Bylaws

of the

Medical Staff

of

Crouse Health Hospital, Inc.

including amendments approved through July 11, 2024

Crouse Health Hospital, Inc.
736 Irving Avenue, Syracuse, New York 13210

MEDICAL STAFF BYLAWS

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THE BYLAWS OF THE MEDICAL STAFF OF CROUSE HEALTH HOSPITAL, INC.

DEFINITIONS

ADMINISTRATION means the President of the Hospital and his/her supporting staff, acting on behalf of the Board in the overall management of the Hospital.

BOARD OF DIRECTORS ("BOARD") means the Board of Directors of Crouse Health Hospital, Inc.

CHIEF MEDICAL OFFICER means a physician qualified for membership on the Medical Staff and who is appointed by the Board of Directors to serve as medical director pursuant to 10 N.Y.C.R.R. 405.2(e)(2).

CLINICAL PRIVILEGES ("PRIVILEGES") means specific diagnostic, therapeutic, medical, dental, or surgical activities which an individual has been granted permission to perform by the Board of Directors.

CLINICAL PSYCHOLOGIST means an individual who has been duly licensed to practice psychology in the State of New York.

DENTIST means an individual who has been duly licensed to practice dentistry in the State of New York.

DIRECTOR means, in contrast to the Board of Directors, an individual appointed by the Hospital in an administrative capacity.

EXECUTIVE SESSION means any meeting of any group or body at which proceedings are confidential and at which only voting members may attend, except as may be permitted by the Chair of the group or body.

EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting privileges.

HOSPITAL means Crouse Health Hospital, Inc.

LICENSED HEALTH CARE PRACTITIONER means a person licensed to practice medicine under Article 131 of Title VIII of the New York Education Law and all other persons licensed to practice their professions under other appropriate Articles of Title VIII of the New York Education Law.

LIMITED LICENSE HEALTH CARE PRACTITIONER means a person who holds a valid limited license to practice medicine under Article 6525 of the New York Education Law and all

other persons holding limited licenses to practice their professions under other appropriate Articles of Title VIII of the New York Education Law.

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff.

MEDICAL STAFF OR STAFF means all Licensed Health Care Practitioners who have received privileges to attend patients in the Hospital.

MEDICAL STAFF MEMBER OR MEMBER means a Licensed Health Care Practitioner who is a member of the Medical Staff.

OPTOMETRIST means an individual who has graduated from an approved school of optometry, been awarded a degree of Doctor of Optometry valid in the State of New York, and who meets the requirements of the New York State Education Law for the practice of Optometry.

ORAL SURGEON means an individual who has graduated from an approved school of dentistry, been awarded a degree of Doctor of Dental Surgery valid in the State of New York, meets the requirements of the New York Education Law for the practice of Dentistry and has received the additional training necessary to be able to perform medical evaluations along with the provision of dental treatment.

PEER means a Licensed Health Care Practitioner within the same professional grouping.

PHYSICIAN means an individual who has been duly licensed to practice medicine in the State of New York.

PODIATRIST means an individual who has graduated from an approved school of podiatry, been awarded a degree of Doctor of Podiatric Medicine, valid in the State of New York, and who meets the requirements of the New York State Education Law for the practice of Podiatry.

PRESIDENT OF THE HOSPITAL means the individual appointed by the Board of Directors as its direct executive representative in the management of the Hospital.

SPECIAL NOTICE means written notification given by personal delivery or by certified mail, return receipt requested or other documented means.

ARTICLE I. NAME AND PURPOSE

1.1 The name of this organization shall be the "Medical Staff of Crouse Health Hospital, Inc." and hereinafter to be described as “Medical Staff” or “Staff”.

1.2 The purpose of the Medical Staff shall be:

1.2.1 To ensure that all patients admitted to or treated at the Hospital receive the best possible care;

1.2.2 To provide a structure for the governance of the Medical Staff;

1.2.3 To provide means whereby problems of a medico-administrative nature will be discussed by the Medical Staff with the Board of Directors, its Chair and the Administration;

1.2.4 To provide a system whereby policies of the Board of Directors will be carried out by the Medical Staff for the continuing improvement of patient care rendered at the Hospital;

1.2.5 To initiate and maintain policies, rules and regulations for government of the Medical Staff that enhance the professional performance of all Members through an ongoing review and evaluation of the clinical performance of each Member of the Medical Staff; and

1.2.6 To provide for and participate in educational and research programs that will maintain scientific standards and lead to continuous advancement in professional knowledge, skill and training.

1.3 Appointment to the Medical Staff is a privilege granted by the Board of Directors of the Hospital. These Bylaws shall outline the threshold qualifications, policies and procedures in the process by which appointment and reappointment to the Medical Staff are made and clinical privileges are granted.

ARTICLE II. OBJECTIVES AND RESPONSIBILITIES

2.1 The Medical Staff of the Hospital resolves to do its share in building an integrated delivery system with the Hospital that meets the health care needs of the people of Central New York. The objectives and responsibilities of the Medical Staff shall be to:

2.1.1 ensure the best possible care for all patients treated by any department or unit of the Hospital;

2.1.2 account to the Board of Directors for the quality of patient care;

2.1.3 establish objective standards of patient care and conduct to be followed by all practitioners granted privileges at the Hospital;

2.1.4 assure that patient care is consistent with Federal Law, N.Y. State Scope of Practice Laws and prevailing standards of practice and conduct of each profession for each Licensed Health Care Practitioner;

2.1.5 be certain all patients are afforded their individual rights according to New York State law;

2.1.6 establish mechanisms to monitor ongoing performance of Medical Staff Members in the practice of their professions, including compliance with these Bylaws and pertinent Hospital Bylaws, policies and procedures;

2.1.7 recommend to the Board of Directors action with respect to Medical Staff appointments, reappointments, modification of appointments, assignment to Department and/or service, division, category, clinical privileges, specific services, education and corrective actions;

2.1.8 review performance of Medical Staff Members, and when appropriate, recommend to the Board of Directors the limitation or suspension of the privileges of those who do not practice in compliance with the scope of their privileges, these Bylaws, Department Rules and Regulations, standards of performance, or Hospital policies and procedures; and

2.1.9 assure that corrective measures are developed and put into place when necessary.

2.2 The Medical Staff shall be subject to the ultimate authority of the Board of Directors of the Hospital, with whom final responsibility lies.

2.3 Where not expressly stated or implied, the requirements as stated in the Hospital Code of New York State shall apply.

ARTICLE III. MEMBERSHIP

3.1 Nature of Membership

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent persons practicing medicine as defined in Article 131 of Title VIII of the New York Education Law, and other professionally competent Licensed Health Care Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations of the Medical Staff. Appointment to and membership on the Staff shall confer on the appointee or Member only such clinical privileges and prerogatives as have been granted by the Board of Directors in accordance with these Bylaws.

3.2 Qualifications of Membership

3.2.1 Basic Qualifications

Membership, except for Emeritus Staff and Retired Staff as provided in Section 4.2.1(c), shall be limited to Licensed Health Care Practitioners, appropriately licensed and currently registered or having other official authorization to practice, in the State of New York without encumbrances, who:

a. document their good reputation and character, background, education, training, experience, ability, and current professional competence as required by the Credentials Committee, Medical Executive Committee, Board of Directors, and these Bylaws, including, for new applicants to the Medical Staff, satisfactory completion of residency training at a level that would allow sitting for the appropriate board examination or equivalent experience;

b. document, upon appropriate request of the Credentials Committee, Medical Executive Committee, Board of Directors, Chief Medical Officer or Department Chief, the current status of their mental and physical health, including their submission to laboratory testing and mental and physical examination by laboratories and physicians designated by the requesting body, with waiver of admissibility of results;

c. are determined on the basis of documented references to adhere to the ethics of their profession, to work cooperatively with others, and to be willing to participate in and discharge their Medical Staff and departmental responsibilities; and

d. with sufficient adequacy to support a finding by the Medical Executive Committee and the Board of Directors, in their sole discretion, that any patient treated by them in the Hospital on an inpatient or outpatient basis, will be given quality medical care.

3.2.2 Membership Disqualification

A prospective applicant shall be deemed disqualified and ineligible for Medical Staff membership, nor shall a practitioner be allowed to request modification of his/her appointment under Section 5.5 under the following circumstances:

a. the Board of Directors determines that the Hospital does not have the ability to provide adequate facilities or services for the prospective applicant or the patients to be treated by the prospective applicant;

b. the Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with, provided, however, the Hospital and contracting

party may agree to amend the contract to allow the applicant to apply for membership;

c. the prospective applicant is excluded from participation in Medicare or Medicaid;

d. the prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision; or has resigned while under investigation or to avoid an investigation of an alleged professional misconduct or to avoid the imposition of disciplinary measures;

e. the prospective applicant does not have a valid unrestricted state license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, probation, requirement or restriction of any kind pertaining to his/her license; or

f. the prospective applicant has been convicted of a felony or convicted of a misdemeanor related to the practitioner's fitness to practice medicine; or

g. the prospective applicant intentionally failed to disclose any information requested on the Miscellaneous Information page of the medical staff initial application.

Upon preliminary review of the application, the prospective applicant shall be advised of the information relied on as grounds for ineligibility and the prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide him/her with, or to process, an application for initial appointment or reappointment under this Section 3.2.2.

Upon request from and at the Hospital's sole discretion, the prospective applicant will consent to and authorize the Hospital to conduct a criminal background investigation to substantiate eligibility or ineligibility for Medical Staff membership.

3.2.3 **Effect of Other Affiliations**

No Licensed Health Care Practitioner is automatically entitled to membership on the Medical Staff or to the exercise of any clinical privileges in the Hospital merely because he/she is licensed to practice in this or any other state; or because of past or present staff membership or privileges in any other health care facility, health care organization or practice setting; or because of employment within the Crouse

Health System or its affiliates; or because of certification, fellowship or membership in a specialty body or society.

3.2.4 **Nondiscrimination**

Medical Staff membership or clinical privileges shall not be denied on the basis of sex, sexual orientation, race, creed, color, age, ethnic or national origin, or membership in any organization or on the basis of any criterion unrelated to standards of patient care, patient welfare, the objectives of the Hospital, or the character or competency of the applicant.

3.2.5 **Medico-Administrative Staff**

a. Licensed Health Care Practitioners employed by the Hospital, or related entities, in a purely administrative capacity with no clinical duties are subject to the regular personnel policies of the Hospital and their contract or other terms of employment and need not be members of the Medical Staff.

b. Licensed Health Care Practitioners employed by the Hospital either full time or part time in medical administrative capacities and whose activities include clinical responsibilities, shall achieve and maintain Medical Staff membership through the same procedures provided for all other Medical Staff Members.

   Such Medical Staff Members will be assigned to a Category appropriate to their activity, with their privileges delineated in terms of their education, training, competence and character, as well as, the terms of their employment. Their Medical Staff membership may or may not be made contingent on continued employment with the Hospital.

c. Licensed Health Care Practitioners employed by the Hospital, either full or part-time, whose duties are medical administrative in nature and are of a supervisory nature not involving direct patient care, shall achieve and maintain Medical Staff membership through the same procedures provided for all other Medical Staff Members. Such Medical Staff Members will be assigned to this Category of membership, shall have no clinical privileges, may not admit or attend patients, may not vote or hold office on the Medical Staff and do not pay Medical Staff dues or assessments. Such members may serve on Medical Staff committees and attend Medical Staff meetings. Their Medical Staff membership may or may not be made contingent on continued employment with the Hospital.

d. The Chief Medical Officer is a physician member of the Hospital Administration, appointed by the Board of Directors after consultation with the Medical Executive Committee, and subject to the other applicable paragraphs of this Section 3.2.5, whose principle responsibilities are the administrative support of the Medical Staff and liaison between the Medical Staff and the Hospital in all matters relating to patient care, quality assurance and

credentialing. Unless otherwise provided, the Chief Medical Officer serves as a member of the Quality Improvement Committee and is an ex-officio member, without vote, on all Medical Staff committees, including the Medical Executive Committee. The Chief Medical Officer shall advise on appointments to standing and special Medical Staff committees and be responsible for:

i. compliance with due process procedures and implementation of resultant corrective actions;

ii. participation in the appointment and reappointment process;

iii. activities and evaluation of Department Chiefs, including administrative, professional and postgraduate educational activities;

iv. Medical Staff participation in quality assurance and malpractice prevention programs; and

v. reporting on the clinical activities, continuing medical education.

e. Any Licensed Health Care Practitioner whose employment by the Hospital requires membership on the Medical Staff as described herein or who provides medical services pursuant to a contract with the Hospital that requires membership on the Medical Staff shall not have his/her Medical Staff privileges terminated unless the provisions of Articles XI and XII are followed, except as may otherwise be provided by the Licensed Health Care Practitioner's employment or contractual relationship with the Hospital. The provisions of Articles XI and XII cover only Medical Staff appointments and privileges, and do not apply to any contractual or employment relationships with the Hospital or any entity that contracts with the Hospital.

3.2.6 **Telemedicine**

a. To the extent that a practitioner proposes that particular clinical services be provided to patients via telemedicine, he/she must satisfy all the requirements and qualifications required of the Medical Staff, and he/she shall be permitted to provide telemedicine services in accordance with federal and New York State law ("Telemedicine Practitioner"), provided the Telemedicine Practitioner shall be exempt from health immunizations and PPD requirements since he/she is not physically present at the Hospital.

b. The practitioner shall advise the Hospital which clinical services he/she proposes to be delivered through the use of electronic communication or other communication technologies to provide or support clinical care at a distance, according to commonly accepted quality standards.

c. Any Telemedicine Practitioner who proposes to prescribe, render a diagnosis, or otherwise provide clinical treatment to patients shall be subject

to the Hospital's appointment and privileging processes and shall submit an application for clinical privileges as described in Article V of these Bylaws.

d. The appropriate utilization of telemedicine equipment by the Telemedicine Practitioner shall be considered.

e. The Medical Executive Committee shall determine in what areas telemedicine can be used.

3.2.7 **Orders for Outpatient Services**

Orders for outpatient services must be ordered by a practitioner who meets the following conditions:

a. Is responsible for the care of the patient.

b. Is licensed in the State where he/she or she provides care to the patient.

c. Is acting within his/her or her scope of practice under State law.

d. Is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following:

i. All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.
ii. All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.

