant will be told to contact the Medical Staff Office to arrange an interview with the Department Chair.

1. After thirty (30) days from the date the application was initially processed, a memorandum will be sent to the Applicant by the SVO notifying him/her of any outstanding documents and that only sixty (60) days remain for the completion of his/her application or it will be inactivated because the information regarding current competence will be outdated.
2. After sixty (60) days from the date the application was initially processed, a certified letter will be sent to the Applicant by the SVO notifying him/her of any outstanding documents and that only thirty (30) days remain for the completion of his/her application or it will be inactivated because the information regarding current competence will be outdated.
3. At the end of the ninety (90) day time frame, a “close out” letter will be prepared by the SVO, for the Hospital Medical Staff Office to send to the Applicant stating that the file will be closed out unless further communication from the Applicant correcting the deficit(s) is received immediately. The letter and file will then be forwarded to the Medical Staff Office to be signed by the Vice President of Medical Affairs and mailed out to the Applicant by certified mail, return receipt requested. The Applicant’s file will be put in “closed out” status after the letter is sent.
4. When all verifications and supporting documents are received, the Applicant’s file will be sent by the SVO to the Medical Staff Office to complete the application process. The application will then be reviewed as outlined in the following sections of these Medical Staff Bylaws by the Hospital and its designated Committees to make a determination as to whether Medical Staff membership and the requested clinical privileges will be granted.

#### B. HOSPITAL AND DEPARTMENT REVIEW

When collection and verification has been accomplished by the SVO and forwarded to the Medical Staff Office, the President of the Medical Staff or designee shall transmit the Application and all supporting materials to the Chair of each department in which the Applicant seeks clinical privileges and to the Credentials Committee. Within thirty (30) days of receipt of a completed application, the Chair of such department shall review the application and supporting documentation, conduct a personal interview with the Applicant and transmit to the Credentials Committee a written report of recommendations as to Medical Staff appointment and, if appointment is recommended, as to staff category, department(s) and clinical privileges to be granted. Should a

Department Chair determine that an interview with a specific candidate is not necessary, he/she will document the reason(s) for waiving the interview, on the interview form report. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by a Chair, which shall be forwarded to the Credentials Committee along with the recommendation.

#### C. CREDENTIALS COMMITTEE REVIEW

At its next regularly scheduled meeting, after receipt of the department Chair's report and recommendations, the Credentials Committee shall consider the report and recommendations and such other relevant information available to it. The Credentials Committee shall examine the evidence of the character, current professional competence, qualifications and ethical standing of the Applicant and shall determine through information contained in the Department Chair's report, references given by the Applicant and from other sources available to the Committee, whether the Applicant has established and meets all the necessary qualifications of the category of Medical Staff membership and the clinical privileges requested by him/her. Together with this report, the Credentials Committee shall submit to the Medical Executive Committee the completed application and a recommendation that the Applicant be either provisionally appointed to the Medical Staff, rejected for Medical Staff membership, or that the application be deferred for further consideration.

1. Unless deferred, the Credentials Committee shall make its written report to the Medical Executive Committee within thirty (30) days of receipt of the application for its consideration.
2. When the Credentials Committee initially defers the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation.

### **Section V: Approval by Medical Staff and Governing Body**

#### A. MEDICAL EXECUTIVE COMMITTEE REVIEW

At its next regularly scheduled meeting after receiving the report and recommendation from the Credentials Committee, the Medical Executive Committee shall consider the character, qualifications and standing of the Applicant, his/her willingness to contribute toward meeting the educational and professional needs of the Hospital and the report and recommendations of the Credentials Committee. The Medical Executive Committee shall determine whether to recommend to the Governing Body that the Applicant be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration. The Applicant may be invited to appear before the Medical Executive Committee for a personal interview, at the Medical Executive Committee's sole discretion. All recommendations to appoint must also recommend the specific clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

1. When the recommendation of the Medical Executive Committee is favorable to the Applicant, the President of the Hospital shall promptly

forward it, together with all supporting documentation, to the Governing Body.

2. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for an adverse recommendation for Medical Staff membership.
3. When the recommendation of the Medical Executive Committee is adverse to the Applicant, either in respect to appointment or clinical privileges, the President shall promptly so notify the Applicant by certified mail, return receipt requested, of his/her procedural rights as provided by these Medical Staff Bylaws. An appeal can be honored only if received in writing within thirty (30) days of the notification to the Applicant that his application has been denied. No such adverse recommendation shall be forwarded to the Governing Body until after the Applicant has exercised, or been deemed to have waived, his/her right to a Hearing as provided under these Medical Staff Bylaws. If, after the Medical Executive Committee has considered the report and recommendation of the Hearing Panel and the Hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the Applicant, the President shall promptly forward it, together with all supporting documentation, to the Governing Body.

If such recommendation continues to be adverse, the President of the Hospital shall promptly so notify the Applicant by certified mail, return receipt requested. The President of the Hospital shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the Applicant has exercised or has been deemed to have waived his/her right to an Appellate Review as provided under these Medical Staff Bylaws.

The application shall be recommended by the Medical Executive Committee to the Governing Body for acceptance or rejection or deferral.

#### B. GOVERNING BODY REVIEW

At its next regularly scheduled meeting after receipt of a favorable recommendation for membership to the Medical Staff from the Medical Executive Committee, the Governing Body or a duly appointed Subcommittee thereof shall act upon the application. When the Medical Executive Committee makes a favorable recommendation, the Governing Body may adopt, in whole or in part, reject or refer the recommendation back to the Medical Executive Committee for further consideration.

1. If the final decision of the Governing Body is to adopt the favorable recommendation of the Medical Executive Committee, the Governing Body shall send notice of such decision through the President of the

Hospital to the Medical Executive Committee, the department concerned and the Applicant.

2. If the Governing Body's proposed final action will be contrary to the Medical Executive Committee's recommendation, the Governing Body shall submit the matter to a Medical Staff-Governing Body Review Committee for review before making its final decision. This Committee shall consist of equal numbers of members of the Governing Body and the Medical Executive Committee appointed by the respective Chair of each committee.

If the Governing Body's action remains adverse to the Applicant, when the Medical Executive Committee's recommendation was favorable, the President shall promptly so notify the Applicant by certified mail, return receipt requested and such adverse decision shall be held in abeyance until the Applicant has exercised or has been deemed to have waived his/her procedural rights as provided under these Medical Staff Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

3. If the Governing Body defers its final determination by referring the matter back to the Medical Executive Committee for further reconsideration, such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made and may include a directive that an additional Hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Governing Body shall make a final decision either to appoint the Applicant to the Medical Staff or to reject such Applicant for Medical Staff membership.

When the Medical Executive Committee makes an adverse recommendation, the President shall forward such recommendation and documentation to the Governing Body. The Governing Body shall take no action thereon until the Applicant has exhausted or has been deemed to have waived his/her procedural rights as provided under these Medical Staff Bylaws.

At its next regularly scheduled meeting after all the Applicant's rights under these Medical Staff Bylaws have been exhausted or waived and the Medical Executive Committee's decision remains adverse to the Applicant, the Governing Body shall act in the matter by adopting, in whole or in part, rejecting or referring the recommendation back to the Medical Executive Committee for further consideration.

#### C. NOTICE OF FINAL DECISION

1. Notice of the Governing Body's final decision shall be given through the President of the Hospital to the Chair of the Medical Executive



Committee, to the Chair of each department concerned, and to the Applicant.

2. A decision and notice to appoint shall include (a) the Medical Staff category to which the Applicant is appointed, (b) the department to which such Applicant is assigned, (c) the clinical privileges such Applicant has been granted, and (d) any special conditions attached to the appointment.

D. TERM OF INITIAL APPOINTMENT

1. The Governing Body shall make the initial appointment to the appropriate staff category with provisional status. The initial term of appointment is for a period of no greater than two (2) years.

## **Section VI: Reappointment Process**

A. INTRODUCTION

Reappointment to the Medical Staff shall take place every two (2) years. As described in Section II, above, with respect to the initial application process, the Hospital has delegated the administrative and technical aspects of the reappointment process to the System Verification Office (SVO) of the Catholic Health System and has appointed CHS as its exclusive agent to provide administrative, technical and verification services through its SVO to the Hospital in connection with the reappointment of physicians, dentists, podiatrists and Allied Health Professionals (Applicants for Reappointment) seeking to renew Medical Staff clinical privileges at the Hospital. As stated in Section II above with respect to the initial application process, the Hospital reserves to the Governing Body and any duly authorized committees thereof and to the Medical Staff any and all rights and obligations to determine whether an Applicant for Reappointment shall be reappointed to the Hospital's Medical Staff. All such decisions by the Hospital are made in accordance with the requirements contained in these Medical Staff Bylaws and according to statutory and regulatory authority.

B. PROCESS

In order for the Hospital to assure that the credentials, physical and mental capacity and competence in delivering health care services of all members of the Medical Staff are reviewed at least biennially, as required under the Public Health Law, Rules and Regulations of New York State, and in order to assure that the Medical Staff/Credentials file maintained on each member of the Medical Staff is updated at least biennially, the Hospital has requested that SVO personnel continually monitor the appointment terms of all members of the Medical Staff.

To accomplish the reappointment process in a timely manner, periodic reappointment reports listing members of the Medical Staff whose current appointment term will expire within approximately the next eight (8) months are produced by the SVO and forwarded to the Medical Staff Office requesting authority to forward reappointment packets to the listed members of the Medical Staff. The Medical Staff Office will forward to the

PI/Health Information Management/Risk Management Department(s), as applicable, the Applicants for Reappointment whose terms will expire within the prescribed time period.

The SVO forwards a reappointment packet, including the request for clinical privileges form, to the Applicants for Reappointment whose terms will be expiring during the time period. A blank copy of the Application for Reappointment to the Medical Staff as periodically revised and updated shall be available, on file, in the Administrative and/or Medical Staff Office of the Hospital.

A completed application for reappointment shall require information which shall include, but not be limited to the following information, documentation and copies where requested in the Application for Reappointment Form:

1. Applicant for Reappointment's Statement of Intent to request reappointment to the Medical Staff, to request not to be reappointed to the Medical Staff or to request a change in the current status as a member of the Medical Staff.
2. Any and all change in status of name, address (home and office), telephone number(s), e-mail address, beeper number and other demographic information of the Applicant for Reappointment.
3. Any changes in Medicare and UPIN Numbers.
4. The Applicant for Reappointment's alternate/covering physician(s), where applicable to clinical privileges requested. Alternate/covering physician(s) must be member(s) of the Medical Staff of this Hospital. In certain circumstances, this requirement may be waived where it is felt that there is a lack of physicians within that specialty to provide coverage.  
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5. Any changes in status of the Applicant for Reappointment's New York State License, DEA registration, ACLS/ATLS certification (if required) and current certificate of completion of "Infection Control & Barrier Precautions" training, including copies of current documents if expired since last application/reapplication.
6. Any changes in status of the Applicant for Reappointment's hospital affiliations since last application/reapplication.
7. Any changes in status of the Applicant for Reappointment's specialty or sub-specialty Board certification, re-certification or current qualification status to sit for the examination.
8. The Applicant for Reappointment's Academic Appointments and Professional Society Memberships.

9. Information concerning the current status of the Applicant for Reappointment's physical and mental health status, including alcohol or drug dependence, which may interfere with his/her ability to perform professional or medical staff duties appropriately and current health assessment on appropriate form. Information concerning current status of PPD testing.
10. The Applicant for Reappointment's request for clinical privileges, including supporting documentation of training and/or experience for new or additional privileges requested, completed on the authorized request for clinical privileges form. Peer recommendations are used to recommend individuals for the renewal of clinical privileges when insufficient practitioner-specific data are available.
11. Evidence of the Applicant for Reappointment's Continuing Medical Education and professional training obtained since appointment/reappointment and the total number CME credits. The CME shall total a minimum of 50 hours of Type I CME over the two-year reappointment cycle. Re-certification in the re-applicant's specialty board shall be the equivalent of this CME minimum.
12. The Applicant for Reappointment's current committee membership(s).
13. The Applicant for Reappointment's Publications, Awards, Commendations and/or Certifications, if any, since appointment/reappointment.
14. Any changes in the Applicant for Reappointment's malpractice insurance coverage, both primary and excess, and evidence of current coverage. Any changes in the Applicant for Reappointment's professional liability history and experience including currently pending claims, suits, settlements, judgments or arbitration proceedings.
15. The Applicant for Reappointment's voluntary or involuntary relinquishment of participation in, or sanction by, any private, federal or state insurance program, including but not limited to Medicare and Medicaid.
16. Information regarding whether the Applicant for Reappointment, since his/her last appointment, has any Disciplinary Actions (i.e. currently in the process of being or having been involuntarily denied, revoked, suspended, reduced, limited, placed on probation, not renewed or voluntarily relinquished) and an explanation thereof, in any of the following: license, registration, academic appointment, membership, affiliation, clinical privileges, prerogatives, rights on any health care facility, professional society membership or fellowship board certification, professional liability

insurance, misdemeanor or felony criminal charges, any professional misconduct proceedings or findings, any previously successful or currently pending challenges to any licensure or registration or the voluntary/involuntary relinquishment of such licensure or registration or any other type of professional sanction.

17. Since the last appointment, any information relative to findings that the Applicant for Reappointment has violated a patient's rights as set forth in the Patient's Bill of Rights under the State Hospital Code.
18. The Applicant for Reappointment's Sponsoring Physician, applicable for Allied Health Professional Staff Membership.

In addition to the foregoing request for information listed above, a completed Application for Reappointment shall contain the following Consents, Waivers and Releases:

1. The Applicant for Reappointment acknowledges that any misstatements in, or omissions from the Application for Reappointment may constitute cause for summary dismissal from the Medical Staff.
2. The Applicant for Reappointment's acknowledgement that his/her Medical Staff appointment and requested clinical privileges are conditional upon the satisfactory demonstration of his/her capability of exercising the requested clinical privileges safely and competently.
3. The Applicant for Reappointment's verification that the information provided in the Application for Reappointment is true and accurate to the best of his/her knowledge and belief.
4. The Applicant for Reappointment's acknowledgement of his/her continuing responsibility to promptly notify the Hospital in the event that any of the information contained in the Application for Reappointment changes.
5. The Applicant for Reappointment agrees to abide by the terms of the Medical Staff Bylaws in all matters relating to the consideration of his/her Application for Reappointment to the Medical Staff.
6. The Applicant for Reappointment pledges to provide for continuous care for his/her patients and further agrees to abide by such Hospital and Medical Staff Rules and Regulations as may be from time to time enacted.
7. The Applicant for Reappointment pledges that he/she will not receive from or pay to another, either directly or indirectly, any part of a fee received for professional services and that he/she will maintain an ethical practice.

8. The Applicant for Reappointment signifies his/her willingness to appear for interviews in regard to his/her Application for Reappointment.
9. The Applicant for Reappointment authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her professional qualifications, current competence, character and moral and ethical qualifications.
10. The Applicant for Reappointment consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and current competence to carry out the clinical privileges he/she requests as well as of his/her professional and moral and ethical qualifications for Medical Staff membership.
11. The Applicant for Reappointment releases from any liability all representatives of the Hospital, and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the Applicant for Reappointment and his/her credentials and qualifications and releases from any liability, any and all individuals and organizations who provide information, including otherwise privileged or confidential information, to the Hospital in good faith and without malice concerning the Applicant for Reappointment's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and delineation of clinical privileges.
12. The Applicant for Reappointment waives any confidentiality provision concerning the information to be provided to hospitals and other medical facilities pursuant to required legislation.
13. The Applicant for Reappointment authorizes and consents to the release of information, on request, by the Hospital or its Medical Staff to other hospitals, Medical Associations and other organizations concerned with provider performance and the quality and efficiency of patient care regarding any information relevant to such matters the Hospital and the Medical Staff may have concerning the Applicant for Reappointment, as long as such release of information is done in good faith and without malice and the Applicant for Reappointment releases from liability the Hospital and the Medical Staff for so doing.
14. The Applicant for Reappointment acknowledges the burden of producing adequate information for a proper evaluation of his/her current competence, character, ethics and other qualifications.

15. The Applicant for Reappointment acknowledges that Medical Staff membership is a privilege which may be withdrawn in accordance with the Hospital's Medical Staff Bylaws, Rules and Regulations and agrees, in the event of an adverse ruling made with respect to Medical Staff status or clinical privileges, to exhaust the administrative remedies afforded by these Medical Staff Bylaws, Rules and Regulations before any other remedies are pursued.
16. The Applicant for Reappointment acknowledges his/her understanding that the Hospital has appointed the CHS System Verification Office as its exclusive agent to provide administrative, technical and verification services in connection with the recredentialing of physicians, dentists, podiatrists and Allied Health Professionals seeking to renew Medical Staff membership and clinical privileges at the Hospital.

The Applicant for Reappointment will receive the Application for Reappointment six (6) months prior to the expiration of his/her term. The Applicant for Reappointment has thirty (30) days in which to return the Application for Reappointment and supporting documents to the SVO. Should the Applicant for Reappointment fail to return the completed Application for Reappointment by the due date given, a certified letter (a copy of which is sent to the Medical Staff Office) will be sent to the Applicant for Reappointment from the SVO, requesting return of the required documents within ten (10) days from the date of letter.

Absent good cause, failure to submit the Application for Reappointment prior to the expiration of the Applicant for Reappointment's current clinical privileges shall result in the automatic termination of Medical Staff membership and clinical privileges at the expiration of his/her current term. Such termination shall be deemed a voluntary resignation from the Medical Staff. A practitioner whose Medical Staff membership is so terminated shall be entitled to the procedural rights provided in these Medical Staff Bylaws, for the sole purpose of determining the issue of good cause.

Upon receipt of a completed Application for Reappointment, the SVO checks for completeness, cross checks and updates all information, queries the NPDB and HIPDB and hospital affiliations, verifies the status of NYS license via Internet, checks OPMC via Internet and updates the Medicare/Medicaid CSR's. The SVO reviews the request for clinical privilege form for any change in clinical privilege requests and informs the Medical Staff Office of such changes. The Applicant for Reappointment is informed if any supporting documents/information are missing. Once all supporting documents and verifications are received, the file is forwarded to the Medical Staff Office to complete the reappointment process.

#### C. MODIFICATION OF PRIVILEGES

A Medical Staff member may either in connection with reappointment or at any other time, request modification of his/her staff category, departmental assignment, or clinical privileges by submitting a written application to the Medical Staff Office on the

prescribed form. Such application shall be processed in the same manner as provided for reappointment.

#### D. HOSPITAL AND DEPARTMENT REVIEW

As a process of reappointment, the Department Chair shall conduct a reevaluation of the Medical Staff member in accordance with the current information provided in the Application for Reappointment. The reevaluation must be documented in the Chair's recommendation concerning reappointment. Recommendations regarding reappointment shall be based upon current information obtained pursuant to the Application for Reappointment and the Applicant for Reappointment's performance including, but not limited to:

1. The Applicant for Reappointment's professional competency, clinical judgment and technical skills in the treatment of patients as demonstrated by quality assurance reviews and peer review;
2. Continuing education as required by the Department in which the Applicant for Reappointment has clinical privileges;
3. Ethics and conduct toward patients, peers and employees of Hospital;
4. Physical and mental capabilities;
5. Participation in Medical Staff affairs, including, but not limited to attendance at Medical Staff meetings, Department meetings and participation in Performance Improvement (PI) activities, as required by his/her department;
6. Compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations, including timeliness of medical record completion;
7. Cooperation with hospital personnel;
8. Efficient and economic use of the Hospital's facilities for patients;
9. Relations with other staff members and general attitude toward patients, the Hospital and the public and;
10. Any other information providing indicia of current clinical competence.

The Application for Reappointment and the recommendation to reappoint, not to reappoint, to curtail or diminish clinical privileges shall be forwarded to the Credentials Committee in the same manner as an Application for Medical Staff Membership, as provided in this Article.

#### E. CREDENTIALS COMMITTEE REVIEW

At its next regularly scheduled meeting, after receipt of the Department Chair's report and recommendations, the Credentials Committee shall consider the report and recommendations and such other relevant information available to it. The Credentials Committee shall examine the evidence of the character, current professional competence, qualifications and ethical standing of the Applicant for Reappointment and shall determine through information contained in the Department Chair's report and from all other sources available to the Credentials Committee, whether the Applicant for Reappointment has maintained all the necessary qualifications of the category of Medical Staff membership and the clinical privileges requested by him/her. Together with this report, the Credentials Committee shall submit to the Medical Executive Committee the completed Application for Reappointment and their recommendation to reappoint, not to reappoint, to curtail or diminish clinical privileges or that the Application for Reappointment has been deferred for further consideration.

1. Unless deferred, the Credentials Committee shall make its written report to the Medical Executive Committee within thirty (30) days of receipt of the Application for Reappointment for its consideration.
2. When the Credentials Committee initially defers the Application for Reappointment for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation to the Medical Executive Committee.

#### F. CONDITIONAL REAPPOINTMENTS

1. Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve a matter reportable to the National Practitioner Data Bank, or the applicable state licensure board, the imposition of such conditions does not entitle an individual to request a hearing or appeal.
2. In addition, reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two (2) years does not, in and of itself, entitle an individual to request a hearing or appeal.

### **Section VII: Approval by Medical Staff and Governing Body**

#### A. MEDICAL EXECUTIVE COMMITTEE REVIEW

At its next regularly scheduled meeting after receiving the report and recommendation from the Credentials Committee, the Medical Executive Committee shall consider the character, qualifications and standing of the Applicant for Reappointment and his/her



willingness to contribute toward meeting the educational and professional needs of the Hospital and the report and recommendations of the Credentials Committee. The Medical Executive Committee shall determine whether to recommend to the Governing Body that the Applicant for Reappointment be reappointed, not reappointed to the Medical Staff or that the Application for Reappointment be deferred for further consideration. The Applicant for Reappointment may be invited to appear before the Medical Executive Committee for a personal interview, at the Medical Executive Committee's sole discretion. All recommendations to reappoint must also recommend the specific clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

1. When the recommendation of the Medical Executive Committee is favorable to the Applicant for Reappointment, the President of the Hospital shall promptly forward it, together with all supporting documentation, to the Governing Body.
2. When the recommendation of the Medical Executive Committee is to defer the Application for Reappointment for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for reappointment with specified clinical privileges or for an adverse recommendation against reappointment.
3. When the recommendation of the Medical Executive Committee is adverse to the Applicant for Reappointment, either in respect to reappointment or clinical privileges, the President of the Hospital shall promptly so notify the Applicant for Reappointment by certified mail, return receipt requested, of his/her procedural rights as provided by these Medical Staff Bylaws. An appeal can be honored only if received in writing within thirty (30) days of the notification to the Applicant for Reappointment that his/her reappointment has been denied. No such adverse recommendation shall be forwarded to the Governing Body until after the Applicant for Reappointment has exercised, or been deemed to have waived, his/her right to a Hearing as provided under these Medical Staff Bylaws.

If, after the Medical Executive Committee has considered the report and recommendation of the Hearing Panel and the Hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the Applicant for Reappointment, the President shall promptly forward it, together with all supporting documentation, to the Governing Body.

If such recommendation continues to be adverse, the President of the Hospital shall promptly so notify the Applicant for Reappointment by certified mail, return receipt requested. The President of the Hospital shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the Applicant for Reappointment has exercised or has been deemed to

have waived his/her right to an Appellate Review as provided under these Medical Staff Bylaws.

The Application for Reappointment shall be recommended by the Medical Executive Committee to the Governing Body for acceptance or rejection or deferral.

#### B. GOVERNING BODY REVIEW

At its next regularly scheduled meeting after receipt of a favorable recommendation for reappointment to the Medical Staff from the Medical Executive Committee, the Governing Body or a duly appointed Subcommittee thereof shall act upon the Application for Reappointment. When the Medical Executive Committee makes a favorable recommendation, the Governing Body may adopt, in whole or in part, reject or refer the recommendation back to the Medical Executive Committee for further consideration.

1. If the final decision of the Governing Body is to adopt the favorable recommendation of the Medical Executive Committee, the Governing Body shall send notice of such decision through the President of the Hospital to the Medical Executive Committee, the department concerned and the Applicant for Reappointment.
2. If the Governing Body's proposed final action will be contrary to the Medical Executive Committee's recommendation, the Governing Body shall submit the matter to a Medical Staff-Governing Body Review Committee for review before making its final decision. This Committee shall consist of equal numbers of members of the Governing Body and the Medical Executive Committee appointed by the respective Chair of each committee.

If the Governing Body's action remains adverse to the Applicant for Reappointment, when the Medical Executive Committee's recommendation was favorable, the President of the Hospital shall promptly so notify the Applicant for Reappointment by certified mail, return receipt requested and such adverse decision shall be held in abeyance until the Applicant for Reappointment has exercised or has been deemed to have waived his/her procedural rights as provided under these Medical Staff Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer clinical privileges where none existed before.

3. If the Governing Body defers its final determination by referring the matter back to the Medical Executive Committee for further reconsideration, such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made and may include a directive that an additional Hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the

matter, if any, the Governing Body shall make a final decision either to reappoint the Applicant for Reappointment to the Medical Staff or to reject such Applicant for Reappointment for Medical Staff membership.

When the Medical Executive Committee makes an adverse recommendation, the President of the Hospital shall forward such recommendation and documentation to the Governing Body. The Governing Body shall take no action thereon until the Applicant for Reappointment has exhausted or has been deemed to have waived his/her procedural rights as provided under these Medical Staff Bylaws.

At its next regularly scheduled meeting after all the Applicant for Reappointment's rights under these Medical Staff Bylaws have been exhausted or waived and the Medical Executive Committee's decision remains adverse to the Applicant for Reappointment, the Governing Body shall act in the matter by adopting, in whole or in part, rejecting or referring the recommendation back to the Medical Executive Committee for further consideration.

C. NOTICE OF FINAL DECISION

1. Notice of the Governing Body's final decision shall be given through the President of the Hospital to the Chair of the Medical Executive Committee, to the Chair of each department concerned, and to the Applicant for Reappointment.
2. A decision and notice to reappoint shall include: (a) the Medical Staff category to which the Applicant for Reappointment is appointed, (b) the department to which such Applicant for Reappointment is assigned, (c) the clinical privileges such Applicant for Reappointment has been granted, and (d) any special conditions attached to the reappointment.

D. TERM OF REAPPOINTMENT

1. Reappointment shall be made by the Governing Body and shall be for a period of no greater than two (2) years.

# **ARTICLE FIVE: CLINICAL PRIVILEGES**

## **Section I: Clinical Privileges**

For purposes of these Medical Staff Bylaws, Clinical Privileges are defined as the authorization granted by the Governing Body to a practitioner to provide specific medical care services in the Hospital within well-defined limits, based on license, professional education, training, experience, current competence, health status, and clinical judgment as well as all of the additional factors listed in this Article and in Article Four, Appointment and Reappointment.

Every patient in the Hospital shall be under the care of a practitioner who is a member of the Medical Staff. No practitioner shall be permitted to treat patients in the Hospital until appropriate clinical privileges that define the scope of patient care services they may provide independently in the Hospital are delineated and approved in the manner set forth in these Medical Staff Bylaws and Rules and Regulations of the Hospital and the department thereof. Every physician, dentist, podiatrist or Allied Health Professional, practicing at this Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to such Medical Staff member by the Governing Body, except as specified in this Article.

## **Section II: Delineation of Clinical Privileges**

### **A. APPLICATION FOR CLINICAL PRIVILEGES**

Every initial application for Medical Staff privileges must contain a request for the specific clinical privileges desired by the Applicant. Evaluation of such request shall be based upon the Applicant's professional education, licensure (as appropriate), training and experience, demonstrated current competence, references and other relevant information, including an appraisal by the clinical department in which the clinical privileges are sought. The Applicant shall have the burden of establishing his/her qualifications and current competency in the clinical privileges he/she requests and documentation of evidence of health status. Each Application for Appointment or Reappointment to the Medical Staff must contain a request in writing for specific clinical privileges desired by the Applicant.

Delineation of clinical privileges for each Medical Staff member shall be defined by the respective department(s) in which he/she is affiliated. Types of privileges in both clinical and service departments are further defined in the Rules and Regulations of the respective department.

## B. INITIAL CLINICAL PRIVILEGES

The determination of initial clinical privileges shall be based upon the requirements set forth above and the following:

1. Professional education, training and experience.
2. Evidence of current clinical competence, health status, technical skills and clinical judgment.
3. Documented experience in categories of treatment areas or procedures and results of such treatment.
4. Consideration of eligibility or certification by the appropriate national certifying organization (Board).
5. Ability of the Hospital to provide adequate facilities and supportive services for Applicant and patients, as determined by the Governing Body.
6. Patient care needs for additional Medical Staff members with Applicant's skills and training, as determined by the Governing Body.
7. Ability of the Hospital to monitor and evaluate the quality of care provided by the Applicant.

## C. TERMS OF CLINICAL PRIVILEGES

Initial granting of clinical privileges and extension of clinical privileges shall be made by the Governing Body after a recommendation from the Medical Executive Committee as provided in these Medical Staff Bylaws. The Governing Body shall make the initial appointment to the appropriate staff category with provisional status. Provisional status may be waived if the applicant currently has privileges at another Catholic Health System Hospital. The initial term of appointment is for a period of no greater than two (2) years. Extension of clinical privileges shall be for a period of no more than two (2) years provided that neither the Medical Executive Committee nor the Governing Body has determined that any specific clinical privileges shall not be extended. In no case shall clinical privileges be denied because of age, sex, race, creed, national origin, marital status, sexual orientation, disability or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, professional qualifications, the Hospital's objectives or the character and/or competency of the Applicant. Rev. 2/18/09

## D. FUNCTION OF THE CREDENTIALS COMMITTEE

The Credentials Committee shall recommend to the Medical Executive Committee the extent of the clinical privileges to be granted to each new Medical Staff member as hereinafter provided.

### **Section III: Reappraisal of Clinical Privileges at Time of Reappointment**

Each recommendation concerning reappointment and the clinical privileges to be granted upon reappointment, redetermination of clinical privileges, and the increase or curtailment of the same, shall be based upon:

1. Practitioner's professional education, training and experience.
2. Practitioner's current clinical competence, technical skills and clinical judgment in the treatment of patients.
3. Consideration of current status of eligibility or certification by the appropriate national certifying organization-
4. The practitioner's physical and mental health, including alcohol or drug dependency.
5. Ethics and conduct.
6. Results of concurrent Peer Review Committee, and Surgical Case Review Committees, and upon the recommendation of the department Chair.
7. Direct observation by department Chair of care provided.
8. Retrospective record review of patients treated in this and other hospitals.
9. Review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care and utilization of the facilities for patients.
10. Compliance with Corporate Bylaws and Medical Staff Bylaws and Rules and Regulations.
11. Cooperation with personnel and general attitude toward peers and patients.
12. Attendance at meetings and participation in Medical Staff affairs.
13. Any other criteria mandated by the Public Health Law.
14. Documentation of CME credit hours is required. Failure to meet CME requirement will result in a one (1) year reappointment, by which time the deficiency must be corrected.

