

**BY-LAWS**  
**OF THE**  
**MEDICAL STAFF**  
**OF**  
**ST. JOSEPH'S HOSPITAL HEALTH CENTER**  
**SYRACUSE, NEW YORK**

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**ST. JOSEPH'S HOSPITAL HEALTH CENTER**

**BY-LAWS OF THE MEDICAL STAFF**

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## **PREAMBLE**

**WHEREAS**, St. Joseph's Hospital Health Center is a non-profit corporation, organized under the laws of the State of New York hereinafter referred to as "Hospital"; and

**WHEREAS**, its purpose is to serve as a general hospital providing patient care, education and research; and

**WHEREAS**, it is recognized that the Medical Staff is responsible for the quality of medical care at the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Hospital Governing Body and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Body are necessary to fulfill the Hospital's obligation to its patients; therefore the physicians, dentists and midwives practicing at the Hospital hereby organize themselves into a Medical Staff in conformity with these By-Laws.

## **DEFINITIONS**

A. The term "Medical Staff" shall mean all physicians, dentists, and midwives, who are duly licensed and who are privileged to attend patients in St. Joseph's Hospital Health Center.

B. The term "Physician" shall mean an individual who has graduated from a college of medicine approved by the Liaison Committee on Medical Education and who has been awarded a degree, valid in the State of New York, of Doctor of Medicine, or an individual who has graduated from a college of osteopathy approved by the American Osteopathic Association and who has been awarded a degree, valid in the State of New York, of Doctor of Osteopathy, and who is licensed to practice medicine in the State of New York.

C. The term "Dentist" shall mean an individual who has graduated from a college of dentistry, approved by the Commission on Accreditation of the American Dental Association, and who has been awarded a degree, valid in the State of New York, of Doctor of Dental Surgery or Doctor of Medicine Dentistry and who is licensed to practice dentistry in the State of New York.

D. The term "Midwife" shall mean an individual who has obtained a license to practice midwifery under Title VIII Education Law – Article 140 in the State of New York.

## **II**

The term "Governing Body" shall mean the Board of Trustees of St. Joseph's Hospital Health Center.

## **III**

The term "Executive Committee" shall mean the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

## **IV**

The term "Chief Executive Officer" shall mean the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.

## **V**

The term, "Super-Majority" shall mean the minimum of two-third (2/3) of the votes cast, a quorum having been present to initiate the meeting.

**BY-LAWS**

**ST. JOSEPH'S HOSPITAL HEALTH CENTER**

**MEDICAL STAFF**

**ARTICLE I**

**NAME**

The name of this organization shall be the Medical Staff of the St. Joseph's Hospital Health Center.

**ARTICLE II**

**PURPOSE**

The purposes of this organization shall be:

1. To ensure the highest quality medical care for all patients admitted to the Hospital or its outpatient programs.
2. To provide the best possible environment for medical education and the education of allied professions.
3. To initiate and maintain Rules and Regulations for self government of the Medical Staff.
4. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the Chief Executive Officer.
5. To function as a nonprofit member organization of Trinity Health.

**ARTICLE III**

**CONFIDENTIALITY**

To the fullest extent permitted by law, all information, records and documentation collected and maintained pursuant to quality assurance activities, granting or renewal of privileges, and incident reporting shall be kept confidential. For purposes of these By-Laws, all such activities of standing committees shall be considered quality assurance activities.



## ARTICLE IV

### MEDICAL STAFF MEMBERSHIP

#### **Section 1. Qualification for Membership**

A. Only those physicians, dentists, and licensed midwives holding a verified current unrestricted license to practice in the State of New York, not subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind shall be eligible for Medical Staff membership. Individuals must offer evidence that their training, experience, current competence, professional techniques, proof of liability insurance as established in the Rules and Regulations of the Medical Staff, ability to work with others, and, if requested, health status are adequate to assure the Medical Staff and Governing Body that any patient treated by them will receive care compatible with current medical standards.

B. No individual shall be automatically entitled to membership on the Medical Staff or to the exercise of any clinical privileges merely because he/she is licensed in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical examining board, or because he/she has clinical privileges or Staff membership at another hospital or free standing clinic. Medical Staff members under contract with the Hospital shall be subject to the same membership and privileging procedures as set forth in these By-Laws.

C. The majority of the Medical Staff shall be physicians.

D. Physicians (M.D. and D.O.) applying and reapplying for membership on the Medical Staff must achieve and maintain certification by a specialty board. The specialty board must be recognized or authorized by the American Board of Medical Specialties, or by the Osteopathic Association Specialty Certifying Boards. Certification by another American specialty board or a board outside of the United States will be considered on a case-by-case basis. Physicians shall have six years from completion of residency or fellowship training to achieve such certification. Licensed Midwives (C.N.M. and C.M.) applying and reapplying for membership on the Medical Staff must achieve and maintain certification by the American Midwifery Certification Board. This requirement may be waived by the Medical Executive Committee upon recommendation by the Department Chair and upon approval by the Board of Trustees. Criteria for such waiver shall be training, service and experience which demonstrate excellence equivalent to that of a Board Certified physician. A temporary waiver may be granted by the Medical Executive Committee, upon recommendation by the Department Chair and approval by the Board of Trustees, to allow an unsuccessful candidate to re-challenge a certification or recertification examination. A temporary waiver may be granted by the Medical Executive Committee, upon recommendation by the Department Chair and approval by the Board of Trustees, in case of illness or other personal hardship. Such temporary waivers shall be for one year, and may be renewed if appropriate in the judgment of the Department Chair, Medical Executive Committee and Board of Trustees.

E. It is required that each member of the Medical Staff shall comply with and participate in the Quality Management/Performance Improvement Program of St. Joseph's Hospital, which has been established to improve quality, patient care and to ensure optimum utilization of medical services.

F. Members of the Medical Staff shall be trained and demonstrate competency in the use of the Hospital's electronic medical record (EMR) appropriate to their level of participation as defined in the

Medical Staff Rules and Regulations. The CMO or Chief Medical Informaticist, or designee shall approve the training requirements of each Department for these members, and will review and approve each such member's request.

**Section 2. Acceptance of Membership**

Acceptance of membership in the Medical Staff shall constitute the Staff member's agreement that he/she will strictly abide by the ethical principles of his/her profession and by the *Ethical and Religious Directives for Catholic Health Care Services*.

**Section 3. Method of Selection**

Each applicant for Staff membership shall complete and sign an application form. At a minimum, this document shall provide information relative to the applicant's professional education, training, professional experience, references who are knowledgeable about his/her competence and ethical character, verified current licensure, proof of current professional liability insurance, **in accordance with the requirements set forth in the Rules and Regulations** and a specific request for Staff assignments and clinical privileges. The application shall contain the applicant's pledge to:

- abide by and be governed by the Medical Staff By-Laws;
- maintain an ethical practice;
- provide for continuous care of his/her patients;
- refrain from fee splitting or other inducements relating to patient referral;
- refrain from delegating the responsibility for diagnosis or care of patients to a medical or dental practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;
- seek consultation whenever necessary;
- refrain from providing "ghost" surgical or medical services;
- acknowledge the requirement for release and immunity from civil liability provisions.
- afford patients their rights as outlined in Section 405.7 of the New York State Minimum Standards for Hospitals.

The application shall further provide information relating to involvement in any adverse malpractice action and to any previously successful challenges to licensure or registration or to loss of professional organizational membership or to loss of Medical Staff membership or privileges at another hospital or to loss of license to prescribe DEA scheduled drugs. Prior to the granting of privileges, the applicant shall also provide information as to any pending professional or dental misconduct procedures or any pending medical malpractice actions in this State or another State. The substance of these allegations in such proceedings or actions will be required and any additional information concerning such proceedings or actions as the applicant may deem appropriate. The applicant shall further provide information relating to any mental or physical impairment, incompetence or endangerment of patient safety or welfare, voluntary or involuntary resignation, withdrawal, limitation, reduction or loss of association or privileges with a hospital, voluntary or

involuntary relinquishment of any license or registration, a criminal conviction, and any information relative to findings pertinent to violations of patients' rights.

The applicant attests to the accuracy of the application and agrees that any substantive omission or misrepresentation in the Medical Executive Committee's or Board's opinion may be grounds for termination of the application process without access to a fair/judicial hearing or review.

The applicant shall provide the names of any facilities with which he/she is or has been associated. Further, in situations where such associations have been discontinued, the applicant shall provide the reasons for such discontinuance. There shall be a waiver by the applicant or dentist of any confidentiality provisions concerning the information to be provided to the Hospital pursuant to this requirement.

The National Practitioner Data Bank must be queried for information related to professional conduct and competence, licensure status, and malpractice claims experience of each physician, dentist, midwife, or clinical affiliate who applies for appointment to the Medical Staff.

The applicant will verify that the information provided is true and accurate.

In evaluating the applicant's eligibility for Medical Staff membership and/or privileges, consideration shall be given to the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his/her patients and to the patient care requirement for additional Staff members with the applicant's skills and training. An applicant's eligibility for Medical Staff membership and/or privileges shall not involve consideration of his/her gender, race, creed, national origin or sexual orientation.

#### **Section 4. Conditions and Duration of Appointment**

A. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments or ratification of appointments only after there has been a recommendation from the Medical Staff as provided in these By-Laws. In the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or Medical Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

B. Upon initial appointment, a focused professional practice evaluation of clinical performance will be conducted for a period of one year, which time period may be extended at the discretion of the Department Chairperson. Appointments and reappointments to the Medical Staff shall be for a period of not more than two (2) years. For the purposes of these By-Laws, the Medical Staff year commences on the 1st day of February and ends on the 31st day of January of each year.