3.3 **Basic Responsibilities of Membership**

Each Member of the Medical Staff with clinical privileges shall:

3.3.1 provide his/her inpatients with continuous professional care at generally recognized levels of quality and timeliness or, in his/her absence, delegate the responsibility for his/her patients only to another Staff Member who is qualified to undertake this responsibility and with whom prior arrangement has been made;

3.3.2 abide by the ethical principles of his/her profession and sign a pledge thereto;

3.3.3 abide by these Medical Staff Bylaws, Medical Staff Rules and Regulations and all other applicable standards, policies, laws, regulations, and rules of the Hospital, including EMTALA (42 C.F.R. Sections 489.24 and 489.20);

3.3.4 discharge Medical Staff, Department, service, committee, and Hospital functions for which he/she is responsible;

3.3.5 maintain his/her current professional competence by participating in continuing education programs and document this participation annually;

3.3.6 refrain from exceeding his/her professional expertise or the capabilities of the Hospital in caring for patients, unless an emergency exists and better alternate resources are not readily available;

3.3.7 refrain from attending patients if he/she is unable to do so with skill and safety;

3.3.8 seek consultation from a specialist physician when appropriate to provide for the diagnosis and treatment of patients in accordance with generally accepted standards of patient care;

3.3.9 accept responsibility for being available to the Emergency Room as specified in the Department Manual for the Department of which he/she is a member, to care for those patients referred during the course of their illness, and to be responsible for appropriate follow-up for that condition;

3.3.10 timely prepare and complete, as specified in the Medical Staff Rules and Regulations, the medical and other required records, including history and physicals, for all patients he/she admits or in any way provides care for in the Hospital;

3.3.11 properly supervise Affiliate Staff members for whom he/she is responsible (Affiliate Staff members may complete History and Physicals or Medical Screening Exams upon patient admission);

3.3.12 comply with limits on working hours as established by the Board of Directors in compliance with the laws and rules and regulations of the State of New York;

3.3.13 maintain in force at all times professional liability insurance for acts and omissions occurring in the exercise of his/her practice and privileges:

a. The type and minimum amount of insurance coverage required shall be established by the Medical Executive Committee and as stated in the Rules and Regulations.

b. Liability insurance shall be acceptable only if issued by a carrier approved by the New York State Department of Insurance or an institutional self-insured program approved by the Hospital Risk Management Department.

c. It shall be the responsibility of each Staff Member to provide the Hospital with a certificate of coverage issued by the insurance carrier in a form reasonably satisfactory to the Hospital containing a clause that in the event of any material

change in, cancellation of, or failure to renew the policy of professional liability insurance, the insurance carrier will give thirty (30) days written notice of such an event to the Hospital. Failure to give such notice, however, shall impose no obligation or liability upon the insurance carrier. It shall also be the responsibility of each Staff Member to immediately inform the Hospital of any lapse or change in coverage, cancellation or failure to renew the policy of professional liability insurance.

3.3.14 cooperate and participate in the Hospital's corporate compliance program, including the prompt notification to the Chief Medical Officer in the event of the Member's exclusion from the Medicare, Medicaid or any other federal health program;

3.3.15 comply with and document commitment to abide by all Hospital policies and procedures involving the confidential use of electronic or computer transmission and authentication of protected health information, including medical records, orders and patient specific information; and

3.3.16 cooperate with Hospital personnel in obtaining and maintaining in the medical record any and all patient consents or authorizations required under any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3.3.17 notify the President of the Medical Staff and the Chief Executive Officer, in writing, immediately upon learning that he:

a. has been charged with misconduct by any licensing or disciplinary authority of any state or federal agency or professional organization;

b. has been charged with a crime;

c. has been notified that his/her professional liability insurance carrier intends to cancel, not renew, restrict or impose any conditions or deductibles on his/her professional liability insurance for any reason related to the practitioner's clinical practices or claims history;

d. has been notified of the loss of his/her DEA number or exclusion from the Medicaid or Medicare program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid;

e. is or has been the subject of any actual or proposed disciplinary action, including any modification of clinical privileges, restriction of clinical privileges, or placing of conditions on clinical privileges (including any form of monitoring or review), by any other hospital or healthcare facility or organization;

f. is or has been the subject of any actual or proposed disciplinary action by any regulator, licensing or disciplinary authority or professional organization, including any form of reprimand or sanction;

g. has voluntarily relinquished, agreed not to exercise, or involuntarily lost any licensure, certification, registration, medical staff membership or clinical privileges at any healthcare facility;

h. has entered into a contract or agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder; or

i. has developed any mental or physical illness or sustained any injury which could have an effect on the exercise of the individual's clinical privileges.

j. is or has been the subject of cognitive or behavioral testing mandated by any healthcare facility as a condition of clinical privileging;

k. has been granted a voluntary or involuntary leave of absence from any healthcare facility.

3.3.18 comply with Hospital policies regarding timely submission of expirable documents and timely completion of medical records. Failure to comply with Hospital policies shall result in administrative suspension until such time as documentation has been received and/or medical records completed. Any Member who has been suspended and fails to remedy a suspension imposed under this Section 3.3.18 within 90 days of notification shall be deemed to have voluntarily resigned from the Medical Staff and is not entitled to a hearing or any other procedural rights once such voluntary resignation has been imposed.

3.4 General Rights of Medical Staff Members

3.4.1 Any Medical Staff Member who is dissatisfied with the operation of any segment of the Hospital shall have the right to have his/her dissatisfaction reviewed, upon written request, by the appropriate committee chair and by the Chair or Section Chief, as is appropriate, of the Department to which he/she has been assigned. If, after a thirty (30) day interval, review is not granted or the Medical Staff Member is dissatisfied with the resolution of the problem, he/she may similarly request that his/her dissatisfaction be reviewed in a timely fashion by the President of the Medical Staff, Chief Medical Officer, Medical Executive Committee, and/or the Board of Directors, in accordance with the following:

a. Any named body shall not be required to consider a request for a review without evidence that the matter has been considered by the preceding body.

b. No Staff Member shall be subject to sanctions for initiating or supporting a request for a review.

c. If the grievance involves a member and/or department of the Administration, a copy of the written request shall be submitted to the appropriate administratively responsible individual as well as the applicable Medical Staff party mentioned herein. The transmission of such copy may be delayed for a maximum of 15 days at the discretion of the involved Committee Chair, Section Chief, or Department Chief who shall attempt to resolve the problem at this level. The petitioning Medical Staff Member has the same right of appeal as outlined herein.

3.4.2 Medical Staff Members and Affiliate Staff members as identified in Sections 4.2.7.f.i (Midwives) and 4.2.7.f.ii (Podiatrists) shall be entitled to exercise independent judgment in the care of patients where alternate forms of diagnosis or therapy are readily available and which are generally accepted as being reasonably equivalent.

3.4.3 Medical Staff Members shall be entitled to Medical Staff status commensurate with their qualifications, experience, and contribution to Hospital affairs.

3.4.4 No Medical Staff Member shall be subject to sanctions related to:

a. refusal to allow residents, Affiliate Staff, paramedical personnel, or allied health professionals to write orders, see patients, or participate in patient care except in emergency situations when the Medical Staff Member or his/her designee is not readily available; or

b. acting in accordance with religious or moral beliefs; or

c. not exceeding what he/she feels are his/her professional limitations in caring for patients in emergency situations; or

d. refusal to participate in an induced termination of pregnancy.

3.5 Appointments

All appointments, reappointments, modifications of appointments, privileges, and modification of privileges shall be made by the Board of Directors on recommendation of the Medical Executive Committee as specified in Article V. Any proposed changes by the Board of Directors in these recommendations shall occur only after consultation with the Medical Executive Committee.

3.6 Duration of Appointments/Expansion of Privileges

3.6.1 Initial appointments of individuals shall not be more than three (3) years duration.

3.6.2 Modification of appointment from one Medical Staff Category to another shall be for the duration of the appointment.

3.6.3 Modification of clinical privileges shall be for the duration of the appointment.

3.6.4 Reappointments shall be for a period of no more than three (3) years, unless there is a concomitant modification of appointment.

3.6.5 During the appointment periods set forth in Sections 3.6.1, 3.6.2 and 3.6.3, such Member shall be observed by the Chief of the Department to which the Member has been assigned, or by designees of that Chief, to determine the Member's expansion of clinical privileges, eligibility to exercise those privileges on a continuing basis or the appropriateness of membership on the Medical Staff, as applicable.

3.7 Focused Professional Performance Evaluation (FPPE) Provisional Period

3.7.1 There shall be a FPPE provisional period for new physician appointees to the Active, Consulting and Courtesy Staffs; and this period shall be six (6) months. Provisional appointees shall have all the rights and responsibilities of their Medical Staff Category.

3.7.2 During the provisional period, the appointee must have at least five (5) patient encounters. The Chief of the Department to which the appointee has been assigned shall have primary responsibility for evaluating the provisional appointee and for ensuring that the focused review required by Section 7.7 is carried out. At the end of the provisional period, the appointee's performance during such period shall be reviewed by the Department Chief who shall thereafter submit a written report to the Credentials Committee and the Chief Medical Officer regarding the findings of the review.

The Department Chief's report shall include the following:

a. Whether the requisite number of patient encounters and whether sufficient treatment of patients occurred to meaningfully evaluate the practitioner;

b. Whether the provisional appointment should be extended for an additional period; and

c. His recommendation concerning the provisional appointee's qualifications and fitness for the clinical privileges he/she seeks.

3.7.3 The Credentials Committee shall consider the Department Chief's report and then forward its recommendation to the Executive Committee, which shall then recommend to the Board of Directors one (1) of the following:

a. Termination of provisional status;

b. Continuation of provisional staff status for one additional 6-month period;

c. Termination of the appointment; or

d. Termination of privilege.

3.7.4 If provisional appointment is continued for a second 6-month period, the Executive Committee must, at the end of the second 6-month period, recommend one of the actions provided in Sections 3.7.3.a or 3.7.3.c, above.

3.7.5 Continuation of a provisional appointment shall not be grounds for a hearing and appellate review under Article XII. Termination of appointment shall entitle the appointee to the procedural rights under Article XII.

NOTE: Section 3.7 became effective as of January 26, 2010.

3.8 **Focused Professional Performance Evaluation (FPPE) for Cause**

3.8.1 An FPPE may be implemented for cause when a question or concern arises regarding a currently privileged provider's ability to provide safe, high-quality patient care.

3.8.2 An FPPE for cause may be initiated by the Chief Medical Officer upon recommendation of Department Chief or at the recommendation of the Physician Quality Leadership Committee or the Peer Review Committee.

3.8.3 Prior to implementing an FPPE for cause, objective clinical/performance information and data related to the cause for implementation shall be collected and shared in writing with the provider. Information and data may include, but is not limited to:

a. Patient/staff/provider complaints;

b. Quality Improvement data (i.e., unexpected outcomes, death, unplanned return to the OR, blood utilization, anesthesia/sedation, etc.); and/or

c. Non-compliance with Hospital policies and/or Medical Staff Bylaws (i.e., medical records requirements, professionalism/behavior, time and attendance, submission of credentialing documentation, health assessment/immunizations, etc.).

3.8.4 An FPPE Plan of Correction (POC) may be implemented and may include, but is not limited to:

a. Education/CME;

b. Retrospective Case Review;

c. Evaluation/Assessment/Testing; or

d. Additional Training (Simulation/Hands-On).

3.8.5 The FPPE POC shall address the scope of requirement, acceptable programs, time frames, financial responsibility, documentation, clinical approval, etc.

3.8.6 The practitioner will be provided notice when the FPPE is concluded.

3.8.7 An FPPE deemed unsatisfactorily completed may result in corrective action as prescribed in the Crouse Health Medical Staff Bylaws, with all provider procedural rights contained therein.

The Hospital will comply with all applicable Federal and State agency reporting requirements.

NOTE: This Section 3.8 became effective as of July 8, 2021.

3.9 **Leave of Absence (LOA)**

Voluntary leave of absence by a Medical Staff Member may be granted for good and sufficient reason by the Medical Executive Committee on recommendation of the Department Chief and Credentials Committee. The Medical Staff Member's request shall include the reasons for the leave and any material necessary to properly evaluate the request. All requests concerning leaves of absence shall be addressed to the President of the Hospital or his/her designee.

3.9.1 **Duration and Renewal of Leave of Absence**

a. A leave of absence is granted for a specific period and shall not exceed one year but may be renewed twice upon written request with supporting acceptable reasons to the President of the Hospital. In no event shall the aggregate duration and renewal(s) of an LOA exceed two (2) years. Any LOA exceeding the authorized time period will be considered a resignation from the Medical Staff and is not subject to the Hearing and Appellate Review process described in Article XII.

b. An absence of 120 days or less shall not require a formal request for leave of absence.

3.9.2 **Rights and Responsibilities During Leave of Absence**

The clinical privileges and rights and responsibilities of Medical Staff membership shall be suspended during a leave of absence.

3.9.3 **Reinstatement**

To obtain reinstatement of privileges, the Staff Member on leave of absence shall submit a written request to the Department Chief or the President of the Hospital. The request for reinstatement must be submitted at least one (1) week prior to the meeting of the Credentials Committee at which the request will be considered; shall include a description of the Member's activities during the leave of absence; and, upon request of the Chief Medical Officer, Department Chief, or any appropriate person or committee of the Medical Staff or Hospital, shall include documents and material necessary to properly evaluate the request for reinstatement. Documentation may also be required prior to resumption of clinical activities that, subject to reasonable accommodation, the practitioner is free from any impairment that might interfere with his/her ability to safely care for patients.

a. A Staff Member whose appointment to the Medical Staff has expired during the LOA shall be required to apply for reappointment pursuant to Section 5.4

b. Reinstatement may be granted subject to the observation status set forth in Section 3.6.5 for a period of 6 months, as well as other conditions, such as proctoring and medical education, as recommended by the Department Chief, Section Chief, Credentials Committee or Medical Executive Committee, without the right of a hearing and appellate review under Article XII.

c. If a Staff Member on leave of absence fails to request reinstatement prior to the expiration of the leave of absence, he/she shall be considered as having resigned from the Medical Staff and shall not be entitled to a hearing and appellate review under Article XII. A subsequent request for Medical Staff membership shall be submitted and processed in the manner specified for application for initial appointment.

d. Reinstatement shall be granted by the Medical Executive Committee subject to the approval of the Board of Directors. The Department Chief and/or Section Chief, as well as the Credentials Committee, shall review each request for reinstatement of privileges and shall make recommendations concerning same to the Medical Executive Committee.

e. Denial of reinstatement shall mean automatic loss of Medical Staff membership and shall not entitle the Staff Member to a hearing and appellate review under Article XII except in those cases where such denial is reportable to the NPDB or the NYS Office of Professional Misconduct.