Privilege re-determination shall be done at least every two (2) years at time of reappointment but shall not be limited to such time. The Credentials Committee shall review all pertinent information available on each practitioner scheduled for periodic

appraisal, including the recommendation of the Chair of Department for the purpose of determining its recommendations concerning the extension of clinical privileges for the ensuing period. Where a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. Each recommendation concerning the extension of clinical privileges shall be based upon the requirements specified in these Medical Staff Bylaws.

Applications for additional clinical privileges must be in writing and must be accompanied by documentation of training or experience to support the request. To assure uniformity they should be submitted on a prescribed form on which the type of clinical privileges desired and the Applicant's relevant recent training and/or experience must be stated. Such applications should be processed in the same manner as applications for initial appointment or reappointment.

#### **Section IV:           Delineation of Clinical Privileges involving Two or More Departments**

A.     Whenever an Applicant for Appointment or Reappointment requests clinical privileges involving two or more departments, the Chairs of the respective Departments shall collectively define and recommend such clinical privileges. When a practitioner requests clinical privileges in a Department of which such practitioner is not a member and there is overlap between or among Departments concerning the treatment(s)/procedure(s), the practitioner must be granted clinical privileges in all applicable Departments before such clinical privileges are effective. The recommendations of the Chairs of Departments involved must be obtained as provided herein.

B.     In the event of a disagreement among and between Departments, a multidisciplinary committee, including the Chairs of the involved Departments will be convened by the Vice President of Medical Affairs and charged with defining core standards and criteria for the treatment(s)/procedure(s) in question. These criteria must be treatment/procedure-specific, not department specific, consistent, objective and measurable and should reflect, to the extent practicable, the recommendations of the involved Departments and the restrictions of the Hospital's current exclusive contracts, if any. The burden of demonstrating current clinical competence for the specific clinical privilege(s) requested, is on the Applicant. The Chairs of the Departments, with the assistance of the Vice President of Medical Affairs must determine which department will have clinical oversight, once the clinical privilege(s) is granted.

C.     The Credentials Committee will receive and review the recommendation of the Chairs of Departments involved and/or the recommendation of the multidisciplinary committee; and thereafter, shall recommend to the Medical Executive Committee the extent of the clinical privileges to be granted.

## **Section V: Special Conditions for Dental Privileges**

The dental staff shall have demonstrated knowledge and skill in the particular branch of dentistry in which they are granted clinical privileges. Members of the dental staff must belong to one of the categories of the Medical Staff and must fulfill the responsibilities corresponding to such category. Requests for clinical privileges from dentists shall be processed, evaluated, granted or denied in the same manner as specified in this Article.

The determination of clinical privileges for Dentists will be based on current license, documented post-graduate training and experience, health status, demonstrated current clinical competence, technical skills and clinical judgment. In granting of clinical privileges, consideration will be given to eligibility or certification by the appropriate national certifying organization (Board). The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chair of the Department of Surgery. Qualified oral and maxillofacial surgeons may perform the medical history and physical examination, if they have such clinical privileges, in order to assess the medical, surgical and anesthetic risks of the proposed operative procedure(s).

All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

## **Section VI: Special Conditions for Podiatry Privileges**

Qualified podiatrists may treat patients surgically and non-surgically as defined in the Department of Podiatry Rules and Regulations. Members of the podiatry staff must belong to one of the categories of the Medical Staff and must fulfill the responsibilities corresponding to such category. Requests for clinical privileges from podiatrists shall be processed, evaluated, granted or denied in the same manner as specified in this Article.

The determination of clinical privileges for Podiatrists will be based on current license, documented post-graduate training and experience, health status, demonstrated current clinical competence, technical skills and clinical judgment. In granting of clinical privileges, consideration will be given to eligibility or certification by the appropriate national certifying organization (Board). The scope and extent of surgical procedures that a podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges.

All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that



may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Qualified podiatrists will be able to perform surgery utilizing general anesthesia in the operating room suites according to their clinical privileges.

## **Section VII: Special Conditions for Telemedicine**

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at or from a distance. The specific clinical services to be delivered through this medium and consideration of appropriate utilization of telemedicine equipment must be determined by the Medical Staff.

Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the organization that receives the telemedicine service. Whenever a telemedicine practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient in this Hospital, the telemedicine practitioner must be credentialed and privileged through the Medical Staff mechanisms set forth under these Medical Staff Bylaws. Credentialing information from another JC accredited facility may be used, as long as the decision with respect to the specific delineation of clinical privileges for each specific telemedicine practitioner is made at this Hospital, in accordance with the process established by the Medical Staff.

## **Section VIII: Temporary Privileges**

### **A. CIRCUMSTANCES FOR PENDENCY OF APPLICATION OR LOCUM TENENS**

Upon the written concurrence of the Chair of the department where the clinical privileges will be exercised, or his/her designee if unavailable, or, in all other circumstances, the Vice President of Medical Affairs, the President of the Hospital or designee may grant temporary clinical privileges in the following circumstances:

#### **1. Pendency of Application**

After receipt of a complete application for Medical Staff appointment, including a request for specific temporary clinical privileges, and in accordance with the conditions specified in these Medical Staff Bylaws, an appropriately licensed applicant may be granted temporary admitting and clinical privileges for a period not to exceed 120 days. In exercising such clinical privileges, the Applicant shall act under the supervision of the Chair of the Department to which he/she is assigned. Temporary clinical privileges may only be granted on a case by case basis when there is an important patient care need that mandates authorization to practice as above described during the pendency of the approval process of the application, all verification requirements having been accomplished.

2. Locum Tenens

A practitioner who contemplates serving as “locum tenens” must complete an application as if he/she were applying for Medical Staff membership and must be reviewed, approved, and have clinical privileges delineated in accordance with these Medical Staff Bylaws. The practitioner engaging the locum tenens practitioner must file a letter requesting temporary clinical privileges for the locum tenens practitioner, acknowledging responsibility for his/her actions and quality of practice. Temporary clinical privileges may be granted for the locum tenens practitioner for a period not to exceed 120 days.

B. CONDITIONS FOR PENDENCY OF APPLICATION OR LOCUM TENENS

Temporary clinical privileges in any of the above categories shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner’s qualifications, ethical standards, clinical judgment and current competence to exercise the clinical privileges requested and only after the practitioner has satisfied the requirement of these Medical Staff Bylaws and submitted copies of a current New York State license, current DEA registration, evidence of current malpractice insurance coverage and a signed Medicare Annual Penalty Statement. The Applicant’s current hospital affiliations, National Practitioner Data Bank and professional, educational and work experience for the last ten (10) years must be queried. The practitioner shall agree in writing to abide by the Bylaws, Rules and Regulations and policies of the Medical Staff of the Hospital in all matters relating to such temporary clinical privileges.

Special requirements of supervision, reporting and/or consultation may be imposed by the Department and/or Division Chair/Chief upon any practitioner granted temporary clinical privileges. Temporary clinical privileges shall be immediately terminated by the President of the Hospital upon notice of any failure by the practitioner to comply with special conditions.

C. CIRCUMSTANCES FOR CARE OF SPECIFIC PATIENTS

Upon the written concurrence of the Chair of the department where the clinical privileges will be exercised, or, his/her designee if unavailable, or, in all other circumstances, the Vice President of Medical Affairs, the President of the Hospital or designee may grant one (1) time temporary clinical privileges in the following circumstances:

1. Care of Specific Patients

Upon documented request, an appropriately licensed practitioner who is not an applicant for membership on the Medical Staff may be granted temporary clinical privileges for the care of one or more specific patient(s). In this specific circumstance, temporary clinical privileges will be granted for no longer than seven (7) days. If the care of a specific patient is incomplete, reapplication for temporary clinical privileges can be made and may be granted for the duration of the admission. Such clinical privileges shall be restricted to the treatment of not more than four (4) patients in any one (1) year by any practitioner, after which such

practitioner shall be required to apply for membership on the Medical Staff before being allowed to care for additional patients. In the exercise of such clinical privileges, a practitioner shall be under the supervision of the Chair of the Department.

#### D. CONDITIONS FOR CARE OF SPECIFIC PATIENTS

One-time temporary clinical privileges of the above categories shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ethical standards, clinical judgment and current competence to exercise the clinical privileges requested and only after the practitioner has satisfied the requirement of these Medical Staff Bylaws and submitted copies of a current New York State license, current DEA registration and evidence of current malpractice insurance coverage. The practitioner shall agree in writing to abide by the Medical Staff Bylaws, Rules and Regulations and policies of the Medical Staff of the Hospital in all matters relating to such one-time temporary clinical privileges.

The Chair of the Department, or the Chief of the Division involved, is responsible for making a recommendation to grant one-time temporary clinical privileges based upon his/her personal knowledge of the physician making this request and/or his/her discussion of the physician's qualifications with the Chair of the Department in another hospital where the physician is a member of the Medical Staff, in good standing, and has the clinical privileges being requested.

Special requirements of supervision, reporting and/or consultation may be imposed by the Department and/or Division Chair/Chief upon any practitioner granted one-time temporary clinical privileges. Temporary clinical privileges shall be immediately terminated by the President of the Hospital upon notice of any failure by the practitioner to comply with special conditions.

#### E. TERMINATION

In any of the above categories, with the discovery of any adverse information regarding professional competence or conduct, the President of the Hospital or his/her designee on the recommendation of the Chair of the Medical Executive Committee or the Department Chair may terminate any or all of such clinical privileges at any time. When the conduct of the practitioner exercising such clinical privileges so indicates, such practitioner's temporary clinical privileges would then be terminated, effective as of the discharge from the Hospital of all patients then under his/her care. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination shall be effective immediately pursuant to the Summary Suspension, Article Seven of these Medical Staff Bylaws. In this event, the appropriate Department Chair or, in his/her absence, the Chair of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of a member of the Medical Staff. A practitioner shall not be entitled to the procedural rights afforded by Article Seven of these Medical Staff Bylaws because of his/her inability to obtain

temporary clinical privileges or because of any termination, modification or suspension of temporary clinical privileges.

## **Section IX: Emergency Privileges**

For the purpose of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

In the case of emergency, any physician, to the degree permitted by his/her license, all Rules and Regulations notwithstanding, and regardless of Department, clinical privileges or Medical Staff status, shall be permitted to do, and be assisted by Hospital personnel in doing, everything possible to save the life of a patient, or to save a patient from serious harm. A practitioner exercising emergency clinical privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up care.

## **Section X: Granting of Disaster Privileges during “Extreme Emergency”**

### **A. PURPOSE**

The consequences of recent natural disasters and terrorist attacks have made the need for rapid access to additional professional healthcare staff obvious. For the purpose of this Section, an “extreme emergency” is defined as a situation in which the Hospital invokes its Emergency Management Plan. The Emergency Management Plan shall be available, on file, in the Hospital’s Administrative Offices and is incorporated by reference herein. If deemed necessary by the Hospital, disaster clinical privileges may be granted when the Emergency Management Plan has been activated and the organization is unable to handle the immediate patient care needs without additional staff.

### **B. CREDENTIALING VOLUNTEER HEALTHCARE PRACTITIONERS IN EXTREME EMERGENCIES**

1. During disaster(s), in which the Emergency Management Plan has been activated, the President of the Hospital, the Vice President of Medical Affairs or President of the Medical Staff or their designee(s) has the option to grant emergency clinical privileges, upon presentation of any of the following:
  - a. A current picture hospital ID card.
  - b. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.
  - c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

- d. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances; such authority having been granted by a federal, state or municipal entity.
  - e. Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding practitioner's identity.
2. During extreme emergencies, the Hospital may reduce its privileging and credentialing requirements, while still providing oversight of care by any Volunteer Healthcare Practitioners, i.e. licensed practitioners, such as physicians, dentists, podiatrists and Allied Health Professionals. The care provided by these practitioners must be within the scope of the individual's license.

**C. VERIFICATION PROCESS FOR VOLUNTEER HEALTHCARE PRACTITIONERS IN EXTREME EMERGENCIES**

The verification process of credentials, clinical privileges and current competence of individuals who receive emergency clinical privileges must begin as soon as the immediate emergency situation is under control. This privileging process is identical to the process established under the Medical Staff Bylaws for granting temporary clinical privileges to fulfill an important patient care need.

**Section XI: Exception for Organ Procurement Practitioners**

Practitioners from outside organ procurement organizations designated by the Administrator of the Centers for Medicare and Medicaid Services (CMS), Department of Health & Human Services, engaged solely at the Hospital in harvesting of tissues or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and the requirement of Section 405.25 of the State Hospital Code, will be exempt from the need to acquire clinical privileges. However, such practitioners are required to provide to the Vice President of Medical Affairs verification of authority to act pursuant to such laws and regulations.

**Section XII: Leave of Absence**

**A. LEAVE OF ABSENCE**

**1. Voluntary Leave**

A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written notice to his/her Department and Division Chair/Chief(s), who shall forward the request along with their recommendation to the Credentials Committee, for review, and to the Medical Executive Committee stating the specific reasons for the leave of

absence, the anticipated date for commencement and the approximate time period, which in no event can extend beyond the term of appointment. The Medical Executive Committee will consider the request and recommend approval, denial and/or impose any limitations and/or conditions, believed to be appropriate, on the leave. If the Medical Staff member fails to satisfy the stated conditions, the Medical Executive Committee shall have the right to deny reinstatement. During the period of the leave, the Medical Staff member's clinical privileges, prerogatives and responsibilities shall be suspended.

2. Medical Leave

A medical leave of absence from the Medical Staff may be granted when a practitioner is unable to exercise clinical privileges for medical reasons. A request for medical leave may be originated by the practitioner, by a Department Chair, by the Credentials Committee or by the Medical Executive Committee. The request shall be in writing and submitted, if by practitioner, to the Department Chair, if by the Department Chair, to the Credentials Committee and if by the Credentials Committee, to the Medical Executive Committee. Medical leave of absence shall in no event extend beyond the term of appointment. The Medical Executive Committee will consider the request and recommend approval, denial and/or impose any limitations and/or conditions, believed to be appropriate; that is, specify conditions that the Medical Staff member must meet in order to have his/her clinical privileges and prerogatives reinstated following a medical leave of absence. If the Medical Staff member fails to satisfy the stated conditions, the Medical Executive Committee shall have the right to deny reinstatement. During the period of the leave, the Medical Staff member's clinical privileges, prerogatives and responsibilities shall be suspended.

B. TERMINATION OF LEAVE

1. At least sixty (60) days prior to the date the practitioner wishes to return to practice, he/she shall submit a written request for reinstatement of Medical Staff membership and to the Department and Division Chair/Chief(s) concerned, along with clinical privileges desired and a written summary of the practitioner's activities during the leave. This information and the Department and Division Chair/Chief(s) recommendation for reinstatement shall be forwarded to the Credentials Committee, for review, and Medical Executive Committee for final consideration. The practitioner has the burden of providing evidence satisfactory to the Credentials Committee/Medical Executive Committee of his/her ability to resume exercising of some or all of the clinical privileges exercised prior to the leave of absence. The Medical Executive Committee shall recommend whether to approve the Medical Staff member's request for reinstatement of his/her clinical privileges and prerogatives. Thereafter, the procedure set forth in this Article shall be followed, except that the

Medical Staff member shall not be entitled to the Hearing or Appellate Review procedures set forth in Article VII, where an adverse recommendation by the Medical Executive Committee is based on the Medical Staff member's failure to satisfy conditions specified by the Medical Executive Committee at the time the leave was approved. For a leave of absence where 60 day notification period is impractical (e.g., leave of absence of less than 60 day duration or prolonged leave with unexpected ability to return), this provision may be waived at the discretion of the Medical Executive Committee.

2. Failure, without good cause, to request reinstatement prior to the expiration of the term of Appointment/Reappointment or to provide a summary of activity upon request shall be deemed a voluntary resignation, with no right to invoke the Hearing or Appellate Review procedures set forth in Article Seven. The practitioner must reapply to become a member of the Medical Staff. A request for Medical Staff membership subsequently received from a Medical Staff member, so resigned, shall be submitted and proposed in the manner specified for Application for Initial Appointment under these Medical Staff Bylaws.

#### C. MILITARY LEAVE

In the case of leave necessitated by Armed Services obligations, the foregoing requirements are automatically waived.

# ARTICLE SIX: CORRECTIVE ACTION

## Section I: Procedure

### A. INTRODUCTION

“The Medical Staff shall review and, when appropriate, recommend to the Governing Body, the limitation or suspension of the privileges of practitioners who do not practice in compliance within the scope of their privileges, Medical Staff Bylaws, standards of performance and policies and procedures, and assure that corrective measures are developed and put into place, when necessary.” [10 NYCRR Part 405.4(a)(3)] The decision to commence an investigation and determining exactly when an investigation has commenced are important and have long-reaching consequences in terms of reports being sent to the National Practitioner Data Bank (NPDB). Under the Federal Health Care Quality Improvement Act (HCQIA), hospitals must have a formal written peer review process and are mandated to report certain professional review actions taken against practitioners such as acceptance of the surrender or restriction of clinical privileges while the practitioner is under investigation or in return for not conducting an investigation relating to possible professional incompetence or improper professional conduct and summary suspensions which are in effect or imposed for more than thirty (30) days.

### B. REFERRAL TO MEDICAL EXECUTIVE COMMITTEE AND CRITERIA FOR INITIATION OF CORRECTED ACTION

A matter may be referred to the Medical Executive Committee whenever collegial steps have not resolved the matter or involves professional conduct reasonably probable of being detrimental to patient safety or to the quality delivery of patient care within the Hospital; or is lower than the standards or aims of the Medical Staff; or is below generally accepted standards of professional practice; or involves violations of Hospital and Medical Staff Bylaws, Rules, Regulations and policies; or is disruptive to the operations of the Hospital; or is unethical; or the professional skills of any member of the Medical Staff are impaired by reason of physical or mental disability.

Collegial steps may include counseling, education, and related steps, such as the following:

1. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of records.
2. Proctoring, monitoring or consultation
3. Sharing comparative quality, utilization and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.



### C. REQUEST AND NOTICES

1. Corrective action may be requested of the Medical Executive Committee by any of the following: the President of the Medical Staff, by the Chair of any clinical department, by the Vice President of Medical Affairs, by the President of the Hospital or by the Governing Body. Notification to these individuals of situations which may potentially trigger an investigation may come from any number of individuals throughout the Hospital: practitioners, Medical Staff committees or departments, administrators, nursing personnel, Health Information department, and other hospital personnel.
2. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. The Medical Executive Committee shall determine when an investigation is to be initiated.
3. The Chair of the Medical Executive Committee shall promptly notify the President of the Hospital in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the President of the Hospital fully informed of all action taken in connection therewith.

### D. GROUNDS FOR CORRECTIVE ACTION

Grounds for corrective action, including suspension or expulsion from Medical Staff membership and/or clinical privileges, shall include, but not be limited to, the following:

1. Any activity or professional conduct considered to be lower than the standards or aims of the Medical Staff, or to reflect adversely upon the reputation of the Medical Staff or Hospital or to be disruptive to the operations of the Hospital.
2. Professional Misconduct.
3. Unethical practice.
4. Conviction of a felony.
5. Incompetency or failure to maintain appropriate quality of medical care and treatment.
6. Revocation, suspension or limitation of the practitioner's license by the appropriate state agency or voluntary surrender by the practitioner.
7. Suspension or revocation of the practitioner's narcotics (DEA) registration.

8. Failure to complete medical records in accordance with the Rules and Regulations of the Hospital.
9. Exercising of clinical privileges while the practitioner's professional ability is impaired, whether through illness, accident, substance abuse or any other reason.
10. Significant misstatement in or omission from any application for Medical Staff membership or clinical privileges or any misrepresentation in presenting the practitioner's credentials.
11. Violation of the Bylaws, Rules and Regulations of the Medical Staff, Standards of Behavior of the Catholic Health System, Code of Ethics of the applicable professional association, regulations of the New York State Department of Health, or the Ethical and Religious Directives for Catholic Health Care Services.
12. Failure to continually update the practitioner's credential file as indicated in the Appointment/Reappointment process.

E. INVESTIGATION

1. Medical Executive Committee Decision to Investigate and Assignment of Investigation  
Whenever the corrective action could lead to a reduction or suspension of clinical privileges, the Medical Executive Committee (or the Vice President of Medical Affairs or President of the Medical Staff if time or special circumstances do not permit review by the Medical Executive Committee) will determine that an investigation will be undertaken and how it will be conducted.

The Medical Executive Committee may either conduct the investigation itself, or it may assign the task to a Medical Staff Officer, a Medical Staff Department Chair wherein the practitioner has such clinical privileges, a Medical Staff Member or an "Ad Hoc" Investigating Committee, appointed either by the Medical Executive Committee or the Department Chair. The Medical Executive Committee's determination regarding how the investigation will be conducted will allow the process to be tailored to the particular problems or issues presented by the request for consideration by the Medical Executive Committee.

If the Medical Executive Committee requests an investigation, said request should be in writing, stating the specific allegations and the reasoning of the Medical Executive Committee in going forward with an investigation.

The matter should not be referred to the Department Chair if the request for corrective action originated in the Department and is supported by a written report by the Department.

2. Notice to Affected Practitioner

The affected practitioner shall be notified in appropriate circumstances that an investigation is being conducted. Under some circumstances it may not be feasible to notify the affected practitioner, e.g., if there is reasonable concern that the investigation may be comprised. Notification will indicate when an investigation is considered to have commenced and the reasons for undertaking the investigation.

3. Interview with Ad Hoc Investigating Committee

Prior to the making of a report to the Medical Executive Committee, the affected practitioner against whom corrective action has been requested shall have an opportunity for an interview with the “Ad Hoc” Investigating Committee, if the investigation is being conducted by an “Ad Hoc” investigating committee. At such interview, the affected practitioner shall be informed of the general nature of the charges against him/her and that such charges may result in action entitling him/her to a formal Hearing. The affected practitioner shall be permitted to discuss, explain or refute his/her conduct. If specific cases are going to be discussed, the affected practitioner should be so notified, in advance of the interview, so that he/she can defend his/her position. The affected practitioner should also be cautioned against any attempted retaliation against potential witnesses.

This *interview* shall not constitute a Hearing, shall be preliminary in nature and none of the procedural rules provided in these Medical Staff Bylaws with respect to Hearings shall apply thereto. A record of such interview shall be made by the “Ad Hoc” Investigating Committee and included with its report to the Medical Executive Committee.

4. Scope of Investigation

The investigating officer or committee should review whatever materials or cases as are necessary. This can include, but not be limited to, incident reports, patient or hospital staff complaints, patient medical reports, reports of monitors or proctors, etc.

The investigating officer or committee should also interview other practitioners, nurses, or hospital staff who may have direct knowledge relating to the affected practitioner. If outside consultants are used to review patient medical records, the consultants’ findings and recommendations should also be reviewed by the investigating officer or

committee. If clarification is needed, the consultants should be interviewed.

#### F. REPORT TO THE MEDICAL EXECUTIVE COMMITTEE

Within thirty (30) days after the receipt of the request for corrective action, a report of the investigation (by the Medical Executive Committee, Medical Staff Officer, Department Chair or “Ad Hoc” Investigating Committee) shall be submitted to the Medical Executive Committee. The full written report may include recommendations for appropriate corrective action based on the reasonable belief that such action is in furtherance of quality health care. Said written report should be given to the Medical Executive Committee as soon as practicable. The report generated by the investigating officer or committee should be thorough, since it may be referred to if a corrective action is later taken against the affected practitioner. Pertinent facts and evidence and the reasoning behind any conclusions or recommendations may be submitted to the Medical Executive Committee.

#### G. MEDICAL EXECUTIVE COMMITTEE ACTION

##### 1. Authority of the Medical Executive Committee

Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

Within thirty (30) days following receipt of the report of the investigating officer or committee the Medical Executive Committee shall take action. Such action shall include, without limitation:

- a. Determining that no corrective action be taken and, if the Medical Executive Committee determines that there was no credible evidence for the complaint in the first instance, removal of any adverse information from the affected practitioner’s profile.
- b. Modifying the request for corrective action.
- c. Issuing letters of admonition, censure, reprimand or warning. In the event such letters are issued, such affected practitioner may make a written response which shall be placed in his/her profile. The Medical Executive Committee shall review the affected practitioner’s written response and if approved remove such adverse information from his/her file.
- d. Recommending performance improvement plan for a specified term or number of cases or conditions or the imposition of probation for a specified term or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

- e. Requiring training and/or education.
  - f. Recommending reduction, modification, suspension, or revocation of clinical privileges.
  - g. Recommending that an already imposed summary suspension of clinical privileges be terminated, modified or sustained.
  - h. Recommending reduction of Medical Staff category or limitation of Medical Staff prerogatives directly related to such affected practitioner's delivery of patient care.
  - i. Recommending suspension or revocation of Medical Staff membership.
2. Opportunity for an Appearance before the Medical Executive Committee  
If the corrective action could involve a reduction or suspension of clinical privileges or a suspension or expulsion from the Medical Staff, the affected practitioner shall be given notice of the anticipated charges and shall be permitted to make an appearance before the Medical Executive Committee prior to its taking such proposed action. Practitioner shall be allowed to attend with counsel, although counsel's role will be to provide advice to the practitioner about suspension and not to make a presentation or question the Medical Executive Committee members.  
This *appearance* shall not constitute a Hearing, shall be preliminary in nature and none of the procedural rules provided in these Medical Staff Bylaws with respect to Hearing(s) and Appellate Review(s) shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.
3. Report  
The Medical Executive Committee shall make a written report of any action taken, including the reasons for the action taken and any minority views and shall forward the report to the President of the Hospital for submission to the Governing Body.

#### H. PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall be transmitted in writing to the affected practitioner. The affected practitioner shall then be entitled to the procedural rights provided in these Medical Staff Bylaws for Hearing and Appellate Review. The Medical Executive Committee's recommendation need not be forwarded to the Governing Body until the affected practitioner has

exercised, waived or been deemed to have waived his/her rights to Hearing and Appellate Review.

Requests for corrective action shall be considered in a timely and good faith manner by all individuals and groups required by these Medical Staff Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in these Medical Staff Bylaws and the Hearing and Appellate Review process. The time periods specified for corrective action are to guide the acting parties in accomplishing their tasks and shall not be deemed to create any additional rights for the affected practitioner.

#### I. REPORTING REQUIREMENTS

The conclusions or recommendations reached by the investigating officer or committee are not typically reportable. However, reporting requirements obligate the Hospital to report to the NPDB, if an affected practitioner resigns from the Medical Staff following notice of a pending investigation or during an investigation.

### **Section II: Suspension**

#### A. CRITERIA FOR INITIATION AND AUTHORITY TO IMPOSE

Whenever a practitioner's conduct requires that immediate action be taken to protect the life or well-being of any patient(s) or other person or to reduce the substantial likelihood of significant impairment to the life, health, or safety of any patient, employee or other person present in the Hospital, any one of the following: President of the Medical Staff, Chair of a Department, Vice President of Medical Affairs, President of the Hospital and the Executive Committee of either the Medical Staff or the Governing Body, shall each have the authority to impose a precautionary summary suspension of the Medical Staff membership status and all or any portion of the clinical privileges of such practitioner and such precautionary summary suspension shall become effective immediately upon imposition. If time permits, the practitioner may be given an opportunity to voluntarily refrain from exercising privileges pending an investigation.

##### 1. Notice

The President of the Hospital shall promptly give special notice of the suspension to the affected practitioner, the Governing Body, the Vice President of Medical Affairs, and the Medical Executive Committee. Such notice shall include the reason(s) for the suspension.

Immediately upon the imposition of a precautionary summary suspension, the Vice President of Medical Affairs, Chair of the Medical Executive Committee and the responsible Department and/or Division Chair/Chief shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner remaining in the Hospital at the time of such precautionary summary suspension. The wishes of the patient and the suspended practitioner shall be considered in the selection of such alternative practitioner.

2. Precautionary Summary Suspension

Such precautionary summary suspension shall be deemed a precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended practitioner but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

3. Timing

When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

B. MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken and to either confirm, modify, or overturn the original decision. unless such suspension were originally imposed by the Governing Body.

The Medical Executive Committee may, upon the affected practitioner's request, and as soon as practicable, afford the affected practitioner an opportunity to meet with the Medical Executive Committee in special session to informally discuss the suspension.

In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

The Medical Executive Committee shall be authorized to lift, maintain or modify the suspension, except a suspension imposed by the Governing Body.

1. If the Suspension is Not Lifted

If the suspension is not lifted by the Medical Executive Committee and the affected practitioner requests a Hearing on the professional review action and also requests removal of the suspension until the Hearing, the suspension shall remain in effect and the Executive Committee of the Governing Body shall be convened within four (4) days of receipt of the request for a Hearing. The Executive Committee of the Governing Body shall consider the written positions of the practitioner and the Medical Executive Committee on the sole issue of maintenance of the suspension pending Hearing and Appellate Review, as well as the recommendation of the President of the Hospital, the President of the Medical Staff and the Chair of the affected practitioner's Department. The Executive Committee of the Governing Body shall be authorized to maintain, modify or lift the suspension pending the Hearing and shall reduce its determination to a written finding.

2. Notice  
The Medical Executive Committee shall furnish the affected practitioner with notice of its decision. If the decision is adverse to the affected practitioner, this notice shall be the notice required under the Hearing and Appellate Review process as set forth in the Medical Staff Bylaws.

C. PROCEDURAL RIGHTS

1. Unless the Medical Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the affected practitioner shall be entitled to the procedural rights provided in the Hearing and Appellate Review process. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect.
2. An affected practitioner shall be entitled to request an expedited Hearing. Such expedited Hearing shall be held in general accord with the principles and procedures set forth in the Hearing and Appellate Review process, adjusted as needed to facilitate expedited review while still affording a fair proceeding to the affected practitioner.
3. If, as a result of such Hearing, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall be entitled to request an Appellate Review by the Governing Body, in accordance with the Appellate Review process in these Medical Staff Bylaws; however, the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Governing Body.

D. REPORTING REQUIREMENTS

A summary suspension is reportable if:

1. It is in effect for more than thirty (30) days, or it is imposed for a period of time longer than thirty (30) days; and
2. It is based on the professional competence or professional conduct of the affected practitioner that adversely affected, or could adversely affect, the health or welfare of a patient; and
3. It is the result of a professional review action taken by a Hospital.

If the suspension is modified or revised as part of a final decision by the Governing Body following a Hearing or other procedures, the Hospital will file a revision to the original report made to the NPDB.



### **Section III: Action by Regulatory Authority**

#### **A. AUTOMATIC SUSPENSION**

Automatic suspension by definition requires no decision by the Medical Staff and is imposed automatically, with no rights to the Hearing and Appellate Review process. In the following instances, a practitioner's clinical privileges or Medical Staff membership shall be suspended as provided:

1. Action by Licensing Agency
  - a. Revocation and Suspension. Whenever a practitioner's license certificate or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
  - b. Restriction. When a practitioner's license certificate or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which such practitioner has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
  - c. Probation. Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his/her Medical Staff membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
2. Controlled Substances
  - a. Revocation, Suspension and Restriction. Whenever a practitioner's DEA Certificate or prescribing authority is revoked, suspended, limited or restricted, such practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
  - b. Probation. Whenever a practitioner's DEA Certificate or prescribing authority is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.
3. Action by Federal Authority  
Clinical privileges will be automatically suspended in the event that the practitioner is the subject of actions by a Federal program including fraud

and abuse of the Medicare/Medicaid program resulting in termination or suspension from same.