C. Members of the medical staff are obliged to disclose to the CMO/Department Chair any impairment of ability to provide safe patient care. For any concerns identified there will be a referral to the Health Committee.

D. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body in accordance with these By-Laws.

E. Every application for Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff By-Laws and Rules and Regulations and to accept committee assignments.

F. As an ongoing condition of Medical Staff membership, members of the Medical

Staff shall abide by these Medical Staff By-Laws, Rules and Regulations of the Medical Staff, the Policies and Procedures of the Health System, and applicable state and federal laws, including but not limited to accurate, complete and timely completion of medical and other records for which he/she is responsible, on call responsibility and obligations when on call, performance and documentation of medical history and physical examinations, consultations, and seeking consent for the performance of autopsies when indicated.

## **ARTICLE V**

### **CATEGORIES OF THE MEDICAL STAFF**

#### **Section 1. The Medical Staff**

The Medical Staff shall be divided into Senior, Active, Consulting, Courtesy, Associate and Community Staff categories. The Medical Staff shall enforce and comply with the Medical Staff By-Laws.

##### **Subsection 1.**

The Senior Medical Staff shall consist of those physicians, dentists and midwives who, at the age of 60, request senior status, or at an earlier age at the discretion of the Executive Committee, if he/she has served ten (10) years as an attending practitioner. The Senior Staff shall have no regularly assigned duties. They may admit and attend private patients and may consult on patients upon request. They may vote, may not hold elective office, shall not be required to pay dues or attend Medical Staff meetings, and may serve on committees.

##### **Subsection 2.**

The Active Medical Staff shall consist of physicians, dentists and midwives, who regularly admit patients to the Hospital and who assume all functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, hold office, and serve on the Medical Staff committees and shall be required to attend Medical Staff meetings and pay dues. Members of the Active Medical Staff shall have the privilege of admitting and attending patients, shall attend service patients in the Hospital and in the outpatient programs as assigned. Members of the Active Medical Staff shall be classified as follows: Attending, Associate Attending, Assistant Attending, and Voluntary Assistant.

##### **Subsection 3.**

The Consulting Medical Staff shall consist of physicians and dentists who possess special talents, training and education. They may attend patients only upon request of a member of the attending staff, but are not eligible to admit patients. Members of the Consulting Medical Staff shall not be eligible to vote or hold office, and are not required to attend Medical Staff meetings or to pay dues. They may serve on committees.

##### **Subsection 4.**

The Courtesy Medical Staff shall consist of physicians, dentists and midwives, qualified for Medical Staff membership who wish to attend private patients in the Hospital. Members of the Courtesy Medical Staff shall admit no more than four (4) patients a year, excluding normal newborns. Members of the Courtesy Medical Staff shall not be eligible to vote, serve on committees or hold office. Courtesy Medical Staff members are not required to attend Medical Staff meetings. They are required to pay dues. Courtesy Medical Staff members shall maintain Active privileges at another hospital within Onondaga County or a contiguous county.

### **Subsection 5.**

The Associate Medical Staff shall consist of physicians, dentists and midwives, whose sphere of professional activity within the Hospital is limited to the Ambulatory Outpatient Departments (excluding procedures performed in the Operating Room). They shall perform such teaching and service assignments as requested by the appropriate Clinical Department Chairperson or his/her designated representative. The Associate Medical Staff members shall not be eligible to vote. They may not hold elective office but may hold appointive office. They shall not be required to pay dues or attend meetings.

### **Subsection 6.**

The Community Medical Staff shall consist of physicians, dentists and midwives qualified for Medical Staff membership, but who would not participate in direct patient care or maintain clinical privileges. Members of the Community Medical Staff shall be permitted to visit patient and review medical records, but shall have no admitting privileges nor be permitted to write inpatient orders. A consultation and/or progress note may be written in the medical record at the request of the admitting Medical Staff member. Community Medical Staff members shall not be eligible to vote or hold elective office, but may hold appointive office. They are required to pay dues and may serve on committees.

### **Subsection 7.**

A leave of absence may be granted by the Department Chairperson for a period of no more than one year. Requests shall be made in writing to the Department Chairperson. Prior to the resumption of clinical activities, a Medical Staff member must provide to the Chairperson, in writing, the reason for the leave of absence as well as any other information the Chairperson reasonably needs to evaluate the Medical Staff member's current competency and health status.

### **Subsection 8.**

Organ Procurement: Practitioners from organ procurement organizations designated by the Secretary, U.S. Department of Health and Human Services, who are engaged in the Hospital solely in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and the requirements of the laws of the State of New York are exempt from the requirement to obtain Medical Staff appointment and privileges in order to carry out their activities in the Hospital.

## **Section 2. Initial Appointments**

A. Medical Staff applicant members shall be assigned to a Department where their performance shall be observed by the Chairperson of the Department or his/her representative to determine the eligibility of such members for regular Medical Staff membership and for exercising the clinical privileges initially granted to them. Members who have shown no clinical activity may advance to regular staff membership by providing proof of competent clinical activity at another institution. If the applicant has no clinical activity at another institution, presenting information from another competent source that has observed the applicant and can attest to his/her clinical competence must be provided for consideration.

B. An unfavorable focused professional practice evaluation will result in failure to advance an initial appointee to regular Medical Staff status and shall be deemed a termination of his/her Medical Staff appointment. An initial appointee whose membership is so terminated shall have the rights accorded by these By-Laws to a member of the Medical Staff who has failed to be reappointed.

**Section 3. Clinical Affiliates**

Members of medically related professions who play a significant role in the program of patient care at St. Joseph's Hospital Health Center who meet the qualifications as set forth in the Rules and Regulations of the Medical Staff may be appointed as Clinical Affiliates of the Hospital. Podiatrists who meet the qualifications as set forth in the Rules and Regulations of the Medical Staff may be privileged to admit patients to the hospital.

**Section 4. Emeritus Status**

Appointment to the Emeritus Medical Staff may be offered to physicians, dentists and midwives who have retired from the Medical Staff and who have retired from active patient care in the Hospital and who have served on the Medical Staff in an exemplary fashion.

Emeritus Medical Staff members are not required to have a current professional license. Emeritus Medical Staff members may attend Medical Staff and Department meetings as well as other activities sponsored by the Medical Staff. They shall not admit or attend patients in the Hospital and shall have no clinical privileges. They shall otherwise abide by the Medical Staff By-Laws and all other policies and rules of the Hospital. They may not vote, may not hold elective office, and shall not be required to pay dues.

**Section 5. Dues**

Dues shall be assessed by the Medical Staff at its Annual Meeting to support activities and obligations of the Medical Staff. Members in categories required to pay dues shall receive a notice of assessment in conjunction with their reappointment application, and payment will be due by their next reappointment date. Any Member who fails to pay dues will be ineligible for reappointment, subject to appeal to the Medical Executive Committee in case of hardship. Those Members not reappointed will need to reapply for membership on the Medical Staff.

**ARTICLE VI**

**PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT**

**Section 1. Application for Appointment**

A. Application for membership to the Medical Staff shall be presented in writing on the prescribed form which shall include authenticated qualifications and references by the applicant who shall also have signified his/her agreement to abide by the By-Laws, Rules and Regulations of the Medical Staff, and Policies and Procedures of the Health System. All supporting documentation must be received within 180 days of the presentation of the application form; otherwise the application will be deemed to have been withdrawn by the applicant. The completed application for membership shall be presented to the Chief Executive Officer of the Hospital who shall transmit it to the Credentials Committee within fifteen (15) days for evaluation. All the specified documentation and information shall be maintained in the credentials file of each applicant.

Pursuant to New York State regulations, the Hospital may designate, by contract, an agent to receive and collect credentialing information, perform all required verification activities, and act on behalf of the Hospital for such credentialing purposes.

B. Within sixty (60) days after the receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the

Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of character, professional competence, qualifications, a verified current licensure with the New York State Education Department, verification of identity, and ethical standing of the practitioner and shall determine through information contained in references given by the practitioner and other sources available to the Committee, including an appraisal from the Clinical Department Chairperson in which the privileges are sought, whether the practitioner has established and meets all necessary qualifications for the category of Medical Staff membership and the clinical privileges requested by him/her. Experience, ability and current competence in performing requested privilege(s) may include an assessment for proficiency in the following areas: Patient Care, Medical/Clinical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice. The Chairperson of every Department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations, including delineation of the practitioner's clinical privileges. These recommendations shall be based upon sufficient clinical performance information to make such a recommendation.

C. At its next regular meeting after receipt of the application and report of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the practitioner be appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint shall also specifically recommend the clinical privileges to be granted. The recommendation of the Executive Committee shall be transmitted to the Governing Board through the Chief Executive Officer. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within forty (40) days with a subsequent recommendation either for appointment with specified clinical privileges or for rejection for Medical Staff membership.

D. When the recommendation of the Executive Committee is adverse to the applicant, either in respect to the appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these By-Laws. If, after considering the report and recommendation of the Hearing Committee and the hearing record, consistent with the provisions of Article VIII of these By-Laws, the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph C of this Section 1. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article VIII of these By-Laws. At its next regular meeting, after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act in the matter. If the Governing Body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these By-Laws and until there has been compliance with subparagraph B of this Section 1. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before. At its next regular meeting after all of the practitioner's rights under Article VIII have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The

Governing Body's decision shall be conclusive except that the Governing Body may defer final determination by referring the matter back to the Executive Committee of the Medical Staff for further reconsideration. Any such referral back shall state the reasons therefor, 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. At its next regular meeting after receipt of such subsequent recommendations and new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the practitioner to the Medical Staff or to reject him/her for Medical Staff membership. All decisions to appoint shall include the delineation of the clinical privileges which the practitioner may exercise. Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Governing Body shall submit the matter to the Joint Conference Committee as set forth in Article VIII, Section 6, subparagraph E for review and recommendation and shall consider such recommendation before making its decision final. When the Governing Body's decision is final, it shall send notice of such decision through the Chief Executive Officer to the Secretary of the Medical Staff, to the Chairperson of the Executive Committee, the Department concerned, and by certified mail to the practitioner.