3.10 **Resignation and Retirement**

A Member may resign or retire from the Medical Staff by notifying the President of the Hospital, in writing, and stating where possible the reasons for his/her action. Resignation or retirement shall be effective upon receipt by the President of the Hospital and shall be reported to the Board of Directors.

ARTICLE IV. STRUCTURE OF THE MEDICAL STAFF

4.1 Qualifications

The Medical Staff shall consist of physicians defined in Article 131 of Title VIII of the New York Education Law, oral surgeons who are dentists as defined in Article 133 of Title VIII of the New York Education Law and board certified in oral surgery, and other Licensed Health Care Practitioners as defined in Title VIII of the New York Education Law, each of whom:

i. shall meet the basic qualifications specified in Section 3.2; and

ii. may regularly admit, to the extent granted admitting privileges, and attend patients in accordance with the privileges granted by the Board of Directors, or be involved regularly in the care of patients and activities of the Medical Staff and Hospital. Patients may only be admitted to the Hospital by members of the Medical Staff with admitting privileges. In order to assure a high standard of patient care and the assurance of quality care, all patients shall have a physical examination and an admission history completed by a qualified member of the Staff in accordance with the requirements stated in the Rules and Regulations.

4.2 Medical Staff Categories

Each member of the Medical Staff shall be assigned to one of the following Categories designated by the Board of Directors: Active; Consulting; Courtesy; Associate; Senior; Retired; Emeritus; and Affiliate Staff.

a. In determining Category assignment, the following attributes, among others shall be considered: length of service as a Medical Staff Member; contributions to Hospital and Staff affairs; contributions to health and medical science; and excellence in professional activities.

b. Physicians and dentists are eligible for assignment to the Emeritus, Retired, Senior, Active, Consulting, Courtesy and Associate Staffs. Other licensed health care professionals are eligible for assignment to the Affiliate Staff.

c. Changes in Category may be made upon recommendation of the Chief of the Department to which an individual is assigned by the method specified in Section 5.3.

4.2.1 **Active Staff**

Physicians and dentists who have demonstrated a commitment to quality health care and the Hospital may be assigned to the Active Staff.

a. **Qualifications**. A member of the Active Staff:

i. shall meet the qualifications specified in Section 3.2; and

ii. may regularly admit or attend patients or be involved regularly in the care of patients and activities of the Medical Staff and Hospital in accordance with the privileges granted by the Board of Directors.

b. **Rights and Responsibilities**. A member of the Active Staff may exercise the additional privileges specified in the Rules and Regulations of the Department to which he/she is assigned.

i. **Rights**. A member of the Active Staff may:

1. admit and attend patients within his/her credentials and in accordance with the privileges granted by the Board of Directors;

2. exercise the general rights as specified in Section 3.4;

3. exercise the clinical privileges as granted pursuant to Article VII;

4. vote on all matters presented at Medical Staff meetings and at meetings of committees of which he/she is a member; and

5. hold office in the Medical Staff, a Department of the Medical Staff, and committees of which he/she is a member.

ii. **Responsibilities**. Each member of the Active Staff shall:

1. meet the responsibilities specified in Section 3.3;

2. attend Medical Staff, Department, and committee meetings as specified in Article X;

3. pay Medical Staff dues as determined by the Medical Executive Committee;

4. participate in care of service patients and emergency room calls as required by the Department to which he/she is assigned;
5. actively participate in quality assurance and malpractice prevention programs required by the Board of Directors, the Chief Medical Officer, the Medical Executive Committee, the Quality Improvement Committee and the laws, rules and regulations of the State of New York;

6. supervise Members in the observation status set forth in Section 3.6.5 as required by the appropriate Department Chief;

7. supervise and direct persons in the Affiliate Staff as required by the Board of Directors; and

8. attempt to secure permission for autopsies.

4.2.2 **Courtesy Staff**

The Courtesy Staff shall consist of individuals who desire a limited affiliation with the Medical Staff of the Hospital.

a. **Qualifications.** A member of the Courtesy Staff shall:

i. meet the qualifications specified in Section 3.2;

ii. meet the qualifications required for membership in the Medical Staff; and

iii. maintain active status on the medical staff of another hospital located in the State of New York.

b. **Rights and Responsibilities**. A member of the Courtesy Staff shall:

i. attend patients within his/her credentials and according to the privileges granted by the Board of Directors and be allowed to admit patients, subject to the limitation of subsection ix below;

ii. exercise the rights specified in Section 3.4;

iii. exercise the clinical privileges granted by the Board of Directors pursuant to Article VII;

iv. be eligible to admit and attend an annual maximum number of patients determined by the appropriate Department Chief as specified in the Department Manual; the foregoing determination of

admissions to include ambulatory surgery center services, one-day surgical services and one-day endoscopy services performed at Hospital facilities;

v. discharge the responsibilities specified in Section 3.3;

vi. pay Medical Staff dues as determined by the Medical Executive Committee;

vii. be ineligible to vote or hold office in the Medical Staff;

viii. not be required to attend Medical Staff, departmental and Hospital educational meetings;

ix. not be required to participate in emergency room call or in the care of service patients;

x. not be required to supervise Members in the observation status set forth in Section 3.6.5;

xi. be assigned to supervise or collaborate with a member of the Affiliate Staff at the discretion of the Department Chief; and

xii. attempt to secure permission for autopsies.

4.2.3 **Consulting Staff**

The Consulting Staff shall be reserved for those individuals of recognized professional ability who possess special talent, training and education.

a. **Qualifications.** A member of the Consulting Staff shall meet the qualifications specified in Section 3.2.

b. **Rights and Responsibilities**. A member of the Consulting Staff shall:

i. attend patients only upon request of a physician or dentist member of the Medical Staff;

ii. exercise the clinical privileges granted by the Board of Directors pursuant to Article VII;

iii. meet the responsibilities specified in Section 3.3;

iv. not be eligible to admit patients;

v. not be eligible to vote or hold Medical Staff office, as determined by the Medical Executive Committee;

vi. may be required to pay Medical Staff dues as determined by the Medical Staff Executive Committee, but may be waived upon the recommendation of the Department Chief;

vii. not be required to attend Hospital and Department meetings;

viii. serve on Medical Staff committees voluntarily with vote; and

ix. not be required to participate in emergency room calls or the care of service patients.

4.2.4 **Associate Staff**

The Associate Staff shall consist of those individuals who desire to have some involvement in patient care, such as visiting patients, and reviewing medical records, but would not actively participate in the direct care of patients and would have no admitting or clinical privileges.

a. **Qualifications.** A member of the Associate Staff shall meet the qualifications specified in Section 3.2.

b. **Rights and Responsibilities**. A member of the Associate Staff shall:

i. have no clinical privileges;

ii. exercise the rights specified in Section 3.4;

iii. meet the responsibilities specified in Section 3.3 except for 3.3.1 and 3.3.9;

iv. not be eligible to admit patients;

v. be required to pay Medical Staff dues;

vi. not be eligible to vote or hold Medical Staff office;

vii. not be required to attend Hospital and Department meetings;

viii. serve on Medical Staff committees voluntarily without vote;

xi. not be required to participate in emergency room calls or the care of service patients; and

x. not be required to supervise members in the observation status set forth in Section 3.6.5.

4.2.5 **Senior Staff**

Members of the Medical Staff and who have reached the age of 65 and have served on the Medical Staff for at least five (5) years may request assignment to Senior Staff.

a. **Qualifications.** A member of the Senior Staff shall:

i. meet the qualifications specified in Section 3.2; and

ii. regularly admit or attend patients or be involved regularly in the care of patients and activities of the Medical Staff and Hospital in accordance with the privileges granted by the Board of Directors.

b. **Rights and Responsibilities.** A member of the Senior Staff shall:

i. attend patients within his/her credentials according to the privileges granted by the Board of Directors and if qualified for the Attending Staff be allowed to admit patients;

ii. meet the responsibilities specified in Section 3.3;

iii. have clinical privileges determined in the same manner as other Medical Staff members;

iv. be required to attend Medical Staff and Department meetings as specified in Article X;

v. serve on Medical Staff committees voluntarily with vote;

vi. exercise the rights specified in Section 3.4;

vii. be subject to patient care audit and Quality Assurance programs;

viii. vote, but not hold Medical Staff office;

ix. not be required to pay Medical Staff dues;

x. not be required to participate in care of service patients or emergency room calls;

xi. not be required to supervise Medical Staff members in the observation status set forth in Section 3.6.5;

xii. supervise and direct members of the Affiliate Staff as required by the Board of Directors; and

xiii. attempt to secure permission for autopsies.

c. **Procedure for Assignment**. A member of the Medical Staff who desires to be assigned to Senior Staff shall submit his/her written request to the Chief of his/her Department. The request will be processed as specified in Sections 5.3.3 to 5.3.6.

4.2.6 **Retired Staff**

Retired Staff may be offered to those individuals who are members of the Medical Staff and who have retired from the practice of their profession but wish to maintain contact with the Medical Staff.

a. **Qualifications.** Members of the Retired Staff shall not be required to have a current license to practice.

b. **Rights and Limitations**. Members of the Retired Staff:

i. may attend Medical Staff, Departmental and Hospital educational meetings;

ii. may not admit or attend patients in the Hospital;

iii. will have no clinical or voting privileges, except for voting on committees of which he/she is a member;

iv. will not be required to pay dues:

v. may serve on Medical Staff Committees voluntarily with vote.

c. **Procedure for Assignment**. Retired Staff may be requested by individuals who are retiring from the practice of his/her profession. The assignment to the Retired Staff shall be accomplished in the same manner as all other Staff categories.

4.2.7 **Affiliate Staff**

a. **General Provisions**

i. The Affiliate Staff shall consist of Licensed Health Care Practitioners, also known as Advanced Practice Providers (APP) or Advanced Practice Clinicians (APC), including but not limited to physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives, podiatrists and clinical psychologists who desire to be Members of the Medical Staff of the Hospital. Affiliates must be licensed and certified as

appropriate by the State of New York. Clinical privileges may be granted by the Hospital Board of Directors which shall, except for podiatrists, require the supervision or collaboration of the Affiliate by a physician member of the Medical Staff.

ii. The Board of Directors shall designate, in writing, a member of the Medical Staff who shall be responsible for each Affiliate, as applicable.

iii. A member of the Medical Staff shall not supervise or collaborate with more than six (6) Affiliates.

iv. Privileges may be granted to Affiliates that are within the scope, practice and privileges of the member of the Medical Staff designated to supervise the Affiliate.

b. **Qualifications**

Only individuals appropriately certified, registered, or licensed, if applicable, and who meet substantially the same basic qualifications required by Section 3.2 shall be eligible to become a member of the Affiliate Staff. Where appropriate, the Credentials Committee and the Medical Executive Committee, in cooperation with the Hospital Administration and with the approval of the Board of Directors, shall develop specific qualifications in addition to licensure, registration, or certification requirements for members of a specific group of Affiliates.

Affiliate Staff, as appropriate, shall be under the supervision of, or shall collaborate with, an appropriately privileged member of the Medical Staff. Continued appointment as an Affiliate shall be contingent upon continued supervision by, or collaboration with, a member of the Medical Staff whose ability to provide adequate supervision/collaboration will be determined before granting the appointment to an Affiliate.

c. **Procedure for Appointment and Specification of Services**

Application for appointment, reappointment, clinical privileges, and specific services for members of the Affiliate Staff shall be submitted and processed in the same manner as provided in Articles V and VII for Medical Staff membership and clinical privileges. An Affiliate shall be assigned to a Department or service appropriate to his/her professional training and ability. Regular Hospital employees who are members of the Affiliate Staff shall be subject to regular Hospital personnel practices, including corrective action, suspension of services, or termination of employment.

d. **Rights and Responsibilities.** A member of the Affiliate Staff may:

i. exercise specified clinical privileges and provide patient care services under the supervision of, or collaboration with, an appropriately privileged member of the Medical Staff, as applicable, consistent with limitations established pursuant to Article VII, the Medical Staff Rules and Regulations and applicable laws and regulations, including:

A) medical screening;

B) record reports and progress notes on patient records as permitted by regulations of the appropriate Department of the Medical Staff to which they are assigned; and

C) write orders to the extent established for them by the scope of practice appropriate to their particular profession, the appropriate Department and to the extent provided by New York State law;

ii. serve on Medical Staff committees voluntarily with vote;

iii. attend Medical Staff meetings and shall attend Department meetings as determined by the appropriate Department Chief;

iv. not vote or hold office in the Medical Staff organization;

v. not admit patients, except with respect to nurse midwives and podiatrists who may be granted admitting privileges;

vi. be required to pay Medical Staff dues;

vii. shall meet the responsibilities in Section 3.3;

viii. actively participate in quality assurance and malpractice prevention programs required by the Board of Directors, the Chief Medical Officer, the Medical Executive Committee, the Quality Improvement Committee, and the laws, rules and regulations of the State of New York; and

ix. shall not be entitled to procedural due process under Articles XI and XII unless the action taken or proposed to be taken is reportable to the New York State Office of Professional Discipline or, in the case of physician assistants, to the New York State Office of Professional Medical Conduct.

e. **Duration of Appointment and Reappointment for Affiliates**

Members of the Affiliate Staff shall be appointed for the same duration as members of the Medical Staff and shall be subject to the same procedures and appraisal of their services before reappointment.

f. **Specific Groups of Affiliates**

i. **Midwives.** Midwifery practice is the independent management of care of essentially normal women and newborns: antapartally, intrapartally and postpartally in collaboration with a physician.

1. Midwives must have a New York State license to practice midwifery and be certified by the American College of Nurse Midwives. They shall be members of the Department of Obstetrics and Gynecology with admitting privileges, working in close relationship with a collaborating physician(s) who has Active Staff privileges in obstetrics at the Hospital.