4. Conviction of Felony  
Clinical privileges will be automatically suspended in the event that the practitioner is convicted of a felony involving moral turpitude.
5. Termination of Liability Insurance  
Clinical privileges will be automatically suspended in the event that the practitioner's liability insurance is terminated.
6. Failure to Complete Medical Records  
Failure to complete medical records within such reasonable times as provided in the Rules and Regulations of the Hospital shall be grounds for temporary automatic suspension without right of Hearing and Appellate Review, provided the clinical privileges may be restored in accordance with such rules. Repeated violation of the Rules and Regulations relative to completion of medical records may be grounds for corrective action, as set forth above.

#### B. MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after action is taken or warranted, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure for initiating corrective action.

#### C. REINSTATEMENT

##### Removal from Medical Staff

Upon expiration of a sanction of a regulatory authority involving removal from the Medical Staff, the member of the Medical Staff, if he/she wishes will be required to submit a new Application for Appointment to the Medical Staff, as required under the appointment process.

##### Suspension from Medical Staff

Upon expiration of suspension from the Medical Staff as a result of action of regulatory authority, the member of the Medical Staff shall submit current pertinent documentation as required under the reappointment process or as may be requested to allow for the review and consideration of reinstatement of clinical privileges.

#### D. REPORTING REQUIREMENTS

Based upon the facts of an automatic suspension it will be the determination of the Medical Executive Committee whether an automatic suspension is reportable.

E. MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS  
Practitioners who are directly under contract with the Hospital or serve in a medical-administrative capacity shall be subject to the procedural rights specified in these Medical Staff Bylaws, unless otherwise provided by contract.

# **ARTICLE SEVEN: HEARING AND APPELLATE REVIEW**

## **HEARING**

### **INTRODUCTION**

The statute, 42 U.S.C. §11112(a), provides that if the following procedures are followed, a Hospital is deemed to have met the notice and hearing requirements of the Health Care Quality Improvement Act (HCQIA): The process for fair hearing and appeal is the same for all medical staff members. Individuals applying for clinical privileges who are not members of the medical staff are afforded a fair hearing and appeal process. In order to achieve immunity, “the peer review action must be taken (1) in the reasonable belief that the action is in furtherance of quality healthcare, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the affected practitioner or after such other procedures as are fair under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after reasonable effort was made to obtain facts and after meeting the requirements of adequate notice and hearing procedures.”

### **Section I: Right to Hearing and Appellate Review**

#### **A. PROCEDURAL RIGHTS**

All Hearings and Appellate Reviews shall be in accordance with the procedural safeguards set forth in this section to assure that the affected practitioner is accorded all rights to which he/she is entitled.

#### **B. GROUNDS FOR HEARING**

Except as otherwise provided in these Medical Staff Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and shall entitle the practitioner affected thereby, whether presently on the Medical Staff with clinical privileges or a new Applicant requesting Medical Staff membership and clinical privileges, to a Hearing:

1. Denial of initial appointment to the Medical Staff.
2. Denial of Medical Staff membership.
3. Denial of Medical Staff reappointment.
4. Revocation of Medical Staff membership.

5. Denial of requested clinical privileges, excluding temporary clinical privileges.
6. Involuntary reduction of current clinical privileges, excluding temporary clinical privileges.
7. Suspension of clinical privileges, other than automatic suspensions, excluding temporary clinical privileges.
8. Revocation of all clinical privileges, excluding temporary clinical privileges.
9. Restriction or curtailment of privileges

C. EXCEPTIONS FOR OFFICERS AND/OR HOSPITAL-EMPLOYED PHYSICIANS

Removal from office/position of a Hospital-employed practitioner may be accomplished in accordance with the terms of such individual's contractual agreement. If such individual has Medical Staff membership and clinical privileges, removal from office/position shall not terminate such clinical privileges and Medical Staff membership unless provision to the contrary is made in the individual's contractual relationship with the Hospital.

**Section II: Notice of Adverse Recommendation and Right to Hearing**

A. NOTICE OF ADVERSE RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

When any practitioner receives notice of a recommendation of the Medical Executive Committee that if ratified by decision of the Governing Body will adversely affect the practitioner's appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, the affected practitioner shall be entitled to a Hearing before a panel appointed by the Medical Staff. If the recommendation of the Medical Executive Committee, following such a Hearing is still adverse to the affected practitioner, he/she shall then be entitled to an Appellate Review by the Governing Body before the Governing Body makes a final decision on the matter. . If the practitioner receives notice of more than one action by the Medical Executive Committee and the Governing Body resulting from one investigation, such as, summary suspension in addition to permanent limitation on privileges, the practitioner is entitled to one Hearing and one Appellate Review.

B. NOTICE OF ADVERSE DECISION BY THE GOVERNING BODY

When any practitioner receives notice of a decision by the Governing Body that will affect his/her appointment to or status as a member of the Medical Staff or his/her

exercise of clinical privileges and such decision is not based on a prior adverse recommendation by the Medical Executive Committee with respect to which the affected practitioner was entitled to a Hearing and Appellate Review, he/she shall be entitled to a Hearing by the Governing Body or a Hearing Committee appointed by the Governing Body. If such Hearing does not result in a favorable recommendation, the affected practitioner shall be entitled to an Appellate Review by the Governing Body, before the Governing Body makes a final decision on the matter.

C. NOTICE OF ADVERSE RECOMMENDATION OR PROPOSED ACTION:

1. The President of the Hospital shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a Hearing or to an Appellate Review. Such notice shall be given by certified mail, return receipt requested.
2. The notice to the affected practitioner shall contain the following information:
  - a. That a professional review action has been taken or is proposed to be taken against the affected practitioner and a description of such action.
  - b. The basis for the recommendation or proposed action which impacts the physician and a list of medical records in question where applicable.
  - c. That the affected practitioner has a right of Hearing or Appellate Review pursuant to these Medical Staff Bylaws and must request such Hearing within thirty (30) days following receipt of notice of such recommendation/proposed action or the right to a Hearing shall be considered to be waived.
  - d. A copy of this Article.

**Section III: Request for Hearing**

A. REQUEST FOR HEARING

1. The affected practitioner shall have thirty (30) days following receipt of notice of an adverse recommendation or proposed adverse action to request a Hearing. The request shall be in writing and addressed to the President of the Hospital and delivered either in person or by certified or registered mail.
2. If an effective date is specified for a professional review action, the recommended action shall take effect as of that date unless the affected practitioner submits a Hearing request before that date. Receipt by the President of the Hospital of a request for Hearing prior to the effective

date shall toll the effective date of the action and maintain the status quo of the affected practitioner unless the Executive Committee of the Governing Body, with Medical Executive Committee recommendation, imposes limitations on the clinical privileges or Medical Staff membership of the affected practitioner pending completion of the Hearing process.

B. WAIVER OF HEARING BY AFFECTED PRACTITIONER

1. Failure of an affected practitioner to request a Hearing to which he/she is entitled under these Medical Staff Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such a Hearing and to any Appellate Review to which he/she might otherwise have been entitled on the matter. The affected practitioner shall be deemed to have accepted the recommendation involved.
  - a. When the Hearing or Appellate Review waived relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Governing Body, the same shall thereupon become and remain effective against the affected practitioner pending the Governing Body's decision on the matter. At the Governing Body's next regularly scheduled meeting following waiver, it shall:
    - i. Consider the Medical Executive Committee's recommendation, review all the information and material considered by the Medical Executive Committee, and consider all other relevant information received from any source.
    - ii. If the Governing Body's action on the matter is in accord with the Medical Executive Committee's recommendation, such action shall constitute the final decision of the Governing Body.
    - iii. If the Governing Body's action has the effect of changing the Medical Executive Committee's recommendation, the matter shall be submitted to the Medical Staff-Governing Body Review Committee. The Governing Body's action on the matter following receipt of the Medical Staff-Governing Body Review Committee's recommendation shall constitute its final decision.
2. The President of the Hospital shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested of each action taken and shall notify the President of the Medical Staff and the Medical Executive Committee of each action.

## **Section IV: Notice of Hearing**

### **A. NOTICE**

Within fifteen (15) days after receipt of a request for Hearing from an affected practitioner entitled to same, the President of the Hospital shall schedule and arrange for such a Hearing and shall notify the affected practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The date of the commencement of the Hearing shall be no more than sixty (60) days from the date of receipt of the request for Hearing by the President of the Hospital.

The notice of Hearing shall state the basis for recommendation or action of which the affected practitioner is charged, a list of specific or representative medical records being questioned, if any, a preliminary list of witnesses, if any, who may be requested to testify at the Hearing on behalf of the Medical Executive Committee and any other reasons or subject matter that were considered in making the adverse recommendation or proposed action and the names of those individuals who have been appointed to hear the matter. The notice shall also contain a warning that the affected practitioner's failure to appear at the Hearing without good cause will result in forfeiture of such affected practitioner's right to a Hearing.

### **B. RIGHTS OF THE PARTIES**

1. Both the affected practitioner and the Medical Executive Committee or Governing Body have the following rights:
  - a. To be represented at any phase of the Hearing or preliminary procedures by an attorney at law or by any other person of that party's choice;
  - b. To have a record made of the proceedings, copies of which may be obtained by the affected practitioner upon payment of any reasonable charges associated with the preparation thereof;
  - c. To call, examine, cross-examine and impeach witnesses and/or expert witnesses on any matters relevant to the issues of the Hearing;
  - d. To introduce exhibits, present and/or rebut evidence determined to be relevant by the Hearing Panel, regardless of its admissibility in a court of law;
  - e. To possibly be called by the Hearing Panel or the other party and examined as if under cross-examination, if the affected practitioner does not testify in his/her own behalf;
  - f. To submit a written statement at the close of the Hearing.



## Section V: Hearing Procedure

### A. HEARING PROCEDURE

#### 1. Appointment of Hearing Panel or Hearing Committee

##### a. Composition of Hearing Panel

When a Hearing relates to an adverse recommendation of the Medical Executive Committee, such Hearing shall be conducted by a Hearing Panel appointed by the Medical Executive Committee of not less than five (5) members of the Medical Staff appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee.

##### b. Presiding Officer

One of the members of the Hearing Panel shall be designated as Chair of the Hearing Panel to serve as the Presiding Officer. The Chair of the Hearing Panel shall preside over the Hearing and maintain decorum.

In the alternative, at the request of the Medical Executive Committee, a Hearing Officer may be retained to serve as the Presiding Officer of the Hearing Panel. The Hearing Officer should be an accredited attorney or have experience as an Administrative Law Judge. The Hearing Officer would be charged with advising the Hearing Panel with respect to legal and technical issues, as well as maintaining decorum of the Hearing.

The Medical Staff should consider participation on hearing panels as part of the duty of a Medical Staff member. No Medical Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed as a member of the Hearing Panel. No Medical Staff member in direct economic competition with the affected practitioner shall be eligible to serve on the Hearing Panel or be its chair.

i. Direct economic competition shall be defined to mean those practitioners actively engaged in practice in the primary medical community of the affected practitioner, and who practice in the same medical specialty or subspecialty. The Hearing Panel should engage, on a consulting basis, member(s) of the specific medical specialty or subspecialty as the affected practitioner, to provide technical expertise to the Hearing Panel as needed throughout the Hearing.

Each member of the Hearing Panel will be selected based on his/her ability to understand the issues and to make judgments

regarding the practice of the affected practitioner in a fair and unbiased manner.

c. There shall be at least a majority of the members of the Hearing Panel present when the Hearing takes place and only those present may vote.

d. Selection of Alternate Hearing Panel Members

In addition to appointing the prescribed number of practitioners to serve as Hearing Panel members, additional practitioners should be appointed to serve as alternate Hearing Panel members. The alternates should attend all proceedings and be prepared to take the place of a Hearing Panel member who may be called away from the Hearing proceedings. Alternates will vote on the outcome of the proceedings only if taking the place of a Hearing Panel member, but should attend all deliberations of the Hearing Panel.

e. Composition of Hearing Committee

When a Hearing relates to an adverse decision of the Governing Body that is contrary to the recommendation of the Medical Executive Committee, the Governing Body shall appoint a Hearing Committee to conduct such Hearing and shall designate one (1) of the members of this Hearing Committee as Chair. At least two (2) representatives from the Medical Staff, not in direct economic competition with the affected practitioner and not having participated in the adverse decision making shall be included on this Hearing Committee.

2. Failure to Appear

The personal presence of the affected practitioner for whom the Hearing has been scheduled shall be required. No Hearing shall be conducted without the personal presence of the affected practitioner unless he/she waives such appearance or fails without good cause to appear for the Hearing after appropriate notice. Failure by the affected practitioner to personally attend the Hearing without good cause, shall be deemed to constitute voluntary abandonment of the Hearing or Appeal and the professional review action involved shall become final and effective immediately when approved by the Governing Body and shall be deemed to be a waiver of the right to a Hearing or any further Appeal in the matter.

3. Postponements and Extensions

Once a request for a Hearing is initiated, postponements and extensions of time may be permitted by the Hearing Chair, within his/her discretion on a showing of good cause and if mutually acceptable to the parties concerned.

B. PRE-HEARING PROCESS

The Hearing Officer may require the individual or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. All objections to documents or witnesses will be submitted in writing five (5) days in advance of the pre-hearing conference. The Hearing Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause. At the pre-hearing conference, the Hearing Officer will resolve all procedural questions, including any objections to exhibits or witnesses. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded. The Hearing Officer will establish the time to be allotted to each witness's testimony and cross-examination.

1. Witnesses

At least ten (10) days prior to the Hearing, each party shall furnish to the other a written list of the names and addresses of the individuals that party intends to call as witnesses at the Hearing. Each party shall update such witness list if and when additional witnesses are identified prior to the Hearing, and neither party shall call witnesses not so named in advance except in rebuttal.

2. Discovery of Documents

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

Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with the following:

- a.) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
- b.) reports of experts relied upon by the Medical Executive Committee
- c.) copies of relevant minutes (with portions regarding other physicians an unrelated matters deleted) and
- d.) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege.

3. No right exists to discovery of documents or other evidence in advance of the Hearing, except as provided in item #2 above.

## **Section VI: Conduct of Hearing**

### **A. CONDUCT OF HEARING**

The Chair of the Hearing Panel or Appointed Hearing Officer shall preside over the Hearing and assure that all participants in the Hearing have a reasonable opportunity to present relevant oral and documentary evidence and maintain decorum. The Chair of the Hearing Panel or Appointed Hearing Officer shall be entitled to determine the order of procedure during the Hearing, the procedure for presenting evidence and making argument during the Hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.

Just prior to the start of the Hearing, the Chair of the Hearing Panel or Hearing Officer shall admonish each committee member and each witness to treat information disclosed or obtained during the Hearing as confidential and not to divulge it to any other party.

1. **Objections of Affected Practitioner Prior to Hearing**

At the beginning of the Hearing, the affected practitioner should be given the opportunity to raise any potential procedural problems or objections. If the affected practitioner does not raise any objections to the Hearing procedure prior to the Hearing, such objections may be deemed waived.

### **B. PROCEDURE**

1. Each party shall, prior to or during the Hearing, be entitled to submit memoranda concerning any issue of procedure, of law or of fact and such memoranda shall become a part of the Hearing record.
2. The Chair of the Hearing Panel or Appointed Hearing Officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.
3. The Hearing Panel shall be entitled to consider any pertinent material on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws in connection with Applications for Appointment or Reappointment to the Medical Staff or for clinical privileges. The Hearing Panel shall be entitled to conduct independent review, research and interviews including interviews of witnesses presented by either party, but may utilize the product of such in its decision only if the parties are aware of such and have the opportunity to rebut any information so gathered.

The Chair of the Hearing Panel or Appointed Hearing Officer and Hearing Panel members may interrogate the witnesses called by either party or call additional witnesses when appropriate.

4. The Hearing Panel may meet without the presence of the parties to deliberate and establish Hearing procedures in accordance with these Medical Staff Bylaws. The Hearing Panel may require that the parties submit written detailed statements of the case to the Hearing Panel and to each other.
5. Statements from members of the Medical Staff, nursing or other Hospital staff, other professional personnel, patients or others may be distributed to the Hearing Panel and the parties in advance of or at the Hearing. Such shall be made a part of the record of the Hearing and given such weight as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the Hearing for questioning by either party and the Hearing Panel if so requested.
6. Any legal advice or clarification required by the Hearing Panel must be sought from counsel other than the attorney advising the Medical Staff or Governing Body so as to avoid or be able to defend against a claim that the entire process was tainted by the Hospital attorney's dual representation.
7. The Medical Executive Committee, when its action is the subject of the Hearing, shall appoint one (1) of its members or some other Medical Staff member to represent it at the Hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The Governing Body, when its action is the subject of the Hearing, shall appoint one (1) of its members to represent it at the Hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse decision and to examine witnesses. The affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

#### C. REPRESENTATION

The affected practitioner shall be entitled to be accompanied by and/or represented at the Hearing by a member of the Active Medical Staff in good standing or by a member of his/her professional society or his/her attorney.

The Hearings provided for in these Medical Staff Bylaws are for the purpose of intra-professional resolution of matters bearing on professional competency and conduct. Accordingly, neither the affected practitioner nor the Medical Executive Committee nor the Governing Body shall be represented at any phase of the Hearing procedure by an attorney at law unless the Hearing Panel, in its discretion, permits both sides to be represented by counsel. Any affected practitioner who incurs legal fees in his/her own behalf shall be solely responsible for payment thereof. The foregoing shall not be deemed

to deprive the affected practitioner, the Medical Executive Committee or the Governing Body of the right to legal counsel in connection with preparation for the Hearing or for a possible appeal.

Should the affected practitioner request to be represented by counsel at the Hearing, the Medical Staff shall also be represented by counsel at the Hearing. In this event, attorneys will be permitted to attend the Hearing to provide guidance, without the right to address the Hearing Panel or Chair.

The affected practitioner must, at the time of requesting a Hearing, notify the Medical Executive Committee that he/she will be accompanied by counsel, in the manner described above.

#### D. RECORD OF HEARING

1. A record of the Hearing must be kept that is of sufficient accuracy to permit the making of an informed and valid judgment by anybody that may later be called upon to review the record and render a recommendation or a decision in the matter.
2. The mechanism of the recording shall be by use of a certified stenographic or court reporter. Private deliberations of the Hearing Panel outside the presence of the affected practitioner for whom the Hearing was convened shall not be recorded.
3. The records from the Hearing procedure shall be retained in the office of the Vice President of Medical Affairs until such time as the conflict in question is resolved to the satisfaction of all parties. The affected practitioner for whom the Hearing is being held shall be allowed to review the records if he/she so desires, but only in the presence of the Chair of the Hearing Panel or the Vice President of Medical Affairs or their duly appointed designee. The records may be copied by the affected practitioner at his/her expense, but the original records are not to leave the Hospital premises under any circumstances.

#### E. MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the Hearing, examination of witnesses and presentation of evidence shall not apply to a Hearing conducted under these Medical Staff Bylaws. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the admissibility of such evidence in a court of law. Hearsay evidence that has rational probative force and which is corroborated may constitute evidence in these Hearings.

#### F. OFFICIAL NOTICE

In reaching a decision, the Hearing Panel may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific

matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of New York. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Panel.

#### G. STANDARD OF PROOF

The affected practitioner shall have the burden to establish, by clear and convincing proof, that the Medical Executive Committee's recommendation was arbitrary, unreasonable, or not sustained by the evidence.

#### H. ADJOURNMENT AND CONCLUSION

##### 1. Adjournment

The Hearing Chair or Hearing Panel, as a whole may, without special notice, adjourn or recess the Hearing and reconvene the same at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the Hearing and for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

##### 2. Conclusion

Upon conclusion of the presentation of oral and written evidence or the receipt of closing written arguments, if they are to be submitted, the Hearing shall be closed. The Hearing Panel may thereupon, at a time convenient to itself, within the time frame previously set forth in this plan, conduct its deliberations outside the presence of the affected practitioner for whom the Hearing was convened and the representative of the Medical Executive Committee or the Governing Body. Upon conclusion of its deliberations, the Hearing shall be declared finally adjourned.

#### I. Basis for Recommendation

The recommendation of the Hearing Panel shall be based on the evidence introduced at the Hearing including all logical and reasonable inferences from the evidence and the testimony.

### **Section VII: Recommendation and Report of the Hearing Panel or Hearing Committee**

#### A. RECOMMENDATION AND REPORT OF THE HEARING PANEL OR HEARING COMMITTEE

Within fifteen (15) days after final adjournment of the Hearing, the Hearing Panel (or Hearing Committee) shall make a written report and recommendation, stating the reasons for the recommendation and shall forward the same, together with the Hearing record and all other documentation to the Medical Executive Committee or to the Governing Body, whichever appointed it, with a copy to the President of the Hospital. All findings and

recommendations by the Hearing Panel (or Hearing Committee) shall be supported by reference to the Hearing record and other documentation considered by it. The report of the Hearing Panel (or Hearing Committee) may recommend confirmation, modification or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Governing Body.

The report and recommendation should be clearly written such that subsequent reviewing bodies (e.g., the Hospital's Governing Body or a judge) can easily discern the complaint(s) against the affected practitioner which gave rise to the peer review, whether the complaints were meritorious, how the conduct affected or could affect patient care and what sanctions are recommended.

1. Action on Hearing Panel Report

At the next Medical Executive Committee meeting, after receipt of the report of the Hearing Panel, the Medical Executive Committee shall consider the recommendation and affirm, modify or reject same. The results of that consideration shall be transmitted to the President of the Hospital, together with the Hearing record, the report of the Hearing Panel and all other documentation considered.

2. Favorable Result by the Medical Executive Committee

a. If the Medical Executive Committee result is favorable to the affected practitioner, the President of the Hospital shall, within seven (7) days of his receipt thereof, forward it, together with all supporting documentation, to the Governing Body.

b. The Governing Body shall, at the its next regularly scheduled meeting, following its Chair's receipt of the results favorable to the affected practitioner from the Medical Executive Committee, take action thereon by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Governing Body must be made, and may include a directive that an additional Hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Governing Body shall take final action.

c. Any action favorable to the affected practitioner by the Governing Body shall become its final action and the matter will be finally closed.

3. Unfavorable (Adverse) Result

If the result of the Medical Executive Committee or the Governing Body is or remains adverse to the affected practitioner, he/she shall have the



right to request an Appellate Review by the Governing Body as set forth in these Medical Staff Bylaws.

**B. NOTICE OF RESULT**

The President of the Hospital shall promptly send a copy of the result to the affected practitioner by special notice, certified mail, return receipt requested. The affected practitioner shall be furnished a copy of the Hearing Panel's report with such notice as well as the written decision or recommendation of the body acting on the Hearing Panel's report.

If the result sent to the affected practitioner is or continues to be unfavorable to him/her, the special notice shall state, in addition to the result:

1. That the affected practitioner has a right to request an Appellate Review by the Governing Body of the decision made.
2. That the affected practitioner has thirty (30) days, following mailing the notice required by this section, to file a written request for Appellate Review and that failure to properly request such review shall constitute a waiver of the right to review.

A summary of the Appellate Review procedures shall be sent with the notice.

**C. WAIVER OF TIME LIMITS**

Any time limits set forth in this process may be extended or accelerated by mutual agreement of the affected practitioner and the President of the Hospital or the Medical Executive Committee. The time periods specified herein for action by the Medical Staff, the Governing Body and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action.

**D. SUBSTANTIAL COMPLIANCE**

Technical or insignificant deviations from the procedures set forth herein shall not be grounds for invalidating the action taken.

**APPELLATE REVIEW**

**Section I: Appeal to the Governing Body/Waiver of Appeal**

**A. APPEAL TO THE GOVERNING BODY**

Within fifteen (15) days after receipt of notice of an adverse recommendation or decision made or adhered to after a Hearing, the affected practitioner may request an Appellate Review by the Governing Body. Such request for Appellate Review must be made in writing to the Governing Body and delivered to the President of the Hospital by certified mail, return receipt requested. The affected

practitioner may request that the Appellate Review be held only on the record on which the adverse recommendation or decision is based, as supported by his/her written statement provided for below or he/she may also request that oral argument be permitted as part of the Appellate Review. Appellate Review shall include all material which was considered in making the adverse recommendation, whether favorable or unfavorable and whether or not previously forwarded to the Governing Body.

1. Waiver

If such Appellate Review is not requested within thirty (30) days after receipt of notice of the right to same, the affected practitioner shall be deemed to have waived his/her right to same and to have accepted such adverse recommendation or decision which shall become effective immediately as provided in this section.

If permission to present oral argument is not requested within thirty (30) days after receipt of notice of the right to same, the affected practitioner shall be deemed to have waived his/her right to oral argument.

B. NOTICE OF APPELLATE REVIEW

Upon receipt of a timely request for Appellate Review, the President of the Hospital shall deliver such request to the Chair of the Governing Body. Within fifteen (15) days after receipt of such notice of request for Appellate Review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the President of the Hospital, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the Appellate Review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request for Appellate Review, except that when the affected practitioner requesting the Appellate Review is under a suspension which is then in effect.

When the affected practitioner requesting the Appellate Review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fifteen (15) days from the date of receipt of request for same, unless such time is formally waived, in writing, by the affected practitioner. In such case, the affected practitioner shall be afforded notice of the time, date and place of review as soon as practicable. The time for the Appellate Review may be extended by the Appellate Review body for good cause. The Appellate Review can occur at a regularly scheduled meeting of the Governing Body.

C. RIGHTS OF THE AFFECTED PRACTITIONER

The affected practitioner shall have access to the report and record (and transcription, if any) of the Hearing Panel and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she shall have thirty (30) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reason for such disagreement, shall be specified. This written statement may cover any matters

raised at any step in the procedure to which the appeal is related and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body through the President of the Hospital by certified mail, return receipt requested, at least ten (10) days prior to the scheduled date for the Appellate Review. A similar statement may be submitted by the Medical Executive Committee or by the Chair of the Hearing Committee appointed by the Governing Body and, if submitted, the President of the Hospital shall provide a copy thereof to the affected practitioner at least five (5) days prior to the date of such Appellate Review by certified mail, return receipt requested. These filing deadlines do not apply to an expedited review as permitted above.

## **Section II: Appellate Review Procedure**

A. The Appellate Review shall be conducted by the Governing Body, as a whole, or by an Appellate Review Committee composed of not less than five (5) members of the Governing Body, appointed by its Chair. If an Appellate Review Committee is appointed, the Chair of the Governing Body shall designate one of its members as Chair. The Appellate Review body should not include any members who have participated in the professional review activity at any earlier stage. Such persons should not be appointed to a Committee of the Governing Body and should be recused as members when the Governing Body, as a whole, is hearing the matter.

1. **Presiding Officer**

The Chair of the Appellate Review Committee shall be the Presiding Officer. He/she shall determine the order of the procedure during the review, make all required rulings and maintain decorum. When the Appellate Review is conducted by the Governing Body as a whole, its Chair shall act as the Presiding Officer.

The Governing Body or its appointed review committee shall act as an Appellate Review body. It shall review the record created in the proceedings, consider the written statements submitted by the parties and the oral argument, if any, for the purpose of ascertaining the fairness of the procedure and to determine whether the adverse recommendation or decision against the affected practitioner is supported by the evidence, was justified and was not arbitrary or capricious.

If oral argument is requested as part of the Appellate Review procedure, the affected practitioner shall be present at such Appellate Review, for the purpose of oral argument only, shall be permitted to speak against the adverse recommendation or decision and shall answer questions put to him/her by any member of the Appellate Review body. The Medical Executive Committee or the Governing Body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the Appellate Review body. The Appellate Review body and the Governing Body shall make an

independent judgment based upon the facts which are contained in the record.

New or additional matters or evidence not raised during the original Hearing or in the Hearing Panel report, nor otherwise reflected in the record, shall only be introduced at the Appellate Review under unusual and compelling circumstances. The party requesting the consideration of such matters or evidence shall explain the reasons for not presenting such evidence during the Hearing of the matter and in what way consideration of same is necessary and appropriate. The Governing Body or the committee thereof appointed to conduct the Appellate Review shall in its sole discretion determine whether such new matters or evidence shall be considered or accepted.

2. Representation

Nothing in these Medical Staff Bylaws prevents either the affected practitioner, the Governing Body or the Medical Staff from seeking advise of counsel in their preparation for the Appellate Review. Should the affected practitioner have requested oral argument and wish to be represented by counsel at his/her appearance for same, counsel for the Medical Staff will also be in attendance. The attorneys will be permitted to attend to provide guidance, without the right to address the Governing Body or Appellate Review Committee. The affected practitioner must, at the time of requesting Appellate Review with oral argument notify the Appellate Review body that he/she will be accompanied by counsel, in the manner described above.

3. Powers

The Appellate Review Committee shall have all the powers granted to the Hearing Committee and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

4. Recesses and Adjournments

The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants. Upon the conclusion of oral arguments, if any, the Appellate Review shall be closed. The Appellate Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided in this section have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Body may be taken by a committee thereof duly authorized to so act.

## B. STANDARD OF REVIEW

As an Appellate Review body, the Governing Body, or Appellate Review Committee thereof, shall review the decision of the Medical Executive Committee to determine the following:

1. That the recommendation is substantiated by the evidence in the record;
2. That the recommendation will improve the quality of healthcare at the Hospital;
3. That the Hearing Committee and other individuals and committees made a reasonable effort to ascertain the facts prior to formulating the recommendation;
4. That the process employed in reaching the recommendation was fair under the circumstances, that the affected practitioner was afforded adequate due process and that all procedures were, at a minimum, in substantial compliance with the Medical Staff Bylaws or applicable law.

In the event the Governing Body, or Appellate Review Committee thereof, determines that any of the standards for review have not been fully met, it can undertake to correct the deficiency, or refer the matter back to the Hearing Committee or Medical Executive Committee as appropriate, with instructions for remedial action.

## C. ACTION TAKEN

If the Appellate Review is conducted by the Governing Body as a whole, it may affirm, modify or reverse the prior decision or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee arrange for further Hearing to resolve specified disputed issues.

The Governing Body shall memorialize its findings and conclusions in a written decision, which includes the rationale for the decision, and that it is based entirely upon the record on Appellate Review which was compiled at the Hearing level.

If the Appellate Review is conducted by an Appellate Review Committee appointed by the Governing Body such committee shall, within fifteen (15) days after the scheduled or adjourned date of the Appellate Review, either make a written report recommending that the Governing Body affirm, modify or reverse the prior decision or refer the matter back to the Medical Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee arrange for a further Hearing to resolve disputed issues. Within fifteen (15) days after receipt of such recommendation after referral, the Appellate Review Committee shall make its recommendation to the Governing Body as above provided.

The Appellate Review Committee shall memorialize its findings and conclusions in a written decision, which includes the rationale for the decision, based upon the record on

Appellate Review which was compiled at the Hearing level. The decision is then forwarded to the Governing Body for its consideration and written final decision.

### **Section III: Final Decision of the Governing Body**

#### **A. GOVERNING BODY ACTION**

Within fifteen (15) days after the conclusion of the Appellate Review, the Governing Body shall make its final decision, including the rationale for such decision.