## **Section 2. Reappointment Process**

A. The Department Chair shall review all pertinent information available on each practitioner, including consideration of his/her health status, and shall make recommendations to the MEC who will then recommend to the Governing Body regarding reappointment and changes in category of appointment and in clinical privileges. This process shall include a report by the appropriate Department Chairperson of the individual's continuing education effort made since the previous appointment and the individual's statement relative to any change in health status. Reappointment includes minimum criteria for CME and any other department approved criteria.

The minimum criteria for continuing education shall be:

1. Current American Medical Association Physician's Recognition Award; or
2. Current satisfaction of the continuing education requirement of a recognized specialty society; or
3. Passing a certification or recognition examination of a specialty board within the past three years;  
or
4. Obtaining a certificate of additional training from a specialty board within the past three years; or
5. Completing an ACGME accredited residency or fellowship program within the past three years; or
6. Fulfillment of 50 hours of AMA category I credits for physicians, 30 hours of ADA credits for dentists and 30 hours of credits for midwives per reappointment cycle.

Each Medical Staff member shall further provide information relating to involvement in



any adverse settlement or judgment of malpractice actions, any successful challenges to licensure or registration, voluntary or involuntary relinquishment of any license or registration, and to loss of medical or dental organization memberships. The Medical Staff member shall provide the names of any facilities with which he/she is or has been associated. Further, in situations where such associations have been voluntarily or involuntarily discontinued, the Medical Staff member shall provide the reasons for such discontinuance. Each Medical Staff member shall provide additional information regarding the voluntary or involuntary resignation, withdrawal, limitation, reduction or loss of association or clinical privileges at another facility. There shall be a waiver by the Medical Staff member of any confidentiality provisions concerning the information to be provided to the Hospital pursuant to this requirement.

In addition, it is required that the Medical Staff member provide information concerning the substance of allegations in any pending professional medical or dental misconduct proceeding or malpractice actions, and any additional information concerning such proceedings or actions as the practitioner may deem appropriate.

The Medical Staff member will verify and attest that the information provided is true and accurate.

The National Practitioner Data Bank must be queried at least every two years for information related to professional conduct and competence, licensure status, and malpractice claims experience of each Medical Staff member or clinical affiliate on staff.

Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

- B. All information will be maintained in the credentials file of each Medical Staff member.
- C. Thereafter, the procedure provided in Section I of this Article VI relating to recommendations on applications for initial appointment shall be followed.

### **Section 3. Revision of Privileges**

A Medical Staff member may request a revision of his/her privileges at times other than at appointment or reappointment. The request shall include pertinent information relative to the member's education, training, professional experience, references who are knowledgeable about his/her competence, current health status, pending professional misconduct proceedings or pending malpractice actions, and judgments or settlements of malpractice actions or any findings of professional misconduct. The National Practitioner Data Bank must be queried prior to granting a revision of privileges.

Requests for revised privileges may be recommended by the Department Chairperson and granted by the Governing Body in the same manner as requests for renewal of privileges. Adverse decisions regarding requests for revision of privileges shall entitle the affected practitioner to the procedural rights provided by Article VIII of the By-Laws.

**Section 4. Emergency Privileges**

In the case of an emergency, any member of the Medical Staff member to the degree permitted by his/her license and regardless of his/her service or Medical Staff status or lack thereof, shall be permitted and assisted to do everything possible to save the life of a patient, including using every facility of the Hospital necessary and calling for any consultation necessary or desirable. When an emergency situation no longer exists, such member of the Medical Staff must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an emergency is defined as a condition in which serious permanent harm would result to a patient without immediate treatment or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

**Section 5. Temporary Privileges**

A. Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, and in order to fulfill an important patient care, treatment and service need, the Chief Executive Officer or designee may, upon the basis of information then available, which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with the concurrence of the Medical Executive Committee, or President of the Medical Staff, grant temporary admitting and clinical privileges to the applicant for a period not to exceed 120 days. In exercising such privileges, the applicant shall act under the supervision of the Chairperson of the Department to which he/she is assigned. For the purpose of granting temporary membership and clinical privileges, the Department Chairperson may act on behalf of the Medical Executive Committee.

B. Temporary admitting and clinical privileges may be granted, prior to the review by the Governing Body, to an applicant with a complete application that raises no concerns to the Department Chairperson, Medical Staff President and Hospital Chief Executive Officer.

C. Temporary clinical privileges may be granted for the care of a specific patient by the Chief Executive Officer or designee to a physician whose specific expertise is otherwise not available and is necessary for the care of the specific patient. The physician does not need to apply for membership on the medical staff prior to seeing a patient. The physician must have unrestricted privileges at another hospital that has a credentialing process that meets the requirements of the Medicare Conditions of Participation. The physician shall be required to sign acknowledgment that he/she has received and read copies of the Medical Staff By-Laws, Rules and Regulations and the Code of Conduct. He/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than three patients in any one Medical Staff year by any physician, after which such physician shall be required to apply for membership in the Medical Staff before being allowed to attend additional patients.

D. The Chief Executive Officer or designee may grant temporary clinical privileges, with the concurrence of the Medical Executive Committee to a practitioner of documented competence and ethical standing who is serving as a locum tenens for a member of the Medical Staff for the term of the locum tenens, but not to exceed a period of 6 months.

E. Criteria for granting temporary clinical privileges shall include:

- Verification of education;
- Demonstration of current competence;
- Primary verification of State professional licenses;
- Receipt of professional references (including current competence);
- Receipt of database profiles from the AMA, AOA, NPDB, OIG

Medicare/Medicaid Exclusions.

#### **Section 6. Disaster Privileges**

Practitioners who are not members of the Medical Staff or Clinical Affiliate Staff or do not have approved clinical privileges at the Hospital may practice at the Hospital during an “emergency” (defined as any officially declared emergency, whether it is local, state or national). Emergency disaster privileges may only be granted when the Hospital Emergency/Disaster Operation Plan has been activated as a result of an emergency-disaster situation and the Hospital is unable to handle the immediate patient needs. The following procedure will be followed:

- All practitioners requesting temporary emergency privileges are to be referred to the Medical Staff Office.
- Each individual will provide to the hospital at a minimum:
  - ⇒ A valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport)

**AND** (at least one of the following):

- ⇒ A current hospital photo identification card or state issued photo identification that clearly identifies professional designation;
- ⇒ A current license, certification, or registration primary source verification of licensure, certification or registration;

⇒ Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organizations or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances. Such agencies would include:

- The Department of Health and Human Services in partnership with other Federal Agencies such as Department of Defense, Department of Veterans Affairs, and the Federal Emergency Management Agency

In addition to the above, the practitioner shall complete the Disaster Credentialing Form.

- Verification of the information will be done as quickly as possible. Telephone inquiry will be obtained and documented from the hospital where active staff privileges are held. Verification of current, valid licensure will be obtained as soon as the immediate situation is under control and completed within 72 hours from the time the practitioner presents to the hospital via the applicable State's web site and/or direct telephone communication to the licensing agency. In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (for example, no means of communication or lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the practitioner has not provided care, treatment, and services under the disaster responsibilities. Queries to the National Practitioner Data Bank will be placed. Records of the verified information will be maintained.
- Any information that is gathered that is not consistent with that provided by the practitioner shall be referred to the Chief Medical Officer immediately, who will determine the need for additional action.
- The Chief Medical Officer or the Department Chairperson will review the request for temporary emergency privileges. The Chief Executive Officer or his physician designee will approve/disapprove the temporary emergency privileges on a case-by-case basis at his or her discretion.
- The practitioner shall be granted privileges on an emergency basis for his or her specialty. The Chief Medical Officer or Department Chair shall assign tasks consistent with the Hospital's immediate needs. Practitioners shall wear identification armbands for the benefit of the Hospital and Medical Staff.

Declaration by the Chief Executive Officer or his designee that all emergency/disaster operations have

been terminated will automatically terminate all temporary emergency privileges.

**Section 7. Expedited Credentialing**

An expedited process for appointment to the Medical Staff or Clinical Affiliate Staff and the granting of privileges may be utilized to meet the urgent need of the hospital, provided that the applicant has submitted a complete application and the Credentials Committee and Medical Executive Committee have made a favorable recommendation for appointment. Expedited appointment to the Medical Staff and Clinical Affiliate Staff requires approval by at least two members of the Governing Body.

An applicant is ineligible for the expedited process if any of the following occur:

- The applicant submits an incomplete application.
- The Medical Staff Executive Committee makes a final recommendation that is adverse or has limitations.
- There is a current challenge or a previously successful challenge to the applicant's licensure or registration.
- The applicant has received an involuntary termination of Medical Staff membership at another organization.
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
- The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

**Section 8. Telemedicine Privileges**

- (a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO in consultation with the President of the Medical Staff:
  - 1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such case, the individual must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to geography location and emergency call responsibilities.

- 2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
  - i. Confirmation that the practitioner is licensed in New York;
  - ii. A current list of privileges granted to the practitioner;
  - iii. Information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
  - iv. A signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
  - v. A signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate and up-to-date; and
  - vi. Any other attestations or information or required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection (2), the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in these Bylaws.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.
- (f) Notwithstanding the process set forth in this subsection (2), the Hospital shall still obtain license verification for New York and a report pertaining to the applicant from the National Provider Data Bank.