2. Midwives shall maintain documentation of their collaborating physician relationships and make such information available to their patients.

ii. **Podiatry.** Podiatrists shall be members of the Department of Orthopedics, with admitting privileges, as specified in the podiatry section of the Department of Orthopedics rules. Clinical privileges may be granted to licensed podiatrists as members of the Affiliate Staff in accordance with their professional training, experience, demonstrated competence and professional qualifications. Appropriate professional accreditation and education requirements must be submitted, including graduation from an accredited postgraduate school of podiatric medicine, certification by the National Board of Podiatry Examiners, and licensure by the New York State Department of Education. Applicants for surgical privileges shall demonstrate satisfactory completion of an approved two-year residency program or, in lieu thereof, certification by the American Board of Podiatric Surgeons. In addition, there must be submitted evidence of documented surgical experience.

4.3 Emeritus Status

Emeritus Status may be offered to a physician/dentist member of the Medical Staff who has retired from practice and who has rendered distinguished service to the Hospital and to his/her profession, and holds Crouse Health as his/her primary hospital.[1]

a. **Qualifications**. Members with Emeritus Status shall not be required to have a current license to practice.

b. **Rights and Limitations.** Members with Emeritus Status:

i. may attend Medical Staff, Departmental and Hospital educational meetings;

ii. may not admit or attend patients in the Hospital;

iii. will have no clinical privileges;

iv. will not be required to pay dues; and

v. may serve on Medical Staff committees voluntarily with vote.

c. **Responsibilities**. Each member with Emeritus Status shall be required to discharge the responsibilities specified in Sections 3.3.2 and 3.3.3.

d. **Procedures for Assignment**. Emeritus Status may be granted to any physician or dentist member of the Medical Staff by the Board of Directors upon recommendation of the Credentials Committee and Medical Executive Committee. Recommendation for Emeritus Status shall be initiated by any Medical Staff Member (except for nominee) or Department Chief and approved by the Credentials Committee.

4.4 Organ Procurement

Practitioners appointed by or procurement coordinators employed by a federally-accredited organ procurement organization designated by the Secretary, U.S. Department of Health and Human Services, who are engaged in the Hospital solely in the recovery 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 privileges in order to carry out their activities in the Hospital.

[1] Section 4.3 was revised to add "*physician/dentist*" before the word "*member*", and "*…and holds Crouse Hospital as his/her primary hospital*" to the end of this Section, which revisions became effective July 9, 2020.

4.5 Teaching

Reflecting the longstanding policy of this Hospital with respect to medical education, every effort is made to conduct its clinical services in a manner consistent with that of teaching services. In an effort to ensure high-level quality and experience in the teaching of residents, as well as medical and other clinical students, all Members are asked to consider their private patients as part of the teaching services. The attending physician maintains the responsibility for the care of the patient, including the ability to write orders but it is encouraged that the resident staff be given as much responsibility for care and management as is commensurate with their level of experience and personal maturity. The requirements and standards governing house staff and medical students shall be as set forth in the Medical Staff Rules and Regulations.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 General Procedure

The Medical Staff through its Departments, committees, and officers shall investigate and evaluate every application for appointment and reappointment to the Medical Staff; every request for modification of appointment; every request for clinical privileges; and thereafter shall recommend action to the Board of Directors.

5.2 Application Form and Content for Initial Appointment

5.2.1 Pre-Application: The response to a request for an application shall be an application, accompanied by a letter from the Hospital enumerating the eligibility requirements in Section 3.2 and informing the requestor that such requirements must be met before the application can be considered (including the non-refundable application fee which must be received prior to processing the application).

5.2.2 Each application for appointment shall be made in writing to the President of the Hospital on such forms as shall be approved by the Credentials Committee and signed by the applicant. The information in the application shall be consistent with the laws, rules and regulations of the State of New York and include but not be limited to the following items:

a. A statement that the applicant has read the Bylaws and Rules and Regulations of the Medical Staff and Hospital and agrees to be bound by their terms and principles, and to be bound by all terms relating to the consideration of his/her application without regard to whether or not he/she is granted membership and/or clinical privileges.

b. A statement whereby the applicant agrees that if an adverse ruling is made with respect to his/her Staff membership or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws as a prerequisite to any other action.

c. Specific requests as to Staff division, Department, Section, Category, and clinical privileges for which the applicant wishes to be considered.

d. Detailed and authenticated information concerning the applicant's experience and qualifications, including information as to the basic qualifications specified in Section 3.2. and to any additional qualifications specified in these Bylaws or requested by reviewing authorities for the particular Staff category to which the applicant requests appointment and privileges.

e. References from three (3) physicians who are able to attest to the applicant's qualifications and abilities, and, unless waived by the Credentials Committee for good cause, with at least two (2) of the references from peers who are knowledgeable relative to the applicant's current professional ability, competence, ethics, moral character, and ability to work and communicate with others, and such other references as may be requested by the Department Chief, Chief Medical Officer, Credentials Committee, Medical Executive Committee, or Board of Directors.

f. The collection of the following information from an applicant prior to his/her beginning association with the Hospital:

   i. the name and address of any hospital or facility with which or at which the applicant has had any association, employment, privilege or practice and the reason, if discontinued, for the discontinuation;

   ii. information concerning any pending professional misconduct or malpractice claims, actions or medical conduct proceedings in this or any other state, including the substance of the allegations;

   iii. any judgment, settlement, or finding of any medical malpractice action and any finding of professional misconduct in this or any other state resulting in any limitation, revocation, surrender or qualification of a license to practice, including the substance of allegations and the amount of any judgments or settlements in such actions;

   iv. any information relative to findings pertinent to violations of patients' rights by the applicant;

   v. a statement regarding his/her current mental and physical health; the effect, if any, of his/her health on his/her ability to practice medicine and the details of any changes in his/her health status;

   vi. a physical examination completed within one (1) year prior to the application date signed by a licensed healthcare practitioner other than the applicant, including proof of immunization and/or immunity as may be required by Medical Staff policy;

vii. information concerning past or pending corrective or disciplinary actions at other hospitals or facilities;

viii. such other information and documents concerning the applicant's license registration, professional training, qualifications and competency as the President of the Hospital shall deem appropriate;

ix. upon application for Staff privileges, the receipt of a waiver by the applicant of any confidentiality provisions concerning the above information; and

x. a sworn statement by the applicant that the information is complete, true and accurate.

g. The collection and consideration of information related to the applicant's professional practice, if any, within the Hospital and during his/her association with other facilities within at least the last ten years.

h. Detailed information relating to successful past or current challenge, reduction, suspension, loss, voluntary surrender, or denial of:

i. membership or clinical privileges in any hospital or health care setting;

ii. membership in any professional organization;

iii. specialty board certification;

iv. license or registration to practice in any jurisdiction;

v. Drug Enforcement Administration (DEA) registration; and

vi. professional liability insurance coverage.

i. Information relating to any pending criminal proceedings or criminal convictions, including misdemeanors and felonies.

j. A statement and authentication that the applicant carries at least the minimum professional liability insurance coverage consistent with his/her practice and requested privileges as required by Section 3.3.13.

k. Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 5.3 and Article XIII, which shall apply whether or not the applicant is granted membership and shall apply during membership if granted.

l. Information regarding maintenance of his/her current competence by participating in continuing education programs.

m. A bibliography of published articles and papers.

n. Place of residence.

o. Location of offices

p. Professional society memberships.

q. Other medical staff or health care setting memberships and/or affiliations.

r. Current licensure or current limited licensure and registration with government-issued photo ID and signature authentication.

s. A copy of Section 3.3 specifying membership responsibilities and a statement whereby the applicant agrees thereto.

t. Information regarding awards or recognitions granted or conferred in health care fields.

u. A statement signifying his/her willingness to appear for interviews in regard to his/her application.

v. A consent for the Hospital, Medical Staff, and its authorized representatives to consult any individuals, organizations, records, or documents that may have information which may be material to an evaluation of the applicant's eligibility and requested clinical privileges including a consent for release of information by these sources:

    i. The applicant shall consent to the release of information by his/her present and past malpractice insurance carriers; and

    ii. The applicant shall indicate his/her willingness to submit to the testing and examinations specified in Section 3.2.1(b) if requested, and shall waive admissibility of any finding.

w. A release from liability for the Hospital, Medical Staff, and their representatives for actions performed in evaluating the applicant and his/her credentials.

x. A release from liability for all individuals and organizations that provide information, including otherwise privileged and confidential information, regarding the applicant's eligibility and suitability for appointment.

y. A consent for the Hospital to provide other hospitals with any credentialing information which the Hospital may have concerning the applicant, and a release of the Hospital and its representatives from liability in so doing.

All information and documentation required by Section 5.2 shall be placed and permanently maintained in each applicant's file in accordance with Section 5.6.

5.3 Processing the Application

5.3.1 Initial Presentation and Verification

Any application for Medical Staff membership shall be made to the President of the Hospital who, upon receipt of a properly completed application through Medical Staff Administration, shall seek to promptly collect and verify the references, licensure, and other qualification evidence presented, including any hospital or facility with or at which the applicant had or has privileges or was associated or employed, within the past five (5) years or, at the discretion of the Credentials Committee, within as many years deemed necessary to establish an adequate history relative to the following matters:

a. past or pending professional misconduct proceedings and any findings in such proceedings;

b. professional liability/malpractice actions which are pending or which were commenced, including any judgments or settlements of such actions; and

c. information concerning malpractice, disciplinary actions and possible professional misconduct which hospitals are required to report under applicable statutes and regulations.

Medical Staff Administration shall also query the National Practitioner Data Bank, and may query the American Medical Association, to request primary verification of the applicant's graduation from medical or dental school, any postgraduate training, malpractice history, State licensing actions, DEA actions, Medicare/Medicaid exclusions, limitations and/or restrictions. A criminal background check may be obtained at the discretion of the Hospital.

The credentialing coordinator, within 15 days of completion of the collection and verification of all necessary information, shall promptly transmit the application with all supporting materials to the Chief of each Department in which the applicant seeks clinical privileges.

d. The President of the Hospital or his/her designee shall at approximately 30-day intervals after the initial application advise the applicant in writing of any items in the application and necessary supporting materials which are incomplete or are not satisfactorily verified. If the applicant fails to provide or cause to be provided any information or verification within thirty (30) calendar days after being requested to do so, the application shall be automatically deemed to be withdrawn, unless the time to obtain the information is extended for good cause by the President of the Medical Staff and the Hospital President or designee.

5.3.2 **Basis for Appointment**

Each recommendation concerning an applicant for Staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2 and all the standards and requirements set forth in all sections of these Bylaws and the Rules and Regulations of the Medical Staff. Recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession and other hospitals' medical staff bylaws, rules and regulations, and policies, rendition of services to his/her patients, any physician or mental impairment which might interfere with the applicant's ability to practice his/her profession with reasonable skill and safety, and his/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications. The applicant shall have the burden of establishing such competency and qualifications, and of resolving any questions or concerns as to such competency or qualifications, to the satisfaction of the Credentials Committee, Medical Executive Committee, and the Board of Directors and shall have the burden of proof at all stages of any hearing and appellate review process pursuant to Article XII.

5.3.3 **Department Chief Action**

Upon receipt, the Chief of each Department in which the applicant is seeking privileges shall review the application and supporting materials, and may, within 30 days after his/her receipt of the application, conduct a personal interview with the applicant, either in person, by telephone, or by video conference. Confirmation that the interview occurred will be documented by the Chief on the form recommending the applicant for appointment. Within 45 days of his/her receipt of the application, the Department Chief shall indicate on the application form his/her or her recommendation to the Credentials Committee that the applicant be appointed to the Medical Staff, rejected for membership, or that the application be deferred for further consideration.

a. If the Department Chief recommends appointment to the Medical Staff, he/she shall also recommend assignment to the division, Department, Section, Category, clinical privileges, and any special conditions to be attached to the appointment. If the Department Chief recommends that the application be denied or deferred, he/she shall state the reasons for such recommendation.

b. When the recommendation of the Department Chief to the Credentials Committee is to defer the application for further consideration, a further recommendation by the Department Chief must be made within forty (40) days to the Credentials Committee.

5.3.4 **Credentials Committee Action**

a. At the next meeting of the Credentials Committee following receipt of necessary materials, the Department Chief's report and recommendation, the

report and recommendation of the Chief Medical Officer, if applicable, and any information available through other sources which is relevant to consideration of the application, the Credentials Committee shall review all the material available and, by majority vote, make a written recommendation with supporting reasons to the Medical Executive Committee that the applicant be appointed to the Medical Staff, rejected for membership, or that the application be deferred for further consideration.

b. The Credentials Committee may require the applicant to appear for a personal interview, either in person or via the telephone, in which event the Credentials Committee shall not be required to submit a final report until the interview has occurred. If the Credentials Committee is considering a recommendation which is adverse to the applicant, it may interview the applicant prior to making its final recommendation.

c. When the Credentials Committee recommends appointment to the Medical Staff, it shall also recommend assignment to the division, Department, Section, Category, clinical privileges to be granted, and any special conditions to be attached to the appointment.

d. When the recommendation of the Credentials Committee to the Medical Executive Committee is to defer the application for further consideration, a further recommendation by the Credentials Committee must be made within forty (40) days of the action to the Medical Executive Committee.

5.3.5 **Medical Executive Committee Action**

a. At its next regular meeting after receipt of the Credentials Committee report and recommendation on the application, the Medical Executive Committee shall consider the report and recommendation of the Credentials Committee and any other information available to it through other sources which are relevant to consideration of the application, and shall transmit its written recommendation, by majority vote, with supporting reasons, to the Board of Directors that the applicant be appointed to the Medical Staff, be rejected for membership, or that the application be deferred for further consideration.

b. When the Medical Executive Committee recommends appointment to the Medical Staff, it shall also recommend assignment to the division, Department, Section, Category, clinical privileges to be granted, and any special conditions to be attached to the appointment.

c. The Medical Executive Committee may defer final recommendation by referring the matter back to the Credentials Committee for further consideration. Any referral back shall state the supporting reasons therefore, shall set a time limit of not more than 31 days within which a subsequent recommendation by the Credentials Committee to the Medical Executive shall be made, and may include a directive that an interview with the applicant or

investigation into specific matters be conducted to clarify issues which are in doubt. After receipt of the subsequent recommendation and of any new evidence in the matter, the Medical Executive Committee shall make a final recommendation on the applicant with supporting reasons to the Board of Directors.

d. The Medical Executive Committee shall have the right to interview the applicant, either in person or via the telephone, and in that case no recommendation need be forwarded to the Board of Directors until the interview has occurred.

e. When the Medical Executive Committee's proposed recommendation is contrary to that of the Credentials Committee, the Medical Executive Committee may submit the matter to a conference of equal numbers of the Credentials Committee and Medical Executive Committee, and the Medical Executive Committee shall consider the opinion of the conference before making its final recommendation to the Board of Directors.