1. If this decision is to affirm the Medical Executive Committee's last adverse recommendation in the matter, if any, it shall be immediately effective and final and shall not be subject to further Hearing or Appellate Reviews. The Governing Body shall send notice thereof to the Medical Executive Committee and, through the President of the Hospital, to the affected practitioner by certified mail, return receipt requested.
2. If the Governing Body's action has the effect of changing the Medical Executive Committee's last adverse recommendation, if any, the Governing Body shall refer the matter to the Medical Staff-Governing Body Review Committee as provided in these Medical Staff Bylaws. The Governing Body's action on the matter following receipt of the Medical Staff-Governing Body Review Committee's recommendation shall be immediately effective and final. The Governing Body shall send notice thereof to the Medical Executive Committee and, through the President of the Hospital, to the affected practitioner by certified mail, return receipt requested.
3. If the Governing Body's action has the effect of changing the Medical Executive Committee's last favorable recommendation, if any, the Governing Body shall refer the matter to the Medical Staff-Governing Body Review Committee as provided in these Medical Staff Bylaws. The Governing Body's action on the matter following receipt of the Medical Staff-Governing Body Review Committee's recommendation shall be immediately effective and final. The Governing Body shall send notice thereof to the Medical Executive Committee and, through the President of the Hospital, to the affected practitioner by certified mail, return receipt requested.

#### **B. MANDATORY REPORTING REQUIREMENTS**

HCQIA requires a written report to the NPDB of any adverse action affecting the clinical privileges of any practitioner for a period of more than thirty (30) days. When making a final decision on a recommendation for adverse action, the Governing Body should review a draft report which will be made to the NPDB. Failure to report may result in civil monetary penalties and/or the loss of immunity for peer review participants.

C. NUMBER OF HEARINGS

Notwithstanding any other provision of these Medical Staff Bylaws, no practitioner shall be entitled as a right to more than one Hearing and one Appellate Review on any matter which shall have been the subject of action by the Medical Executive Committee or by the Governing Body or by a duly authorized committee thereof or by both.

D. EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a practitioner's Medical Staff membership status, or clinical privileges at any time, regardless of whether he/she is an Applicant or a Medical Staff member, he/she must exhaust the intra-organizational remedies afforded by these Medical Staff Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or participants in the decision process; and the exclusive procedure for obtaining judicial review shall be by invoking the applicable provisions of New York Public Health Law.

E. PROTECTION FROM LIABILITY

In matters relating to corrective action, Hearings and Appellate Reviews, all Medical Staff members and other practitioners and all appropriate Hospital personnel including members of the Governing Body and Hospital Administration, shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in these Medical Staff Bylaws.

F. EXCEPTIONS TO HEARING RIGHTS

1. Automatic Suspension or Limitation of Practice Privileges  
No Hearing is required when practitioner's license, certification or legal credential to practice has been revoked or suspended as set forth in these Medical Staff Bylaws. In other cases, the issues which may be considered at a Hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the practitioner may continue practice in the Hospital with those limitations imposed.
2. Medical-Administrative Officers and Contract Physicians  
Practitioners who are directly under contract with the Hospital or serve in a medical-administrative capacity shall be subject to the procedural rights specified in these Medical Staff Bylaws, unless otherwise provided by contract.

**Section IV: Medical Staff-Governing Body Review Committee**

Membership and Time Limits

1. The Medical Staff-Governing Body Review Committee shall be composed of three (3) members of the Medical Staff appointed by the President of the Medical Staff and three (3) members of the Governing Body appointed by the Chair of the Governing Body.

2. Within seven (7) days following receipt of a matter referred to the Medical Staff-Governing Body Review Committee by the Governing Body pursuant to the provisions of these Medical Staff Bylaws, the Committee shall convene to consider the matter.
3. Within seven (7) days following the conclusion of its consideration, the Medical Staff-Governing Body Review Committee shall submit its recommendations to the Governing Body.
4. The Governing Body's action on the matter following receipt of the Medical Staff-Governing Body Review Committee's recommendation shall be immediately effective and final.



# **ARTICLE EIGHT: CATEGORIES OF THE MEDICAL STAFF: QUALIFICATIONS, PREROGATIVES AND RESPONSIBILITIES**

## **Section I:           The Medical Staff**

As required in the Codes, Rules and Regulations of the State of New York, in 10 NYCRR §405.4 C (2), the Medical Staff shall adopt and enforce Medical Staff Bylaws which include a statement of the qualifications, prerogatives and responsibilities of each category of Medical Staff membership. The categories of Medical Staff shall be: Active, Active-Provisional, Courtesy, Consulting, Honorary, Emeritus, Retired and House Physician. The qualifications, prerogatives and responsibilities of each Medical Staff category are as set forth herein.

## **Section II:           The Active Medical Staff**

### **A.     QUALIFICATIONS FOR THE ACTIVE MEDICAL STAFF**

The Active Medical Staff shall consist of physicians, dentists and podiatrists who have satisfied the basic qualifications for Medical Staff membership as set forth in these Medical Staff Bylaws and who:

1.     Admit patients regularly to the Hospital, or otherwise are regularly involved in teaching, or in the care of patients in the Hospital facilities [minimum of twelve (12) procedures or consultations/year].
2.     Have been appointed to the Active Medical Staff after completing provisional Medical Staff requirements.
3.     Must be located (office and residence) close enough to the Hospital to provide continuing care to their patients.
4.     Shall be appointed for a term of not more than two (2) years.

### **B.     PREROGATIVES OF THE ACTIVE MEDICAL STAFF**

A member of the Active Medical Staff may:

1.     Admit patients to the Hospital.
2.     Exercise such clinical privileges as are granted to him/her.

3. Vote on all matters presented at General and Special Staff meetings of the Medical Staff and of Departmental, Divisional and committee meetings of which he/she is a member.
4. Hold office at any level in the Medical Staff organization or be a member of or Chair of any committee.

C. RESPONSIBILITIES OF THE ACTIVE MEDICAL STAFF

Each member of the Active Medical Staff shall:

1. Meet responsibilities set forth in these Medical Staff Bylaws.
2. Retain responsibility within the member's area of professional competence for the daily care and supervision of each patient in the Hospital for whom the member is providing services, or arrange a suitable alternative for such care and supervision.
3. Be appointed to a specific department.
4. Actively participate in the Quality Review and Performance Improvement activities required of the Medical Staff and facility.
5. Actively participate in supervising and in reviewing performance of Active-Provisional appointees of the same discipline as member.
6. Assume all the functions and responsibilities of Medical Staff membership on the Active Medical Staff including serving on-call as determined by the Department to which he/she is assigned, emergency service care, attendance of service patients as required, consultation to other Medical Staff members consistent with his/her delineated clinical privileges, teaching assignments as required and such other Medical Staff functions as may reasonably be required.
7. Abide by the Rules and Regulations of the Medical Staff and the Department to which he/she has been assigned.
8. Actively participate in the Medical Staff's continuing education programs.
9. Satisfy the requirements set forth in the Bylaws and Rules and Regulations of the Medical Staff for attendance at meetings of the Medical Staff, Department, Division and committees of which he/she is a member.
10. Contribute to the organizational and administrative affairs of the Medical Staff, including service on Hospital and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed.

11. Be required to pay such annual dues and financial obligations as may be determined by the Medical Staff.

#### D. INACTIVE MEDICAL STAFF STATUS

Members of the Active Medical Staff who, because of illness, leave of absence, or other acceptable reasons, are no longer attending patients in the Hospital shall be considered Inactive. During the period of inactivity, he/she shall have none of the prerogatives or responsibilities set forth above. His/her previous Medical Staff status may be reinstated upon request after appropriate credentialing and recommendation by the Medical Executive Committee as set forth in these Medical Staff Bylaws. Inactive status shall in no event extend beyond the term of appointment.

### **Section III: The Active-Provisional Medical Staff**

#### A. QUALIFICATIONS FOR ACTIVE-PROVISIONAL MEDICAL STAFF

The Active-Provisional Medical Staff shall consist of newly appointed physicians, dentists and podiatrists who are being considered for advancement to the Active Medical Staff who have satisfied the basic qualifications for Medical Staff membership as set forth in these Medical Staff Bylaws and who:

1. Are initially appointed to the Medical Staff provisionally for a period of at least one (1) year.
2. Will regularly admit patients to or otherwise will be regularly involved in the care of patients in the Hospital.
3. Are qualified for advancement to Active Medical Staff membership.
4. Must demonstrate in the development of their practice, the ability to meet the qualifications of Active Medical Staff membership. After serving this provisional period, an Active-Provisional Medical Staff member must be evaluated for the purpose of transfer to Active Medical Staff or assignment to a different Medical Staff category for which he/she is eligible.
5. Shall be assigned to a Department/Division where his/her performance shall be observed by the Chair/Chief of the Department/Division or his/her representative to determine his/her eligibility for Active Medical Staff membership, and for exercising the clinical privileges provisionally granted to him/her.
  - a. At the end of the one (1) year period, the Chair of the respective Department shall submit a letter to the Credentials Committee stating that the new appointee has been observed and evaluated during the provisional period and making a recommendation regarding the new appointee's transfer from Active-Provisional to the Active Medical Staff and the specific Department.

- b. If not so advanced and except for good cause, the appointee may be subject to a reduction in Medical Staff category or to revocation of Medical Staff clinical privileges.
  - c. If neither option is applicable, the matter must be referred to the Credentials Committee for review and recommendation and to the Medical Executive Committee. Such action must take the form of a recommendation for extension of the Active-Provisional Medical Staff membership for a maximum of one (1) additional year with justification or termination of Medical Staff membership.
  - d. A practitioner who is not recommended for advancement to the regular Medical Staff within two (2) years of initial appointment shall be scheduled for a personal interview with the Medical Executive Committee to discuss the status of his/her continued interest in membership on the Medical Staff. The Medical Executive Committee will then recommend either advancement or termination of his/her Medical Staff appointment. A provisional appointee whose Medical Staff membership is so terminated shall have the rights accorded by these Medical Staff Bylaws to a member of the Medical Staff who has failed to be reappointed.
6. Shall be initially appointed to the Medical Staff as provisional except for Consultant Medical Staff appointments and under extraordinary circumstances. If a waiver of the provisional staff requirements to secure an immediate Active Medical Staff appointment for an Applicant is needed to assure the continued proficiency of a Department or Service, such would require a request from the Department Chair and the approval and recommendation of the Medical Executive Committee and the Credentials Committee.

#### B. PREROGATIVES OF THE ACTIVE-PROVISIONAL MEDICAL STAFF

An Active-Provisional Medical Staff member may:

- 1. Admit patients in the same manner as Active Medical Staff members.
- 2. Attend Medical Staff meetings, Departmental and Divisional meetings, of which he/she is a member, and educational programs.
- 3. Exercise such clinical privileges as are granted to him/her.

Active-Provisional Medical Staff members are not eligible to hold office in the Medical Staff organization, to serve on the Medical Executive Committee or to vote for Medical Staff officers or on revisions to the Medical Staff Bylaws, Rules and Regulations.

#### C. RESPONSIBILITIES OF THE ACTIVE-PROVISIONAL MEDICAL STAFF

Each member of the Active-Provisional Medical Staff shall:

1. Discharge the same responsibilities as those specified for Medical Staff members of the Active Medical Staff above in Section II, (C). Failure to fulfill those obligations is grounds for denial of Active Medical Staff status.
2. Be appointed to a clinical or service department and subject to the Rules and Regulations of that Department.

## **Section IV: The Courtesy Medical Staff**

### **A. QUALIFICATIONS FOR THE COURTESY MEDICAL STAFF**

The Courtesy Medical Staff shall consist of physicians, dentists and podiatrists qualified for Medical Staff membership who only occasionally admit or treat patients in the Hospital, or who provide specific limited service to patients in the Hospital and who:

1. Meet the qualifications for Medical Staff membership.
2. Are located reasonably proximate to the Hospital or otherwise arranges to provide continuous care to patients.
3. Shall, unless otherwise exempt, demonstrate active participation in the Active or Active-Provisional (or equivalent) Medical Staff at another licensed hospital in Western New York, requiring Quality Review and Performance Improvement activities of a substance and character similar to those at this Hospital or agree to fulfill the obligations of Active Medical Staff membership concerning participation in Quality Review and Performance Improvement activities at Departmental and/or Divisional meetings and committee meetings. When appropriate, exempt status shall be evaluated and recommended by the Credentials Committee.
4. After serving provisionally for a period of at least one (1) year, must be evaluated for reappointment as a Courtesy Staff member or for assignment to a different Medical Staff category for which he/she is eligible.

### **B. PREROGATIVES OF THE COURTESY MEDICAL STAFF**

A Courtesy Medical Staff member may:

1. Admit patients to the Hospital or otherwise care for patients, not to exceed twelve (12) in a calendar year and/or have no more than twelve (12) patient contacts (admissions with on-going patient care responsibility) or perform no more than twelve (12) medical/surgical procedures per calendar year. Newborn visits, in-hospital patient visits by covering physicians, Emergency Department service referrals and service admissions, and procedures by the in-house obstetrical anesthesiologists are excepted. Exceeding this maximum requires automatic evaluation for transfer to Active Medical Staff except when it can be demonstrated that a unique set of circumstances exist. This determination will be made by the

Credentials Committee and approved by the Medical Executive Committee.

2. Exercise such clinical privileges as are granted pursuant to these Medical Staff Bylaws.
3. Attend meetings of the Medical Staff and the Department of which he/she is a member and any staff or Hospital education programs but will be exempt from attendance requirements at staff meetings and committee assignments.
4. Serve on Medical Staff committees.
5. Not be eligible to vote or to hold office.

**C. RESPONSIBILITIES OF THE COURTESY MEDICAL STAFF**

Each member of the Courtesy Medical Staff shall be required to discharge the basic responsibilities specified in these Medical Staff Bylaws and, further, shall retain responsibility within the Medical Staff member's area of professional competence for the care and supervision of each patient in this Hospital for whom he/she is providing services or shall arrange a suitable alternative for such care and supervision.

1. They shall be appointed to a clinical or service department and subject to the Rules and Regulations of that Department.
2. They are required to pay Medical Staff dues.

**D. INACTIVE MEDICAL STAFF STATUS**

Members of the Courtesy Medical Staff who, because of illness, leave of absence, or other acceptable reasons, are no longer attending patients in the Hospital shall be considered Inactive. During the period of inactivity, he/she shall have none of the prerogatives or responsibilities set forth above. His/her previous Medical Staff status may be reinstated upon request after appropriate credentialing and recommendation by the Medical Executive Committee as set forth in these Medical Staff Bylaws. Inactive status shall in no event extend beyond the term of appointment.

**Section V: The Consulting Medical Staff**

**A. QUALIFICATIONS FOR THE CONSULTING MEDICAL STAFF**

The Consulting Medical Staff shall be composed of outstanding physicians, dentists and podiatrists who have attained distinction in a particular specialty. They shall be specifically invited by the Governing Body, Medical Executive Committee or Clinical Department Chair for this status and who:

1. Meet the qualifications set forth in the Medical Staff Bylaws for Medical Staff membership.

2. Possess specialized skills needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a Department/Division Chair/Chief or a member of the Medical Staff. They shall provide services only on an occasional basis. The Consulting Medical Staff member who has more than occasional contacts per year should be reviewed and may be reassigned to another appropriate Medical Staff category, except where it can be demonstrated that the excess occurred because of a unique set of circumstances.
3. May be a member of the Medical Staff of another local hospital where such Consultant actively participates in patient care and Quality Review and Performance Improvement activities.

**B. PREROGATIVES OF THE CONSULTING MEDICAL STAFF**

A member of the Consulting Medical Staff may:

1. Examine patients at the specific request of the physician or physicians primarily responsible for the care of a patient and make recommendations within the area of the Consulting Medical Staff's clinical expertise.
2. Exercise such clinical privileges as are granted pursuant to these Medical Staff Bylaws.
3. Not be eligible to admit patients to the Hospital or to hold office in the Medical Staff organization or to vote at meetings of the Medical Staff, Departmental/Divisional meetings or committee meetings.

**C. RESPONSIBILITIES OF THE CONSULTING MEDICAL STAFF**

Each member of the Consulting Medical Staff shall:

1. Have no assigned duties, shall not be required to attend meetings, serve on committees, hold office, or pay Medical Staff dues.

**Section VI: The Honorary Medical Staff**

**A. QUALIFICATIONS FOR THE HONORARY MEDICAL STAFF**

The Honorary Medical Staff shall consist of physicians, dentists and podiatrists recognized for their previous long-standing meritorious service on the Medical Staff and in their field of medicine.

**B. PREROGATIVES OF THE HONORARY MEDICAL STAFF**

A member of the Honorary Medical Staff may:

1. Not be eligible to admit patients to the Hospital nor exercise clinical privileges.
  - a. Under special circumstances, the Medical Executive Committee may recommend clinical privileges for an Honorary Medical Staff member. He/she will be required to comply with the licensure and

professional liability insurance provisions of these Medical Staff Bylaws.

2. Not be required to have a Drug Enforcement Agency (DEA) registration, malpractice insurance or a current license to practice in New York State.
3. Attend Medical Staff and department meetings and any Medical Staff or Hospital education meetings.
4. Not be eligible to vote or to hold office in the Medical Staff organization or serve on standing Medical Staff committees.

C. RESPONSIBILITIES OF THE HONORARY MEDICAL STAFF

Each member of the Honorary Medical Staff shall:

1. Have no assigned duties or responsibilities.
2. Be exempt from paying Medical Staff dues and assessments.

**Section VII: The Emeritus Medical Staff**

A. QUALIFICATIONS OF THE EMERITUS MEDICAL STAFF

The Emeritus Medical Staff shall consist of members of the Active Medical Staff, who shall be nominated by the Chair of the Department or the Medical Executive Committee, who are practitioners of outstanding reputation, not necessarily residents of the community and who elect to become Emeritus Medical Staff members.

B. PREROGATIVES OF THE EMERITUS MEDICAL STAFF

A member of the Emeritus Medical Staff may:

1. Not be eligible to admit patients to the Hospital nor exercise clinical privileges.
  - a. Under special circumstances, the Medical Executive Committee may recommend clinical privileges for an Emeritus Medical Staff member. He/she will be required to comply with the licensure and professional liability insurance provisions of these Medical Staff Bylaws.
2. Not be required to have a Drug Enforcement Agency (DEA) registration, malpractice insurance or a current license to practice in New York State.
3. Attend Medical Staff and department meetings and any Medical Staff or Hospital education meetings.
4. Not be eligible to vote or to hold office in the Medical Staff organization or serve on standing Medical Staff committees.



C. RESPONSIBILITIES OF THE EMERITUS MEDICAL STAFF

Each member of the Emeritus Medical Staff shall:

1. Have no assigned duties or responsibilities.
2. Be exempt from paying Medical Staff dues and assessments.

**Section VIII: The Retired Medical Staff**

The Retired Medical Staff shall consist of physicians, dentists and podiatrists who are fully retired from practice, who have voluntarily relinquished all clinical privileges and are deemed deserving of continued Medical Staff membership by virtue of their long standing service to the Hospital.

Retired Medical Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. The Retired Medical Staff may attend Medical Staff and Department meetings and any Medical Staff or Hospital education meetings. Retired Medical Staff members shall not be eligible to vote or to hold office in the Medical Staff organization and are exempt from paying Medical Staff dues and assessments.

**Section IX: House Physician Staff**

A. QUALIFICATIONS FOR THE HOUSE PHYSICIAN STAFF

House Physician Staff shall meet the basic qualifications set forth in the Medical Staff Bylaws for physicians applying for membership and clinical privileges on the Medical Staff. House Physician Staff shall not be eligible to vote nor hold office and are not required to attend meetings of the Medical Staff organization. They will not be required to pay Medical Staff dues.

B. PREROGATIVES OF HOUSE PHYSICIAN STAFF

A member of the House Physician Staff shall:

1. Perform duties skillfully and to the best of such House Physician's ability under the general supervision of the Vice President of Medical Affairs, the attending physician responsible for the patient, the Chair of the Department involved and/or the Emergency Department Physician.
2. Exercise such clinical privileges as are granted pursuant to these Medical Staff Bylaws.

C. RESPONSIBILITIES OF HOUSE PHYSICIAN STAFF

Each member of the House Physician Staff shall:

1. Meet responsibilities set forth in these Medical Staff Bylaws.

2. Retain responsibility within such area of professional competence for the care and supervision of each patient in the Hospital for whom such House Physician is providing services or arrange a suitable alternative for such care and supervision.
3. Not vote in general or special staff meetings nor pay Medical Staff dues nor attend Medical Staff meetings.
4. Perform duties which shall include the services generally performed by House Physicians in an acute general hospital setting. Such services shall be designated by the Chair of the Department in which such physician is covering and in the case of Medical/Surgical Service, carry out specific duties of House Physician Staff as delineated in his/her specific Job Description and as are more fully delineated in Appendix A, the Medical Staff Rules and Regulations.

## **Section X: The Affiliate Medical Staff**

Added: 10/20/10

### **A. QUALIFICATIONS FOR THE AFFILIATE MEDICAL STAFF**

The Affiliate Medical Staff shall consist of physicians, dentists and podiatrists qualified for Medical Staff membership who only do not admit or treat patients in the Hospital, or who provide specific limited service to patients in the Hospital and who:

1. Meet the qualifications for Medical Staff membership.
2. Are located reasonably proximate to the Hospital or otherwise arranges to provide continuous care to patients.
3. After serving provisionally for a period of at least one (1) year, must be evaluated for reappointment as an Affiliate Staff member or for assignment to a different Medical Staff category for which he/she is eligible.

### **B. PREROGATIVES OF THE AFFILIATE MEDICAL STAFF**

An Affiliate Medical Staff member may:

1. Exercise such clinical privileges as are granted pursuant to these Medical Staff Bylaws.
2. Attend meetings of the Medical Staff and the Department of which he/she is a member and any staff or Hospital education programs but will be exempt from attendance requirements at staff meetings and committee assignments.
3. Serve on Medical Staff committees.
4. Not be eligible to vote or to hold office.

C. RESPONSIBILITIES OF THE AFFILIATE MEDICAL STAFF

Each member of the Affiliate Medical Staff shall be required to discharge the basic responsibilities specified in these Medical Staff Bylaws and, further, shall retain responsibility within the Medical Staff member's area of professional competence for the care and supervision of each patient in this Hospital for whom he/she is providing services or shall arrange a suitable alternative for such care and supervision.

1. They shall be appointed to a clinical or service department and subject to the Rules and Regulations of that Department.
2. They are required to pay Medical Staff dues.

D. INACTIVE MEDICAL STAFF STATUS

Members of the Affiliate Medical Staff who, because of illness, leave of absence, or other acceptable reasons, are no longer attending patients in the Hospital shall be considered Inactive. During the period of inactivity, he/she shall have none of the prerogatives or responsibilities set forth above. His/her previous Medical Staff status may be reinstated upon request after appropriate credentialing and recommendation by the Medical Executive Committee as set forth in these Medical Staff Bylaws. Inactive status shall in no event extend beyond the term of appointment.

**ARTICLE NINE:  
VICE PRESIDENT OF MEDICAL AFFAIRS AND  
OFFICERS OF THE MEDICAL STAFF**

**Section I: Vice President of Medical Affairs**

The Governing Body shall appoint a Vice President of Medical Affairs and shall delegate to that individual the authority and responsibility for the operation, evaluation and enforcement of policies, rules and regulations related to medical matters in the Hospital. The Vice President of Medical Affairs shall be responsible for directing the Medical Staff organization in accordance with the provisions of 10 NYCRR, Part 405, §405.4, the standards of the Joint Commission and the provisions of these Medical Staff Bylaws. He/she shall act as a liaison between the Medical Staff, Administration, and the Governing Body in coordinating clinical activities and resources to enhance efficiency of the Hospital in delivering quality health service.

The Vice President of Medical Affairs shall be appointed by the Governing Body after consultation with the Medical Staff. He/she shall be a physician who is qualified for membership on the Medical Staff. The job description of the Vice President of Medical Affairs shall be developed and defined in writing by the Governing Body in consultation with the Medical Staff. The Vice President of Medical Affairs shall report to the Governing Body through the President of the Hospital or as determined by the Governing Body.

**A. DUTIES OF THE VICE PRESIDENT OF MEDICAL AFFAIRS**

The duties of the Vice President of Medical Affairs include, but are not limited to, those set forth below.

The Vice President of Medical Affairs shall:

1. Be responsible, in consultation with the Medical Staff, for developing and defining in writing the organization and conduct of the Medical, Dental, Podiatric and Allied Health Professional Staff.
2. Develop and implement, in cooperation with Department Chairs, and the Credentials Committee, methods for credentials review and for delineation of clinical privileges.
3. Work in conjunction with the Department Chairs with respect to monitoring and improving physician clinical performance.
4. Be responsible for the general supervision of the House Physician Staff.

5. Work in conjunction with the President of the Medical Staff and the Department Chairs, in developing and implementing continuing education programs and Performance Improvement activities.
6. Be responsible, as Site Director of Graduate Medical Education, for coordinating these programs with the Director of the Residency Program.
7. Be accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and professional performance within the Hospital.
8. Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations.
9. Initiate through the clinical Department Chairs, whenever possible, any formal investigation of the clinical performance or personal conduct of a Medical Staff member within that Department.
10. Be responsible for implementation of sanctions, where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
11. Act, in all Medical-Administrative matters, in cooperation with the President of the Hospital and with the Governing Body.
12. In the event of a disaster(s), when the Emergency Management Plan has been activated, be responsible, along with the President of the Hospital and/or the President of the Medical Staff, for assignment of personnel, movement of patients and granting of emergency privileges, in accordance with the duties outlined in the Hospital's Emergency Management Plan.
13. Serve as member of the Medical Executive Committee as outlined further in these Medical Staff Bylaws and shall have the right to attend all appropriate Medical Staff and Departmental meetings.
14. Not be eligible to hold an elective Medical Staff office.
15. Serve as a participant at meetings of the Governing Body.

**B. TERMS OF APPOINTMENT, REMOVAL AND VACANCY**

The Vice President of Medical Affairs shall serve at the pleasure of the Governing Body. Removal of the Vice President of Medical Affairs may be initiated by the Governing Body upon its own recommendation or upon the recommendation of the Medical

Executive Committee. Interim appointment in the event of vacancy will be made by the Governing Body as outlined above.

## **Section II: Elected Officers**

### **A. THE OFFICERS OF THE MEDICAL STAFF SHALL BE:**

1. President of the Medical Staff
2. President-Elect
3. Secretary-Treasurer
4. Delegate to the Medical Executive Committee

### **B. QUALIFICATIONS OF OFFICERS OF THE MEDICAL STAFF**

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such Medical Staff status shall immediately create a vacancy in the office involved. Officers should be nominated from among practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience and ability to direct the Medico-Administrative aspects of Hospital and Medical Staff activities.

### **C. ELECTION OF OFFICERS OF THE MEDICAL STAFF**

1. Officers shall be elected at the annual meeting of the Medical Staff.
2. Only Active Medical Staff members accorded the prerogative to vote for officers, as set forth in these Medical Staff Bylaws, shall be eligible to vote.
3. Nomination of Officers
  - a. The Nominating Committee, as set forth in these Medical Staff Bylaws, shall convene not less than thirty (30) days prior to the annual meeting of the Medical Staff when elections are held and shall submit to the Medical Staff one (1) or more qualified candidates for each office to be filled at said election.
  - b. Nominations may also be made, not less than forty-five (45) days prior to election:
    - i. By submission in writing from any member of the Active Medical Staff eligible to vote and/or
    - ii. From the floor at any general meeting prior to the election.
  - c. Nominations shall be closed no less than thirty (30) days prior to the election.

- d. On receipt from the Nominating Committee and the other methodologies, the nominating slate shall be posted and mailed to each member of the Active Medical Staff eligible to vote in the election, not less than fifteen (15) days prior to the date of election.
4. Voting for Officers
    - a. Voting shall be by secret written ballot. Absentee ballot may be requested and must be returned to the Medical Staff Office prior to the meeting
    - b. Ballots shall be distributed at the election.
    - c. The Chair of the Nominating Committee or his/her designee shall preside over the election.
    - d. Candidates are elected by a plurality of votes of the Active Medical Staff members present or voting by absentee ballot.

D. TERM OF OFFICE

1. All officers shall serve a two (2) year term commencing on the first day of the Medical Staff year following the election. Each officer shall serve until the end of the term, unless such officer resigns, is removed from office or is unable to continue to serve. All officers will subsequently serve as Secretary/Treasurer, Vice President and President. Should an upper level officer be unable to complete the progression, lower officers will move up and a new election will be held. Rev. 2/18/09
2. Where the office of President-Elect of the Medical Staff exists, upon completion of the term of office, he/she immediately succeeds to the office of President of the Medical Staff and then to the office of Immediate Past-President of the Medical Staff.

E. VACANCIES IN ELECTED OFFICE

Vacancies in office during the Medical Staff year except for the Presidency, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President of the Medical Staff, the President-Elect shall serve out the remaining term.

F. REMOVAL OF ELECTED OFFICERS OF THE MEDICAL STAFF

Removal of an elected officer of the Medical Staff may be initiated by petition signed by at least fifteen (15) members of the Active Medical Staff. Removal may be accomplished by a vote of no less than 2/3 of the members of the Medical Staff eligible to vote and present at a special meeting of the Medical Staff to consider the removal of said officer. An individual who is under disciplinary action such as suspension from the Medical Staff as a result of allegations of quality or ethical infractions, shall not be eligible to hold office and will be automatically removed if such disciplinary action occurs during term of office.

### **Section III: Duties of Elected Officers**

#### **A. PRESIDENT OF THE MEDICAL STAFF**

The President of the Medical Staff shall serve as the principal elected official of the Medical Staff and shall coordinate the activities of the other Medical Staff officers. The President of the Medical Staff shall:

1. Aid in coordinating the activities and concerns of the President of the Medical Staff and the Vice President of Medical Affairs in all matters of mutual concern within the Hospital.
2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
3. Be the Chair or designate the Chair of the Medical Executive Committee.
4. Be an ex-officio member of all Medical Staff committees unless membership in a particular committee is required by these Medical Staff Bylaws.
5. Appoint, with Medical Executive Committee's approval, committee Chairs to all standing and special Medical Staff committees except where otherwise provided by these Medical Staff Bylaws.
6. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Governing Body, the President of the Hospital, the Vice President of Medical Affairs and other officers of the Medical Staff.
7. Receive, present and interpret the policies of the Governing Body to the Medical Staff.
8. In conjunction with the Vice President of Medical Affairs and Department Chairs, enforce the Medical Staff Bylaws, Rules and Regulations, implement sanctions where indicated, and ensure the Medical Staff's compliance with procedural safeguards in all instances where action to correct or discipline a practitioner has been recommended.
9. Serve as an ex-officio member of the Governing Body.
10. Assist the Vice President of Medical Affairs and the Department Chairs in developing and implementing continuing education programs and Performance Improvement activities.
11. Be the spokesman for the Medical Staff in its external professional and public relations.



**B. PRESIDENT-ELECT OF THE MEDICAL STAFF**

In the absence of the President of the Medical Staff, the President-Elect shall assume all the duties and have the authority of the President of the Medical Staff. The President-Elect shall be a member of the Medical Executive Committee of the Medical Staff. He/she shall automatically succeed the President of the Medical Staff when the latter fails to serve for any reason. The President-Elect shall perform such additional duties as may be assigned to the President-Elect by the President of the Medical Staff, the Medical Executive Committee of the Medical Staff and the Governing Body.