#### **Section 9. Locum Tenens Privileges**

- 1) Please see Locum Tenens definition, policy, and procedure at <https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=12917>

- 2) Receipt of a completed Application for Staff Membership and Delineation of Clinical Privileges within thirty days of release.
- 3) A minimum of three documented references, all of whom have personal knowledge of the applicant's current clinical ability/competence, ethical character, ability to perform the requested privileges and ability to work cooperatively with others and who have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time. At least one should have current organizational responsibility for supervision of his performance (e.g. Department Chairman, Service Chief, and/or Director of Training Program).
- 4) No record of involuntary termination of medical staff membership at another organization or involuntarily limitation, reduction, denial, or loss of clinical privileges, without thorough investigation. A voluntary resignation will not be accepted after the initiation of an investigation or proceeding pertaining to a possible loss or reduction of privileges.
- 5) No record of current or previously successful challenge to licensure or registration without thorough investigation.
- 6) Verification of relevant training and experience – (AMA)
- 7) Verification of current New York State license in good standing and DEA.
- 8) Verification of coverage by professional liability insurance in the amount of \$1,300,000-\$3,900,000 and verification of claims history
- 9) Enrollment in the K-Checks on-going monitoring system indicates no findings as noted above without thorough investigation.
- 10) Reports from the National Practitioner Data Bank and NYS Office of Professional Medical Conduct indicate no findings as noted above without thorough investigation.
- 11) Required in services
- 12) Required documentation to include but not limited to: Attestation Statement, Confidentiality Statement, COBRA card, Site and Side cards, History & Physical, Infection Control certificate and Photo.
- 13) Delineation of Privileges
- 14) Last 3 years employment history/Affiliations
- 15) Board Certification
- 16) Locums are credentialed for a period not to exceed 180 consecutive days. Privileges are relinquished when contract is ended.

**Section 10. Responsibility of Medical Staff Membership**

Report any of the following events in writing to the CMO within fifteen (15) days after it occurs: (a) the Member is convicted of (or pleads guilty or no contest to) a felony, (b) disciplinary action is imposed on the Member by a licensed health facility, (c) the Member resigns or limits his clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings, (d) the Member's license to practice a health profession or to prescribe drugs in any jurisdiction is terminated, limited, placed on probation, relinquished, or lapses, (e) payment is made in settlement or judgement of a professional liability claim against the Member, or (f) Member is being investigated or sanctioned by the Office of the Professional Medical Conduct (OPMC)

**ARTICLE VII**

**CORRECTIVE ACTION**

**Section 1. Procedure**

A. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or abusive or harassing, or to be disruptive to the operations of the Hospital, or in violation of the By-Laws, Rules and Regulations, or Policies and Procedures of the Health System, corrective action against such practitioner may be requested by: any officer of the Medical Staff, the Chairperson of any Clinical Department, the Chairperson of any Standing Committee of the Medical Staff, the Director of Corporate Compliance, the Chief Nursing Officer, the Chief Executive Officer, the Chief Medical Officer, or the Governing Body. All requests for corrective action shall be in writing, shall be made to the Grievance Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

B. The recommendation of the Grievance Committee on a request for corrective action may be one or more of the following: rejection or modification of the request for corrective action; issuance of a warning, a letter of admonition, or a letter of reprimand; imposition of terms of probation or a requirement for consultation; recommendation of reduction, suspension or revocation of clinical privileges. On receipt of a formal complaint the Grievance Committee will conduct a thorough review, allowing the medical staff member the opportunity to participate. The action of the Grievance Committee shall be decided by a majority vote. The recommendation of the Grievance Committee shall be reported to the MEC and then submitted to the Governing Board for final approval.

C. Any recommendation by the Grievance Committee approved by the Governing Board for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article VIII of these By-Laws.

D. The Chairperson of the Grievance Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Grievance Committee



and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection herewith.

**Section 2. Administrative Suspension**

A. A temporary suspension of admitting privileges (No Admit List) may be imposed after failing to complete medical records within thirty (30) days after discharge. The temporary suspension of privileges shall remain in effect until all medical records that are over 30 days past discharge have been completed. If a physician fails to complete the delinquent records within 7 days (one week) of being suspended, this will be counted as one (1) occurrence of Administrative Suspension of Privileges.

B. If there have been more than three (3) consecutive weeks of occurrences of Administrative Suspension or six (6) cumulative weeks of occurrences of Administrative Suspension within the Medical Staff year due to incomplete medical records over thirty (30) days old, a summary suspension may occur as set forth in the procedure outlines in the Rules and Regulations.

**Section 3. Automatic Suspension**

A. Immediate and automatic suspension of a practitioner's clinical privileges will occur in any of the following instances. Should any of the following occur, it is the obligation of the practitioner to immediately notify the Chief Executive Officer of the Hospital with a copy sent to the pertinent Department Chairperson and the President of the Medical Staff, in writing by either e-mail or US mail.

- The practitioner's professional license has been revoked or suspended for any reason.
- If convicted of a felony related to misuse of controlled substances, illegal drugs, fraud or abuse, violence, or any act that would reflect adversely on the reputation of the healthcare organization and/or the confidence of the community, the practitioner shall automatically and voluntarily relinquish membership and privileges without right to a fair/judicial hearing or review.
- The practitioner's DEA certificate has been revoked, suspended or on probation for any reason.
- The practitioner has failed to maintain the minimum specified amount of professional liability insurance as required in the Medical Staff Rules and Regulations.
- The practitioner's Medicaid or Medicare participation has been terminated or the practitioner revoked or excluded.

- B. It shall be the duty of the President of the Medical Staff to cooperate with the Chief Executive Officer in enforcing all automatic suspensions.

**Section 4. Summary Suspension**

A. Any two of the following - President of the Medical Staff, Chief Medical Officer, the Chairperson of a Clinical Department, or the Chief Executive Officer, - shall have the authority, whenever action must be taken immediately in the best interest of patient care and safety at the Hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

B. Specific circumstances that may warrant summary suspension include, but are not limited to: a pattern of practice below generally accepted standards; grossly negligent care; evidence of gross incompetence; practicing while impaired by alcohol, drugs, physical disability or mental disability; or a significant violation of the Code of Conduct.

C. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Grievance Committee of the Medical Staff hold a hearing within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Grievance Committee shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The date shall not be less than thirty (30) nor more than ninety (90) days after the date of the notice of hearing, unless mutually agreed upon between the parties. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, a list of the witnesses, if any, expected to testify at the hearing on the part of the hearing body, and any other reasons or subject matter that were considered in making the adverse recommendation or decision.

D. Immediately upon the imposition of a summary suspension, the President of the Medical Staff or responsible Department Chairperson shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

**ARTICLE VIII**

**HEARING AND APPELLATE REVIEW PROCEDURE**

**Section 1. Right to Hearing and Appellate Review**

A. When any practitioner receives notice of corrective action from the Grievance Committee that will adversely affect his/her appointment to or status as a member of the Medical Staff

or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before the Executive Committee of the Medical Staff.

B. If the decision of the Executive Committee following such hearing is 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.

## **Section 2. Request for Hearing**

A. The Chief Executive Officer shall be responsible for giving prompt written notice of a request for corrective action or decision to any affected practitioner who is entitled under these By-Laws to a hearing or to an appellate review, by certified mail, return receipt requested. Notice shall include the actions or recommended actions proposed to be taken against the practitioner, the reasons therefore, and that the practitioner's rights in the hearing are as set forth in this Article VIII, a copy of which shall accompany the notice.

B. The practitioner's request for hearing or appellate review must be in writing, addressed to the President of the Medical Staff with a copy to the Chief Executive Officer and must be made within thirty (30) days of the mailing of the notice of corrective action.

C. The failure of a practitioner to request a hearing or an appellate review to which he/she is entitled by these By-Laws within thirty (30) days of the mailing of a notice of corrective action shall be deemed a waiver of his/her right to such hearing or to any appellate review to which he/she might otherwise have been entitled in the matter, and the decision or recommendation shall be effective as against the practitioner in the same manner as a final decision of the Governing Body.

## **Section 3. Notice of Hearing**

A. Within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested, which date shall not be less than thirty (30) nor more than ninety (90) days after the date of the notice of hearing, unless mutually agreed upon between the parties.

B. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, a list of the witnesses, if any, expected to testify at the hearing on the part of the hearing body, and any other reasons or subject matter that were considered in making the adverse recommendation or decision.

## **Section 4. Composition of Hearing Body**

A. When a Hearing relates to a request for corrective action, such Hearing shall be conducted by the Executive Committee.

B. When a hearing relates to an appeal from a decision of the Executive Committee, such hearing shall be conducted by the Governing Body or a Hearing Committee appointed by the Governing Body which committee shall report the evidence and its recommendations to the Governing Body.

**Section 5. Conduct of Hearing**

A. There shall be at least a majority of the members of the Hearing body present when the Hearing takes place, and no member may vote by proxy. Any member who is in direct economic competition with the practitioner, as reasonably determined by the Hearing Committee or the person who made the request for an investigation or for corrective action shall be disqualified from voting at the Hearing. Any partner or member of a practice group of the charged practitioner shall also be disqualified from voting at the Hearing.

B. Hearings shall be held as a separate session of the Executive Committee. Committee members shall be sent notice of the time, place and date of the Hearing at least seven (7) days in advance of the Hearing.

C. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Article VIII and to have accepted the adverse recommendation or decision involved.