5.3.6 **Board of Directors Action**

a. At its next regular meeting after receipt of the Medical Executive Committee report and recommendation on the application, the Board of Directors shall consider that report and recommendation of the Medical Executive Committee and decide whether or not the applicant shall be appointed to the Medical Staff, or whether the application shall be deferred for further consideration.

b. The Board of Directors may interview the applicant, either in person or via the telephone, and in that event no decision on the applicant by the Board of Directors need be made until that interview has occurred.

c. When the Board of Directors' decision is to appoint the applicant to the Medical Staff that decision shall include assignment to the division, Department, Section, Category, clinical privileges, and any special conditions to be attached to the appointment. The Board shall then promptly advise the applicant of the decision. Acceptance of the appointment by the appointee shall constitute his/her pledge to abide by the Medical Staff Bylaws and Rules and Regulations and Bylaws of the Hospital.

d. The Board of Directors may defer final action by referring the matter back to the Medical Executive Committee for further consideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an interview with the applicant or investigation into specific matters be conducted to clarify issues which are in doubt. After receipt of the subsequent recommendation and of any new evidence in the matter, the Board of Directors shall make a decision on the applicant and, depending

whether it is favorable to or adverse to the applicant, further processing shall occur as specified in (c) or (e) of this Section.

e. When the Board of Directors' decision is adverse to the applicant, the Chair of the Board of Directors shall promptly inform the applicant by special notice of the decision and of his/her right to a hearing and appellate review as provided in Article XII. The application shall then be held in abeyance until the applicant has exhausted his/her rights under Article XII or has waived such rights.

f. When the Board of Director's proposed decision is contrary to the recommendation of the Medical Executive Committee, the Board of Directors may submit the matter to a conference of equal numbers of the Board of Directors and the Medical Executive Committee and shall consider the opinion of such conference before making a final decision.

g. When the Board of Directors does not receive a recommendation on an applicant within the time periods specified in Article V, it may act on its own initiative on the application after consideration of the same material and information as specified in these Bylaws and it shall notify the Medical Executive Committee both before and after its deliberations. If the subsequent Board of Directors decision is favorable to the applicant, the matter shall be further processed as in (b) of this Section. When the Board of Directors decision is adverse to the applicant, the matter shall be further processed as in (d) of this Section.

h. The final decision of the Board of Directors shall be communicated to the applicant, the Medical Executive Committee, Credentials Committee and Chief of the appropriate Department by the Chair of the Board of Directors.

i. Once approved, the applicant must present to Crouse Hospital with state or federal issued photo identification to receive his/her Crouse Hospital identification badge. Except for telemedicine providers, a Medical Staff Member who fails to personally present at Crouse Hospital to obtain his/her Crouse Hospital identification badge within ninety (90) days will be deemed to have voluntarily resigned from the Medical Staff.

5.3.7 **Reapplication After Adverse Appointment Decision**

a. An applicant who has received a final decision which is adverse regarding appointment or who withdrew an application or request for Staff membership or clinical privileges following an adverse recommendation by the Credentials Committee, the Medical Executive Committee or the Board of Directors; a former Medical Staff Member who has received a final adverse decision resulting in termination of Medical Staff membership and clinical privileges or resigned from the Medical Staff following the issuance of a Medical Staff or Board of Directors recommendation adverse to the Member's Medical Staff membership or clinical privileges; or an Medical Staff Member who has

received a final adverse decision resulting in termination or restriction of clinical privileges or denial of a request for additional clinical privileges, shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by the previous action for a period of at least eighteen (18) months from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff Member's resignation became effective, whichever is applicable.

b. After the eighteen (18) months period, the former applicant, former Staff Member, or Staff Member, as applicable, may submit an application for Medical Staff membership and/or clinical privileges which shall be processed as an initial application. The former applicant, former Staff Member, or Staff Member, as applicable, shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such application shall not be processed unless the applicant or Member submits satisfactory evidence that all of the specific requirements any adverse decision may have included, such as completion of additional training, have been satisfied.

5.4 **Reappointment Process**

5.4.1 **Application for Reappointment**

At least ninety (90) days prior to the expiration date of the current appointment of each Medical Staff Member, the President of the Hospital or his/her designee shall provide the Staff Member with a reappointment application form and instructions regarding reappointment. The reappointment application shall be completed by the Staff Member and returned to the President or his/her designee within thirty (30) days. Failure to return the completed application shall be deemed a decision to not reapply and will result in the termination of Medical Staff membership at the expiration of the individual's current appointment.

5.4.2 **Reappointment Application Form and Content**

Each reappointment application shall be in writing on forms approved by the Credentials Committee, shall be signed by the Staff Member and, in addition, shall furnish information necessary to properly evaluate the individual's continuing fulfillment of the qualifications and responsibilities of membership and continuing adherence to the Bylaws and Rules and Regulations of the Medical Staff and Hospital. The application, which shall be the individual's responsibility to complete, with authentication when requested, shall be consistent with the laws, rules and regulations of the State of New York and include but not be limited to:

a. a specific request for renewal of his/her current appointment and privileges and the basis for any requested change;

b. a copy of his/her current New York State professional registration;

c. the collection of the following information subsequent to the applicant's most recent appointment:

   i. the name of any hospital or facility with which the applicant has had any association, employment, privileges or practice and the reason, if discontinued, for discontinuation;

   ii. the substance of any pending professional malpractice claims, actions or medical conduct proceedings in this State or any other state;

   iii. any judgment, settlement, or finding of any medical malpractice action and any finding of professional misconduct in this or any other state;

   iv. any information relative to findings pertinent to violations of patients' rights;

   v. the receipt of a waiver by the applicant of any confidentiality provisions concerning the above information; and

   vi. a sworn statement by the applicant that the information is complete, true and accurate;

d. peer recommendations when requested;

e. information regarding maintenance of his/her current competence by participation in relevant continuing education programs including:

   i. evidence of earning continuing medical education credit hours, as required by the appropriate licensing or regulatory agencies, during the two (2) years immediately preceding the application notice issued pursuant to Section 5.4.1; and

   ii. evidence of fulfilling the specific requirements for continuing education as outlined in the Medical Staff Rules and Regulations.

f. a statement regarding his/her current mental and physical health; the effect, if any, of his/her health on his/her ability to practice medicine and the details of any changes in his/her health status since his/her initial appointment or last reappointment;

g. a current certificate of professional liability insurance coverage consistent with practice, requested clinical privileges and Section 3.3.13;

h. information relating to successful past or current challenge, reduction, suspension, loss, voluntary surrender, or denial of:

   i. membership or clinical privileges in any hospital or health care setting;

   ii. membership in any professional organization;

   iii. specialty board certification;

   iv. license or registration to practice in any jurisdiction; or

   v. Drug Enforcement Administration (DEA) registration.

i. information relating to any pending criminal proceedings or criminal convictions;

j. any other information that may bear on the individual's eligibility and suitability for reappointment; and

k. a statement that the applicant for reappointment continuously agrees to be bound by the terms and principles delineated in the Bylaws and Rules and Regulations of the Medical Staff and Hospital, including the ethical pledge specified in Section 3.3.2. and consents for release of information specified in Article XIII.

5.4.3 **Processing the Application for Reappointment**

a. **Verification and Collection of Material**

Upon receipt of the properly completed application for reappointment, the President of the Hospital, through the Medical Staff Administration, shall promptly seek to collect and verify the information in the application and, any other materials or information deemed pertinent, including information regarding the individual's professional activities, clinical performance and conduct, in this Hospital and any other hospital or health care facility. Within fifteen (15) days of completion and verification, the application with all supporting materials shall be forwarded to the appropriate Department Chief.

b. **Basis for Reappointment**.

Each recommendation concerning an applicant for reappointment shall be based upon whether the applicant meets the qualifications specified in Section 3.2 and meets all of the standards and requirements set forth in all sections of these Bylaws and Rules and Regulations of the Medical Staff. Specifically, recommendations shall be based upon the practitioner's compliance with legal and ethical requirements applicable to the practice of his/her profession, the Medical Staff Bylaws, Rules and Regulations, policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice his/her profession with reasonable skill and safety, attendance at committee, Department and Medical Staff meetings, working cooperatively with others, maintenance of satisfactory medical records, continuing medical education activities since the last appointment and his/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications. The applicant shall have the burden of establishing such competency and qualifications, and of resolving any questions or concerns as to such competency or qualifications, to the satisfaction of the Credentials Committee, Medical Executive Committee and the Board of Directors and shall have the burden of proof at all stages of any hearing and appellate review process pursuant to Article XII.

c. **Department Chief and Chief Medical Officer**

The appropriate Department Chief or Chief Medical Officer shall review the material presented and the individual's credential file, including the Physician Practice Profile and, jointly or separately, within thirty (30) days of verification of the completed application, transmit recommendations with supporting reasons to the Credentials Committee that the individual be reappointed to the Medical Staff, rejected for reappointment, or that the application be deferred for further consideration.

i. The recommendations may document personal observations by the Department Chief or Chief Medical Officer, the individual's Hospital and professional performance including information concerning professional performance, judgment, and clinical technical skills, as indicated by the results of quality assurance activities and other reasonable indicators of continuing qualifications.

ii. If the recommendations are for reappointment, they shall also recommend assignment to the division, Department, Section, Category, clinical privileges, and any special conditions to be attached to the reappointment.

iii. Prior to any recommendation of a reduction in requested reappointment status, within thirty (30) days, the Department Chief or Chief Medical Officer shall request a personal interview with the individual concerned, either in person or via the telephone. Their recommendation shall not be

forwarded to the Credentials Committee until the interview has occurred or the opportunity has been declined.

iv. When the applicant for reappointment is the Department Chief, the review provided for above shall be conducted by the Vice Chief.

d. **Subsequent Processing of Reappointment Applications**

The application for reappointment shall thereafter be processed through the Credentials Committee and Medical Executive Committee to the Board of Directors in the same manner as an application for initial appointment as provided in Sections 5.3.3-5.3.6.

5.5 Modification of Appointment

5.5.1 Subject to Section 3.2.2, a Medical Staff Member may at any time request modification of his/her appointment or clinical privileges by submitting a written request to the Chief of the Department. The request shall be processed in the same manner as an application for reappointment as specified in Section 5.4.3 and shall contain detailed and authenticated information to justify the requested change.

5.5.2 Appropriate malpractice insurance must be in force for the privileges requested.

5.6 Credential Files

The President of the Hospital or his/her designee shall maintain a Credential File for each Medical Staff Member and any individual requesting clinical privileges. The file shall contain all information submitted by the individual for appointment, reappointment, and modification of appointment as delineated in the Bylaws and Rules and Regulations of the Medical Staff and Hospital, including the ethical pledge specified in Section 3.3.2 and consents for release of information specified in Article XIII. All relevant information gathered in accordance with the above requirements shall be maintained in this file. The file of any individual not appointed shall be maintained for five years.

5.6.1 The contents of each file shall be kept secure and confidential except for credentialing, review procedures and corrective action. Access to the file shall be limited to the President of the Hospital or his/her designee, the Chief Medical Officer, the President of the Medical Staff, the Chief of the Department and/or Section Chief to which the individual has been assigned and members of the Credentials Committee and Medical Staff Administration personnel (except when the individual gives specific written permission to the contrary allowing access to others).

5.6.2 When any information contained in the Credential File is released by the Hospital to the New York State Department of Health or any other state or federal agency, the Medical Staff Member shall be notified and shall be furnished copies of all released information upon request.

5.6.3 The Credential File of any Medical Staff Member shall be available for review by the Member at any time.

5.7 Physician Practice Profile Files

As a part of the Quality Assessment Improvement Program of the Hospital and Medical Staff, information concerning a physician's performance shall be gathered and maintained in the Medical Staff Administration of the Hospital. Such information may be measured by, but not limited to information such as: mortality review, surgical case review, review of transfusions, medical record performance, attendance at meetings, and comments of the Department Chief. This information shall be compiled in a Quality Assessment/Physician Practice Profile file for each Medical Staff Member and kept confidential according to State and federal law.

5.7.1 Each file shall be kept separate and distinct from an individual's Credential File and be kept in a secure manner.

5.7.2 As part of the reappointment process, information from the Quality Assessment monitoring and evaluation activities shall be summarized into a Physician Practice Profile. This profile of performance shall be used by those individuals and committees evaluating the reappointment.

5.7.3 The Physician Practice Profile file of any Medical Staff Member shall be available for review by the Member at any time.

5.7.4 The individual Medical Staff Member may enter additional comments into his/her file, regarding material contained therein on a separate and individual document dated and signed by the Medical Staff Member.

5.7.5 The procedures for the collection of information and maintenance of the Physician Practice Profile file shall be made a part of the Rules and Regulations of these Bylaws.

ARTICLE VI. CLINICAL DEPARTMENTS

6.1 Organization

The Medical Staff shall be divided into clinical Departments each of which shall have a Chief who shall be responsible for the overall supervision of the clinical work within the Department and whose selection, authority, and responsibility are specified in Section 6.6. The Departments are Anesthesiology; Emergency Medicine; Family Medicine**;** Medicine; Pathology; Medical Imaging; Neurology; Neurosurgery; Obstetrics and Gynecology; Ophthalmology; Orthopedics; Otolaryngology; Pediatrics; Psychiatry; Surgery; and Urology.

6.2 Clinical Sections

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 may, as indicated, have a Chief of the Section whose selection, authority, and responsibility shall be as specified in Section 6.7. Sections include: Interventional Radiology; Radiation Oncology; Cardiology; Podiatry; Plastic Surgery; Thoracic Surgery; Oral Surgery (Dentistry); Nephrology; Gastroenterology; Echocardiology; Electrophysiology; Physical Medicine and Rehabilitation; Bariatrics; Robotics; and Pulmonology.[2]

6.2.1 Designations of Departments and Sections

a. The Medical Executive Committee shall have the responsibility for designating, changing, creating or eliminating Departments with the approval of the Board of Directors.

b. Each Department Chief shall have the responsibility for designating, changing, creating or eliminating Sections within the respective Department with the approval of the Medical Executive Committee.