**C. IMMEDIATE PAST-PRESIDENT OF THE MEDICAL STAFF**

The immediate Past-President shall be a member of the Medical Executive Committee and shall perform such other advisory duties as are assigned by the President of the Medical Staff, the Medical Executive Committee and the Governing Body.

**D. SECRETARY-TREASURER**

The Secretary-Treasurer shall be a member of the Medical Executive Committee and shall serve on other committees as set forth in these Medical Staff Bylaws. The duties of the Secretary-Treasurer shall be to:

1. Give proper notice of all general Medical Staff and Medical Executive Committee meetings on order of the appropriate authority.
2. Attend to all correspondence and perform such duties as ordinarily pertain to the office.
3. Provide an accurate roster of Medical Staff members attending all Medical Staff meetings.
4. Prepare accurate and complete minutes for general Medical Staff and Medical Executive Committee meetings.
5. Be accountable for the collection and accounting for any funds that may be collected in the form of Medical Staff dues or assessments and pay all bills as authorized by the Medical Staff.
6. Provide for the Medical Executive Committee and Medical Staff meetings, a detailed record of income and disbursements.

**E. DELEGATE TO THE MEDICAL EXECUTIVE COMMITTEE**

The Delegate to the Medical Executive Committee shall serve as the representative of the Medical Staff to the Medical Executive Committee in all matters of interest or concern to the Medical Staff and shall serve on committees as set forth in these Medical Staff Bylaws.

# **ARTICLE TEN: CLINICAL DEPARTMENTS AND SERVICES**

## **Section I:            Organization of Clinical Departments and Divisions**

Each Department shall be organized as a separate, but integral, part of the Medical Staff and shall have a Chair who shall be responsible for the overall supervision of his/her Department, who is selected in accordance with and has the authority, duties, and responsibilities as specified in these Medical Staff Bylaws. Each Division, if any, of a Department shall be organized as a specialty subdivision within that Department, shall be directly responsible to the Department within which it functions, and shall have a Division Chief who is selected in accordance with and has the authority, duties, and responsibilities specified in these Medical Staff Bylaws.

### **A.    DESIGNATION OF DEPARTMENTS**

The Departments of the Medical Staff shall be:

- Anesthesiology
- Emergency Medicine
- Family Practice
- Medicine
- Obstetrics and Gynecology
- Pathology and Clinical Laboratories
- Radiology
- Surgery

### **B.    DESIGNATION OF DIVISIONS**

1. The following Divisions shall be under the Department of Medicine:

- Cardiology
- Endoscopy Services

2. The following Divisions shall be under the Department of Surgery:

- Dentistry
- Ears, Nose and Throat Surgery
- Neurosurgery
- Ophthalmology
- Orthopedics
- Plastic Surgery
- Podiatry
- Urology

### C. RECONFIGURATION OF DEPARTMENTS AND/OR DIVISIONS

For the purpose of delivering optimal care and facilitating the function and clinical review of departmental operations, the Chairs of the major clinical Departments, with the approval of the Medical Executive Committee, the Medical Staff and the Governing Body, may create, eliminate, subdivide, or combine Divisions and/or Departments.

## **Section II: Assignment to Departments and Divisions**

The Medical Executive Committee shall, after consideration of the recommendations of the Department, as received and approved or amended by the Credentials Committee, recommend initial and continuing departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges, subject to final approval of the Governing Body. Each practitioner shall be assigned membership in at least one (1) Department and Division, where appropriate, within such Department, but may be granted Medical Staff membership and/or clinical privileges in one (1) or more other Department(s) or Division(s). The exercise of clinical privileges or the performance of specified services within each Department and Division shall be subject to the rules and regulations of that Department and Division and the authority of the Department Chair and/or Division Chief.

## **Section III: Functions of Departments/Divisions**

### A. FUNCTIONS OF DEPARTMENTS

The primary responsibility of each Department is to improve the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Department shall:

1. Recommend, subject to approval of the Medical Executive Committee and Governing Body, objective criteria that reflect current knowledge and clinical experience to be used in the monitoring and evaluation of patient care.
2. Monitor and evaluate medical care provided by members of the Department on a retrospective, concurrent and prospective basis. This monitoring and evaluation, in accordance with such procedures as may be adopted by the Performance Improvement Committee, must at least include:
  - a. Retrospective review of completed records of discharged patients and other pertinent medical information relating to patient care for the purpose of selecting cases for presentation at the departmental meetings. Such review should at least include a consideration of selected deaths, unimproved patients, patients with nosocomial infections, complications and pertinent questions arising with respect to diagnosis and treatment.

- b. The number of such performance improvement reviews, in accordance with the determination of the Medical Executive Committee and no less than the number required by the Joint Commission.
  - c. Review, by each Department, of all clinical work performed under its jurisdiction, whether or not the specific practitioner, subject to such review, is a member of that Department.
  - d. Conducting a comprehensive review, if relevant to the specialties within the Department, to examine indications of procedure performed, whether tissue was removed or not, and to evaluate the acceptability of the procedure chosen, specifically considering the agreement or disagreement of the pre and post procedure (including pathological) diagnoses.
3. Establish guidelines for the granting of clinical privileges and the performance of specified services within the Department. Submit to the Credentials Committee, recommendations regarding the specific clinical privileges each Medical Staff member or Applicant may exercise and the specified services each Medical Staff member or Allied Health Professional may provide.
4. Conduct and/or participate in, and make recommendations to the members of its Department regarding the need for continuing medical education programs pertinent to changes in the state-of-the-art and to findings of review, evaluation and monitoring activities.
5. Monitor on a continuing and concurrent basis adherence to:
  - a. Medical Staff and Hospital policies and procedures,
  - b. Requirements for alternate coverage and for consultations,
  - c. Sound principles of clinical practice, and
  - d. Fire and other regulations designed to promote patient safety.
6. Coordinate the patient care provided by the Department's Medical Staff members with nursing and ancillary patient care services and with administrative support services.
7. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:
  - a. Findings of the Department's Performance Improvement review, evaluation and monitoring activities, actions taken thereon, and the results of such action;

- b. Recommendations for maintaining and improving the quality of care provided in the Department and in the Hospital; and
  - c. Such other matters as may be requested from time to time by the Medical Executive Committee.
8. Meet:
- a. As necessary for the purpose of reviewing patient care findings and the results of the Department's other review, evaluation, monitoring and educational activities. Maintain records of such meetings.
  - b. At least quarterly.
9. Establish such committees or other mechanisms as are necessary and desirable to properly perform its functions.

**B. FUNCTIONS OF DIVISIONS**

Each Division, upon approval of the Medical Executive Committee and the Governing Body, shall perform the functions assigned to it by the Department Chair. Such functions may include, but are not limited to, retrospective patient care findings, the continuous monitoring of patient care practices, credentials review and clinical privilege delineation, and continuing education programs. The Division shall transmit regular reports to the Department Chair on the conduct of its assigned functions. Unless otherwise directed by the Department Chair, each Division shall meet at least quarterly.

**Section IV: Qualifications, Selections and Tenure of Department Chairs**

The JC Standard regarding Department "Directors" requires that any Medical Staff Department Chair appointed or reappointed after January 1, 1992, be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

The appointment of Department Chairs will be made in accordance with JC Standards.

**A. QUALIFICATIONS**

The Chair of each Medical Staff Department shall be a member of or eligible for membership on the Active Medical Staff, is certified by an appropriate specialty board, if such board certification exists, or affirmatively establishes comparable competence through the credentialing process. He/she shall also be qualified by training, experience, interest and demonstrated current ability in his/her clinical area and be willing and able to discharge the administrative responsibilities of the office.

**B. SELECTION**

Medical Staff Department Chairs shall be appointed by the Governing Body at the recommendation of a Search Committee. The President of the Medical Staff shall appoint the Committee and he/she or his/her designee shall act as Chair. The Search Committee will be composed of the President of the Hospital, Vice President of Medical Affairs, President of the Medical Staff, the Chair of the Governing Body or his/her designee, two (2) elected Medical Staff Officers and a minimum of two (2) at-large members selected from the involved Department. Additional members may be appointed at the discretion of the Search Committee and President of the Medical Staff, with the approval of the Medical Executive Committee.

The Search Committee's recommendation must be presented to the Medical Executive Committee, after which, the recommendation must be presented to the Governing Body for approval.

#### C. TENURE

The Medical Staff Department Chair shall be appointed for a three (3) year term. On accepting the position, the Chair will be given a written outline of the duties and responsibilities of the position, based on current Medical Staff Bylaws, Rules and Regulations of the Department, Regulations of the Department of Health and the Standards of the JC. Each Chair shall be evaluated annually by the Vice President of Medical Affairs, with appropriate input from the Department's members, according to the duties and responsibilities as outlined.

#### D. REAPPOINTMENT

After each three (3) year term, the Medical Staff Department Chair's performance shall be re-evaluated by the Governing Body with recommendations from the President of the Medical Staff, Medical Executive Committee, and the Vice President of Medical Affairs. This re-evaluation shall include input from Department members. If his/her performance is deemed satisfactory, the Chair shall be appointed to an additional three (3) year term, after which a Search Committee shall be convened, according to the procedure outlined in these Medical Staff Bylaws.

If the Chair is not reappointed, selection of a new Departmental Chair shall take place by the method outlined in these Medical Staff Bylaws. Department Chairs who are relieved of their administrative duties for whatever reason will not lose Medical Staff membership or clinical privileges solely for that reason unless otherwise provided by contract.

#### E. REMOVAL

If questions are raised regarding the performance of a Medical Staff Department Chair by the President of the Medical Staff, the Vice President of Medical Affairs or by twenty-five percent (25%) of the members (Active Medical Staff status) of the subject Department, the matter will be reviewed by an Ad Hoc Committee, appointed by the President of the Medical Staff which will make a recommendation to the Medical Executive Committee. If removal for cause is recommended by the Ad Hoc Committee, a majority vote of the Medical Executive Committee is required. The Governing Body will receive the recommendation of the Medical Executive Committee and has the final

authority to remove the Department Chair. Owing to the serious nature of removal of a Chair, it is recommended that the Medical Executive Committee, upon receipt of an adverse recommendation from the Ad Hoc Committee, seek review from legal counsel to determine that sufficient “cause” can be demonstrated by credible evidence.

## **Section V: Authority, Duties and Responsibilities of Department Chairs**

Medical Staff Department Chairs shall be responsible for the organization and supervision of their respective Departments, in conformance with the Medical Staff Bylaws, Rules and Regulations.

- A. The Joint Commission’s requirements as set forth in the yearly updated JC Standards of Medical Staff Department Leadership shall be available, on file, in the Administrative and/or Medical Staff Offices of the Hospital and incorporated by reference, herein.
- B. In addition to the JC requirements, the Chair of the Department will have the following functions and responsibilities:
  - 1. Enforcement of the Hospital Bylaws, Medical Staff Bylaws, and Rules and Regulations within the Department.
  - 2. Interact with Vice President of Medical Affairs and Administration on an ongoing basis.
  - 3. Interact with Division Chief and subspecialty divisions on an ongoing basis and oversee documentation of Division Performance Improvement activities.
  - 4. Participate in every phase of administration of his/her Department through cooperation with Patient Care Services and Hospital Administration in matters affecting patient care including personnel, supplies, special regulations, standing orders and quality of care.
  - 5. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department, as may be required by the Medical Executive Committee, the President of the Hospital or the Governing Body.
  - 6. Insuring that all patients have Attending Physicians at all times. He/she will have responsibility and authority to intervene in patient care where need for immediate action is brought to his/her attention.

7. Assignment of members of the Department to duties of education, research and administration based on the needs of the Department.
8. Summary suspension as provided by these Medical Staff Bylaws.

**Section VI: Appointment, Authority, Duties and Responsibilities of Division Chief**

Chiefs of Divisions are appointed by the Medical Executive Committee at the recommendation of the Chair of the Department, serve at the discretion of the Chair and can be terminated by the Chair, with due cause. The qualifications of Division Chiefs are similar to that of Department Chairs, as set forth in these Medical Staff Bylaws. Their tenure shall coincide with that of the Medical Staff Department Chair. They shall be reviewed annually by the Chair of the Department. Their duties and responsibilities shall be set forth by the Chair.



# **ARTICLE ELEVEN: STANDING AND AD HOC COMMITTEES**

## **Section I: Medical Executive Committee**

The Medical Executive Committee is delegated the primary authority over activities related to self-governance of the Medical Staff and over activities related to the functions of performance improvement of professional services provided by individuals with clinical privileges. The Medical Executive Committee has the authority to represent and to act on behalf of the Medical Staff, in between its regular meetings, in all matters, without requirement of subsequent approval of the Medical Staff, subject only to any limitations imposed by these Medical Staff Bylaws. Defined in detail below are the Medical Executive Committee's structure, size and composition, method of selection, functions, activities and frequency of meetings. Minutes of the deliberations of the Medical Executive Committee must indicate that the Committee carries out its stated functions and must be available for review as authorized by authority of law.

### **A. COMPOSITION**

The Medical Executive Committee (MEC) shall be a standing committee of the Medical Staff and shall consist of the following members of the Active Medical Staff:

1. The President of the Medical Staff .
2. All other Medical Staff Officers as set forth in these Medical Staff Bylaws shall serve as members of the Medical Executive Committee.
3. The Chairs of each of the Medical Staff Departments shall be eligible to serve on the Medical Executive Committee. Each year, the Medical Executive Committee will determine which Chairs will serve during that year.
4. One (1) delegate elected at-large. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty.
5. The Vice President of Medical Affairs.
6. A majority of voting members of the Medical Executive Committee are fully licensed physician members of the Medical Staff in active practice.
7. The President of the Hospital or his/her designee attends each Medical Executive Committee meeting.

8. Other non-physician members of the Medical Executive Committee may include, but are not limited to, the Vice President for Patient Care Services or a member of the Governing Body. Voting status of Committee members who are not Medical Staff members shall be determined by the Medical Executive Committee.

#### B. DUTIES/RESPONSIBILITIES

The duties and responsibilities of the Medical Executive Committee shall be, at a minimum:

1. To fulfill the Medical Staff's accountability to the Governing Body for the overall quality and efficiency of medical care rendered to patients in the Hospital; to be responsible for organizing the Medical Staff's Performance Improvement activities; to establish a mechanism designed to conduct, evaluate, and revise such activities and to make recommendations directly to the Governing Body for its approval, regarding, but not limited to:
  - a. The structure of the Medical Staff;
  - b. The mechanism used to review credentials and to delineate individual clinical privileges;
  - c. The participation of the Medical Staff in the Performance Improvement activities of the Hospital;
  - d. The mechanism by which Medical Staff membership may be terminated;
  - e. The mechanism for fair hearing procedures.
2. To develop, coordinate and implement the professional, clinical and organizational activities and policies of the Medical Staff and to enforce Hospital and Medical Staff Bylaws, Rules and Regulations in the best interest of patient care;
3. To review the credentials of all Applicants for Medical Staff membership and to make recommendations to the Governing Body regarding Medical Staff appointments, assignments to departments and clinical privileges;
4. To review periodically, all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges and as a result of such reviews, to make recommendations for reappointment, renewal or changes in clinical privileges;
5. To take all reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of all Medical Staff members, including the initiation of, and/or participation in, Medical Staff corrective action when warranted, in accordance with these Medical Staff Bylaws;

6. To hear grievances and disputes between members of the staff, to mediate between the parties concerned and to make written recommendations to the Governing Body concerning such grievances and disputes;
7. To receive, review and act on reports and recommendations from Medical Staff committees, clinical departments/divisions, assigned activity groups, officers of the Medical Staff and the Vice President of Medical Affairs;
8. To receive, review and act upon reports and recommendations of the Catholic Health System's Bylaws Committee. To fulfill the legal and regulatory requirements which specify that organized Medical Staffs adopt and enforce Medical Staff Bylaws to carry out their responsibilities, the Medical Executive Committee has delegated to the Catholic Health System's Bylaws Committee certain duties and responsibilities for initial drafting of and initial recommendation for amendments to, the Medical Staff Bylaws of each of the constituent hospitals. The Medical Executive Committee of each hospital retains the ultimate responsibility with respect to adoption and/or amendment to the Medical Staff Bylaws and for reporting and recommending same to the Medical Staff and the Governing Body;
9. To receive, review and act on reports and recommendations from the Catholic Health System's Medical Staff Pharmacy and Therapeutics Committee, in furtherance of the Medical Staff's duty to monitor and evaluate the quality and appropriateness of patient services provided by the pharmaceutical services;
10. To provide liaison between the Medical Staff and the President of the Hospital and to recommend action to the President of the Hospital on matters of a Medical-Administrative nature;
11. To assist in obtaining and maintaining accreditation of the Hospital and to ensure that the standards of the Joint Commission and the requirements of the New York State Hospital Code are being met;
12. To represent and act on behalf of the Medical Staff, in between its regular meetings, in all matters, without requirement of subsequent approval by the Medical Staff, subject only to any limitations imposed by these Medical Staff Bylaws;
13. To report to the Medical Staff at each general Medical Staff meeting;
14. To appoint such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

15. To provide for the preparation of all meeting programs, directly or through delegation, to a program committee or other suitable agent and to assure the availability of continuing education activities/programs for the Medical Staff.

#### C. MEETINGS

The Medical Executive Committee shall meet no less than ten (10) times a year; however, it will meet more often, in special session if necessary to transact pending business. The Medical Executive Committee will maintain a permanent record of its proceedings and actions which will be reported, in summary, to the Governing Body and to the Medical Staff membership.

#### D. CHAIR

The Chair of the Medical Executive Committee shall be the President of the Medical Staff or his/her designee.

### **Section II: Credentials Committee**

#### A. COMPOSITION

The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of not less than seven (7) members of the Active Medical Staff, to include the President or Vice President of the Medical Staff and a minimum of five (5) members of the Active Medical Staff serving as Department Chairs. The Vice President of Medical Affairs and the President of the Hospital and/or a member of the Governing Body shall also serve on this Committee. The Credentials Committee Chair shall be appointed by the President of the Medical Staff. The Credentials Committee shall request consultation from appropriate Department/Division Chairs/Chiefs (who are not serving as members of the Credentials Committee) when reviewing specific credentials or evaluating specific performance. The committee may include a representative from the Allied Health Professional Staff.

#### B. DUTIES/RESPONSIBILITIES

The duties and responsibilities of the Credentials Committee shall be, at a minimum:

1. To review and evaluate the qualifications of each Applicant for Medical Staff membership for initial appointment, reappointment, or modification of appointment and to take into consideration the recommendations of the Department.
2. To make a report to the Medical Executive Committee on each Applicant, with respect to appointment, staff category, department and service affiliation, clinical privileges or specialized services, and special conditions attached thereto.
3. To, upon request of the Medical Executive Committee or the Chair of any Department, review, as questions arise, all information available regarding the clinical competence and/or aberrant behavior of persons currently appointed

to the Medical Staff and of those practicing as Allied Health Professionals and, as a result of such review, to make a report of its findings and to make recommendations for granting the extension or restriction of clinical privileges and reappointment to the Medical Executive Committee and the Chair of the Department.

4. To submit reports to the Medical Executive Committee on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

#### C. MEETINGS

The Credentials Committee shall meet no fewer than ten (10) times a year; however, it will meet more often, in special session, if necessary to accomplish its duties, shall maintain a written record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

#### D. CHAIR

The Chair of the Credentials Committee shall be appointed annually by the President of the Medical Staff.

### **Section III: Nominating Committee**

#### A. COMPOSITION

The Nominating Committee shall consist of three (3) elected Past-Presidents of the Medical Staff who are active members of the Medical Staff. All Past-Presidents of the Medical Staff who are members of the Active Medical Staff shall be eligible for election to the Nominating Committee. The Nominating Committee shall be elected yearly at the annual meeting of the Medical Staff, from a ballot provided by the sitting Nominating Committee. The three (3) Past-Presidents of the Medical Staff receiving the most votes shall become the Nominating Committee.

Term of membership on the Nominating Committee shall be for one (1) year, after which all Past-Presidents of the Medical Staff who remain Active Medical Staff members are eligible to be reelected.

#### B. DUTIES/RESPONSIBILITIES

The duties and responsibilities of the Nominating Committee shall be, at minimum:

1. To consult with members of the Medical Staff concerning the qualifications and acceptability of prospective nominees; and
2. To submit to the Medical Executive Committee at the appropriate times as provided in these Medical Staff Bylaws, one (1) or more nominations for:
  - a. Each elective office of the Medical Staff to be filled;
  - b. Each of the Delegate positions on the Medical Executive Committee;

- c. Such other elective positions as may be required by these Medical Staff Bylaws.
3. To present the ballot of candidates to the Medical Staff at its Annual Meeting;
4. To present the ballot of eligible Past-Presidents of the Medical Staff for election to the Nominating Committee at its Annual Meeting.

#### C. MEETINGS

The Nominating Committee shall meet as necessary to carry out its duties and responsibilities.

#### D. CHAIR

The Past-President of the Medical Staff standing for election to receive the highest number of votes will become the Chair of the Nominating Committee. In the event of a tie, the nominee who has most recently served as the President of the Medical Staff will become the Chair of the Nominating Committee.

### **Section IV: Medical Staff-Governing Body Review Committee**

With respect to Procedures for Appointment and Reappointment to the Medical Staff, if the Governing Body's proposed final action will be contrary to the Medical Executive Committee's recommendation, the Governing Body shall submit the matter to a Medical Staff-Governing Body Review Committee for review before making its final decision. This Committee shall consist of equal numbers of members of the Governing Body and the Medical Executive Committee appointed by the respective Chair of each committee.

**THE FOLLOWING COMMITTEES WILL BE COMMITTEES OF THE CATHOLIC HEALTH SYSTEM WITH REPRESENTATION FROM THE MEDICAL STAFFS OF EACH CONSTITUENT HOSPITAL, AS APPROPRIATE:**

### **Section V: Medical Staff Bylaws Committee**

The legal and regulatory requirements specify that hospitals have an organized Medical Staff that operates under Medical Staff Bylaws approved by the Governing Body and that the Medical Staff shall adopt and enforce Medical Staff Bylaws to carry out its responsibilities.

The self-governing, organized Medical Staff must initiate, develop and approve Medical Staff Bylaws, as well as approve or disapprove amendments to the Medical Staff Bylaws

which define its role within the context of a hospital setting and clearly delineate its responsibilities in the oversight of care, treatment, and services.

As long as the ultimate approval is retained by the Medical Staff and Governing Body of each of the constituent hospitals, the duties/responsibilities set forth below for a Catholic Health System Medical Staff Bylaws Committee of reviewing and recommending are not in conflict with the legal and regulatory requirements.

#### A. COMPOSITION

The Catholic Health System Bylaws Committee shall consist of the President of the Medical Staff or his/her designee, the Vice President of Medical Affairs and one (1) additional Medical Staff representative from each hospital, appointed by the President of the Medical Staff, of each constituent hospital and the Senior Vice President of Medical Affairs of the Catholic Health System.

#### B. DUTIES/RESPONSIBILITIES

As set forth in these Medical Staff Bylaws under Adoption and Amendment of Bylaws, the Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Governing Body, Medical Staff Bylaws and amendments thereto, which shall become effective upon approval by the Governing Body.

It shall be the duty of the Catholic Health System Bylaws Committee to:

1. Conduct an annual review of the Medical Staff Bylaws and be responsible for making recommendations for updating of the Medical Staff Bylaws.
2. Recommend amendments to the Medical Staff Bylaws regarding directives by government and regulatory agencies.
3. Recommend amendments to the Medical Staff Bylaws with respect to changes in medical practice.
4. Receive and consider all matters referred by the Governing Bodies, the Medical Executive Committees, Presidents of the Hospitals, Departments and committees of each constituent hospital.
5. Submit recommendations to the Medical Executive Committee of each constituent hospital.
6. The President of the Medical Staff or his/her designee of each constituent hospital shall submit recommendations as appropriate to the Governing Body following Medical Executive Committee action.

#### C. MEETINGS

The Catholic Health System Bylaws Committee shall meet as often as necessary at the call of its Chair, but at least annually and shall submit a report of its activities to the Medical Executive Committees of each of the constituent hospital.

D. CHAIR

The Chair of the Catholic Health System Medical Staff Bylaws Committee shall be the Senior Vice President of the Medical Affairs of the Catholic Health System or his/her designee.

**Section VI: Medical Staff Pharmacy and Therapeutics Committee**

Public Health Law requires that hospitals have Pharmaceutical Services and that the Director of Pharmaceutical Services, in conjunction with the Medical Staff, shall ensure the monitoring and evaluation of the quality and appropriateness of patient services provided by the Pharmaceutical Services. Additionally, it is required that the Director participate in those aspects of the Hospital's overall quality assurance program that relate to drug utilization and effectiveness.

As long as the ultimate approval is retained by the Pharmaceutical Services, Medical Staff and Governing Body of each of the constituent hospitals, the duties/responsibilities set forth below for a Catholic Health System Medical Staff Pharmacy and Therapeutics Committee of reviewing and recommending are not in conflict with the legal requirements.

A. COMPOSITION

The Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall consist of the Site Director of Pharmacy of each constituent hospital, the Senior Vice President of Medical Affairs of the Catholic Health System or his/her designee and a minimum of one (1) Vice President of Patient Care Services, representing Patient Care Services on behalf of the constituent hospitals. Additionally, a minimum of two (2) representatives of each Medical Staff shall be appointed by the President of the Medical Staff of each constituent hospital. It shall be the prerogative of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee to invite other members or associates of the Catholic Health System to attend meetings as consultants to the Committee, as appropriate. Rev. 2/18/09

B. DUTIES/RESPONSIBILITIES

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the constituent hospitals in order to assure optimal clinical results and minimal potential for hazard. The Performance Improvement functions of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee are to ensure appropriateness, timeliness and efficiency of drug usage.

The duties of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall be to:

1. Serve as an advisory group to the Medical Staffs and the Pharmaceutical Departments of each constituent hospital on matters pertaining to the choice of available drugs for patient care and diagnostic testing.



2. Assist in the formulation of broad professional policies regarding evaluation, selection, storage, distribution, use, safety procedures, administration, and all other matters relating to drugs and diagnostic testing materials in the constituent hospitals.
3. Develop, review periodically and revise as necessary, the formulary of accepted drugs for use in the constituent hospitals.
4. Evaluate clinical data concerning new drugs or preparations requested for use in the constituent hospitals and review non-formulary drugs ordered.
5. Prevent unnecessary duplication in stocking drugs and standardize, to the extent practicable, drugs and related supplies in the pharmacy.
6. Make recommendations concerning drugs to be stocked on the nursing unit floors of the constituent hospitals and by other services of the constituent hospitals.
7. Review the appropriateness, safety and effectiveness of the prophylactic, empiric, and therapeutic use of all types of drugs used in the constituent hospitals.
8. Make readily available to the staffs of the constituent hospitals, information regarding the compatibility of drugs.
9. Review all significant untoward drug reactions and make recommendations as needed.
10. Periodically evaluate medication errors considering their incidence and cause.
11. Consider policies and procedures relating to the labeling, distribution, administration by professional personnel and all other matters related to the use of hazardous drugs in the constituent hospitals.
12. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs. Evaluate and approve all protocols concerning the use of investigational or experimental drugs.
13. Maintain a permanent record of all activities relating to the pharmacy and therapeutics function.
14. The Committee shall submit regular reports to the Medical Executive Committee of each constituent hospital. This report will be presented by the Chair of the Committee or his/her designee.

C. MEETINGS

The Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall meet as often as necessary at the call of the Chair, but at least quarterly and shall submit a report of its activities to the Medical Executive Committees of each of the constituent hospital.

D. CHAIR

The Chair of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall be a physician selected by a majority vote of the Committee members. The selection shall occur yearly at the first regularly scheduled meeting of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee.

**Section VII: Health Information Management Committee**

Legal and regulatory requirements specify that all hospitals have a department that has administrative responsibility for Health Information, which ensures the integrity and confidentiality of all patient records and the appropriate release of medical information as permitted by Federal and State laws.

As long as the ultimate approval is retained by the Medical Staff and Governing Body of each of the constituent hospitals, the duties/responsibilities set forth below for a Catholic Health System Health Information Management Committee of reviewing and recommending actions related to Health Information are not in conflict with legal and regulatory requirements.

A. COMPOSITION

The Catholic Health System Health Information Management Committee shall consist of the Site Manager of Health Information Management Department for each constituent hospital, the Senior Vice President of Medical Affairs for CHS or his/her designee and a minimum of one (1) Vice President of Patient Care Services representing Patient Care Services on behalf of constituent hospitals. Additionally, a minimum of two (2) representatives of each Medical Staff shall be appointed by the President of the Medical Staff of each constituent hospital. It shall be the prerogative of the Catholic Health System Health Information Management Committee to invite other members or associates of the Catholic Health System to attend meetings as consultants to the Committee, as appropriate.

Rev. 2/18/09

B. DUTIES/RESPONSIBILITIES

This Committee shall be responsible for the quality, timeliness and security of the medical record in order to assure optimal clinical results and a safe patient care environment.

The duties of the Catholic Health System Health Information Management Committee shall be to:

1. Serve as an advisory group to the Medical Staffs and Health Information Departments of each constituent hospital on matters pertaining to Health Information.
2. Assist in the formulation of broad professional policies regarding Health Information for the constituent hospitals and Medical Staffs.
3. Review periodically and revise as necessary the Health Information policies of the constituent hospitals.
4. Recommend and review the appropriateness and format of Health Information forms used within the constituent hospitals and make recommendations for revisions, as necessary.
5. Make readily available to the Medical Staffs of the constituent hospitals current information regarding Health Information.
6. Establish standards concerning the use and completion of Health Information records for members of the Medical Staffs and other associates of the constituent hospitals.
7. Maintain a permanent record of all activities relating to the Health Information Committee.
8. Submit regular reports to the Medical Executive Committees of the constituent hospitals.

#### C. MEETINGS

The Catholic Health System Health Information Committee shall meet as often as necessary at the call of the Chair, at least quarterly, and shall submit a report of its activities to the Executive Committees of the Medical Staffs of each of the constituent hospitals.

#### D. CHAIR

The Chair of the Catholic Health System Health Information Committee shall be a physician selected by the majority vote of the Committee members. The selection shall occur yearly at the first regularly scheduled meeting of the Catholic Health System Health Information Committee.

# **ARTICLE TWELVE: GENERAL MEDICAL STAFF, COMMITTEE AND DEPARTMENT MEETINGS**

## **Section I: Meetings of the General Medical Staff**

### **A. REGULAR MEETINGS**

Regular meetings of the membership of the Medical Staff shall be held at least two (2) times per year. The Medical Executive Committee shall determine the date, place and time of these meetings.