D. Postponement of hearings beyond the time set forth in these By-Laws shall be made only with the approval of the hearing body. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

E. The hearing need not be conducted strictly according to the rules of the law relating to the examination of witnesses or presentation of evidence. The Executive Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person authorized to do so who is designated by the Executive Committee or by affirmation under penalty of perjury to the presiding officer. Any evidence determined relevant by the presiding officer, including hearsay, shall be admissible if it is the sort of evidence upon which responsible persons customarily rely in the conduct of serious affairs, regardless of the existence of any common law rule which might make evidence inadmissible over objection in a civil or criminal action. The Chairperson of the Executive Committee shall appoint a member of the Medical Staff to present the case against the practitioner. Both sides shall be entitled to call, examine and cross-examine witnesses, to present documentary evidence determined to be relevant by the presiding officer and to submit prior to the close of the hearing written memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing records. The Executive Committee may, itself, interrogate witnesses and call additional witnesses if it deems necessary or appropriate.

F. The practitioner and the Executive Committee may have legal counsel present and may consult with and receive advice from counsel, but such counsel shall have no right to interrogate witnesses, offer evidence or otherwise actively participate in the proceedings.

G. The Executive Committee shall arrange for the presence of a stenographer at the hearing and shall, upon payment of the reasonable cost of same by the practitioner, provide the practitioner with a written transcript of the proceeding.

H. The Hearing body may, without special notice, recess the Hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. If the Hearing is recessed and reconvened, only those members of the Executive Committee who participated in the original Hearing may participate in the reconvened Hearing. Upon conclusion of the presentation of oral and written evidence, the Hearing shall be closed. The Hearing body may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the Hearing was convened. The action of the Hearing body shall be determined by a majority of the votes cast except when a 2/3 vote is required, in which case the 2/3 shall be determined by a count of the votes cast.

I. Within thirty (30) days after final adjournment of the hearing, the hearing body shall make a written report and recommendation, which shall include a statement of the basis for the recommendation, and shall forward the same and all other documentation to the Chief Executive Officer. Any recommendation by the hearing body for revocation of membership or revocation or permanent reduction of clinical privileges must be supported by two-third (2/3) of the votes cast.

## **6. Appellate Review: Appeal to the Governing Body**

A. Within thirty (30) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision of the Executive Committee relating to a reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff, he/she may, by written notice to the Governing Body delivered to the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the Governing Body.

B. If such appellate review is not requested within thirty (30) days after date or receipt of a notice of such adverse recommendation or decision, the affected practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article.

C. Within thirty (30) 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 Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same.

D. The Governing Body shall act as the appellate body. It shall review the record created in the proceedings, and shall consider any written statements for the purpose of determining whether the decision against the affected practitioner was justified. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the Governing Body.

E. The Governing Body may affirm, modify or reverse the prior decision of the Executive Committee or, in its discretion, refer the matter back to the Executive Committee of the

Medical Staff for further review and recommendation within twenty (20) days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues. If any proposed corrective action by the Board of Trustees will substantially modify the recommendation of the Executive Committee, the Board shall submit the matter to an ad hoc Joint Conference Committee for review and recommendation prior to making its final decision. This Committee shall be appointed by the Board and shall be composed of an equal number of members of the Board and members of the Active Medical Staff.

F. Notice of the final determination of the Board, including a statement of the basis for the decision, will be promptly sent by certified mail, return receipt requested, from the Chief Executive Officer to the affected practitioner and to the Executive Committee.

G. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital By-Laws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

#### **Section 7. Reapplication after Adverse Appointment Decision**

An applicant receiving a final adverse decision regarding appointment or expulsion is not eligible to reapply for appointment to the Medical Staff or the Clinical Affiliate Staff for a period of one year from the date of the final adverse decision. Any such reapplication shall be processed as an initial application. The applicant will be expected to submit such additional information as the Medical Staff and the Governing Body may require to determine that the basis for the earlier adverse action no longer exists.

### **ARTICLE IX**

#### **CLINICAL DEPARTMENTS**

##### **Section 1. Organization of Clinical Departments and Services**

A. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who shall be responsible for the overall supervision of the clinical work within his/her Department and the Vice-Chairperson who shall serve during the absence of the Chairperson. Where appropriate a Department may have Clinical Sections which shall be organized as specialty subdivisions within a Department, shall be directly responsible to that Department within which they function, and shall have a Chief of the Section. All appointments to the Medical Staff shall be made in one or more of the Clinical Departments, and where applicable, a Clinical Section.

B. The Medical Staff of the Hospital shall be organized into Clinical Departments with respective Sections where appropriate, as follows:

1. Anesthesiology
2. Emergency Medicine

3. Family Medicine
4. Internal Medicine
5. Musculoskeletal
6. Obstetrics and Gynecology
7. Pathology
8. Pediatrics
9. Psychiatry
10. Radiology
11. Surgery

**Section 2. Qualification, Selection and Tenure of Department Chairpersons, Vice-Chairpersons, and Section Chiefs**

A. Each Chairperson, Vice-Chairperson, and Section Chief shall be a member of the Active Medical Staff best qualified by training, experience, and demonstrated ability for the position and shall be Board certified in his/her specialty or demonstrate equivalent qualifications.

B. The Governing Body shall appoint each Department Chairperson after receiving and considering recommendations for appointment from the Executive Committee of the Medical Staff. The Executive Committee shall submit its recommendation after consultation with the pertinent Department. The Department shall recommend a candidate to the Medical Executive Committee after holding an election to determine the will of the Department. Members qualified to vote in this election shall be Department members in good standing who are members of the Senior or Active Medical Staff. A majority of votes cast in person at a scheduled meeting of the Department shall be required to determine the will of the Department. If there are more than two candidates, in the absence of a majority vote, a runoff election shall be held, dropping the candidate with the lowest vote count from the field of candidates. Those candidates eligible to serve as Chairperson or Vice-Chairperson shall have attended at least fifty percent (50%) of Department meetings during the prior two years or fifty percent (50%) of Department meetings in the prior year or are in their first year of membership on the Medical Staff.

The Department Chairperson shall appoint each Section Chief after receiving and considering recommendations from the members of the Department Section.

C. Each Chairperson shall serve a four-year term and shall be eligible for reappointment by the Governing Body through the process defined in Section 2, subparagraph B of this Article.

D. Each Vice-Chairperson shall be qualified, selected and have tenure as described for the Chairperson in subparagraphs A, B, and C of this section.

E. Each Section Chief shall serve for the duration of the term of the Department Chairperson, but not longer than four (4) years. He/she shall be eligible for reappointment so long as he/she fulfills the responsibilities and duties to the satisfaction of the Section Members and Department Chairperson.

F. A Chair, Vice Chair or Section Chief may be removed for cause by following the same procedures by which they were selected. Conditions for removal of such departmental officer may include, but are not limited to, failure to adequately perform his/her duties as an officer of the

department.

**Section 3. Functions of Department Chairpersons/Section Chiefs**

A. Each Chairperson shall:

1. Be accountable for all professional and administrative activities within his/her Department.
2. Be a member of the Executive Committee giving guidance on overall medical policies of the Hospital, and making specific recommendations and suggestions regarding his/her own Department in order to insure quality patient care.
3. Maintain continuing surveillance of the professional performance of the Medical Staff members who exercise privileges in the Department and render regular reports on each member, at least at the time of reappointment -- reappraisal.
4. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who are currently members of the Clinical Affiliate Staff.
5. Be responsible for enforcement of the Hospital By-Laws and of the Medical Staff By-Laws, Rules and Regulations within his/her Department.
6. Be responsible for implementation within his/her Department of actions taken by the Executive Committee of the Medical Staff.
7. Recommend to the Executive Committee, Medical Staff category and classification and the reappointment and delineation of clinical privileges for all practitioners in his/her Department.
8. Recommend to the Executive Committee the criteria for clinical privileges that are relevant to the care provided in the department.
9. Recommend clinical privileges for each member of the department.
10. Assume ongoing responsibility for support of the program of medical education conducted within the Department. Be responsible for the orientation and continuing education of all practitioners in the Department and for the Residents assigned to the Department.



11. Participate in every phase of administration of his/her Department through cooperation with the Clinical Services and the Hospital Administration in matters affecting patient care, including personnel, facilities, supplies and other resources.
12. Assist in the preparation of such annual reports, including budgetary planning, pertinent to his/her Department as may be required by the Executive Committee, the Chief Executive Officer or the Governing Body.
13. Maintain quality control programs, as appropriate.
14. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital.
15. Coordinate and integrate interdepartmental and intradepartmental services.

B. Each Section Chief shall:

1. Serve under the direction of and be accountable to the Chairperson of his/her Clinical Department with the responsibilities and duties assigned by the appropriate Department Chairperson.
2. Be responsible for the overall supervision of the clinical work within his/her Section.
3. Be accountable for all professional and administrative activities within his/her Section.
4. Participate in the continuing surveillance of the professional performance of the Medical Staff members in his/her Sections and assist the Clinical Department Chairperson at the time of the reappointment-reappraisal process and in the delineation of clinical privileges.

**Section 4. Functions of the Vice-Chairperson**

Each Vice-Chairperson shall assume the functions of the Chairperson during the absence of the Chairperson or when the Chairperson has a conflict of interest with respect to a member of the department as determined by the President of the Medical Staff.