6.3 Assignment to Departments and Sections

Each Member of the Medical Staff shall be a member in at least one Department, and Section if applicable, but may be granted membership and/or clinical privileges in one or more other Departments and/or Sections. The exercise of privileges within each Department and Section shall be subject to the rules and regulations therein and to the authority of the respective Department Chief and Section Chief.

In the case of an individual who seeks or exercises privileges in more than one Department or Section, all the appropriate Department and Section Chiefs shall review and render recommendations on his/her appointment, reappointment, or modification of appointment.

6.4 Functions and Responsibilities of Departments

The Medical Staff leadership of each Department shall assure that the Department:

a. maintain an ongoing review and evaluation of the activities and clinical work in the Department by agreeing on objective criteria to identify opportunities to improve care and to identify problems in patient care. The findings and recommendations as a result of this monitoring as well as the effectiveness of the actions taken shall be documented;

b. establish written guidelines consistent with the polices of the Medical Staff and Hospital, for granting clinical privileges in the Department;

[2] Section 6.2 was revised to add Pulmonology as a clinical section, which revision became effective July 9, 2020.

c. adopt rules and regulations for the Department, consistent with the policies and Bylaws, and Rules and Regulations of the Medical Staff and Hospital, including establishing the responsibility of Department members for being available to the Emergency Room, to care for those patients referred during the course of their illness and to be responsible for appropriate follow-up for that condition. In the case of any inconsistency between departmental rules and regulations and the Bylaws or Rules and Regulations of the Medical Staff, the Medical Staff Bylaws or Rules and Regulations, as applicable, shall be controlling. Departmental rules and regulations shall not become effective until approved by the Medical Executive Committee;

d. provide for ongoing collection of data regarding individual member's clinical performance;

e. make recommendations, where appropriate, to the Medical Executive Committee for the maintenance and improvement of patient care and with respect to the functioning of the Department and Hospital;

f. meet as needed to fulfill the functions and responsibilities of the Department;

g. establish such Department Committees as are necessary and advisable; and

h. maintain liaison with other Departments and elements of the Hospital.

6.5 Functions and Responsibilities of Sections

Each Section shall, upon approval of the Medical Executive Committee, perform the functions assigned to it by the Department Chief. Such functions shall, in general, be similar to those specified in Section 6.4.

6.6 Department Chief

6.6.1 Qualifications

Each Chief of a Department shall:

a. be a member in good standing of the Active Staff;

b. have demonstrated ability in at least one of the clinical areas covered by the Department;

c. be qualified by training experience and demonstrated ability for the position;

d. be willing and able to discharge the functions and responsibilities of the office;

e. be certified by the American Board in his/her specialty if such certification exists;

f. shall not serve as chair of a department or service at another hospital during his/her incumbency except upon recommendation of the Medical Executive Committee to the Board of Directors for a term of service to be determined by the Board of Directors, and shall notify the President of the Hospital and the President of the Medical Staff, in writing, immediately upon his/her employment by another hospital or hospital system; and

g. at all times during his/her term of office have a license in good standing to practice medicine in New York State.

6.6.2 **Responsibilities and Duties**

Each Chief of a Department shall:

a. collaborate with the Chief Medical Officer for all professional and administrative activities within the Department, including but not limited to, maintaining liaison and cooperation with elements of the Medical Staff and Hospital;

b. maintain a continuing review of the Medical Staff privileges, quality of care and/or services of each Department to ensure quality and appropriate patient care is monitored and evaluated, including the focused review of Department members as required by Section 7.6;

c. be responsible for peer review activities within the Department, to include conducting peer review of members of the Department, reporting such activities, as required, to the Peer Review Committee, and keeping members advised of peer review regarding them as required by applicable Hospital policies;

d. serve on the Medical Executive Committee with vote and report regularly on the activities of the Department;

e. make recommendations to the Credentials Committee on appointments, reappointments, and modifications of appointment, including clinical privileges, as specified in Sections 5.3.3, 5.4.3.c, and 5.5; the Chief shall also consider the health status and activity of Department members and make recommendations regarding changes to privileges if necessary;

f. be responsible for teaching, education, and research programs within the Department;

g. recommend for appointment and supervise Chiefs of Sections within the Department;

h. perform an annual review of the departmental rules and regulations to be presented to the Medical Executive Committee;

i. be responsible for the enforcement of the Medical Staff and Hospital Bylaws, Rules and Regulations, and Department Manual;

j. be responsible for implementation within the Department of actions taken by the Medical Executive Committee and/or the Board of Directors;

k. transmit Department recommendations to the Medical Executive Committee or appropriate Departments;

l. be responsible for emergency call assignment and the assignment of a physician to any patient who is admitted to the Department without a personal physician or where alternative coverage is required due to the incapacity of the prior attending; and

m. perform administrative duties as requested by Hospital leadership,

6.6.3 **Procedure for Appointment and Reappointment**

The Board of Directors shall appoint each Department Chief after considering the recommendation of the Medical Executive Committee.

a. The President of the Medical Staff, with the consent of the Medical Executive Committee, shall appoint an ad hoc search committee for each Department Chief. The individual members of the Search Committee shall be approved by the Medical Executive Committee. This committee shall consult the Senior and Active Staff Members of the Medical Staff in order to identify interested and qualified candidates; distribute a list of such candidates to the Senior and Active Staff Members of the Department concerned; poll Department members for the preference of the majority; consider the candidates; and then submit a recommendation to the Medical Executive Committee. This recommendation shall include a report on the preference of the Department; minority reports may be included.

   The search committee shall consist of at least three (3) members of the Medical Staff.

b. After considering the recommendations and reports of the ad hoc search committee, the Medical Executive Committee shall make a recommendation to the Board of Directors. The recommendation shall specifically state the Department preference if it differs from the recommendation of the Medical Executive Committee. The recommendation will be considered by the Board of Directors who will make the appointment.

6.6.4 **Term**

A Department Chief shall serve a term of four (4) years or as may otherwise be established by the Board of Directors and shall be eligible to succeed himself.

6.6.5 **Removal of Department Chief**

a. Department Chief may be removed with or without cause upon recommendation of the Medical Staff Executive Committee to the Board of Directors. Cause shall include any failure to comply with the qualifications listed in Section 6.6.1. A request for removal of a Department Chief from office shall be addressed to the Medical Executive Committee and may be initiated by the:

   i. Medical Executive Committee acting on its own initiative; or

   ii. petition to the Medical Executive Committee by forty (40%) percent of the Senior and Active Staff Members of the Department concerned; or

   iii. recommendation of the Chief Medical Officer or Board of Directors.

b. Removal shall not entitle the individual to a hearing or appellate review under Article XII.

6.7 **Vice Chief**

The duties of the Vice Chief shall be to assist the Department Chief in administering the affairs of the Department. This will include fulfilling any necessary peer review role relative to the department chief and acting in place of the Department Chief in all matters when the Department Chief is temporarily unavailable.

6.7.1 **Qualifications**

a. The qualifications for Vice Chief shall be identical to those for a Department Chief as specified in Section 6.6.1.

b. The qualifications specified in Section 6.6.1.e may be waived at the discretion of the Medical Staff Executive Committee.

6.7.2 **Responsibilities and Duties**

The responsibilities and duties shall be assigned by the appropriate Department Chief.

6.7.3 **Procedure for Appointment**

The Department Chief shall appoint a Vice Chief, subject to the approval of the Medical Executive Committee.

6.7.4 **Term**

The Vice Chief will remain in the position until a new Vice Chief is appointed by the Department Chief.

6.8 **Vacancy**

The Medical Executive Committee shall ensure that the duties and responsibilities of the Department Chiefs are filled at all times. In the event of a vacancy in the position of Department Chief, the Vice Chief shall immediately assume such duties and responsibilities on an interim basis, and the Medical Executive Committee shall initiate the procedures specified in Section 6.6.3 for the regular appointment of a Department Chief.

6.9 **Chief of Section**

6.9.1 **Qualifications**

a. The qualifications for Chief of a Section shall be identical to those for a Department Chief as specified in Section 6.6.1.

b. The qualification specified in Section 6.6.1.e may be waived at the discretion of the Medical Executive Committee.

6.9.2 **Responsibilities and Duties**

The responsibilities and duties shall be assigned by the appropriate Department Chief.

6.9.3 **Procedure for Appointment**

The Medical Executive Committee shall appoint each Section Chief after considering the recommendation of the appropriate Department Chief and the preference of the members of the Section.

6.9.4 **Term**

The Section Chief shall remain in the position until a new Section Chief is appointed by the Department Chief.

6.10 **Medical Director**

A Medical Director may be assigned at the discretion of the President of the Hospital or his/her designee and/or the Chief Medical Officer to direct and oversee strategic program development and clinical activities of a specific division within an established clinical department.

6.10.1 **Qualifications**

The qualifications for Medical Director shall be identical to those for a Department Chief as specified in Section 6.6.1, provided the qualifications specified in Section 6.6.1.e may be waived at the discretion of the President of the Hospital or his/her designee, and/or the Chief Medical Officer upon collaboration with the appropriate Department Chief.

6.10.2 **Responsibilities and Duties**

The responsibilities and duties shall be assigned by the President of the Hospital or his/her designee and/or the Chief Medical Officer.

6.10.3 **Procedure for Assignment**

The President of the Hospital or his/her designee and/or the Chief Medical Officer shall assign each Medical Director.

6.10.4 **Term**

Subject to any applicable contractual terms, the Medical Director shall serve at the discretion of the President of the Hospital or his/her designee and/or the Chief Medical Officer.

6.10.5 **Quality and Clinical Reporting**

a. The Medical Director shall regularly collaborate with the appropriate Department Chief on the quality and clinical activities within the division.

b. The Department Chief shall be responsible for privileging, credentialing, clinical performance, and quality within the division.

ARTICLE VII. DETERMINATION OF PRIVILEGES AND SERVICE

7.1 General

Each Member of the Medical Staff shall be granted clinical privileges in accordance with Hospital policies and Medical Staff Bylaws, Rules and Regulations, subject to approval by the Board of Directors. Members shall be authorized to order outpatient services within the scope of their clinical privileges. Only those privileges granted by the Board, except as provided in Section 7.3, shall be exercised by the individual.

7.1.1 Requests for Privileges

Each applicant for appointment or reappointment to the Medical Staff shall specifically request those privileges desired pursuant to Section 5.2 and 5.4.2. A Medical Staff Member may, at any time, request a change in his/her privileges pursuant to Section 5.5.

7.1.2 Basis for Privilege Determination

Privilege determination shall be based on the individual's education, training, experience, demonstrated ability, current competence and health status, references, the capability of the Hospital to support the patient care he/she provides, State law and any other pertinent information, including an appraisal by the Department in which such privileges are sought. Information regarding the individual's observed clinical performance and conduct in the Hospital or in any other health care setting shall be considered in determining the privileges to be granted. The applicant shall have the burden of establishing qualifications and competency for the clinical privileges requested, and of resolving any questions or concerns as to such competency or qualifications, and shall have the burden of proof at all stages of any hearing and appellate review process pursuant to Article XII. The recommendation of specific privileges shall be the responsibility of the Department Chief.

Any or all clinical privileges may be withheld until satisfactory information is provided by the applicant to make a determination.

7.1.3 Licensed and Limited Licensed Health Care Practitioners Privileges

A Licensed Health Care Practitioner may attend patients in accordance with the Bylaws, and Rules and Regulations provided that a physician Staff Member has assumed responsibility for the basic medical care and appraisal of the patient during hospitalization. Any surgical privileges shall be under the overall supervision of the Department Chief designated by the Medical Executive Committee. Licensed and Limited Licensed Health Care Practitioners who are members of the Affiliate Staff and who are permitted by law to do so may also admit patients to the extent specifically allowed by their clinical privileges. Limited Licensed Health Care Practitioners are required to participate in a supervisory plan approved by the

Supervising Physician, Department Chief, and Chief Medical Officer. They are not allowed to supervise Affiliate Staff.

7.1.4 Visiting Health Care Providers

a. Visiting Health Care Providers may be granted special status by the President of the Hospital upon the recommendation of a member of the Active Staff in the applicable Department for a short duration for the purpose of learning, training or other education. In order to standardize procedures for the granting of such status, only the following categories will be available:

1. **Observer:** Physicians or other health care providers visiting for the purpose of observation in a specific department requested by a Medical Staff Member. This category includes a scrubbed observer in the Operating Room. This category does not include the provision of patient care services, and residents are not eligible for this category. Observer status may be issued for a period of three months or less.

   For privileges for this category, the following items must be presented to the Medical Staff Office:

   - A letter from the Medical Staff Member requesting observer status, which shall include a description of the practitioner's duties/activities during the visit.

   - A physical examination completed within one (1) year prior to the application date signed by a licensed healthcare practitioner other than the applicant, including proof of immunization and/or immunity as may be required by Medical Staff policy.

2. **Education:** Physicians and other healthcare providers participating in training or other educational opportunities to receive medical instruction, to engage in clinical teaching or to review academic and patient care programs at Crouse Hospital.

   For privileges in this category, the following items must be presented to the Medical Staff Office:

   - Proof of current New York State licensure or, in the case of a physician who seeks to participate under Section 6525 or Section 6526(4) of the Education Law, proof of current licensure in another state or country, in which case his/her participation shall not exceed six (6) months duration, shall be limited to such medical instruction and shall be under the supervision of a Medical Staff Member.

   - Proof of malpractice insurance covering participation at Crouse Hospital, a physical examination completed within one (1) year prior to the application date signed by a licensed healthcare

practitioner other than the applicant, including proof of immunization and/or immunity as may be required by Medical Staff policy, National Practitioner Data Bank query, CV, attestation and general release, and any other information which may be requested by the Chief Medical Officer or Chief of the Department.

b. It is the responsibility of the Medical Staff Office to follow up on all documentation required by this Section 7.1.5 for Visiting Health Care Providers, including proof of licensure, malpractice insurance and approved health clearance. All documents must be sent to Medical Staff Office in sufficient time to process the request. Upon receipt of all required documentation, the decision to grant special privileges under this 7.1.5 shall be made by the President of the Hospital upon the recommendation of the Chief of the Department.