#### **1. Order of Business**

The order of business at a regular Medical Staff meeting shall be determined by the President of the Medical Staff. The agenda shall include:

- a. Call to order.
- b. Opening prayer or reflection.
- c. Review and acceptance of the minutes of the last regular and of all special meetings of the Medical Staff held since the last regular Medical Staff meeting.
- d. Review and acceptance of summary of Medical Executive Committee meetings held since the last regular Medical Staff meeting.
- e. Administrative reports from the President of the Medical Staff, the Vice President of Medical Affairs, the President of the Hospital, and others as deemed appropriate by the President of the Medical Staff.
- f. The election of officers and of representatives to Medical Staff and Hospital committees when required under these Medical Staff Bylaws.
- g. Report of Secretary-Treasurer.
- h. Reports by responsible officers, committees and departments on quality assurance activities of the Medical Staff and on the fulfillment of the other required Medical Staff functions.
- i. Reports and recommendations regarding Medical Staff Bylaws proposals.
- j. Reports and recommendations regarding Medical Staff credentials.

- k. Old business.
  - l. New business.
  - m. Adjournment.
- 2. Quorum  
The members in attendance at any Medical Staff meeting shall constitute a quorum at said meeting.
  - 3. Manner of Action  
Except as otherwise specified, the action of a majority of the Medical Staff members present and voting at a Medical Staff meeting shall be the action of the group.
  - 4. Attendance Requirements (General Meetings)  
Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

#### B. ANNUAL MEETING

The annual meeting of the Medical Staff shall be the last meeting before the end of the fiscal year of the Medical Staff. At this Medical Staff meeting, the retiring officers and committees shall make such reports as shall be required and officers for the ensuing year shall be elected. The various Medical Staff committee appointments shall be made as soon as possible after the annual meeting.

#### C. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, the Medical Executive Committee, at the request of the Governing Body or the request of not less than twenty-five (25) members of the Active Medical Staff. The special Medical Staff meeting shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special Medical Staff meeting except that stated in the meeting notice.

Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each Medical Staff member eligible to attend, not less than five (5) calendar days before the date of such special Medical Staff meeting.

- 1. Agenda at Special Medical Staff Meetings:
  - a. Reading of notice calling the special Medical Staff meeting.
  - b. Transaction of the business for which the special Medical Staff meeting was called.
  - c. Adjournment.

2. All recommendations of the special Medical Staff meeting shall be referred in writing to the Medical Executive Committee.

#### D. MINUTES

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of attendance and the vote taken on each matter under consideration. Copies of such minutes shall be signed by the presiding officer and approved by attendees at the next regularly scheduled Medical Staff meeting. A permanent file of the minutes of each Medical Staff meeting shall be maintained and made available to Medical Staff members at their request.

## **Section II: Meetings of the Medical Staff Committees**

#### A. REGULAR MEETINGS

Committees of the Medical Staff meet at least two (2) times per year, or as otherwise provided, at the dates and times established at the first meeting of the committee following the annual meeting of the Medical Staff. Committees of the Medical Staff may, by resolution, provide the time for holding regular committee meetings without notice other than such resolution. Unless otherwise specifically provided, committees of the Medical Staff shall meet as often as necessary to discharge assigned duties in accordance with licensure regulations and accreditation standards.

1. Order of Business
  - a. Call to order.
  - b. Review and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting of said Medical Staff Committee.
  - c. Old business.
  - d. New business.
  - e. Adjournment.
2. Quorum

With respect to the Medical Executive, Credentials and Peer Review Committee meetings, a quorum is fifty percent (50%) of the voting members of the Committee. For all other Medical Staff committees, the members in attendance shall constitute a quorum at said meeting.
3. Manner of Action

Except as otherwise specified, the action of a majority of the Medical Staff members present and voting at a Medical Staff committee meeting shall be the action of the group.

4. Attendance Requirements  
Members of the Medical Executive, Credentials and Peer Review Committees are required to attend at least fifty percent (50%) of the meetings of those committees on which they serve. Members of all other Medical Staff committees are encouraged to attend meetings of the Medical Staff committees on which they serve.
5. Special Appearance  
A practitioner whose patient's clinical course or treatment is scheduled for discussion at a regular Medical Staff committee meeting may be requested to make a special appearance whenever there is an apparent or suspected deviation from standard clinical practice. The Chair of that Medical Staff Committee shall give the practitioner at least twenty-one (21) days advance written notice of the time and place of the meeting. Failure of a practitioner to appear at any Medical Staff committee meeting with respect to which he/she was given such special notice may, unless excused upon a showing of good cause, be referred to the Medical Executive Committee for possible corrective action as defined by these Medical Staff Bylaws.

#### B. SPECIAL MEETINGS

A special meeting of any Medical Staff Committee may be called by or at the request of the Chair thereof, the President of the Medical Staff, or by one-third (1/3) of the group's current Medical Staff members. No business shall be transacted at any special Medical Staff committee meeting except for that stated in the meeting notice.

1. Agenda at Special Medical Staff Committee Meetings:
  - a. Reading of notice calling the meeting.
  - b. Transaction of the business for which the special meeting was called.
  - c. Adjournment.
2. All recommendations of the special Medical Staff Committee meeting shall be referred in writing to the Medical Executive Committee.

#### C. MINUTES

Minutes of each regular and special meeting of each Medical Staff Committee shall be prepared and shall include a record of attendance and the vote taken on each matter under consideration. Copies of such minutes shall be signed by the presiding officer and approved by attendees at the next regularly scheduled meeting of each Medical Staff Committee. A permanent file of the minutes of each Medical Staff committee meeting shall be maintained and made available to Medical Staff members at their request.

#### D. ACTION TAKEN WITHOUT A MEETING

Action may be taken without a meeting by a Medical Staff committee if there is unanimous consent in writing setting forth the action so taken and signed by each member of the Medical Staff committee entitled to vote thereat.

E. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Medical Staff Bylaws as ex-officio members of a Medical Staff committee shall have all rights of regular members of the committee except they shall not be counted in determining the existence of a quorum and shall not have voting privileges.

**Section III: Meetings of Medical Staff Departments**

A. REGULAR MEETINGS

Medical Staff Departments shall meet at least two (2) times per year, or as otherwise provided, at the dates and times established at the first meeting of the Medical Staff Department following the annual meeting of the Medical Staff. Medical Staff Departments may, by resolution, provide the time for holding regular departmental meetings without notice other than such resolution. Unless otherwise specifically provided, Medical Staff Departments shall meet as often as necessary to discharge assigned duties in accordance with licensure regulations and accreditation standards and to review and evaluate the clinical work of members of said Medical Staff Department.

1. Order of Business
  - a. Call to order.
  - b. Review and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting of said Medical Staff Department.
  - c. Old business.
  - d. New business.
  - e. Adjournment.
2. Quorum  
The members in attendance at the Medical Staff Department meeting shall constitute a quorum at said meeting.
3. Manner of Action  
Except as otherwise specified, the action of a majority of the Medical Staff members present and voting at a Medical Staff Department meeting shall be the action of the group.
4. Attendance Requirements  
Members of Medical Staff Departments are encouraged to attend departmental meetings.



5. Special Appearance

A practitioner whose patient's clinical course or treatment is scheduled for discussion at a regular Medical Staff Department meeting may be requested to make a special appearance whenever there is an apparent or suspected deviation from standard clinical practice. The Chair of that Medical Staff Department shall give the practitioner at least twenty-one (21) days advance written notice of the time and place of the meeting. Failure of a practitioner to appear at any Medical Staff Department meeting with respect to which he/she was given such special notice may, unless excused upon a showing of good cause, be referred to the Medical Executive Committee for possible corrective action as defined in these Medical Staff Bylaws.

B. SPECIAL MEETINGS

A special meeting of any Medical Staff Department may be called by or at the request of the Chair thereof, the President of the Medical Staff, or by one-third (1/3) of the group's current Medical Staff members. No business shall be transacted at any special Medical Staff Department meeting except for that stated in the meeting notice.

1. Agenda at Special Medical Staff Department Meetings:

- a. Reading of notice calling the meeting.
- b. Transaction of the business for which the special meeting was called.
- c. Adjournment.

2. All recommendations of the special Medical Staff Department meeting shall be referred in writing to the Medical Executive Committee.

C. MINUTES

Minutes of each regular and special meeting of each Medical Staff Department shall be prepared and shall include a record of attendance and the vote taken on each matter under consideration. Copies of such minutes shall be signed by the presiding officer and approved by attendees at the next regularly scheduled meeting of each Medical Staff Department. A permanent file of the minutes of each Medical Staff Department meeting shall be maintained and made available to Medical Staff members at their request.

D. ACTION TAKEN WITHOUT A MEETING

Action may be taken without a meeting by a Medical Staff Department if there is unanimous consent in writing setting forth the action so taken and signed by each member of the Medical Staff Department entitled to vote thereat.

# **ARTICLE THIRTEEN: CONFIDENTIALITY AND IMMUNITY**

## **Section I: Authorizations and Conditions**

By submitting an Application for Appointment or Reappointment to the Medical Staff, exercising clinical privileges or providing specified patient care services within this Hospital, a practitioner:

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on such practitioner's professional ability, qualifications and current clinical competence.
- B. Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such practitioner to the Hospital and its Medical Staff.
- C. Agrees to be bound by the provisions of these Medical Staff Bylaws and waives any confidentiality provision concerning the information to be provided to hospitals and other medical facilities pursuant to required legislation.
- D. Agrees to waive all legal claims against any representative or third party who acts in accordance with the provisions of these Medical Staff Bylaws so long as such actions have been made in good faith and without malice or breach of confidentiality.
- E. Acknowledges that the provisions of these Medical Staff Bylaws are express conditions to the practitioner's Application for Medical Staff membership, the acceptance and/or the continuation of such Medical Staff membership and/or the practitioner's exercise of clinical privileges at this Hospital.

## **Section II: Confidentiality of Information**

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 healthcare facility or organization, for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching and/or clinical research and determining that healthcare services are indicated and performed in compliance with applicable standards of care shall, to the fullest extent permitted by law, be privileged and confidential and shall not be used in any way except as provided herein or except as otherwise provided by law. Such confidentiality shall also extend to information which may be provided to third parties. This information shall become a part of the Medical

Staff files and shall not become part of any particular patient's file or of the general Hospital records.

Such privilege shall extend to members of the Hospital's Medical Staff and to its Governing Body, its other practitioners, its President and his/her representatives and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "Third Parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

The filing of reports under the Health Care Quality Improvement Act of 1986 (National Practitioner Data Bank) shall not be deemed a breach of confidentiality.

### **Section III: Breach of Confidentiality**

Effective Peer Review and consideration of the qualifications of Medical Staff members and Applicants to perform specific procedures must be based on unconstrained discussions. Breach of confidentiality of these discussions and/or deliberations of Medical Staff Departments, Divisions or Committees, would have a chilling effect on the free and open discourse required to appropriately carry out these statutory obligations. Any such breach of confidentiality will be deemed disruptive to the operations of the Hospital and should it be determined that a breach has occurred, the Medical Executive Committee may undertake such corrective action it deems necessary.

The Hospital has a statutory and ethical obligation to other hospitals and healthcare institutions to respond candidly to requests for references and evaluations of practitioners and of other healthcare personnel practicing, employed or trained at the institution, as well as a statutory imperative to respond to inquiries from licensing authorities, professional societies and to file certain reports. Confidentiality of such communication is essential and any breach of confidentiality will be handled as set forth in these Medical Staff Bylaws.

### **Section IV: Immunity of Liability**

#### **A. IMMUNITY OF LIABILITY FROM ACTION TAKEN**

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged. Each member of the Medical Staff, Allied Health Professional and each Applicant for any such position, agrees that no representative of the Hospital or Medical Staff shall be liable for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after reasonable effort under the

circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

**B. IMMUNITY FROM LIABILITY FOR PROVIDING INFORMATION**

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged. Each member of the Medical Staff, Allied Health Professional and each Applicant for any such position, agrees that no representative of the Hospital or Medical Staff and no third party shall be liable for damages or other relief by reason of providing information, including otherwise privileged or confidential information to a representative of this Hospital or Medical Staff or any other hospital, organization of healthcare professionals, or other health related organization concerning a practitioner or affiliate who is or has been an Applicant to or member of the Medical Staff or who did or does exercise clinical privileges or provide specified services at this Hospital, provided that such representative or third party acts in good faith and without malice.

**C. EFFECT OF IMMUNITY**

In the event a civil suit were to be brought against any representative of the Hospital or Medical Staff, the Hospital agrees to indemnify and hold such representative harmless from any and all claims, actions, suits, proceedings, liability, and damages (including injury of any kind whatsoever to all persons), costs, expenses, (including attorneys' fees) and other costs of litigation arising out of, or connected with the action taken or decision made, so long as such has been made in good faith, without malice or breach of confidentiality, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action statement or recommendation is warranted by such facts.

**Section V: Activities and Information Covered**

A. The confidentiality and immunity provided by these Medical Staff Bylaws applies to all acts, communications, information, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other healthcare facility's or organizations' activities concerning but not limited to:

1. Applications for Appointment, clinical privileges or specified services;
2. Periodic reappraisals for Reappointment, clinical privileges or specified services;
3. Corrective or disciplinary action including summary suspension;
4. Hearing and Appellate Reviews;
5. Quality Assurance/Performance Improvement program activities;

6. Utilization and claims review;
7. Profiles and profile analysis;
8. Medical care evaluations;
9. Malpractice loss prevention;
10. Other Hospital and Medical Staff activities related to monitoring and maintaining quality of patient care and appropriate professional conduct.

B. The acts, communications, information, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures referred to in these Medical Staff Bylaws may relate to a practitioner's qualifications, clinical competence, character, mental or emotional stability, physical conditions, ethics or any other matter that might directly or indirectly have an effect on patient care.

#### **Section VI: Execution of Written Releases**

Each practitioner shall, upon request of the Hospital, execute general and specific releases, releasing from any liability all representatives of the Hospital, and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the practitioner and his/her credentials and qualifications, and releasing from any liability, any and all individuals and organizations who provide information, including otherwise privileged or confidential information, to the Hospital in good faith and without malice, and with the exercise of reasonable effort to ascertain truthfulness, concerning the practitioner's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment, reappointment and/or delineation of clinical privileges.

#### **Section VII: Cumulative Effect**

Provisions in these Medical Staff Bylaws and in Applications for Appointment and Reappointment to the Medical Staff relating to authorization, confidentiality of information and immunities from liability shall be in addition to other protections and/or limitations provided by law.

# **ARTICLE FOURTEEN: MEDICAL STAFF RESPONSIBILITIES WITH RESPECT TO CORPORATE COMPLIANCE PROGRAM**

## **Section I: Commitment to Corporate Compliance**

Formal standards have been established by numerous federal and state statutes necessitating that the Hospital address compliance issues in a coordinated manner. To that end, the Hospital has adopted and implemented a formal Compliance Plan which is designed to prevent, detect and correct any instances of non-compliance with applicable federal and state law and the program requirements of federal, state and private health plans. It is the expectation of the Hospital that all individuals and entities employed by and/or associated with the Hospital will be informed of and adhere to the Standards of Conduct set forth in the Compliance Plan.

## **Section II: Conformance with Corporate Compliance Program**

- A. As further set forth in these Medical Staff Bylaws, each member of the Medical Staff, regardless of assigned category, has certain responsibilities, which include:
1. A responsibility to abide by the Medical Staff Bylaws and all other adopted standards, rules and regulations and other lawful policies and procedures of the Hospital and Medical Staff, and more specifically,
  2. A responsibility to abide by the Hospital's Corporate Compliance Program.
- B. It is expected that each member of the Medical Staff, regardless of assigned staff category, will:
1. Read all materials outlining the Hospital's Compliance Program which are distributed to him/her and act in conformance with the Program's requirements.
  2. Agree to participate in Hospital Compliance training, if and when requested by Hospital.
  3. Sign a Certification stating that the practitioner has read, fully understands the scope and requirements of the Hospital's Compliance Program and agrees to comply with such requirements.

C. As further set forth in these Medical Staff Bylaws, each member of the Medical Staff, regardless of assigned staff category, must adhere to the following Compliance specific reporting requirements, where applicable:

1. Notify the President of the Hospital and Corporate Compliance Officer immediately if any of the following events occur: (a) he/she is notified that he/she may be, will be or is listed as excluded, suspended or otherwise ineligible for participation in any federal or state health care program; (b) or if he/she is a member of a group which is notified that they may be, will be or is listed as excluded, suspended or otherwise ineligible for participation in any federal or state health care program.
  
2. Notify the President of the Hospital and Corporate Compliance Officer immediately if any of the following events occur: (a) he/she is the subject of or is a member of a group which is the subject of an investigation commenced by any governmental agency or other entity; (b) he/she is the subject of or is a member of a group which is subject to an enforcement action taken by any governmental agency or other entity; (c) he/she becomes aware of an investigation commenced by any governmental agency or other entity against an individual, group or other entity affiliated or doing business with the Hospital; (d) he/she becomes aware of an enforcement action taken by any governmental agency or other entity against an individual, group or other entity affiliated or doing business with the Hospital.

# **ARTICLE FIFTEEN: ALLIED HEALTH PROFESSIONALS**

The Joint Commission requires that the organized Medical Staff must credential and privilege all licensed independent practitioners (LIP's) through the Medical Staff process. Physician's Assistants (PA's) and advanced practice registered nurses (APRN's) who are not LIP's may be privileged through the Medical Staff process or a process that has been developed and approved by the Hospital that is equivalent to the process and criteria as set forth in the JC credentialing and clinical privileging standards. When Medical Staff processes are not used, there are mechanisms to assure communication with and input from the Medical Executive Committee regarding those clinical privileges. The Joint Commission does not determine if a practitioner is a licensed independent practitioner. State law and Hospital policy determine whether a practitioner can practice independently.

## **Section I: Definition**

The term Allied Health Professional (AHP) shall mean an individual licensed by the State of New York, other than a physician (except for Residents) dentist or podiatrist who exercises independent judgment within the areas of his/her professional competence and who is qualified to render direct or indirect medical, dental or surgical care under the supervision of or in collaboration with an appropriate member of the Medical Staff.

- A. EXAMPLES OF ALLIED HEALTH PROFESSIONALS ARE AS FOLLOWS:
1. Licensed Registered Nurses:
    - a. Nurse Anesthetists
    - b. Nurse Practitioners
    - c. Nurse Specialists
    - d. Nurse Midwives
    - e. Nurse Clinicians
    - f. Other Licensed Registered Nurses
  2. Specialist Assistant
  3. Resident Physicians
  4. Speech Consultants



5. Physician Assistants
6. Licensed Psychologists
7. Radiation Physicists

This list is not meant to be all inclusive as the needs of the individual hospitals will change from time to time, as will medical practice patterns.

## **Section II: Application for Appointment and Reappointment**

A. Each individual in this category may apply for Appointment or Reappointment as an AHP by presenting his/her qualifications via the procedure for processing Applications for Allied Health Professional Staff Membership. The Application for Appointment or Reappointment for Allied Health Professional Medical Staff Membership is revised and updated periodically and shall be available, on file, in the Administrative and/or Medical Staff Offices of the Hospital. Upon acceptance by the Governing Body, the AHP shall be appointed for at least one (1) year on a provisional basis to that department of the Medical Staff under which his/her practice falls. The Governing Body may grant such individuals clinical privileges as restricted below:

1. They must be duly qualified and registered in their specialty with the New York State Departments of Health or Education.
2. Protocol for AHP's:
  - a. Each department in which the Allied Health Professional works shall develop a protocol defining duties and responsibilities.
  - b. When a physician or physician's group hires and utilizes the services of an AHP, the physician or the physician's group shall furnish, as part of the Application process, a proposed job description for the AHP and submit same to the Department.
3. Supervision by a physician or in collaboration with a physician:

All AHP's shall practice under a supervising physician or in collaboration with a physician who is a Medical Staff member, in that specific department, responsible for their supervision and direction as appropriate.
4. Credentials:

A copy of the AHP's credentials and his/her written protocol shall be on file in the Medical Staff office.

B. The Chair of each Department shall review each AHP biennially, and recommend reappointment with increase, decrease or the same clinical privileges within the AHP's scope of practice or recommend against reappointment.

### **Section III: Membership on the Medical Staff**

A. Limited clinical privileges may be granted by the Governing Body, at the recommendation of the Medical Staff, to AHP's who have had special training in their fields. AHP's may be appointed as members of the Medical Staff, without voting rights. AHP's will not be allowed to hold office and are subject to the Medical Staff Bylaws, Rules and Regulations.

B. All AHP's appointed to membership on the Medical Staff are required to adhere strictly to the statutory limitations of their professional scope of practice, ethical standards of their respective professions, to work cooperatively within the Hospital setting, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

C. Corrective action with regard to AHP's, including termination or suspension of services authorized, shall be accomplished in accordance with usual hospital personnel practices, an affiliates employment agreement, if any, or in accordance with the Medical Staff Bylaws. Reporting to the NYSDOH and the NYSDOE may be required in accordance with regulatory agency policies in the event of denial, suspension, restriction, termination or curtailment of employment, association or professional clinical privileges of AHP's.

D. The Medical Staff is responsible for identifying and managing matters of individual physical and emotional health for AHP's with a process which is separate from actions taken for disciplinary purposes.

E. Proof of continuous professional liability insurance coverage is produced for all AHP's, in the amounts required by the New York State Department of Health or the New York State Education Department for each specific profession and as deemed acceptable by the Medical Executive Committee and approved by the Governing Body. This requirement is applicable regardless of whether the insurance is obtained by the individual or by his/her employer, including the Hospital.

F. All AHP's and other practitioners privileged through the Medical Staff process shall participate in continuing education appropriate to their specific area of practice. Continuing education requirements shall be defined in the Rules and Regulations of the Department wherein the AHP has clinical privileges. The Chair of said Department shall be responsible for monitoring same.

### **Section IV: Prerogatives**

A. AHP's may write orders or admit patients to the extent established for such AHP by the Department to which he/she is assigned, provided that to do so is within the scope of such professionals' license, certificate, or other legal credential.

- B. AHP's may serve on staff, department and hospital committees.
- C. AHP's may attend meetings of the Medical Staff and Department to which they are assigned.
- D. AHP's may attend Hospital educational programs.
- E. AHP's may exercise such other prerogatives as may, by resolution or written policy, be accorded to AHP's as a group or to any specific category of AHP's.

### **Section V: Responsibilities**

- A. AHP's must retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient for whom the AHP is providing services.
- B. AHP's must notify the Chair of the Department within which the AHP practices in the event that the supervising or collaborating practitioner's approval to supervise or collaborate with the AHP has been revoked, limited or otherwise restricted by any action of a licensing agency.
- C. AHP's must notify the Chair of the Department within which the AHP practices if there is any change in the employment status of the AHP.
- D. AHP's shall discharge such other staff functions as may from time to time be requested or required of the AHP, provided that to do so is within the scope of such professional's license, certificate, or other legal credential.

### **Section VI: Participation in Quality Assurance**

Allied Health Professionals are required to participate, as appropriate, in Quality and Patient Safety activities required of the Medical Staff.

# **ARTICLE SIXTEEN: ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS**

## **Section I: Medical Staff Responsibility**

The Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Governing Body, Medical Staff Bylaws and amendments thereto, which shall become effective upon approval by the Governing Body. The responsibility of the Medical Staff shall be exercised in good faith and in a reasonable, responsible and timely manner. The Medical Staff is also responsible for the review, adoption and amendment of the related rules, regulations, policies, procedures and protocols developed to implement various sections of these Medical Staff Bylaws.

## **Section II: Methodology**

All proposed amendments, whether originated by the Medical Executive Committee, the Bylaws Committee, other standing committee or by a member(s) of the Active Medical Staff, must be reviewed and discussed by the Medical Executive Committee prior to their voting on acceptance of said amendment.

1. Amendments may be recommended for approval by the Medical Executive Committee after a majority vote, provided the proposed amendment(s) was first distributed to the members of the Medical Executive Committee at least thirty (30) days prior to a vote.
2. The Medical Executive Committee or the Vice President of Medical Affairs will then schedule and hold a general Medical Staff meeting at which the proposed amendment(s) and associated Medical Executive Committee recommendations will be presented, discussed and acted upon. The proposed amendment(s) will be recommended to the Governing Body if there is an affirmative vote of the majority of those Active Medical Staff members voting in person or by absentee ballot.
3. The Medical Executive Committee shall have the authority to adopt such amendments to these Medical Staff Bylaws as are, in their judgment, technical or legal modifications or clarifications; or are reorganization, renumbering, corrections of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective when approved by the Governing Body.

4. In the event that any portion(s) of these Medical Staff Bylaws is interpreted to be or becomes inconsistent with federal or state statutory or regulatory requirements, said portion(s) shall be deemed to be amended as required.

### **Section III: Approval by the Governing Body**

The Medical Staff Bylaws shall be effective when approved by affirmative vote of a majority of the Governing Body. In the event that the Medical Staff fails to exercise its responsibility and authority as set forth in these Medical Staff Bylaws and after notice from the Governing Body to such effect including a reasonable period of time for response, the Governing Body may, on its own initiative, formulate or amend Medical Staff Bylaws. In such event, Medical Staff recommendations, if received in a timely manner, will be considered by the Governing Body in its deliberations.

# **ARTICLE SEVENTEEN: GENERAL PROVISIONS**

## **Section I: Professional Liability Insurance**

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts required under New York State law. Failure to maintain professional liability insurance shall result in suspension of Medical Staff membership and clinical privileges, as set forth in these Medical Staff Bylaws.

## **Section II: Compliance with Federal and State Laws and Hospital and Medical Staff Bylaws**

Every Medical Staff member and each Allied Health Professional granted clinical privileges at the Hospital is required to comply with all applicable federal and state laws, rules and regulations and with the Hospital's and the Medical Staff's Bylaws, Rules and Regulations.

## **Section III: Interpretation**

Whenever possible, each provision of these Medical Staff Bylaws shall be interpreted in a manner so as to be effective and valid under applicable law. If any provision is prohibited by or invalid under such law, it shall be deemed modified to conform to the minimum requirements of such law.

## **Section IV: Construction of Terms and Headings**

The captions or headings in these Medical Staff Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Medical Staff Bylaws. Words used in these Medical Staff Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context and circumstances require.

## **Section V: Transmittal of Reports**

Reports and other information which these Medical Staff Bylaws require the Medical Staff to transmit to the Governing Body shall be deemed transmitted when delivered to the President of the Hospital, unless otherwise specified.

## **Section VI: Notices**

Except where specified notice provisions are otherwise provided in these Medical Staff Bylaws, any and all notices, demands, requests and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Medical Staff Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first class mail. In the case of a notice to a practitioner, Allied Health Professional or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery and if mailed as provided for above, such notice shall be effective five (5) days after it is placed in the mail. Any party may change its address of record by giving written notice of such change to the other party in the manner above indicated.

## **Section VII: Staff Dues**

The Medical Executive Committee shall have the power to set the amount of annual dues prior to the beginning of each Medical Staff year, for each category of Medical Staff membership and Allied Health Professionals and to determine the manner of expenditure of funds received.

Failure to pay such dues shall, after special written notice of delinquency is mailed to the Medical Staff member, result in the suspension of Medical Staff membership and clinical privileges until the payment for dues is received. The Vice President of Medical Affairs, Medical Executive Committee and the Department in which the delinquent practitioner holds membership will be notified of the suspension.

**ARTICLE EIGHTEEN:**  
**ADOPTION AND AMENDMENT OF**  
**MEDICAL STAFF**  
**RULES AND REGULATIONS**  
**AND POLICIES**

**Section I: Procedure**

The Medical Executive Committee shall adopt such policies, rules and regulations as may be necessary for the proper conduct of its work.

**Section II: Routine Amendments**

Routine amendments of the Rules & Regulations of the Medical Staff shall be carried out in accordance with the Article Sixteen of the Medical Staff Bylaws.

**Section III: Urgent Amendments**

The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the rules and regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have fourteen (14) days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.



**ARTICLE NINETEEN**

**MEDICAL STAFF RULES/REGULATIONS**

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## **Section I                      Staff, Department and Committee Meetings**

### **A.        CONDUCT OF MEETINGS**

All staff, department and committee meetings shall be conducted according to Robert's Rules of Order.

### **B.        SERVICE ON COMMITTEES**

All Active Medical Staff members shall be willing and are encouraged to serve on Medical Staff committees as a condition of Active Medical Staff appointment and reappointment.

### **C.        SCHEDULING OF MEDICAL STAFF MEETINGS**

Medical Staff meetings, except as otherwise written in these Medical Staff Bylaws and Rules and Regulations, shall be set and determined by the Medical Executive Committee.

## **Section II                      Admission and Discharge of Patients**

A.        The Hospital shall admit only those patients whose identified care, treatment and service needs it can meet. If the patient's assessed needs and the hospital's capabilities are different, the patient will be transferred, once stabilized, to a suitable and accepting facility, in accordance with the federal, state and the Joint Commission (JC) requirements. If the patient to be admitted is being accepted in transfer from another institution, this will be accomplished in compliance with Hospital policy for the handling of such requests.

B.        Except in an emergency, all patients shall be admitted in accordance with Hospital criteria and no patient shall be admitted until a provisional diagnosis or valid reason for admission has been established and recorded. In an emergency, the provisional diagnosis shall be established and recorded as soon as possible after admission or within 24 hours.

C.        A medical screening examination will be provided to all patients who present for care, treatment and services at the Hospital or a Primary Care Center that operates under the Hospital's Medicare provider number. This examination can be performed by an Emergency Department or Attending Physician, a Physician's Assistant, a Nurse Practitioner or a Nurse Midwife.

D.        A member of the Medical Staff shall be responsible for the care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the patient's medical record (including medical history and physical examination, within no more than 24 hours of in-patient admission), for special instructions, if any, and for transmitting reports of the condition of the patient to his/her referring practitioner and communicating with the next of kin/responsible party. Whenever these responsibilities are transferred to another member of the Medical Staff, an entry explaining the reason for the transfer, after communication between the two involved Attending Physicians, shall be entered in the medical record.

E. The Attending Physician of record shall be responsible for coordination of medical care when several disciplines are involved in the management of the patient. While consulting physicians are responsible for their participation as consultants, the ultimate responsibility for the overall medical care of the patient belongs to the Attending Physician.

F. Each physician must have a covering physician who, when called upon, will have all of the same responsibilities as the Attending Physician, including discharge.

G. The Attending or covering physician is required, by care management protocols and other applicable standards, to document the need for the patient's continued hospitalization after specific periods of stay.

H. Members of the Medical Staff admitting emergency cases shall document appropriately in the patient's medical record that said emergency admission was a bona fide emergency.

I. A patient who is admitted on an emergency basis and does not have a private physician on the Medical Staff of the Hospital shall be assigned to the Attending Physician on-call for the department appropriate to the patient's illness. The Chair must provide an on-call schedule for such assignments. The physician on-call shall accept all such patients regardless of their ability or mode of payment. The on-call physician shall respond to such calls in a timely manner, generally not to exceed one hour, appropriate to the condition of the patient. An office based private physician may refer his/her patients for hospital admission to an appropriate physician of his/her choice on the Medical Staff.

J. If an Attending Physician on the Medical Staff can not be reached in a timely manner, the Chair of the involved Department or his/her designee, Vice President of Medical Affairs or Administrator on-call has authority to request an appropriate member of the Medical Staff to attend to such patients. Failure of on-call physician to respond in a timely manner will be referred to the Chair of the Department to which he/she has been assigned for follow-up assessment.