**Section 5. Functions of the Departments**

Each Clinical Department shall:

1. Establish its own criteria, consistent with policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges and for the holding of office in the Department.
2. All Section Chairs, Vice Chairs, and Medical Directors will meet the requirements in accordance with Federal and State laws.
3. In conjunction with the Medical Quality Council, establish criteria for conducting a primary, concurrent or retrospective review of records of patients and other pertinent departmental sources of medical information relating to patient care for the purpose of assessing the quality and appropriateness of care. Such review shall be timely and shall include consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnoses and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems.
4. Meet separately to review and analyze the clinical work of the Department. Each surgical division of the Medical Staff shall review the findings of the pertinent care evaluations including tissue review, whether tissue was removed or not, and for the acceptability of the procedure chosen.
5. Submit a report to the Executive Committee detailing each departmental meeting including analysis of patient care.
6. Form a department executive committee, appointed by the chair with the consent of the members, to act on behalf of the department between regularly scheduled departmental meetings. Membership of a departmental executive committee shall include the department chairperson, vice chairperson and at least three other active members of the department. A quorum of the executive committee shall consist, at a minimum, of the chairperson (or vice chair in his/her absence) of the department and at least two other members of the executive committee. The executive committee shall maintain minutes of their proceedings, which are sent to department members.

**Section 6. Creation and Dissolution of Departments and Sections**

- A. The Medical Executive Committee will periodically assess the Hospital's structure and recommend to the Governing Body whether any action is desirable for better organizational efficiency and improved patient care (i.e., creating new or combining departments and/or sections, eliminating departments and/or sections). In addition, any Medical Staff members who satisfy the criteria for departmental or sectional

designation set forth below may petition the Medical Executive Committee in writing and with appropriate supporting documentation for such a designation. The Medical Executive Committee will consider the request and forward its recommendation to the Governing Body for final action. Action taken by the Governing Body pursuant to this section shall be effective on the date of Governing Body action and shall required formal amendment of these By-laws.

B. The following factors shall be considered by the Medical Executive Committee and the Governing Body in determining whether the creation of a department or section is warranted:

1. There exists a number of Medical Staff members who are available for appointment to and are reasonably expected to actively participate in the proposed new department or section (this number must be sufficiently large to enable the department or section to accomplish its functions as set forth in these By-Laws); and
2. The level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental or sectional functions on a routine basis.

C. The following factors shall be considered by the Medical Executive Committee and the Governing Body in determining whether the elimination of a department and/or section is warranted:

1. There is no longer an adequate number of Medical Staff members in the department and/or section to enable it to accomplish the functions set forth in these By-Laws;
2. There is an insubstantial number of patient or insignificant clinical activity to warrant the imposition of the designated duties on the Medical Staff members in the department and/or section;
3. The department and/or section fails to meet to meet often enough to accomplish the functions set forth in these By-Laws;
4. The department and/or section fails to fulfill all department or section responsibilities and functions; or
5. No qualified individual is willing to serve as department chairperson or section chief.

## ARTICLE X

### OFFICERS

#### **Section 1. Officers of the Medical Staff**

The Officers of the Medical Staff shall be:

- A. President
- B. Vice President
- C. Secretary-Treasurer

#### **Section 2. Qualifications of Officers**

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 terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Candidates for office will have demonstrated administrative ability through experience and prior participation in Medical Staff activities and be recognized by their peers for their clinical competence and leadership skills. Candidates for the offices of President and Vice President/President Elect must have served on the Medical Executive Committee or have other demonstrated leadership experience at the Hospital for a period of two years.

#### **Section 3. Election of Officers**

- A. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.
- B. The Nominating Committee shall offer one or more nominees for each office.
- C. Nominations may also be made by petition signed by at least twenty (20) members of the Medical Staff and filed with the Secretary of the Medical Staff at least ten (10) days prior to the annual meeting. Write in candidates are not permitted.
- D. Election ballots will be distributed at the Medical Staff meeting in January. Medical Staff members must be present to vote. Proxy votes are not accepted. Ballots will be tabulated by the Medical Staff office personnel appointed by the President of the Medical Staff for the purpose of tabulating the votes.
- E. The Candidate receiving the most votes (plurality) cast for an office shall be elected. In the event of a tie, there will be an immediate revote involving only the candidates involved in the tie.

**Section 4. Term of Office**

All Officers shall serve a two year term from their election date or until a successor is elected. Officers shall take office immediately prior to the adjournment of the annual meeting at which they are elected.

**Section 5. Vacancies in Office**

Vacancies in office except for the Presidency, occurring during the Medical Staff year shall be filled by action of the Executive Committee of the Medical Staff. Should a vacancy in the office of the President occur, the Vice-President shall serve out the remaining term.

**Section 6. Duties of Officers**

A. The President shall:

1. Act in coordination and cooperation with the Chief Executive Officer 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. Serve as Chairperson of the Medical Staff Executive Committee;
4. Serve as ex-officio member of all other Medical Staff committees without vote;
5. Be responsible for the enforcement of Medical Staff By-Laws, and Rules and Regulations; for implementation of sanctions where they are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
6. Appoint committee members to all standing, special and multi-disciplinary Medical Staff committees, except the Executive Committee.
7. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer; and
8. Receive and incorporate the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibilities to provide medical care.

B. The Vice President shall:

1. In the absence of the President, assume all duties and have the authority of the President.
2. Be a member of the Executive Committee.
3. Automatically succeed the President when the latter fails to serve for any reason.

C. The Secretary-Treasurer shall:

1. Be a member of the Executive Committee of the Medical Staff.
2. Keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence and perform such other duties as ordinarily pertain to this office.
3. Also serve as Secretary of the Executive Committee.
4. Collect dues and pay bills on behalf of the Medical Staff.

**Section 7. Removal of Officers of the Medical Staff**

An officer of the Medical Staff may be removed for cause by a two-thirds vote of the Executive Committee. Conditions for removal of an officer of the Medical Staff may include, but are not limited to, failure to adequately perform his/her duties as an officer of the Medical Staff and/or as a member of the Executive Committee. The affected officer shall have the right to submit the decision for appeal to the Medical Staff. In such event, a two-thirds vote of all voting members of the Medical Staff is required to confirm the Executive Committee action.

**Section 8. Director of Medical Education**

- A. A Director of Medical Education may be appointed by the Governing Body with the concurrence of the Executive Committee of the Medical Staff.
- B. The Director of Medical Education shall:
  1. Assume overall direction of all programs of medical education in the Hospital, including undergraduate, graduate and postgraduate programs.
  2. Appoint all Departmental educational coordinators and direct their teaching activities.

3. Appoint all interns and residents; maintain effective liaison with the SUNY Health Science Center at Syracuse College of Medicine.
4. Serve as a member of the Active Medical Staff.
5. Serve as a permanent member of the Executive Committee.
6. Function as Chairperson of the Department of Medical Education and the Medical Education Committee. Provide regular reports to the Executive Committee regarding departmental activities including, but not limited to the safety and quality of patient care provided by, and the related educational and supervisory needs of residents.
7. Be responsible for implementing the requirements of governmental and medical education accrediting agencies pertaining to residents, unlicensed physicians and medical students.
8. Act as a liaison between Medical Staff and the professional library staff and make recommendations concerning the operations of the medical library, including selection of publications and knowledge-based information services.
9. Function as a liaison between the Medical Education Committee and the Executive Committee.

**Section 9. Medical Staff Director of Corporate Compliance**

A. The Vice President of the Medical Staff shall serve as the Medical Director of Corporate Compliance and shall sit on the Hospital's Corporate Compliance Committee. In the event the vice president is unable to serve in this capacity due to a conflict of interest, the Medical Director of Corporate Compliance shall be appointed by the President of the Medical Staff and confirmed by the Medical Executive Committee. This Director may also hold another office or position in Medical Staff Leadership. This Director shall be free of conflicts of interest to the satisfaction of the Medical Executive Committee.

B. The Medical Staff Director of Corporate Compliance shall:

1. Participate in the review and amendment of any elements of the Business Conduct and Code of Ethics that impact the activity and oversight of Medical Staff members.
2. Participate in the investigation of pertinent complaints about members of the Medical Staff or initiated by members of the Medical Staff.

3. Serve as a liaison between the Office of Corporate Compliance and the Medical Executive Committee.
4. Serve as a member of the Medical Staff.
5. Serve as a member of the Medical Executive Committee.
6. Chair an ad hoc committee of three additional members, appointed by the Medical Staff President, to investigate substantive allegations regarding members of the Medical Staff, and to report the findings of the committee to the Medical Executive Committee for action.

## **ARTICLE XI**

### **COMMITTEES**

Committees of the Medical Staff shall be Standing or Special. Standing Committees of the Medical Staff are:

1. Executive
2. Grievance
3. Credentials
4. Nominating
5. Bylaws
6. Health Information Management
7. Pharmacy and Therapeutics
8. Infection Control
9. Medical Quality Council
10. Health
11. Utilization Review
12. Special Committees

Each of the Standing Committees, except the Executive Committee, shall have a Chairperson, and if appropriate, Vice-Chairperson, appointed annually by the President of the Medical Staff in consultation with the Department Chairperson.

#### **Section 1. Executive Committee**

##### **A. Composition**

The Executive Committee shall be a Standing Committee, whereby the majority of the voting Medical Executive Committee members are fully licensed doctors of medicine or osteopathy actively practicing in the Hospital and shall consist of the Officers of the Medical Staff, the immediate past President of the Medical Staff, the Director of Medical Education, the Medical Staff Director of Corporate Compliance, the Chairperson of each Clinical Department, the Medical Quality Chairperson, a voting member from the Clinical Affiliate Staff actively practicing in the Hospital elected from the Clinical



Affiliate Staff or a term of three (3) years, six (6) Members-at-Large, two (2) of whom shall be elected at each annual meeting of the Medical Staff for a term of three (3) years, and may include other Licensed Independent Practitioners. The Chief Executive Officer, the Chief Nursing Officer and their designees, the Chief Medical Officer, and the By-Laws Committee Chair shall serve as ex-officio members of the Executive Committee without vote. The President may appoint a Medical Staff member as an advisor who participates in all Executive Committee functions ex officio without vote.