7.2 **Special Consultative Privileges**

7.2.1 Special consultative privileges may be granted by the President of the Hospital upon the written recommendation of the Chief of the Department to physicians and other health care providers, upon the request of a member of the Medical Staff, to follow specific patients for a period not to exceed fifteen (15) days.

7.2.2 Practitioners requesting such privileges shall submit the following items to the Medical Staff Office: verification of the practitioner's license in New York or any other state or country, malpractice insurance coverage, physical examination completed within one (1) year prior to the application date signed by a licensed healthcare practitioner other than the applicant, including proof of immunization and/or immunity as may be required by Medical Staff policy, National Practitioner Data Bank query, and any other information which may be requested by the Chief or Chief Medical Officer.

7.2.3 Such privileges shall be granted in writing by the President of the Hospital, or his/her designee, upon the recommendation of the Department Chief.

7.2.4 Special consultative privileges may be terminated at the discretion of the Department Chief or Hospital President at any time for good cause. The granting of such privileges does not make the practitioner a Member of the Medical Staff. The denial or termination of such privileges does not entitle the practitioner to any of the procedural rights under Article XII.

7.3 Temporary Privileges

7.3.1 General

Temporary privileges may be granted to a Licensed Health Care Practitioner or Limited Licensed Health Care Practitioner, who may be required to pay a temporary privilege application fee as determined by Medical Staff policy, under the following circumstances:

a. to meet an important patient care, treatment and service need; or

b. when a new applicant who has filed a properly completed application, including all supporting documentation, that raises no concerns, is awaiting review and approval of the Medical Executive Committee pursuant to Section 5.3.5, or Board of Directors pursuant to Section 5.5.6.

7.3.2 Important Patient Need

Temporary privileges shall be granted to meet an important patient care need by the President of the Hospital or his/her designee on the recommendation of the President of the Medical Staff or his/her designee upon verification of current New York State licensure or limited licensure, education, required malpractice insurance, current DEA, National Practitioner Data Bank query, verification of not being excluded from participation in Medicare or Medicaid and current competence, in addition to a physical examination completed within one (1) year prior to the application date signed by a licensed healthcare practitioner other than the applicant, including proof of immunization and/or immunity as may be required by Medical Staff policy. The request for such privileges must be made at least two (2) weeks in advance unless extenuating circumstances make it impractical to do so. The duration of temporary privileges shall be no longer than necessary to meet the identified patient care need, but in no event shall exceed thirty (30) days, unless extended for good cause by the Board of Directors for up to two (2) additional consecutive thirty (30) day periods.

7.3.3 Pending Application

Temporary privileges shall be granted by the President of the Hospital or his/her designee on the recommendation of the President of the Medical Staff or his/her designee to new applicants under the following conditions:

a. submission of a completed written application along with request for privileges, signed by the Chief of the Department;

b. verification of all of the applicant's current licensures or limited licensures, current DEA, current health assessment, education, relevant training or experience, current competence and ability to perform the privileges requested;

c. query and evaluation of the NPDB information;

d. verification that the application shows no evidence of any current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership or limitation, reduction, denial, or loss of clinical privileges at another institution, and no pending actions or investigations which could affect the exercise of such clinical privileges;

e. verification of current New York State licensure, limited licensure, and required malpractice insurance.

f. verification of not being excluded from participation in Medicare or Medicaid.

The temporary privileges shall apply only through the period of time required to complete the processing of the applicant's Medical Staff application, and, in any event, shall expire thirty (30) days after a Staff appointment is offered to the applicant. The duration of temporary privileges shall in no event exceed thirty (30) days, unless extended for good cause by the Board of Directors for up to two (2) additional consecutive thirty (30) day periods.

7.3.4 **Conditions**

Temporary privileges shall be subject to the conditions listed below.

a. The individual seeking temporary privileges shall submit a written request for such privileges, shall read and agree in writing to be bound by the Bylaws and Rules and Regulations of the Medical Staff and Hospital, and shall agree in writing to the investigation of his/her clinical ability as if he/she was making a formal application for Staff membership.

b. Temporary privileges shall be granted only where the available information supports a favorable determination regarding the clinical ability of the practitioner.

c. Any individual exercising temporary privileges shall be under the supervision of the appropriate Department Chief or his/her designee.

d. Special requirements for consultation and reporting may be imposed upon the individual exercising temporary privileges.

7.3.5 **Termination of Temporary Privileges**

The President of the Hospital or his/her designee, after consultation with the appropriate Department Chief, may terminate any or all of an individual's

temporary privileges. Such a termination shall be immediate relative to admitting privileges, but may allow the care of currently hospitalized patients. However, where it is determined that the life or health of such patients would be endangered by continual treatment by the practitioner; the termination may be imposed immediately. Upon such termination, the individual's patients in the Hospital shall be assigned to a Staff Member by the appropriate Department Chief. The wishes of the patient shall be considered when feasible, in the selection of the substitute practitioner.

7.3.6 **Rights**

An individual seeking or exercising temporary privileges shall not be entitled to the procedural rights afforded by Articles XI and XII because of his/her inability to obtain temporary privileges or, except in those cases where such termination is reportable to the NPDB or the NYS Office of Professional Misconduct, because of any termination of temporary privileges.

7.4 **Emergency Privileges**

In the case of an emergency, any Member, to the degree permitted by his/her license and regardless of Staff status or clinical privileges, shall be permitted and assisted by the Hospital and its personnel to do everything possible to save the patient's life or to save the patient from serious harm. In so doing, the Member shall summon all available consultative aid deemed necessary and make a reasonable effort to communicate promptly with his/her Department Chief or the Chief Medical Officer concerning the need of emergency care and assistance by Members with appropriate privileges. When the emergency situation no longer exists, the Member must request the privileges necessary if he/she is to continue to treat the patient. In the event these privileges are denied or are not requested, the patient shall be assigned to an appropriate Member of the Medical Staff. For purposes of this Section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger or any delay in administering treatment would add to that danger.

7.5 **Disaster Privileges**

During a disaster in which the emergency management plan has been activated and the Hospital is unable to fully meet immediate patient needs, the President of the Hospital or Medical Staff President or his/her or her designee(s) may grant disaster privileges upon presentation of a valid photo identification issued by a state or federal agency and any one of the following:

1. A current picture hospital ID card.
2. A current license to practice.
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or other recognized state or federal response organization or group.

4. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.
5. Presentation by current Hospital or Medical Staff Member(s) with personal knowledge regarding practitioner's identity and abilities.

Primary source verification of licensure shall be completed as soon as the immediate emergency situation is under control or within seventy-two (72) hours from the time the practitioner arrives. If primary source verification of licensure cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the Hospital shall document the following:

1. Reason(s) it could not be performed within seventy-two (72) hours of the practitioner's arrival.
2. Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment and services.

3. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

7.6 **Re-Entry Education Status**

Physicians seeking re-entry to clinical practice after an absence of two or more years may be granted Re-Entry Education Status upon approval by the Board of Directors to exercise clinical judgment and attend patients within their scope of practice, provided they:

1. Are able to meet all medical staff initial appointment terms, conditions and requirements of the Crouse Health Medical Staff Bylaws, except the ability to demonstrate current competence.

2. Are sponsored by a current medical staff physician member with Active privileges in the same department who has assumed clinical oversight and responsibility for all patient care activities and professional behavior as specified in a written Clinical Sponsorship Agreement approved by the Chief Medical Officer, Department Chief, and Supervising Physician, and pursuant to the initial application process;

3. Are at all times under direct and/or indirect supervision of the sponsoring physician or other Active physician member(s) identified in the Clinical Sponsorship Agreement;

4. Re-entry Education Status may be granted for a period of at least six months and may not exceed one year. In consideration of the physician's specialty, prior training and experience and length of time away from clinical practice, the Department Chief, at his discretion and in collaboration with the Chief Medical Officer, may modify the minimum six-month Re-entry Education Status period.

5. Re-entry Education Status excludes granting of specific clinical privileges until such time as applicable conditions of the Clinical Sponsorship Agreement have been satisfied and clinical competence demonstrated sufficient for the physician to be eligible to submit a modification of privilege(s) request;

6. Re-entry Education Status may be terminated at the discretion of the President of the Hospital, Chief Medical Officer, or Department Chief at any time for cause;

7. A physician seeking or exercising Re-entry Education Status shall not be entitled to the procedural rights afforded by Articles XI and XII because of his/her inability to obtain medical staff privileges or, except in those cases where such termination is reportable to the NPDB or the NYS Office of Professional Misconduct, because of any termination of privileges or status.

8. Financial obligation

   The physician seeking re-entry assumes full legal and financial responsibility for costs incurred related to the re-entry process including but not limited to: Application fees, education program fees, examination fees, proctor fees, sponsorship fees, certification fees, and medical malpractice insurance fees.

7.7 Focused Professional Performance Evaluation (FPPE) Review

All physicians having been granted privileges upon their initial appointment to the Medical Staff or, after being appointed, have been granted new privileges, shall undergo a process of focused review of their performance of such privileges. The nature and extent of such focused review, including the period of review, shall be determined by each Department based on criteria developed by the Department and set forth in Department policies. Such review may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques and discussion with other practitioners and Hospital administrative personnel involved in the care of the practitioner's patients, and may also include information from sources outside of the Hospital.

7.8 Locum Tenens Privileges

Locum tenens privileges may be granted by the President of the Hospital or his/her designees on the recommendation of the President of the Medical Staff or his/her designees, for a period not to exceed one hundred eighty (180) days, to a practitioner who is serving as a locum tenens for a current member of the Medical Staff who requires coverage of his/her patients. Such privileges shall be granted according to the same process described in Sections 7.3.2 and 7.3.4 for temporary privileges. In addition, the provisions stated in Sections 7.3.5 and 7.3.6 shall be applicable to locum tenens privileges. Any practitioner who has served as a locum tenens physician for a total of 180 days during any twelve (12) month period, and who requests privileges within 180 days of his/her last day of service as a locum tenens physician, shall be required to apply as a member of the Active Medical Staff under Article V of these Bylaws. Locum tenens practitioners shall not

be required to pay Medical Staff dues; however, such practitioners shall be required to pay an application fee as determined by the Medical Staff.

ARTICLE VIII. OFFICERS OF THE MEDICAL STAFF

8.1 Officers

The officers of the Medical Staff shall be President, Vice President, Secretary-Treasurer, and Past President.

8.2 Qualifications

Each officer of the Medical Staff shall be a physician or dentist member in good standing of the Medical Staff prior to the time of nomination and election and must remain such member in good standing during the terms of office, be willing and able to discharge the responsibilities of the office, and not be the Chief Medical Officer. Failure to maintain such status shall create a vacancy in the office involved. During the term as an officer of the Medical Staff, each officer shall promptly disclose to the Medical Executive Committee any other financial relationship the officer has with the Hospital. The Secretary-Treasurer shall provide notice to the Medical Staff of such relationships in the written notice of the annual meeting required under Section 10.4 of these Bylaws.

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.

8.3 Election

8.3.1 Nominations

a. The Nominating Committee shall present one or more nominees for each elective office to be filled in the Staff organization after consultation with the Medical Executive Committee and Executive Administration concerning the qualifications and acceptability of the prospective nominees. The list of nominees shall be communicated to the Staff at least two (2) weeks prior to the election.

b. Nominations may also be made, with the nominee's approval, by a petition signed by at least ten (10) Staff Members eligible to vote in Staff elections. The petition shall be presented to the Secretary of the Medical Staff at least fifteen (15) days prior to the day of election. As soon thereafter as reasonably possible, the names of those additional nominees shall be reported in writing by the Secretary of the Medical Staff to the Medical Staff.

c. Nominations from the floor at a Medical Staff or Medical Executive Committee meeting shall not be accepted.

d. Should a Member nominated by the Nominating Committee for a position as an officer of the Medical Staff withdraw following presentation to the Medical Staff, the Nominating Committee shall present a new nominee to the Medical Staff by mail or at a special meeting of the Medical Staff and shall reopen the period for written nominations for fourteen (14) days, provided, however, the close of written nominations must occur no later than three (3) working days prior to the election meeting. If the time frame is insufficient to allow for a new period of written nominations, and no other nomination have been received in the initial nomination period, the office will be left vacant and filled according to the provisions of Section 8.5.

8.3.2 **Election**

Officers shall be elected by secret written ballot at the annual meeting of the Staff by a majority of those Staff Members eligible to cast ballots. If no candidate for an office receives a majority on the first ballot, a runoff election shall be held at the same meeting between the two candidates receiving the highest number of votes. Voting by proxy shall be permitted pursuant to Section 10.7.1.

8.3.3 **Exceptions**

Sections 8.3.1 and 8.3.2 shall not apply to the office of Past President. The President of the Medical Staff, upon completion of his/her term of office shall, immediately succeed to the office of Past President.

8.4 Term of Office

8.4.1 Each officer of the Medical Staff shall serve a term of two years or until a successor is elected, unless he/she resigns or is removed from office. Officers shall take office on the 1st day of July following the June semi-annual Medical Staff meeting.

8.4.2 Officers may be re-elected to the same office for one additional 2-year term, but may not serve in the same office for more than two consecutive terms.

8.5 Vacancies of Office

8.5.1 The Vice President of the Medical Staff shall succeed to the office of President if the office becomes vacant.

8.5.2 A vacancy in the office of Past President shall not be filled until the next annual Medical Staff meeting and the duties of the office shall be assumed by the President of the Medical Staff in the interim.

8.5.3 Other vacancies shall be filled, until the next annual meeting of the Medical Staff, by appointment by the Medical Executive Committee.

8.6 **Removal from Office**

8.6.1 A request for removal of any Medical Staff officer from office for cause shall be addressed to the Medical Executive Committee and may be initiated by:

a. Medical Executive Committee on its own recommendation by thirty (30%) percent vote of the entire Committee;

b. petition by ten (10%) percent of the voting members of the Medical Staff; or

c. recommendation of the Board of Directors.

8.6.2 Examples of reasons for removal shall include, but not be limited to: failure to faithfully discharge his/her duties; malfeasance; inability to discharge his/her duties due to physical or mental impairment; removal from the Medical Staff; unprofessional conduct; and/or unethical behavior.