K. The Hospital Admitting Clerk will admit patients on the basis of the following order of priorities:

**1. EMERGENCY ADMISSIONS**

These include those patients requiring documented emergency admission. Within 24 hours following such an emergency admission, the Attending Physician shall sufficiently document the need for the patient's admission.

**2. PRE-OPERATIVE/ELECTIVE ADMISSIONS**

These include all patients currently scheduled for surgery. If it is not possible to accommodate all such admissions, priority should be given according to date scheduled or other criteria as may be agreed upon or determined on a case by case basis by the Vice President of Medical Affairs.

### 3. ROUTINE ADMISSIONS

These include elective admissions involving all services.

L. All Emergent, Urgent and Elective admissions will be admitted to the appropriate floors/units in the Hospital. Admission to and discharge from Critical Care Units shall be in accordance with Hospital protocols which set forth accepted admission and discharge criteria. Questions regarding admission to or discharge from these Units will be resolved by the Unit Director, in consultation with the Attending Physician.

M. When admitted patients require transfer to another facility, the transfer shall comply with current federal, state and the Joint Commission (JC) requirements.

N. The admitting physician on the Medical Staff is responsible for giving such information and alerting hospital personnel as necessary to protect the patient from self-harm and to protect others, in the event the patient might be a source of danger from any cause whatsoever.

O. For the protection of its patients, the Medical and Nursing staffs and the Hospital, certain principles and rules are to be followed when caring for the potentially suicidal patient:

1. Except in an emergency, no patient known or suspected to be suicidal in intent shall be electively admitted to this Hospital, as it would be an inappropriate admission.
2. If the patient has already been admitted and transfer is not immediately possible, consultation by a member of the psychiatric staff must be obtained, as soon as possible.

P. Patients shall be discharged only by an order of a member of the Medical Staff. Should a patient leave the Hospital against the advice of the Attending Physician (AMA) or without proper discharge, a detailed entry of the incident shall be recorded in the patient's medical record. A signed release should be obtained from the patient, if possible.

Q. In the event the patient or his/her representative requests to change his/her Attending Physician, the Attending Physician will inform the Nurse Manager or Administrator on-call and make an entry in the patient's medical record, documenting the request. If no member of the Medical Staff is readily available or chosen by the patient, the Department Chair is notified and the Department Chair or Vice President of Medical Affairs is responsible for assigning another member of the Medical Staff to provide medical care for the patient.

- R. Discharge planning shall begin as soon as possible following admission.
- S. It shall be the responsibility of the Attending Physician or his/her designee to discharge his/her patients in a safe and timely fashion.
- T. In the event of death, the patient shall be pronounced dead by the Attending Physician, or any other physician or Allied Health Professional qualified to do so, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. The Attending Physician or his/her designee shall complete the Death Certificate within 24 hours.
- U. It shall be the duty of all staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. Autopsies shall be performed by the Hospital pathologist.
- V. State Mandated Reporting: State mandated reporting will be in compliance with current regulations of the Department of Health or the Medical Examiner.

### **Section III Health Information Management**

New York State Codes, Rules and Regulations require that hospitals maintain an accurate, clear and comprehensive medical record for every person evaluated or treated as an in-patient, ambulatory patient, emergency patient or out-patient of the Hospital. Additionally, Standards of the Joint Commission (JC) require a complete and accurate medical record for patients assessed, cared for, treated or served.

- A. The Attending Physician, dentist or podiatrist shall be held responsible for the preparation of a complete and accurate medical record for each and every patient encounter. Medical records shall be filed in an easily accessible manner in the Hospital, with privacy, confidentiality and security maintained. A complete medical record contains the following information for each patient:
1. Face sheet/advance directive(if submitted);
  2. Identification data;
  3. Date;
  4. Chief complaint;
  5. History of present illness;
  6. Personal and family history;
  7. Evidence of medical history, including known allergies and physical examination;
  8. Diagnostic and therapeutic orders including dietary orders;
  9. Results of special examination(s) and consultation(s);
  10. Clinical laboratory, x-ray, diagnostic imaging and other reports;
  11. Properly executed and appropriate informed consent(s) for procedures and treatments;

12. Admitting diagnosis;
13. Treatment and medications prescribed (dosage, strength, rate) and administered;
14. Surgical reports, including operative and anesthesia records and pathology report(s);
15. Progress notes including clinical observations documenting therapy and results, including vital signs and other information necessary to monitor the patient's condition;
16. All final diagnoses;
17. Documentation of all complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia;
18. Complete discharge summary including the reason for hospitalization, significant findings, procedures performed, all invasive surgical procedures, discharge instructions, diet, treatment rendered, patient's condition on discharge, physical activity, medications, follow-up care and all relevant diagnoses established by the time of discharge;
19. Autopsy report (when performed), and
20. Signatures, with title, dated and timed and authenticated where required.

B. Medical records are the property of the Hospital and shall not be removed from the Hospital without written consent of the President of the Hospital or his/her designee or pursuant to statute, court order, subpoena or an authorization to release such medical records signed by the subject of the medical records or his/her legally authorized representative. Hospitals can provide access to all relevant health care information from patient's medical records when needed for use in the patient's care, treatment or services. The records of patients who had previous stays or out-patient visits shall be made available for the use of the physician, dentist, podiatrist or Allied Health Professional who is attending the patient when the patient is admitted to the Hospital. This rule shall apply whether the patient is attended by the same physician or another physician.

C. The Chair of the Health Information Management Committee or his/her designee is responsible for declaring any medical record complete for purposes of filing. The Health Information Management Committee is a system-wide committee which requires Medical Staff participation.

D. A complete medical history and physical examination shall be performed no more than thirty (30) days prior to admission or within twenty-four (24) hours after admission and be recorded in the patient's medical record. For histories and physicals completed prior to admission, it is required that an updated assessment of the patient be completed and documented in the medical record within twenty-four (24) hours of admission or before surgery or before a procedure requiring anesthesia services. A provider or appropriately licensed and authorized person shall dictate or write or record the medical history and physical findings in the patient's medical record. By his/her signature, the provider attests to the accuracy of the medical history and physical findings. When necessary, the Attending Provider shall review, verify the findings and provide additional information. The medical history and physical findings entered in the medical record by

House Staff or Allied Health Professionals must be countersigned by the Attending Provider.

E. The Attending Physician shall enter into the medical record of each patient, as soon after admission as possible, the following:

1. The admitting diagnosis;
2. When not specifically stated in the written medical history and physical examination, an initial progress note which sets forth the reason for hospitalization, the clinical findings and course of treatment contemplated must be entered.

F. The medical record shall contain information sufficient to justify the admission and continued hospitalization, to support the diagnosis and to describe the patient's progress and response to treatment, medications and services.

G. Pertinent progress notes shall be recorded at the time of observation and must be in sufficient detail to assure continuity of care. Wherever possible, each of the patient's clinical concerns should be clearly identified in the progress notes and correlated with orders and results of tests and treatments, specific to each clinical issue. Progress notes shall be written daily.

H. When consultations are required or recommended, documentation of consultations shall show evidence of an examination of the patient and a review of the patient's medical record by the recording of the consultant's observations and his/her professional opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations verified in the medical record, be recorded prior to the procedure.

I. In surgical cases, the pre-operative diagnosis shall be given to the surgical supervisor or his/her designee as far in advance of the surgical procedure as circumstances permit. The responsible surgeon or his/her designee shall record the pre-operative diagnosis in the patient's medical record prior to surgery. The surgeon's findings during the operative procedure, as well as the details of the surgical technique utilized, shall also be a part of the patient's medical record. For each patient who receives anesthesia or analgesia/conscious sedation in the operating room and/or recovery room, the pre-operative, operative and post-operative phases of management must be thoroughly documented in the patient's medical record by the anesthesiologist.

J. For each patient who receives analgesia/conscious sedation in a setting other than in the operating room and/or recovery room, the pre-procedure, procedure and post-procedure phases of management must be thoroughly documented in the patient's medical record by the physician or other appropriately credentialed provider performing the procedure(s).

K. All clinical entries in the patient's medical record shall be clearly written or entered into the electronic medical record (EMR) via computerized provider order entry (CPOE) and shall be accurately dated, timed and authenticated by the person completing such entry. Verbal orders must be authenticated as soon as possible by the Attending Physician or practitioner responsible for the care of the patient. When a "rubber stamp signature" is used, the individual whose signature the stamp represents files a statement with the Health Information Department confirming that he/she is the only one who has and will use the stamp and will not delegate its use to anyone else.

L. The operating surgeon is responsible for recording in the patient's medical record pre-operative and post-operative orders as well as daily progress notes of the patient's condition.

M. All operations and surgical procedures that are performed shall be fully described by the operating surgeon or his/her designee immediately following the procedure and contain a description of the findings, the technical procedures used, specimens removed, pre-operative and post-operative diagnosis, primary surgeon and assistants, if any. The completed operative report must be authenticated by the surgeon performing the operation. The Health Information Management Department shall provide the Admissions Department, Surgery Department, Emergency Department and Special Procedure Rooms, a daily listing of physicians whose operative reports have not been dictated, as required, within 24 hours of the procedure. Physicians with delinquent operative reports will not be allowed to admit patients or schedule elective surgery cases, until the delinquent reports are completed. In addition, physicians with delinquent operative reports shall be subject to the penalties set forth in Paragraph R, in this Section of these Rules and Regulations.

N. Unapproved symbols and abbreviations are not to be used. Only standardized, recognized abbreviations shall be used within the Hospital; an official record of abbreviations approved by the Hospital and the Medical Staff shall be kept on file in the Health Information Management Department's Office and at all clinical stations.

O. A practitioner's pre-printed orders, when applicable, shall be reproduced in detail on the order sheet of the patient's medical record, dated and signed by the physician.

P. A discharge summary shall be prepared for each patient's medical record. In all instances, the content of the medical record shall be sufficient to support the diagnosis, the course of treatment and record the outcome. The discharge summary shall concisely outline the reasons for hospitalization, significant findings, procedures performed, treatment(s) rendered, condition of the patient on discharge and specific instructions given to the patient or his/her family. Instructions shall be included on the discharge summary relating to physical activity, medication, diet, follow-up care, physician appointments and the condition of the patient on discharge. The summary should not contain symbols or abbreviations and should be dated and signed by the Attending



Physician. A final progress note may be substituted for the discharge summary for hospitalizations lasting less than forty-eight (48) hours.

All diagnoses and procedures relating to or affecting treatment during each patient's current hospitalization shall be documented at the time of discharge. In cases where the final diagnosis is not known at the time of discharge because the pathology report is pending, the Attending Physician, Dentist or Podiatrist is responsible for having all final diagnoses entered on the face sheet. Failure to enter all final diagnoses and to complete the face sheet in a timely manner will result in such Attending Physician, Dentist or Podiatrist being subject to the penalties set forth in Paragraph R, in this Section of these Rules and Regulations.

If a patient is readmitted within a month's time for the same condition, an interval medical history and physical examination reflecting any subsequent changes must be entered in the patient's medical record.

Q. The Attending Physician, Dentist or Podiatrist shall prepare a complete medical record for each patient as set forth in Paragraph A, in this Section of the Rules and Regulations. Medical records shall be completed in accordance with Kenmore Mercy Hospital Health Information Management Department Policy and Procedure. A copy of this Policy and Procedure is on file in the Medical Staff Office.

The Medical Staff is expected to comply with all Federal Statutes, New York State Codes, Rules and Regulations and JC Standards which pertain directly to the medical records. Only authorized personnel, providing direct patient care will be permitted access to the patient's prior and current medical records at the Hospital. In order to obtain access to medical record information maintained at other facilities, created by other health care providers, specific written authorization from the patient is required.

R. Penalties for noncompliance with the requirements of Paragraph Q, in this Section of these Rules and Regulations, shall be as follows:

1. An automatic suspension shall be imposed, after warning of delinquency, for failure to complete medical records as set forth in Paragraph Q, above, and in the Health Information Management Department's Policy and Procedure Manual.
2. Such suspension shall take the form of denial of a practitioner's admitting privileges or consulting privileges and shall be effective until medical records are completed.

S. Patients may not be admitted under another physician's name or service and later transferred to the physician whose admitting privileges were denied, until such time as that physician's suspension has been officially lifted. If one member of a medical practice group has his/her privileges denied, only that specific physician, not the other members of the group is effected.

T. The Vice President of Medical Affairs or his/her designee shall notify the Chair of the physician's Department, the Admission Office, Surgery and the Emergency Department of such denial of admitting privileges. When the denial of admitting privileges is to be lifted, the same individuals shall be notified.

## **Section IV                    General Rules for Medical Care**

### **A.        CONSENT**

1. A general consent for treatment form, signed by or on behalf of every patient presenting to the Hospital, must be obtained at the time of presentation. The patient's provider should be notified whenever such consent has not been obtained.
2. In addition to obtaining the patient's general consent to treatment, a specific consent form that informs the patient of the nature of and risks/benefits inherent in any invasive treatment or surgical procedure, must be obtained by the qualified provider performing such procedure, prior to any such treatment or procedure, except in emergency situations.
3. The goal of the informed consent process is to establish a mutual understanding between the patient and the provider about the care, treatment and services that the patient receives and to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable practitioner, under similar circumstances would have disclosed in a manner permitting the patient to make a knowledgeable evaluation. A completed informed consent process includes discussion of the nature of the proposed care, treatment, services, medications, interventions or procedures, the potential benefits, risks or side effects of the proposed care, treatment and services, the likelihood of achieving treatment goals, reasonable alternatives to the proposed care, treatment and services including the possible consequences of no treatment.
4. Other than in an emergency, in instances where informed consent cannot be obtained, the Attending Physician shall consult with the President of the Hospital or his/her designee with respect to the appropriate course of action to follow.

B. PROVIDER ORDERS

1. All provider orders for treatment shall be in writing or entered into the electronic medical record (EMR) via computerized provider order entry (CPOE), signed, dated and timed. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her area of competence. A duly authorized person shall be a Licensed Registered Nurse, Licensed Registered Pharmacist, Registered Dietitian or Respiratory Therapist. Each verbal or telephoned order is identified as a verbal order, dated and timed and identified, by name and title, the individual who gave the order and the person who recorded it. The responsible practitioner shall authenticate and sign such orders as soon as possible.
2. Provider orders must be written clearly and legibly or entered into the electronic medical record (EMR) via computerized provider order entry (CPOE). All orders must be complete. Illegible or improperly written provider orders will not be transcribed or implemented until rewritten and/or understood by the nurse. The use of "Renew," "Repeat" and "Continue Orders" is not permitted.
3. All medications and other orders as appropriate are to be held as per hospital policy when patients go to surgery.
4. All provider orders will be considered ongoing and continuous unless time limited in the written order or in compliance with other relevant Hospital policies and procedures.

C. DRUGS AND MEDICATIONS

1. All drugs and medications administered to patients must be obtained from the Hospital's Department of Pharmaceutical Services and shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration. As set forth in the Medical Staff Bylaws, the Catholic Health System's Pharmacy and Therapeutics Committee must evaluate and approve all protocols concerning the use of investigational or experimental drugs.
2. Written authorization from a member of the Medical Staff may be given to the Hospital's Department of Pharmaceutical Services to dispense, in place of a brand name drug of a specific manufacturer, the same drug (generic) compounded by another manufacturer, unless the provider specifies, in writing, to "dispense as ordered."
3. Hospitalized patients may not bring medications from outside the hospital, nor administer their own medication. However, if such medications are medically necessary and not immediately available from the Hospital's Department of

Pharmaceutical Services, the patient's provider may specifically order that the patient's own medication be dispensed, for a limited period of time.

**D. ABBREVIATIONS**

Only standardized, recognized abbreviations shall be used within the Hospital; an official record of abbreviations approved by the Hospital and the Medical Staff shall be kept on file in the Health Information Management Department's Office.

**E. COVERAGE**

As set forth in the Medical Staff Bylaws as a basic responsibility of individual Medical Staff members, each provider must arrange for patient care coverage in the event of a planned or unplanned absence from the Hospital. The name or names of his/her covering provider shall be on file with the Medical Staff Office. Patients must be made aware of any arrangement for prolonged or permanent alternate care coverage and such must be documented in the patient's medical record.

**Section V General Rules for Surgical Care**

Surgery shall be performed by surgeons or other accredited practitioners with appropriate clinical privileges granted to them by their licensing agency, specialty board, hospital policy and the Governing Body as defined in the Medical Staff Bylaws and Rules and Regulations. Each practitioner's surgical privileges must be recorded on the surgery control card and updated whenever any change in surgical privileges occurs.

A. Except in an emergency, where the operation is deemed necessary to save the patient's life, no operation will be performed without a specific Hospital "Informed Consent" form signed by both the patient and the operating surgeon, informing the patient of the nature of and risks inherent in the procedure. In the case of minors or patients who are or have become incompetent, such consent shall be obtained from a parent or the patient's authorized representative.

B. The patient must be informed of who, among the practitioners caring for him/her, is the responsible operating surgeon.

C. The responsible operating surgeon shall examine the patient pre-operatively, document his/her findings and pre-operative diagnosis in the patient's medical record and write pre and post-operative orders for the patient. When appropriate, the responsible operating surgeon may delegate the writing of pre and post-operative orders to the House Staff or an appropriately credentialed Allied Health Professional.

D. All patients scheduled to receive anesthesia will have a case appropriate pre-operative evaluation recorded in the medical record in accordance with the requirements of regulatory agencies, unless the responsible operating surgeon states, in writing, that any delay necessitated thereby would be injurious to the patient.

E. The responsible operating surgeon shall record the pre-operative diagnosis in the patient's medical record prior to surgery. Except in emergencies, a complete medical history and physical examination of the patient must be entered in the patient's medical record or dictated before any surgery is started. Failure to perform and record the medical history and physical examination prior to the surgery would be considered cause for postponing surgery, unless the responsible operating surgeon states, in writing, that such delay would be detrimental to the patient.

F. All operations performed shall be fully described in the patient's medical record by the responsible operating surgeon within 24 hours following any surgery, both out-patient and in-patient. Operative reports are considered delinquent if not completed within 24 hours of the surgery and any practitioner who is delinquent in completing his/her operative reports will be notified, in writing, by the Chair of the Health Information Management Committee of his/her imminent suspension of clinical privileges. If uncorrected, notice will be sent by certified mail, return receipt requested, five (5) business days prior to suspension.

1. A list of all delinquent practitioners is automatically submitted by the Health Information Management Department to the President of the Hospital or his/her designee for distribution to the following specific areas and others, on an as needed basis:
  - a. Surgery
  - b. Other Senior Administrators
  - c. Chair of the Department involved
  - d. Chair of the Medical Records Committee
  - e. Emergency Department
  - f. Admissions
2. If the delinquency is not corrected in five (5) business days, clinical privileges to perform surgical procedures are then revoked without further notification, at the direction of the President of the Hospital or his/her designee upon the recommendation of the Chair of the involved department, until satisfactory completion of the required operative reports is demonstrated.

G. In order to facilitate the scheduling of surgical cases and the orderly functioning of the surgical suite, responsible operating surgeons and all other appropriate personnel must be present in the Operating Room in a timely fashion and in accordance with the Operating Room Rules and Regulations.

H. All surgical specimens removed during surgery must be sent to the Department of Pathology for tissue examination.

## **Section VI                    General Rules for Anesthesia and Recovery Room**

### **A.     THE RESPONSIBILITIES OF THE CHAIR OF THE DEPARTMENT OF ANESTHESIOLOGY**

The Chair of the Department of Anesthesiology will be responsible for:

1.     The development, approval and implementation of guidelines relating to anesthesia, including conscious sedation, administered in the operating room, the recovery room and other appropriate areas throughout the Hospital.
2.     Maintaining an on-call schedule that shall assure 24-hour coverage of Anesthesia Services. The Chair of the Department of Anesthesiology or his/her designee shall be available to arrange additional anesthesia coverage in the event of multiple acute emergencies.

### **B.     THE RESPONSIBILITIES OF THE ANESTHESIOLOGIST**

Because the response to procedures is not always predictable and the administration of anesthesia is a continuum, it is not always possible to predict how an individual patient will respond. Therefore, qualified anesthesiologists are trained in professional standards and techniques to manage patients in the case of a potentially harmful event.

1.     Because the safety of the patient is paramount, the anesthesiologist shall assure that the patient not be exposed to risks that the anesthesiologist, in his/her professional opinion, considers to be unwarranted.
2.     All patients scheduled for surgery must be evaluated pre-operatively by the anesthesiologist, cleared for surgery and an anesthesia note recorded in the patient's medical record.
3.     An Anesthesia Record shall be current and complete and be included in the patient's medical record.
4.     The anesthesiologist continues to monitor the patient post-operatively and a post-operative evaluation must be entered in the patient's medical record indicating that the patient appears medically stable and can be discharged from the recovery room.
5.     Within the first 24 hours following anesthesia, post-operative respiratory care is the joint responsibility of the anesthesiologist and the patient's Attending Physician.
6.     Members of the Department of Anesthesiology shall participate in the OR Committee, Critical Care Committee and in any other committee or department involved with respiratory care, as well as Quality Review and Performance Improvement activities as required.

C. While the recovery room is the primary responsibility of Anesthesia Services, the patients' care shall be shared with other departments of the Hospital.

D. When the OR recovery suite or PACU is closed, patients immediately post-op may be recovered in an appropriate place approved by one of the following: Department of Anesthesiology, Department of Surgery, Department of Obstetrics and Gynecology and the Vice-President of Patient Care Services.

## **Section VII            General Rules for Dental Care**

A. In addition to the professional responsibilities and ethical standards set forth in the Medical Staff Bylaws in the section entitled "Basic Responsibilities of Individual Medical Staff Members," Dental Staff members shall adhere to the Code of Ethics of the American Dental Association.

B. Dental patients with medical comorbidities or complications present upon admission or arising during hospitalization shall be referred to an appropriate member of the Medical Staff for consultation and/or management. The dentist shall perform only the functions which he/she is legally authorized by the State of New York to perform and those surgical procedures which have been specifically delineated and granted in the same manner as all other surgical privileges in this Hospital. Surgical procedures performed by Dentists shall be under the overall supervision of the Chair of the Department of Surgery.

C. The responsibilities of Dentist Members of the Medical Staff are:

1. Recording of a dental history which sets forth the reasons for the necessity of the hospital admission, and

2. The findings on examination of the oral cavity with a pre-operative diagnosis.

3. A complete Operative Report, describing the findings and the operative procedure. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Hospital pathologist.

4. Preparation of Progress Notes with respect to the patient's dental status.

5. Preparation of a chronology of the hospital course and a Discharge Summary.

D. The responsibilities of the physician member(s) of the Medical Staff are:

1. Recording of a medical history pertinent to the patient's general health, and

2. The findings of a physical examination to determine the patient's condition prior to anesthesia and surgery and medical clearance for the dental procedure, where appropriate.

3. Sharing responsibility of patient's care as provided in Paragraph B, above, and management of any medical problem that may be present at the time of admission or that may arise during hospitalization.

E. Discharge and follow-up Dental instructions for the patient shall be on written order of the dentist member of the Medical Staff.

## **Section VIII Department of Family Practice**

A. The Department of Family Practice of the Medical Staff shall consist of physicians qualified in Family Practice, who, as members of the Medical Staff are expected to practice under the professional responsibilities and ethical standards set forth in the Medical Staff Bylaws in the section entitled "Basic Responsibilities of Individual Medical Staff Members." There shall be a Chair of the Department of Family Practice who is appointed as set forth in the Medical Staff Bylaws.

B. Clinical privileges shall be granted in accordance with the Applicant's training and experience and upon the recommendation of the Chair of the Department. If clinical privileges are requested in a second department, recommendation from the Chair of that Department will be required. The Applicant shall have the burden of providing his/her qualifications and current competency for the clinical privileges requested and documentation of evidence of health status. He/she shall be subject to the Medical Staff Bylaws, Rules and Regulations, to the Rules and Regulations of the department in which he/she has clinical privileges and to the jurisdiction of the Chair of that Department.

C. The Department of Family Practice will hold regular Department meetings which will include Quality Review and Performance Improvement discussions on a regular and as needed basis. Attendance at the regular departmental, staff and committee meetings shall be in accordance with the Medical Staff Bylaws concerning Medical Staff membership in the clinical departments.

## **Section IX Allied Health Professionals**

### **A. DEFINITION**

The term Allied Health Professional (AHP) shall mean an individual licensed by the State of New York, other than a physician (except for Residents), dentist or podiatrist who exercises independent judgment within the areas of his/her professional competence and who is qualified to render direct or indirect medical, dental or surgical care under the supervision of a physician or in collaboration with a physician who is a member of the Medical Staff.



## B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

The following categories of AHP's may be granted specified patient care privileges: Nurse Anesthetists, Nurse Practitioners, Nurse Specialists, Nurse Midwives, Nurse Clinicians, other Licensed Registered Nurses, Surgical Technicians, Resident Physicians, Speech Consultants, Physician's Assistants, Licensed Psychologists and Radiation Physicists. This list is not meant to be all inclusive as the needs of the individual hospitals will change from time to time, as will medical practice patterns.

In all instances where a physician or physician's group hires and utilizes the services of any of the above, the physician or the physician's group shall furnish, as part of the

Application process, a proposed job description for the AHP and submit same to the involved Department.

## C. APPOINTMENT AND PRIVILEGES

Each Allied Health Professional may apply for Appointment or Reappointment as an AHP by presenting his/her qualifications via the procedure for processing Applications for Allied Health Professional Staff Membership. AHP's privileges must be reviewed and approved by the Credentials Committee and Medical Executive Committee in a manner consistent with the privileging process of Medical Staff members.

Appointment as an AHP to any of the above named categories may be made to individuals holding a license as required by the State of New York Departments of Health or Education, who can document their education, training and experience and who are able to demonstrate their ability to carry out clinical activities assigned to them. All AHP's are required to adhere strictly to the statutory limitations of their professional scope of practice.

## D. SUPERVISION OR COLLABORATION BY A PHYSICIAN

All Allied Health Professionals shall practice under the supervision of a physician or in collaboration with a physician who is a Medical Staff member responsible for their supervision and direction. The supervising or collaborating practitioner will be responsible for the patient and the patient's medical records. It is the responsibility of the AHP to clearly identify himself/herself to each patient and explain his/her role in that patient's care.

The supervising or collaborating practitioner and the Allied Health Professional shall immediately notify the Credentials Committee and Chair of the Department within which the AHP practices in the event the supervising or collaborating practitioner's approval to supervise or collaborate the AHP has been revoked, limited or otherwise restricted by any action of a licensing agency or if there is any change in the employment status of the AHP.

## E. LIABILITY INSURANCE

The AHP shall provide proof of continuous professional liability insurance coverage in the amounts required by the New York State Department of Health or the New York State Education Department for each specific profession and as deemed acceptable by the

Medical Executive Committee and approved by the Governing Body. This requirement is applicable regardless of whether the insurance is obtained by the individual or by his/her employer, including the Hospital.

#### F. PREROGATIVES OF AHP'S

The following are the prerogatives of AHP's, as Allied Health Professional members of the Medical Staff:

1. The AHP may, as appropriate, admit or discharge patients and may write or enter into the electronic medical record (EMR) via computerized provider order entry (CPOE) appropriate orders to the extent established for such AHP by the Department to which he/she is assigned, provided that to do so is within the scope of such professional's license, certificate or other legal credential.
2. AHP's may serve on staff, department and hospital committees, but may not chair a committee. They may attend meetings of the Medical Staff and Department to which they are assigned, but may not hold office nor vote.
3. AHP's may attend Hospital educational programs and are required to participate, as appropriate, in Quality and Patient Safety activities.

### **Section X Department of Pathology/Clinical Laboratories**

- A. All pathology requisitions must include the pre-operative diagnosis.
- B. All specimens removed during surgery are considered the property of the Hospital and must be sent to the attending pathologist, in accordance with Hospital policy regarding surgical specimen handling. The pathologist performs such examinations, as he/she considers necessary and appropriate and submits a signed report. The examination may consist of: specimen identification, gross examination, gross and microscopic examination and all special examinations the pathologist deems necessary to facilitate the diagnosis. The pathologist's report will be made a part of the patient's medical record.
- C. A provisional diagnosis, once established, will be documented and the report will be made a part of the patient's medical record in a timely manner.
- D. Autopsy permission must be obtained prior to performance of any autopsy, other than those deaths regulated by the Medical Examiner. It shall be the responsibility of the involved practitioner or his/her designee to inquire what the family wishes and to obtain the consent for autopsy, if desired.

### **Section XI Radiology/Nuclear Medicine Department(s) and Special Diagnostic Procedures**

- A. Radiological examinations, nuclear medicine studies and all other diagnostic imaging studies will be performed by specific request of a licensed practitioner or,

consistent with state law, those other practitioners authorized by the Medical Staff and Governing Body to order such services. All such requests shall document the physical signs or symptoms necessitating the studies and any other relevant information indicated.

B. All diagnostic imaging procedures and interpretations shall be formally documented by written reports, dated and signed by the interpreting physician. All findings of a critical nature will be immediately communicated to the patient's Attending Physician by the interpreting physician.

C. All radioactive materials utilized in diagnostic imaging procedures and radiation oncology procedures must be monitored according to the regulations of the Department of Radiology/Division of Invasive Radiology, Nuclear Medicine, Radiation Oncology and shall be used only in consultation with such department and division.

D. Patients having had highly radioactive or long-life isotopes administered and not withdrawn during the current admission, shall not be discharged from the Hospital without consultation with a Nuclear Medicine physician and specific discharge instructions.

## **Section XII Podiatry**

### **A. PODIATRIST MEMBERS OF THE MEDICAL STAFF**

#### **1. Requirements**

Podiatrists requesting membership and clinical privileges on the Medical Staff must provide documentation of having graduated from a school of Podiatric Medicine accredited by the Council on Podiatric Medicine. The Applicant must meet all of the health requirements that are set forth in the Medical Staff Bylaws for all other Medical Staff members. A podiatrist's request for clinical privileges shall be processed in the manner set forth in the Medical Staff Bylaws and Rules and Regulations for all Medical Staff members. In order to obtain surgical privileges, podiatrists must, at minimum, be Board Qualified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics.

#### **2. Organization**

Qualified podiatrists may treat patients surgically and non-surgically. Podiatrists shall be members of the Medical Staff. Qualified podiatrists will be permitted to perform surgery in the operating room according to their clinical privileges, with the patient under general anesthesia.

### **B. HOSPITAL ADMISSIONS BY PODIATRISTS**

Patients can be admitted for podiatric care by the attending podiatrist. Podiatric patients with medical co-morbidities or complications present upon admission or arising during hospitalization shall be referred to an appropriate member of the Medical Staff for consultation and/or management. The podiatrist shall perform only the function which

he/she is legally authorized by the State of New York to perform and those surgical processes which have been specifically delineated and granted in the same manner as all other surgical privileges.

C. ADMISSION HISTORY AND PHYSICAL AND MEDICAL CLEARANCE

**Any physical examination performed by a physician extender (NP or PA) must be countersigned by his/her supervising physician. A history and physical done by an M.D./D.O. employed by the Hospital does not need to be countersigned by another physician. These pre-operative histories and physicals do not constitute medical clearance for surgery. If the patient requires a medical clearance for surgery this must be done by an M.D./D.O.; either the patient's private physician or a physician on the Medical Staff with admitting privileges.** Rev. 2/18/09

1. Pre-operative Medical Consultation and/or Clearance:  
The goal of medical consultation and/or clearance is to assure that the patient is “medically optimized” (that is that the patient is in the best condition possible at that time) and that the “benefits of proceeding outweigh the risks.”