No more than two (2) Members-at-Large may be elected from any one Department. Should any Member-at-Large become an Officer or Department Chairperson, another member from the same Department is to be elected by the Executive Committee for the duration of the term. In the event of a vacancy due to death or resignation, the Executive Committee is empowered to elect a replacement.

A Member-at-Large may be removed for cause by a two-thirds vote of the Executive Committee. Conditions for removal of a Member-at-Large may include, but are not limited to, failure to perform his/her duties as a Member-at-Large. The affected Member-at-Large shall have the right to submit the decision for appeal to the Medical Staff. In such event, a two-thirds vote of all voting members of the Medical Staff is required to confirm the Executive Committee action. In the event of a death, resignation or removal, another member from the same Department is to be elected by the Executive Committee for the duration of the term.

#### B. Duties

The duties of the Executive Committee shall be:

1. To represent and act on behalf of the Medical Staff between meetings of the Medical Staff subject to such limitations as may be imposed by these By-Laws;
2. To coordinate the activities and general policies of the various Departments;
3. To receive and act upon committee reports;
4. To implement policies of the Medical Staff not otherwise the responsibility of the Departments;
5. To provide liaison between the Medical Staff and the Chief Executive Officer and the Governing Body;
6. To recommend action to the Chief Executive Officer on matters of a medical-administrative nature;
7. To make recommendations on Hospital management matters to the Governing Body through the Chief Executive Officer;
8. To fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients;
9. To ensure that the Medical Staff is kept abreast of the accreditation program and

informed of the accreditation status of the Hospital;

10. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
11. To review the credentials of all applicants and make recommendations for Medical Staff membership, assignments to Departments and delineation of clinical privileges;
12. To review periodically all information available regarding the performance and clinical competence of Medical Staff members and, as a result of such review, to make recommendations for reappointment and renewal or changes in clinical privileges;
13. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in the Medical Staff corrective or review measures when warranted;
14. To be responsible for the development and maintenance of methods for protection and care of Hospital patients and others at the time of internal and external disaster. Specifically, the Executive Committee shall be responsible for the adoption and periodic review of a written plan to safeguard patients at the time of an internal disaster, particularly fire; shall assure that all key personnel rehearse fire drills consistent with established current standard; shall adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital and that it adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disasters; and shall assure that the plan is rehearsed by key personnel at least twice yearly;
15. To report at each general Medical Staff meeting.
16. To make recommendations to the Governing Body regarding the process used to review credentials and delineate privileges as well as the structure of the organized Medical Staff.

#### C. Meetings

The Executive Committee shall meet at least eleven (11) times a year and maintain a permanent record of its proceedings and actions. Issues to be discussed and/or voted upon between Executive Committee meetings may be addressed via secure e-mail. Votes taken by e-mail shall require a majority of the total of voting members of the MEC for the action to carry. Actions approved in this manner will be reported on at the next meeting of the MEC.

## **Section 2. Grievance Committee**

### **A. Composition**

The Grievance Committee shall be a committee comprised of the following seven (7) positions: The President of the Medical Staff, who shall serve as chairman; the Department Chairperson of the affected provider; and 5 medical staff members appointed by the Medical Staff President, preferably 3 of whom shall be past presidents. The medical staff members and 2 alternates will be appointed by the Medical Staff President at the beginning of each Medical Staff year and approved by the Medical Executive Committee. The Chief Medical Officer, the hospitals General Counsel and the By-Laws Chair shall serve as ex-officio members without vote. All actions of the Grievance Committee shall require seven (7) voting members to be present.

### **B. Duties**

The duties of the Grievance Committee shall be:

1. Those specified in Article VII.

## **Section 3. Credentials Committee**

### **A. Composition**

The Credentials Committee shall be a standing committee and shall consist of a Chairperson and five (5) members of the Active Medical Staff, appointed by the President. A member of the Clinical Affiliate Staff, appointed by the President and actively practicing in the Hospital, will serve as a voting member of the Committee with respect to review and recommendation of Clinical Affiliate applications only.

### **B. Duties**

1. To review the credentials of all applicants for Medical Staff membership and make recommendations for membership and delineation of clinical privileges.
2. To report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges including specific consideration of the recommendations from the Departments in which such applicant requests privileges.
3. To review a request for transfer to the Active Medical Staff from another staff category.
4. At the request of the Department Chairperson, to review a request for a revision of privileges at times other than at reappointment.

5. The Credentials Committee shall maintain a permanent record of its proceedings and actions.

#### **Section 4. Nominating Committee**

##### **A. Composition**

The Nominating Committee shall consist of the immediate past President of the Medical Staff who shall serve as Chair, and two (2) members of the Active Medical Staff appointed by the President. In the event the immediate past President is unable to serve, the Chair of the Nominating Committee shall be appointed by the President.

##### **B. Duties**

The Nominating Committee shall present candidates for election as Officers and for Members-at-Large on the Executive Committee, one (1) month prior to the annual meeting.

Nominations may also be made by petition signed by at least twenty (20) members of the Medical Staff and filed with the Secretary of the Medical Staff at least ten (10) days prior to the annual meeting.

#### **Section 5. Bylaws**

##### **A. Composition**

The Bylaws Committee shall consist of members of the Medical Staff appointed by the President of the Medical Staff.

##### **B. Duties**

The Bylaws Committee shall review the Bylaws periodically as appropriate and at the request of the MEC or the Governing Board. All proposed amendments to the Bylaws shall be referred to the Bylaws Committee for reviewed and recommendation. The Bylaws Committee shall submit its recommendations to the MEC for approval and then to the Medical Staff to be voted upon for acceptance.

##### **C. Meetings**

The Bylaws Committee shall meet as needed.

**Section 6. Health Information Management Committee**

A. Composition

The Health Information Management Committee shall consist of at least one representative of the Medical Staff from each Clinical Department and one each from the Clinical Services and from the Hospital Administration. The Health Information Management Director shall be a member of this Committee.

B. Duties

The Health Information Management Committee shall be responsible for assuring that all medical records meet that highest standards of patient care usefulness and of historical validity, and that the medical records reflect realistic documentation of medical events through complete and timely documentation. This also includes the review and recommendation for approval of forms used in the legal medical record. The Committee shall conduct a regular review of concurrent and retrospective medical records to assure that they properly reflect compliance with all documentation requirements. The Health Information Management Committee identifies and takes action to inform providers when improvement in documentation compliance is necessary.

C. Meetings

The Health Information Management Committee shall meet at least ten (10) times each year and shall maintain a permanent record of its proceedings and activities.

**Section 7. Pharmacy and Therapeutics Committee**

A. Composition

Membership shall consist of at least four (4) representatives of the Medical Staff, and one each from the Pharmaceutical Service, Clinical Services and the Hospital Administration. At least one Hospital pharmacist shall be a member of and act as Secretary to the Committee.

B. Duties

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to insure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisals, selection, procurement, storage, distribution, use, safety, procedures and other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

1. Serve as an advisory group to the Medical Staff and the pharmacists on matters pertaining to the choice of available drugs;

2. Make recommendations concerning drugs to be stocked in the clinical units and by other services;
3. Develop formulary and review periodically (the Hospital drug list);
4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
5. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
6. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
7. Review reports of drug reactions and make appropriate recommendations; and
8. Maintain a subcommittee to assess and improve the safety of the medication safety use process.

C. Meetings

The Pharmacy and Therapeutics Committee shall meet at least quarterly and report to the Executive Committee.

**Section 8. Infection Control Committee**

A. Composition

The Infection Control Committee shall consist of at least one representative from each Clinical Department, together with one representative from Clinical Services, Housekeeping, Home Care, the Hospital Administration, Infection Control Office Patient Safety and Risk Management and ad hoc members as necessary from Facilities Services, Pharmacy, Central Sterile and Nutritional Services.

B. Duties

The Infection Control Committee shall be responsible for oversight of the recommended surveillance of nosocomial or health care acquired infections and the associated prevention and control activities. The committee will analyze actual infections and shall make appropriate recommendations for the control of infections within the Hospital as well as review

Centers for Disease Control and Prevention and New York State Department of Health advisories, recommendations and guidelines.

C. Meetings

The Infection Control Committee shall meet at least quarterly, shall maintain a record of its proceedings and activities and shall report quarterly to the Medical Quality Council.

**Section 9. Medical Quality Council**

A. Composition

The Medical Quality Council shall consist of a physician and alternate from each of the Clinical Departments: Anesthesia, Emergency, Family Medicine, Medicine, Pathology, Obstetrics/Gynecology, Pediatrics, Psychiatry, Radiology and Surgery. The Medical Quality Council is chaired by the Medical Quality Chairperson. The Quality Resources Director shall be a member and attend all meetings. Non-physicians shall be appointed by the President of the Medical Staff in consultation with Administration. The Chairperson of the Medical Quality Council shall be a voting member of the Medical Staff Executive Committee.

B. Duties

The Medical Quality Council is formed for the purpose of integrating and coordinating the Hospital's peer review process and quality improvement functions. Peer review shall meet at regular intervals to review and analyze medical records of the patients for adequacy and quality of care. Its primary function is to provide a forum for the resolution of the Medical Staff multi-disciplinary patient care issues as well as the ongoing review of policies and procedures related to the peer review process. The Medical Quality Council utilizes a systems analysis approach through project work teams to improve the quality and safety of care, support better outcomes and reduce the risk of health care errors.

The Medical Quality Council will perform tissue review and assess data collected through the peer review process. Identified trends, multi-disciplinary issues and opportunities for improvement will be reviewed by the Medical Quality Council and shared with Medical Staff members with identified performance problems.

Multi-disciplinary project work teams are convened through the Medical Quality Council when opportunities for improvement are identified for intensive assessment by the Performance Improvement and Safety Steering Council. Project work teams will provide monthly minutes and progress reports as needed to the Medical Quality Council. Membership and frequency of meetings is determined by the focus of the initiative.

The file of Performance Improvement activities for each member of the Medical Staff shall be maintained by the Performance Improvement office. The individual member's Performance Improvement profile will be updated at least annually.

Changes in committee functions or procedures may be made as needed by the approval of the Executive Committee of the Medical Staff.

C. Meetings

The Medical Quality Council shall meet monthly at least nine (9) times each year and provide a written report to the Medical Staff Executive Committee and to Hospital Administration as appropriate. The Medical Quality Council will provide an annual report to the Performance Improvement and Safety Steering Council.

**Section 10. Health Committee**

A. Composition

The Health Committee will consist of two members of the Department of Psychiatry, one member of the Department of Medicine and one member of the Department of Family Medicine, none of whom are members of the Executive Committee of the Medical Staff. The members will be appointed by the President of the Medical Staff and Vice President of the Medical Executive Committee.

B. Duties

The purpose of this Committee is to evaluate through referral or self-referral, impaired members of the Medical Staff to assure they can safely reassume or continue their clinical duties and responsibilities. The Health Committee is also responsible to participate in the evaluation of the Advanced Career Practitioner as set forth in the Rules and Regulations.

C. Meetings

On a Ad Hoc basis.

**Section 11. Utilization Review Committee**

A. Composition

The Utilization Review Physician Advisors shall be composed of at least one (1) member of the Department of Family Practice, Medicine, and Surgery. Efforts will be made to stagger terms to assure continuity. No physician member of the Utilization Review Program may review any case in which he or she has been involved, or if he/she has a direct interest in the case reviewed. The Care Compass Service is composed of Professional Nurses and Medical Social Workers, who are unit or service based.



B. Duties

The Utilization Review Program will promote the maintenance of high quality patient care through the effective and efficient utilization of hospital facilities, services and personnel. The program is responsible for determining the medical necessity of care given all federal and non-federal patients and for ensuring care is of an appropriate quality, medically necessary and rendered at the appropriate level consistent with that quality.

C. Meetings

The Utilization Review Committee shall meet every other month minimally and shall maintain a record of its proceedings and activities and shall report to the Executive Committee on a regular basis.

**Section 12. Special Committees**

Special Committees shall be created from time to time by the Executive Committee for special tasks as circumstances warrant. Special Committees shall limit their activities to the accomplishment of the task for which created and appointed, and shall have no power to act except as is specifically conferred by action of the Executive Committee. A permanent record of the proceedings and actions shall be maintained and reported to the Executive Committee as appropriate. Upon completion of the task for which appointed, such Special Committee shall stand discharged.

**ARTICLE XII**

**MEDICAL STAFF MEETINGS**

**Section 1. Regular Meetings**

The annual meeting of the Medical Staff shall be held in January of each year. The agenda shall include reports of review and evaluation of the work done in the Clinical Departments in the performance of required Medical Staff functions and the election of Officers and Executive Committee Members-at-Large.

**Section 2. Special Meetings**

The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within fourteen (14) days after receipt by him/her of a written request for same, signed by not less than one-quarter of the Active Medical Staff and stating the purpose of such meeting. The President shall designate the time and place of any special meeting. The 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 member of the Medical Staff not

less than 96 hours before the date of such meeting by or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Medical Staff member at his/her address as it appears on the records of the Hospital. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

**Section 3. Quorum**

A. Forty (40) voting members or ten (10%) percent of the total voting members of the Active Medical Staff, whichever is the lesser, shall constitute a quorum at any regular or special meeting.

B. Absentee ballots and proxy votes are not valid.

**Section 4. Agenda**

A. The agenda of any regular Medical Staff meeting shall be:

1. Call to order.
2. Acceptance of the minutes of last regular meeting and those of all special meetings.
3. Unfinished business.
4. Communications.
5. Report from the Chief Executive Officer of the Hospital.
6. Reports of Departments.
7. Reports of Committees.
8. New business, including elections.
9. Review and analysis of the clinical work of the Hospital.
10. Reports of the Medical Committees.
11. Discussion and recommendations for improvement of the professional work of the Hospital.
12. Adjournment.

B. The agenda at the special meetings shall be:

1. Reading of the notice calling the meeting.
2. Transaction of business for which the meeting was called.
3. Adjournment.

**ARTICLE XIII**

**COMMITTEE AND DEPARTMENT MEETINGS**

**Section 1. Regular Meetings**

Committees, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least twelve (12) times each year to review and evaluate the clinical work of practitioners with privileges in the Department. A meeting of the departmental executive committee may substitute for eight (8) of these meetings, provided the department meets at least once each quarter year. At the Department business meetings, the principal agenda item is the review of clinical work done in the Department as evidenced by detailed attention to all the facets of the Performance Improvement reports.

Meetings shall be chaired by the committee or department chairperson, or by the vice-chairperson in the absence of the chairperson. If neither the chairperson nor vice-chairperson can attend a regular meeting, the chairperson may appoint a chair pro tem for the sole purpose of conducting such meeting.

**Section 2. Special Meetings**

A special meeting of any Committee or Department may be called by or at the request of the Chairperson or Chairpersons thereof; by the President of the Medical Staff; or by one-third of the Committee members, but not less than two members.

**Section 3. Notice of Meetings**

Written or electronic notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the Committee or Department not less than 48 hours for the Executive Committee, and not less than 5 days for all other committees and all departments, before the time of such meeting by the person or persons calling the meeting. The business to come before the meeting shall be limited to any item specified in the notice of the meeting, as well as such other business as may routinely come before the Committee or Department.

**Section 4. Quorum**

Ten (10%) percent of the Active Medical Staff members of the Committee or Department, but not less than two (2) members, shall constitute a quorum at any meeting, with the exception of the Medical Staff Executive Committee for which a quorum shall be fifty (50%) percent of the members.

**Section 5. Manner of Action**

The action of a majority of the members present at a meeting in which a quorum is present shall be the action of a Committee or Department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote.

**Section 6. Rights of Ex-Officio Members**

Persons serving under these By-Laws as ex-officio members of a Committee shall have all the rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

**Section 7. Minutes**

The minutes of each regular and special meeting of a Committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken in each matter. There shall be full documentation within the minutes of the Department meetings reflecting detailed attention to all the facets of the Performance Improvement reports. The minutes shall be signed by the presiding officer and copies thereof shall be forwarded to the Executive Committee. Each Committee and Department shall maintain a permanent file of the minutes of each meeting.

## ARTICLE XIV

### IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application and/or reapplication for, or exercise of, clinical privileges at this Hospital:

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

2. That such privilege shall extend to members of the Hospital's Medical Staff and its Governing Body, its other practitioners, its Chief Executive Officer 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 XIV, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

3. That there shall be, to the fullest extent permitted by law, 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.

4. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

- A. Applications for initial appointment and clinical privileges;
- B. Periodic reappraisals for reappointment and/or renewing/revising clinical privileges;
- C. Corrective action, including summary suspension;
- D. Hearings and appellate reviews;
- E. Medical care evaluations;
- F. Utilization reviews; and
- G. Other Hospital, departmental, service or Committee activities related to quality patient care and interprofessional conduct.

5. The acts, communications, reports, recommendations and disclosures referred to in this Article XIV may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

6. In furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in Paragraph 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State and the Federal government.

7. The consents, authorizations, releases, rights, privileges and immunities

provided by Section 1 and 2 of Article VI of these By-Laws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

8. For immunity purposes, all proceedings, records and activities of relevant committees are considered to be peer review activities.

## **ARTICLE XV**

### **RULES AND REGULATIONS**

The Executive Committee of the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these By-Laws, subject to the approval of the Governing Body. Such Rules and Regulations shall become effective when approved by the Governing Body. The Medical Staff By-Laws, Rules and Regulations, and policies and the Governing Body By-Laws shall not conflict.

## **ARTICLE XVI**

### **REGULATORY COMPLIANCE**

The Medical Staff of St. Joseph's Hospital Health Center shall abide by all Federal and State regulations pertaining to the Medical Staff organization, including but not limited to, full compliance with all applicable statutes and regulations for reporting misconduct, and shall assist the Administration in its obligation to report disciplinary actions against any member of the Medical Staff.

## ARTICLE XVII

### AMENDMENTS

The By-Laws shall be reviewed annually. These By-Laws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Executive Committee of the Medical Staff. A proposed amendment shall be referred to the Bylaws Committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. Each member of the Active medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the Medical Executive Committee of the Medical Staff. All Active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. Electronic voting shall take place during a five-day period beginning and ending at 11:59 am EST on dates determined by MEC.

The amendment shall be considered approved by the medical staff when the amendment receives a simple majority (fifty percent plus one) marked "yes" of the Active members voting. Amendments so made shall be effective when approved by the Governing Body. The Governing Body approves and complies with the Medical Staff By-Laws.

## ARTICLE XVIII

### ADOPTION

These By-Laws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous By-Laws, and shall become effective when approved by the Governing Body of the Hospital.

**APPROVED:**



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**M. Asad Khan, M.D.**  
**President, Medical Staff**



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**Paul Dominski**  
**Secretary, Board of Trustees**