D. RESPONSIBILITIES OF THE PODIATRIC STAFF ARE:

1. Recording of podiatric history, which sets forth the reason for the necessity of the hospital admission.
2. Findings on examination of the podiatric pathology with a preoperative diagnosis.
3. A complete operative report describing findings from the operative procedure.
4. Preparation of with respect to podiatric care.
5. Preparation of a chronological discharge summary pertaining to podiatric care.

### Section XIII House Physicians

A. HOUSE PHYSICIAN STAFF

House Physician Staff shall meet the basic qualifications set forth in the Medical Staff Bylaws for physicians applying for membership and clinical privileges on the Medical Staff. House Physician Staff shall not be eligible to vote nor hold office and are not required to attend meetings of the Medical Staff organization. They will not be required to pay Medical Staff dues.

B. PREROGATIVES OF HOUSE PHYSICIAN STAFF

A member of the House Physician Staff may:

1. Perform duties skillfully and to the best of such House Physician's ability under the general supervision of the Vice President of Medical Affairs, the Attending Physician responsible for the patient and/or the Chair of the Department involved.

2. Exercise such clinical privileges as are granted pursuant to these Medical Staff Bylaws.

#### C. RESPONSIBILITIES AND DUTIES OF THE HOUSE PHYSICIAN STAFF

Each member of the House Physician Staff shall meet the responsibilities set forth in the Medical Staff Bylaws. House physicians shall perform their duties skillfully and to the best of their ability under the general supervision of the Vice President of Medical Affairs, the Attending Physician responsible for the patient, the Chair of the Department involved and/or the Emergency Department physician. These duties shall include the services generally performed by House Physicians in an acute general hospital setting, including, but not limited to:

1. Responding to in-patient emergencies.
2. Performing routine medical duties such as starting IV solutions, starting blood transfusions, inserting nasogastric tubes, performing cut-downs, drawing arterial bloods, pronouncing patients “dead,” administering and/or performing tests and/or procedures appropriate to his/her credentials and clinical competence.
3. Taking histories and conducting physical examinations as requested in patient emergencies and/or patients who will be taken to surgery within twelve (12) hours.
4. Answering all calls and/or reporting personally to the Nursing Station placing the call, where appropriate.
5. Assessing patients and writing orders or enter orders into the electronic medical record (EMR) via computerized provider order entry (CPOE to address the presenting complaints, pending notification of the patient’s Attending Physician and implementing further recommendations of the Attending Physician, if any.

### **Section XIV            Medical Staff Expenditures and Dues**

All expenditures of Medical Staff funds shall be under the supervision of the Medical Executive Committee and reports will be presented at general Medical Staff meetings. Medical Staff dues shall be allocated at the discretion of the Medical Executive Committee.

Medical Staff dues, except as otherwise written in these Medical Staff Bylaws and Rules and Regulations, shall be set and determined by the Medical Executive Committee. At the discretion of the Medical Executive Committee, clinical privileges may be terminated upon non-payment of Medical Staff dues after a ninety (90) day period of delinquency.

## **Section XV Graduate Education Program(s)**

In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision, by a licensed independent practitioner with appropriate clinical privileges, of each member in the program in carrying out his/her patient care responsibilities.

All Graduate Education programs are under the direction of the Site Vice President of Medical Affairs in his/her role as Site Director of Graduate Medical Education. Residency Programs at Hospitals in the Catholic Health System will be carried out in accordance with Accreditation Council on Graduate Medical Education (ACGME) directives and regulations, the Program and Trainee Review Council of the American Osteopathic Association, the Council on Podiatric Medical Education, the Joint Commission (JC) Standards and in conjunction with relevant affiliation agreements.

The Program Director of a specific Residency Program, in collaboration with the Chair/Chief of each specific Department/Division participating in the Residency Program, is charged with the responsibility of recruiting voluntary teaching faculty from amongst appropriate members of the Medical Staff.

## **Section XVI End of Life/Withdrawal of Care**

### **A. COMPETENT PATIENT**

1. The discussion between the competent patient and his/her physician should be written in the medical record, documenting the disease, prognosis and the patient's mental status.
2. A formal order should be written in the medical record by the patient's Attending Physician defining what level of life prolonging procedures may be carried out, in accordance with the patient's wishes.
3. It is strongly recommended that an appropriate consultant be utilized and that his/her medical opinion be included in the patient's medical record.
4. The above shall be carried out in conjunction with other relevant Hospital policies, with the option, as needed, to request an Ethics Committee consultation.

### **B. INCOMPETENT BUT NOT BRAIN DEAD**

1. A physician should examine the patient and give a medical opinion as to the patient's competence and prognosis.

2. The criteria for determining the patient's incompetence should be documented in the medical record.
3. The patient's health care agent, if any, or if none, his/her next of kin or other representative should be an integral part of making this decision and his/her role in the decision making should be documented in the medical record.
4. The appropriate and specific order concerning withdrawal or non-application of life support measures should be written in the medical record by the patient's Attending Physician.
5. The above shall be carried out in conjunction with other relevant Hospital policies, with the option, as needed, to request an Ethics Committee consultation.

#### C. CEREBRAL (BRAIN) DEATH

When cerebral death occurs as defined below, two (2) physicians, one (1) of whom should be a neurologist or neurosurgeon, shall certify and document in the medical record all the clinical criteria consistent with brain death. The family, if any, or other representative, should be notified. The Attending Physician shall document in the medical record the family members or representative participating in the decision to discontinue or not to apply life support measures. All life support measures may be discontinued after the appropriate consent(s) have been obtained, whenever applicable.

Most generally accepted current criteria for brain death are as follows:

1. That all appropriate examinations and procedures have been performed.
2. That cerebral unresponsiveness, apnea, fixed pupils and absence of cephalic reflexes be present on two (2) separate clinical evaluations at least twelve (12) hours apart. Electroencephalogram silence should be demonstrated at least once.
3. That if one of these standards is met imprecisely or cannot be tested, a confirmatory test be made to demonstrate the absence of cerebral blood flow.
4. The above shall be carried out in conjunction with other relevant Hospital policies, with the option, as needed, to request an Ethics Committee consultation.

## **Section XVII Consultations**

A. Any member of the Medical Staff with clinical privileges in this Hospital, in accordance with his/her duties and responsibilities as a member of the Medical Staff, can

be called for consultation within his/her area of expertise, consistent with his/her delineated clinical privileges.

Consultation should be considered in the following non-emergent situations:

1. When additional input is required to determine if the patient can be cleared for a scheduled operation or treatment or if the risk of such procedure in the patient's current condition outweighs the benefit of the intervention;
2. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed;
3. When additional input is needed in choosing the most appropriate/effective therapeutic measures to be utilized;
4. In complicated situations where specific, specialized skills of other practitioners may be needed;
5. For psychiatric evaluation in instances in which the patient exhibits severe psychiatric symptoms or suicidal tendencies;
6. When requested by the patient or his/her family.

B. Documentation of consultations shall show evidence of an examination of the patient and a review of the patient's medical record by the recording of the consultant's observations and his/her professional opinion and recommendations. This report shall be made a part of the patient's medical record. When operative procedures are involved, the consultation note shall, except in emergency situations verified in the medical record, be recorded prior to the procedure.

C. Consultations shall be performed no later than the next calendar day of being ordered or in accordance with other relevant Hospital policies. The patient's Attending Physician, who is a member of the Medical Staff, is responsible for requesting appropriate consultations when indicated. To insure continuity of care, the Consultant will communicate with the Attending Physician by written consultation note, and, when appropriate, verbally. When indicated, the Attending Physician, will permit another practitioner to co-manage the patient's care.

D. In special circumstances, the President of the Hospital or his/her designee and/or the Chair of the involved Department shall at all times have the right to arrange for a consultant or consultants.

## **Section XVIII Religious and Ethical Directives**

The Medical Staff Bylaws and Rules and Regulations are implemented in accordance with the "Ethical and Religious Directives for Catholic Health Care Services" which shall be available, on file, in the Hospital's Administrative Offices.



## **Section XIX      Emergency Management Plan**

### **A.      PLAN IN THE EVENT OF MASS CASUALTIES**

There shall be a plan for the care of mass casualties, which is implemented at the time of any major disaster and is based on the Hospital's capabilities in conjunction with other responding facilities throughout the community. This Hospital's Emergency Management Plan shall be developed by an Emergency Management Planning Committee which includes members of the Medical Staff, the Vice-President of Patient Care Services, a representative from Hospital Administration and others, as appropriate. The Emergency Management Plan should be approved by the Medical Staff and Governing Body and shall be available, on file, in the Hospital's Administrative Offices. The Emergency Management Plan shall be rehearsed at least once a year, preferably as part of a coordinated drill in which other community emergency service agencies/responding facilities participate.

### **B.      THE EMERGENCY MANAGEMENT PLAN**

**The Emergency Management Plan should make provisions within the Hospital for:**

1.      Availability of adequate basic utilities and supplies including electricity, gas, water, food, medications and essential medical and other supportive materials.
2.      A process for maintaining continuity of information.
3.      An efficient system of notifying and assigning personnel.
4.      Unified medical command under the direction of a designated physician.
5.      Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
6.      Prompt transfer of patients, when necessary, after preliminary medical or surgical services have been rendered, to an accepting facility most appropriate for administering definitive care.
7.      A specially adapted emergency management medical record, such as an appropriately designed tag, that accompanies the injured patient as he/she is moved.
8.      Procedures for prompt discharge or transfer of patients, in the Hospital prior to the disaster, who are stable and can be moved without jeopardy.

9. Maintaining security in order to facilitate prompt patient care and to maintain crowd control with respect to keeping relatives, media and other on-lookers out of the triage area.
10. Pre-establishment of a public information center within the Hospital and pre-assignment of public relations liaison duties to a qualified individual with the goal of providing organized dissemination of information.

#### C. ASSIGNMENT OF PERSONNEL

Selected members of the Medical Staff shall be assigned to various posts within the Hospital and it will be their responsibility to report to their assigned stations at the declaration of a mass casualty situation. The Vice President of Medical Affairs and the President of the Hospital, will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another, or evacuation from the Hospital premises, the Vice President of Medical Affairs or his/her designee will authorize the movement of patients during the disaster. All issues concerning direct patient care will be the joint responsibility of Department Chair(s) and the President of the Hospital or, in their absence, their designee(s) or next in line of authority.

#### D. EMERGENCY PRIVILEGES DURING DISASTER

If deemed necessary by the Hospital, emergency clinical privileges may be granted when the Emergency Management Plan has been activated and the organization is unable to handle its immediate patient care needs without additional staff. During disaster(s), when the Emergency Management Plan has been activated, the President of the Hospital, the Vice President of Medical Affairs, President of the Medical Staff or their designee(s) have the option to grant emergency privileges. The verification process of credentials, clinical privileges and current competence of individuals who receive emergency privileges must begin as soon as the immediate emergency situation is under control.

#### E. ADMISSION OF PATIENTS DURING DISASTER

All patients shall be admitted in accordance with the rules of the Hospital and no patient shall be admitted until an admitting diagnosis has been recorded. In the case of an emergency, the admitting diagnosis shall be recorded as soon after admission as possible.

### **Section XX Institutional Review Board**

In accordance with the Standards of the Joint Commission (JC), hospitals protect research subjects and respect their rights during research, investigation and clinical trials involving human subjects. Hospitals that conduct such research recognize that their first responsibility is to the health and well-being of the research subjects.

A. Final approval by the Institutional Review Board (IRB) of the Hospital, Catholic Health System or other approved IRB, must be obtained for investigational studies. The investigator must furnish a research protocol containing pertinent information for any proposed study. This may include, but need not be limited to, pertinent information

concerning pharmacological and therapeutic properties of investigational medications, implanted devices or new diagnostic or therapeutic procedures. The investigator must also obtain prior informed consent from the research subject(s). Any approved investigational study must be subject to continuing review, reporting of outcome and maintenance of records by the approving IRB.

B. Drugs and devices shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration. As set forth in the Medical Staff Bylaws, the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee must evaluate and approve all protocols concerning the use of investigational or experimental drugs.

C. No investigational or experimental drugs, devices or procedures will be used in the Hospital unless approved as set forth above.

## **Section XXI Medicare/Compliance/Conflict of Interest**

Every Medical Staff member and each Allied Health Professional granted membership and clinical privileges at the Hospital is required to comply with all applicable federal and state laws, rules and regulations and with the Hospital's and the Medical Staff's Bylaws, Rules and Regulations. The Medical Staff Bylaws and Rules and Regulations have been implemented in accordance with all relevant regulatory requirements and with the Catholic Health System Compliance Policies and Procedures and Conflict of Interest Policies.

# **ARTICLE TWENTY: ANTICIPATED MEDICAL STAFF MERGER**

## **Section I: Introduction**

It is the intent of Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital of the Catholic Health System to merge into a single entity recognizing the purpose and responsibilities of Article Two of these Medical Staff Bylaws.

It is the intent of this article to allow for a pathway for this merger to occur. Provisions of this article will become effective at the time of the legal merger.

## **Section II: Purpose**

In accordance with Article Sixteen, these Bylaws will be amended in conjunction of this purpose at the time of the legal merger.

## **Section III: Medical Staff Membership**

Pursuant to the amendments of these Bylaws on the legal date of merger, members of the Medical Staff of Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital will become members of the medical staff of the surviving constituent hospital. Medical Staff category will remain unchanged.

### **A. CURRENT MEDICAL STAFF MEMBERSHIP**

The practitioner's medical staff category will remain unchanged. Clinical privileges previously granted at the constituent hospitals will continue in full force as originally granted. Individual staff category assignments for Medical Staff members who may practice at other entities will be assigned as appropriate.

### **B. APPOINTMENT/REAPPOINTMENT**

The process for appointment and reappointment will continue as outlined in Article Four of these Bylaws, with the exception that Article Four; Section VI: B-1 shall be amended to read: "The CME shall total a minimum of 50 hours of Type I CME over the two-year reappointment cycle. Recertification in the re-applicant's specialty board shall be the equivalent of this CME minimum".

**Section IV: Vice President of Medical Affairs and Officers of the Medical Staff**

**A. VICE PRESIDENT OF MEDICAL AFFAIRS**

A Catholic Health Vice President of Medical Affairs will be appointed as outlined in Article 9, Section I of these bylaws. The duties and responsibilities will continue as outlined in the in Article Nine, Section I-A of these bylaws. The site specific Vice President of Medical Affairs then serving at time of merger will continue in their positions retitled as Associate Catholic Health Vice President of Medical Affairs.

**B. ELECTED OFFICERS**

The elected officers at each of the constituent hospitals will continue in their role until such time that the latest term of the elected officer expires. At that time, an election for Catholic Health Medical Staff Officers will take place as outlined in Article Nine, Section II-C of these bylaws.

**Section V: Clinical Department and Services**

All clinical departments and services will continue as noted in Article Ten of these bylaws, until such time that necessary additional system-wide departments that do not then exist are established.

**Section VI: Department Chairs**

The then serving Department Chairs at the surviving Article 28 entity will remain in their role and the then serving Department Chairs at the other sites will be retitled Associate Department Chair. These individuals will serve in their respective roles until a system-wide Department Chair selection process is initiated and completed. This selection process will occur not later than the latest termination date of the individuals contracted. All serving individuals will be eligible for appointment or reappointment to a position. Following the Chair selection, the position of Associate Chair at the appropriate sites will be maintained.

**Section VII: Credentials Committee**

At the time merger becomes effective, a system-wide Medical Staff Credentials Committee will be established.

**A. COMPOSITION**

The system-wide Credentials Committee will be a standing committee and shall consist of the following members:

1. Vice President of Medical Affairs or his/her designee.
2. President of the Medical Staff of the surviving Article 28 facility.

3. President-elect of the Medical Staff of the surviving Article 28 facility.
4. Four (4) members of the Medical Staff at Large.
5. Six (6) members of the Active Staff serving as Department Chairs, Associate Chairs or Service Line Medical Directors to include the Chair of the Department of Medicine, Chair of the Department of Surgery and Chair of the Department of Obstetrics. The remaining three (3) members will be rotated based on the volume (members) of activity in the departments in the previous year.
6. President of the Hospital.
7. Three (3) Associate Medical Directors, one (1) from each merged entity site in an ex-officio (non-voting) capacity.
8. One (1) Allied Health Professional in a voting capacity.

The twelve (12) physicians identified in #'s 2,3,4 and 5 shall have at least three (3) members each from Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital.

#### B. DUTIES/RESPONSIBILITIES

The duties and responsibilities of the Credentials Committee shall be, at a minimum:

5. To review and evaluate the qualifications of each Applicant for Medical Staff membership for initial appointment, reappointment, or modification of appointment and to take into consideration the recommendations of the Department.
6. To make a report to the Medical Executive Committee on each Applicant, with respect to appointment, staff category, department and service affiliation, clinical privileges or specialized services, and special conditions attached thereto.
7. To, upon request of the Medical Executive Committee or the Chair of any Department, review, as questions arise, all information available regarding the clinical competence and/or aberrant behavior of persons currently appointed to the Medical Staff and of those practicing as Allied Health Professionals and, as a result of such review, to make a report of its findings and to make recommendations for granting the extension or restriction of clinical privileges and reappointment to the Medical Executive Committee and the Chair of the Department.
8. To submit reports to the Medical Executive Committee on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

#### C. MEETINGS

The Credentials Committee shall meet no fewer than ten (10) times a year; however, it will meet more often, in special session, if necessary to accomplish its duties, shall maintain a written record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee.

#### D. CHAIR

The Chair of the Credentials Committee shall be appointed by the President of the Medical Staff.

### **Section VIII: Medical Executive Committee**

A system-wide Medical Executive Committee will be established. The site specific Medical Executive Committees then serving will continue in an advisory role to the new Catholic Health Medical Executive Committee. The advisory committees so constituted shall decide how they shall be constituted on an ongoing basis.

#### A. COMPOSITION

The Catholic Health Medical Executive Committee will be a standing committee and shall consist of the following members:

1. President of the Medical Staff of the surviving Article 28 facility.
2. President-Elect of the Medical Staff of the surviving Article 28 facility.
3. Secretary of the Medical Staff of the surviving Article 28 facility.
4. Treasurer of the Medical Staff of the surviving Article 28 facility.
5. Six (6) Department Chairs to include the Chair of Surgery, Chair of Medicine, Chair of Family Practice and Chair of Obstetrics & Gynecology, two (2) additional Department Chairs and a Service Line Medical Director appointed by the President of the Medical Staff.
6. At the time of the merger, the advisory committees for Kenmore Mercy Hospital and Mercy Hospital of Buffalo will each appoint three representatives to the Medical Executive Committee. Following the first election of the merged entities officers, each of the three Medical Advisory Committees shall appoint three (3) members to the Medical Executive Committee.
7. Senior Vice President of Medical Affairs for the Catholic Health System or his/her designee.
8. Other non-physician voting members of the Medical Executive Committee will include, but are not limited to, a minimum of one (1) Vice President for Patient Care Services or his/her designee and the President and CEO of the hospital. The

Chairperson of the Executive Committee may invite other non-voting participants to the meeting. Voting status of Committee members who are not Medical Staff members shall be determined by the Medical Executive Committee.

**B. TERMS**

Current contract terms will be completed at which time there will be a vote for their replacements.

**C. COMPENSATION**

Compensation of Medical Staff leaders will be recommended by the Medical Executive Committee and approved by the Medical Staff.

**Section IX: Nominating Committee**

**A. COMPOSITION**

The Catholic Health Nominating Committee shall consist of five (5) elected Past-Presidents of the Medical Staff, at least one each from Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital, and all of whom are still active members of the Medical Staff. All Past-Presidents of the Medical Staff who are members of the Active Medical Staff shall be eligible for election to the Catholic Health Nominating Committee. The Catholic Health Nominating Committee shall be elected yearly at the annual meeting of the Medical Staff, from a ballot provided by the sitting Nominating Committee. The five (5) Past-Presidents of the Medical Staff receiving the most votes shall become the Nominating Committee. These five (5) Past-Presidents shall have representation of at least one (1) each from Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital. If necessary, the next highest vote getter who enables this criteria to be satisfied will be elected.

Term of membership on the Catholic Health Nominating Committee shall be for one (1) year, after which all Past-Presidents of the Medical Staff who remain Active Medical Staff members are eligible to be reelected.

**B. DUTIES/RESPONSIBILITIES**

The duties and responsibilities of the Catholic Health Nominating Committee shall be, at a minimum:

1. To consult with members of the Medical Staff concerning the qualifications and acceptability of prospective nominees.
2. To confirm nominees acceptance of candidacy.
3. To submit to the Catholic Health Medical Executive Committee at least one (1) or more nominations each from Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital for each of the following positions:

- a. Medical Staff President



- b. Medical Staff President-Elect
  - c. Medical Staff Secretary/Treasurer
  - d. Medical Staff Delegate
4. Assess each officer mid-term for any issues. If issues are identified or if officer chooses not to continue in his/her role for any reason, a re-election may be held at the end of the first year.

#### C. MEETINGS

The Nominating Committee shall meet as necessary to carry out its duties and responsibilities.

#### D. CHAIR

The President of the Medical Staff shall appoint the Chair of the nominating committee from the elected members of the committee.

### **Section X: Medical Staff Bylaws Committee**

The legal and regulatory requirements specify that hospitals have an organized Medical Staff that operates under Medical Staff Bylaws approved by the Governing Body and that the Medical Staff shall adopt and enforce Medical Staff Bylaws to carry out its responsibilities.

The self-governing, organized Medical Staff must initiate, develop and approve Medical Staff Bylaws, as well as approve or disapprove amendments to the Medical Staff Bylaws which define its role within the context of a hospital setting and clearly delineate its responsibilities in the oversight of care, treatment, and services.

#### A. COMPOSITION

Following the merger, the composition of the Bylaws Committee will be changed to include the President of the Medical Staff of the surviving Article 28 facility or his/her designee, the President-Elect of the Medical Staff of the surviving Article 28 facility and four (4) additional members of the Medical Staff. These four (4) additional members of the Medical Staff are to be selected from the merged Article 28 facilities. Two (2) representatives are to be recommended by each of the site specific Medical Executive Committees. The Vice President of Medical Affairs of the Catholic Health System and those serving in the role as Associate Vice President of Medical Affairs of the Catholic Health System shall also serve as members of the committee.

## B. DUTIES/RESPONSIBILITIES

As set forth in these Medical Staff Bylaws under Adoption and Amendment of Bylaws, the Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Governing Body, Medical Staff Bylaws and amendments thereto, which shall become effective upon approval by the Governing Body.

It shall be the duty of the Catholic Health System Bylaws Committee to:

1. Conduct an annual review of the Medical Staff Bylaws and be responsible for making recommendations for updating of the Medical Staff Bylaws.
2. Recommend amendments to the Medical Staff Bylaws regarding directives by government and regulatory agencies.
3. Recommend amendments to the Medical Staff Bylaws with respect to changes in medical practice.
4. Receive and consider all matters referred by the Governing Body, the Medical Executive Committee, President of the Hospital, Departments and Committees.
5. Submit recommendations to the Medical Executive Committee.
6. The President of the Medical Staff or his/her designee shall submit recommendations as appropriate in accordance with the amendment process to the Governing Body.

## C. MEETINGS

The Catholic Health System Bylaws Committee shall meet as often as necessary at the call of its Chair, but at least annually and shall submit a report of its activities to the Medical Executive Committee.

## D. CHAIR

The Chair of the Catholic Health System Medical Staff Bylaws Committee shall be the Senior Vice President of the Medical Affairs of the Catholic Health System or his/her designee.

## **Section XI: Medical Staff Pharmacy and Therapeutics Committee**

Public Health Law requires that hospitals have Pharmaceutical Services and that the Director of Pharmaceutical Services, in conjunction with the Medical Staff, shall ensure the monitoring and evaluation of the quality and appropriateness of patient services provided by the Pharmaceutical Services. Additionally, it is required that the Director participate in those aspects of the Hospital's overall quality assurance program that relate to drug utilization and effectiveness.

#### A. COMPOSITION

The Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall consist of the Director of Pharmacy or his/her designee, a minimum of two (2) additional pharmacists, the Senior Vice President of Medical Affairs of the Catholic Health System or his/her designee and a minimum of one (1) Vice President of Patient Care Services or his/her designee and the Director of Dietary Services or his/her designee. Additionally, a minimum of five (5) representatives of the Medical Staff shall be appointed by the President of the Medical Staff. It shall be the prerogative of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee to invite other individuals, physicians or associates of the Catholic Health System to attend meetings as consultants to the Committee, as appropriate.

#### B. DUTIES/RESPONSIBILITIES

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the constituent hospitals in order to assure optimal clinical results and minimal potential for hazard. The Performance Improvement functions of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee are to ensure appropriateness, timeliness and efficiency of drug usage.

The duties of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall be to:

1. Serve as an advisory group to the Medical Staff and the Pharmaceutical Departments of the hospital on matters pertaining to the choice of available drugs for patient care and diagnostic testing.
2. Assist in the formulation of broad professional policies regarding evaluation, selection, storage, distribution, use, safety procedures, administration, and all other matters relating to drugs and diagnostic testing materials in the hospital.
3. Develop, review periodically and revise as necessary, the formulary of accepted drugs for use in the hospital.
4. Evaluate clinical data concerning new drugs or preparations requested for use in the hospital and review non-formulary drugs ordered.
5. Prevent unnecessary duplication in stocking drugs and standardize, to the extent practicable, drugs and related supplies in the pharmacy.
6. Make recommendations concerning drugs to be stocked on the nursing unit floors of the constituent hospitals and by other services of the hospital.
7. Review the appropriateness, safety and effectiveness of the prophylactic, empiric, and therapeutic use of all types of drugs used in the hospital.

8. Make readily available to the staffs of the hospital, information regarding the compatibility of drugs.
9. Review all significant untoward drug reactions and make recommendations as needed.
10. Periodically evaluate medication errors considering their incidence and cause.
11. Consider policies and procedures relating to the labeling, distribution, administration by professional personnel and all other matters related to the use of hazardous drugs in the hospital.
12. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs. Evaluate and approve all protocols concerning the use of investigational or experimental drugs.
13. Maintain a permanent record of all activities relating to the pharmacy and therapeutics function.
14. The Committee shall submit regular reports to the Medical Executive Committee. . This report will be presented by the Chair of the Committee or his/her designee.

#### C. MEETINGS

The Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall meet as often as necessary at the call of the Chair, but at least quarterly and shall submit a report of its activities to the Medical Executive Committees of the hospital.

#### D. CHAIR

The Chair of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee shall be a physician selected by a majority vote of the Committee members. The selection shall occur yearly at the first regularly scheduled meeting of the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee.

### **Section XI: Health Information Management Committee**

Legal and regulatory requirements specify that all hospitals have a department that has administrative responsibility for Health Information, which ensures the integrity and confidentiality of all patient records and the appropriate release of medical information as permitted by Federal and State laws.

#### A. COMPOSITION

The Catholic Health System Health Information Management Committee shall consist of the Director of the Health Information Management Department, a minimum of two (2) Site Managers of the Health Information Management Department, the Senior Vice President of Medical Affairs for the Catholic Health System and a minimum of one (1) Vice of President of Patient Care Services or his/her designee. Additionally, a minimum of five (5) representatives of the Medical Staff who shall be appointed by the President of the Medical Staff. It shall be the prerogative of the Catholic Health System Health Information Management Committee to invite other members of the medical staff, associates of the Catholic Health System or other individuals to attend meetings as consultants to the Committee, as appropriate.

#### B. DUTIES/RESPONSIBILITIES

This Committee shall be responsible for the quality, timeliness and security of the medical record in order to assure optimal clinical results and a safe patient care environment.

The duties of the Catholic Health System Health Information Management Committee shall be to:

1. Serve as an advisory group to the Medical Staff and Health Information Departments of the hospital on matters pertaining to Health Information.
2. Assist in the formulation of broad professional policies regarding Health Information for the hospital and Medical Staff.
3. Review periodically and revise as necessary the Health Information policies of the hospital.
4. Recommend and review the appropriateness and format of Health Information forms used within the hospital and make recommendations for revisions, as necessary.
5. Make readily available to the Medical Staff of the hospital current information regarding Health Information.
6. Establish standards concerning the use and completion of Health Information records for members of the Medical Staff and other associates of the hospital.
7. Maintain a permanent record of all activities relating to the Health Information Committee.

8. Submit regular reports to the Medical Executive Committee of the hospital.

C. MEETINGS

The Catholic Health System Health Information Committee shall meet as often as necessary at the call of the Chair, at least quarterly, and shall submit a report of its activities to the Executive Committee of the Medical Staff.

D. CHAIR

The Chair of the Catholic Health System Health Information Committee shall be a physician selected by the majority vote of the Committee members. The selection shall occur yearly at the first regularly scheduled meeting of the Catholic Health System Health Information Committee.

**Section XII: Institutional Review Board**

In accordance with the Standards of the Joint Commission (JC), hospitals protect research subjects and respect their rights during research, investigation and clinical trials involving human subjects. Hospitals that conduct such research recognize that their first responsibility is to the health and well-being of the research subjects.

A. Final approval by the Institutional Review Board (IRB) of the Catholic Health System or other approved IRB, must be obtained for investigational studies. The investigator must furnish a research protocol containing pertinent information for any proposed study. This may include, but need not be limited to, pertinent information concerning pharmacological and therapeutic properties of investigational medications, implanted devices or new diagnostic or therapeutic procedures. The investigator must also obtain prior informed consent from the research subject(s). Any approved investigational study must be subject to continuing review, reporting of outcome and maintenance of records by the approving IRB.

B. Drugs and devices shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration. As set forth in the Medical Staff Bylaws, the Catholic Health System Medical Staff Pharmacy and Therapeutics Committee must evaluate and approve all protocols concerning the use of investigational or experimental drugs.

C. No investigational or experimental drugs, devices or procedures will be used in the Hospital unless approved as set forth above.

### **Section XIII: Allied Health Professionals**

Pursuant to the amendments of these Bylaws on the legal date of merger, members of the Medical Staff of Kenmore Mercy Hospital, Mercy Hospital of Buffalo and Sisters of Charity Hospital will become members of the medical staff of the surviving constituent hospital. Medical Staff category will remain unchanged.

#### **A. CURRENT MEDICAL STAFF MEMBERSHIP**

The medical staff category will remain unchanged. Clinical privileges previously granted at the constituent hospitals will continue in full force as originally granted.

#### **B. APPOINTMENT/REAPPOINTMENT**

The process for appointment and reappointment will continue as outlined in Article Four of these Bylaws.

### **Section XIV: Medical Staff Rules & Regulations**

The Medical Staff Rules and Regulations will continue as outlined in Article Nineteen.

### **Section XV: Closing Statement**

In conjunction with the approval of Article Twenty of these Bylaws, it is recognized that many other aspects will need to be addressed legally. The Medical Staff Bylaws Committee through its amendment process will address many other issues and bring forth recommendations to facilitate the function of the organized Medical Staff.