8.6.3 **Procedure**

The Medical Executive Committee shall refer the matter to an ad hoc committee of Medical Staff Members appointed by the Medical Executive Committee to investigate, review, and make a recommendation to the Medical Executive Committee. Thereafter, the Medical Executive Committee shall review the matter and the recommendation of the ad hoc committee. Removal shall be considered at a special meeting of the Medical Staff called for that purpose. The final decision shall be made by secret written vote with absentee voting permitted. Removal shall require a two-thirds vote of the Medical Staff Members present and eligible to vote for Medical Staff officers.

The officer in question:

a. shall have the right to appear before both the ad hoc committee and Medical Executive Committee to present any relevant views and information;

b. shall not be present during any subsequent discussion or voting on the matter and shall not be permitted to vote on the matter; and

c. shall not have any rights to a hearing or appeal under Article XII.

8.7 **Duties of Medical Staff Officers**

8.7.1 **President**

The President of the Medical Staff shall serve as the chief officer of the Medical Staff and shall:

a. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Medical Executive Committee;

b. serve as Chair of the Medical Executive Committee;

c. be an ex-officio member of all Medical Staff committees, without vote (including the Medical Executive Committee) unless his/her vote in a particular committee is otherwise required by these Bylaws or required to break a tie;

d. appoint members and chairs of all Medical Staff committees with the approval of the Medical Executive Committee and the Board of Directors unless otherwise provided herein;

e. serve as a member of the Quality Improvement Committee;

f. represent the views, policies, needs, and concerns of the Medical Staff to the Board of Directors;

g. aid coordination and cooperation with the Hospital in all matters of mutual concern;

h. report to the Medical Executive Committee on the deliberations and actions of the Quality Improvement Committee and Board of Directors;

i. shall serve at the pleasure of the Board of Directors as a member;

j. serve as a member of the Credentials Committee;

k. be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, as well as the implementation of sanctions where indicated and for the Medical Staff compliance with procedural safeguards in all instances where a correction action has been requested against a Member; and

l. perform such other functions as may be assigned by these Bylaws, the Medical Staff or the Medical Executive Committee.

8.7.2 **Vice President**

The Vice President of the Medical Staff shall:

a. serve as a member of the Medical Executive Committee;

b. in the absence of the President, assume all the duties and authority of the office of President of the Medical Staff;

c. perform such additional duties as may be assigned by the President of Medical Staff or delegated by these Bylaws or by the Medical Executive Committee;

d. serve as co-chair of the Patient Care Improvement Committee.

e. serve as a member of the Credentials Committee.

8.7.3 **Secretary-Treasurer**

The Secretary-Treasurer of the Medical Staff shall:

a. serve as a member and Secretary of the Medical Executive Committee;

b. give proper notice of all Medical Staff and Medical Executive Committee meetings and special meetings, including the annual notice of Medical Staff officers' financial relationships with the Hospital;

c. keep**,** or cause to be kept**,** accurate and complete minutes of the Medical Staff and Medical Executive Committee meetings and special meetings;

d. attend to all correspondence and perform such other duties as ordinarily pertain to the office or as may be assigned by the President of the Medical Staff or the Medical Executive Committee;

e. supervise the collection and accounting of all Staff funds and submit dues statements to Members; and

g. receive applications for Staff membership and maintain or cause to be maintained, a roster of Members.

8.7.4 **Past President**

The Past President of the Medical Staff shall:

a. serve as a member of the Medical Executive Committee;

b. serve as a member of the Credentials Committee; and

c. perform other such duties as assigned by the President.

ARTICLE IX. COMMITTEES

9.1 **Basic Organization**

There shall be a Medical Executive Committee and such other standing and special committees of the Medical Staff as are necessary and appropriate to perform the Medical Staff functions and obligations. These committees shall be responsible to the Medical Executive Committee.

9.2 **Composition, Chairs, and Appointment**

Committee chairs and members, unless otherwise specifically provided in these Bylaws, shall be appointed by the President of the Medical Staff after consultation with the Chief Medical Officer, from the membership of the Medical Staff and shall be representative of the Staff and appropriate to the individual committee function.

a. Membership shall include, where appropriate, representatives from the Hospital and Administration, appointed by the Medical Staff President in consultation with the Hospital President or designee.

b. The President of the Medical Staff and Chief Medical Officer, pursuant to Sections 8.7.1(c) and 3.2.5(d) respectively, shall be ex-officio members of all committees, unless otherwise provided in these Bylaws.

c. Committees may have consultants appointed by the President of the Medical Staff after consultation with the chair of the committee affected.

9.3 **Duration of Appointment**

Committee members and chairs shall serve a minimum of one (1) year, unless otherwise specifically provided in these Bylaws.

9.4 General Duties and Responsibilities Medical Staff committees shall:

a. account for and report in writing to the Medical Executive Committee on the quality, safety, and appropriateness of services and activities for which the committee is responsible;

b. make recommendations as to policy and other matters to the Medical Executive Committee and, if approved, prepare procedural memoranda to implement such recommendations;

c. receive and act on reports and recommendations from the Medical Executive Committee;

d. maintain minutes of the activities, deliberations, and meetings;

e. report, at the discretion of the President of the Medical Staff in consultation with the Chief Medical Officer, directly to the appropriate Department Chief and/or to the Credentials Committee, in which case the Department or Credentials Committee shall ensure that the matter under consideration is properly resolved;

f. make recommendations for appropriate Staff educational programs; and

g. present appropriate fiscal requests to the Medical Executive Committee.

9.5 Ad Hoc Committees

Ad Hoc committees shall be appointed by the President of the Medical Staff as required. They shall confine their work to the specific purposes for which they were appointed and shall be dissolved upon completion of their specific assignments. A quorum for each committee shall be 40% of its appointed members, but not less than two members.

9.6 Standing Committees

The Standing Committees of the Medical Staff shall be:

9.6.1 Bylaws Committee

a. Composition

The Bylaws Committee shall consist of at least four (4) members of the Active or Senior Medical Staff, the Chief Medical Officer and the Director of the Department of Medical Staff Administration.

b. Duties and Meetings

The Bylaws Committee shall:

i. conduct a periodic review of the Bylaws and Rules and Regulations of the Medical Staff and make appropriate recommendations to the Medical Executive Committee, the Medical Staff, and the Board of Directors;

ii. recommend changes to the Bylaws, as well as the Rules and Regulations, so they conform with the federal and State statutes, and the requirements of DNV or The Joint Commission, as applicable;

iii. draft or revise the Bylaws and Rules and Regulations upon request by the Medical Executive Committee or Board of Directors;

iv. make interpretations of the Bylaws and Rules and Regulations when requested;

v. meet at least annually and as necessary; and

vi. submit written reports no less than annually to the Medical Executive Committee.

9.6.2 **Credentials Committee**

a. **Composition and Chair**

The Credentials Committee shall consist of the immediate Past President of the Medical Staff, at least four (4) additional Members, the President and Vice President of the Medical Staff and the Chief Medical Officer. Should any of the members be unable to serve, the President of the Medical Staff may appoint a replacement.

If the committee is considering the performance of one of its own members, that member shall be temporarily replaced by another appointee until the matter under consideration is concluded.

b. **Duties and Meetings**

The Credentials Committee shall:

i. investigate, review, evaluate, and make recommendations to the Medical Executive Committee on all proposed appointments, reappointments, and modifications of appointments to the Medical Staff including recommendations on assignment of privileges;

ii. investigate requests for and make recommendations to the Medical Executive Committee on corrective action in accordance with Article XI;

iii. investigate, review and report on all matters referred to it pursuant to these Bylaws to the Medical Executive Committee;

iv. meets at least ten (10) times per year and as necessary at the call of the Chair, President of the Medical Staff or upon the request of any two (2) members of the committee;

v. submit written reports to the Medical Executive Committee as appropriate; and

vi. require a majority vote for action of the committee on a matter, with absentee voting and minority reports permitted.

9.6.3 **Quality Improvement Committee**

The Quality Improvement Committee of the Hospital shall constitute a mechanism of liaison between the Medical Staff, Board of Directors, and Administration.

a. **Composition and Chair**

The Quality Improvement Committee shall be multidisciplinary, with representation from the Board of Directors, Medical Staff and Hospital Administration and shall consist of thirteen (13) members: five (5) from the Medical Staff, to include the President of the Medical Staff, and four (4) additional members appointed by the President of the Medical Staff with the approval of the Medical Executive Committee; four (4) Directors appointed by the Chair of the Board of Directors; and four (4) members from the Hospital Administration, to include the President of the Hospital, and three (3) other administrative representatives appointed by the President of the Hospital. The Committee shall have the responsibility to ensure the development and implementation of the Hospital's comprehensive, coordinated and integrated quality improvement program. The Chair of the Committee shall be one of the members appointed by the Chair of the Board of Directors.

b. **Duties and Meetings**

The Quality Improvement Committee shall:

i. receive and make recommendations to the Board of Directors regarding any communications, requests, or recommendations presented by the Medical Staff through its duly authorized representatives;

ii. constitute a liaison group that shall discuss medical administrative matters, and oversee the quality assessment and improvement process;

iii. receive and consider reports on the work of the Medical Staff and make recommendations to the Board of Directors considered to be in the best interest of the Hospital and its patients;

iv. report to the Board of Directors the opinion or opinions of one or more members of the committee that are in the minority on any action taken by the committee at the time it is reported to the Board, if requested by the member or members of the committee who hold the minority opinion or opinions; and

v. meet at least quarterly, and at other times at the call of the Chair or any three members of the committee.

9.6.4 **Medical Executive Committee**

a. **Composition and Chair**

The Medical Executive Committee shall be chaired by the President of the Medical Staff and shall consist of the immediate Past President of the Medical Staff, the officers of the Medical Staff, Department Chiefs, six (6) members-at-

large, and one (1) Affiliate Staff member with vote nominated by his/her peers and approved by the President of the Medical Staff in consultation with the Chief Medical Officer. All members from the Medical Staff are of the Active or Senior Staff. The President of the Hospital, Chief Medical Officer, Chief Nursing Officer and other members of senior management shall be ex-officio members without vote.

b. **Method of Selection and Duration of Term**

Each individual who serves on the Medical Executive Committee by virtue of holding an office which qualifies him/her for membership shall serve only so long as he/she retains such office.

The six (6) members-at-large shall be nominated from the Medical Staff by the method specified in Section 8.3.1, shall serve for a period of two (2) years, and may succeed themselves for one additional term, not to exceed a total of four (4) years. They will maintain Active or Senior Staff of the Medical Staff throughout their term. They shall be elected by secret written ballot at the annual meeting of the Staff by those Staff members eligible to cast ballots. Voting by absentee ballot shall be permitted, and absentee ballots shall be made available to Medical Staff members who cannot attend the annual meeting. The candidates, equal in number to the number of open at-large positions, receiving the largest number of votes shall be elected as at-large members (e.g., if there are three (3) open at-large positions, the three (3) candidates receiving the largest number of votes shall be elected).

c. **Vacancies; Removal**

i. Vacancies in the Medical Executive Committee shall remain until filled at the next occurring annual meeting of the Staff.

ii. Removal from membership on the Medical Executive Committee shall be accomplished by the method specified in Section 8.6.

d. **Duties and Meetings**

The Medical Executive Committee shall:

i. represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by the Staff, these Bylaws, the Hospital Bylaws, or by law;

ii. receive and act upon reports and recommendations from the clinical Departments, Medical Staff committees, officers of the Medical Staff, Patient Care Improvement Council, and the Quality Improvement Committee of the Board of Directors;

iii. coordinate the activities and general policies of the Staff, Departments, and committees;

iv. account to the Board of Directors and to the Staff for the overall quality and efficiency of patient care in the Hospital;

v. monitor and inform the Staff regarding implementation of the Medical Staff Objectives and Responsibilities as specified in Article II, and where indicated initiate action to further their implementation;

vi. make recommendations to the Staff, Board of Directors, or Hospital on policy or action regarding patient care, Hospital affairs, or other matters;

vii. regularly report to the Staff on the work of the Staff and on Hospital affairs;

viii. make recommendations to the Board of Directors on all matters relating to appointments, reappointments, staff category, Department and service assignments, clinical privileges and specified services, corrective action, and consult on the appointment of the Chief Medical Officer;

ix. pursue corrective action in accordance with Article XI;

x. inform the Staff of the accreditation program and the accreditation status of the Hospital;

xi. provide liaison between the Medical Staff and Hospital;

xii. keep and appropriately distribute written records of all meetings;

xiii. make recommendations on proposed appointments for Administrative positions as required;

xiv. collect, hold, and disburse Staff funds and act on fiscal requests directed to it;

xv. review departmental rules and regulations on an annual basis and approve any changes to such rules and regulations; and

xvi. meet no less than ten (10) times a year, upon call of the President of the Staff, or upon written petition of any three (3) members of the Medical Executive Committee.

e. Executive Sessions

An executive session including the President of the Medical Staff, Medical Executive Committee voting members, and other individuals specifically invited by the President of the Medical Staff shall be held at the discretion of the President of the Medical Staff. A voting member of the Medical Executive Committee may request an executive session after conferring with the Medical Staff President. Proceedings of the Medical Staff executive session shall remain confidential, provided, however, any proposed resolution or other formal action discussed in executive session shall be made and voted upon in a reconvened regular session and recorded in the minutes of such session.

9.6.5 **Nominating Committee**

a. **Composition**

The Nominating Committee shall be appointed with the approval of the Medical Executive Committee and consist of three (3) physician or dentist members from the Medical Staff.

b. **Duties and Meetings**

The Nominating Committee shall:

i. present one or more nominees for each elective office to be filled by the Staff pursuant to Section 8.3.1, after consultation with the Medical Executive Committee and Administration concerning the qualifications and acceptability of the prospective nominees; and

ii. meet and report at least annually.

9.6.6 **Other Standing Committees**

Other Standing Committees of the Medical Staff shall be defined in the Rules and Regulations.

ARTICLE X. MEETINGS OF THE MEDICAL STAFF

10.1 **General Staff Meetings**

10.1.1 **Regular Meetings**

One (1) Semi-Annual and one (1) Annual meeting of the entire Medical Staff shall be held in each calendar year at a time and place to be fixed by the Medical Executive Committee.

10.1.2 **Annual Meeting**

The Annual meeting of the Medical Staff shall be the meeting at which the following actions shall be taken.

a. Medical Staff officers and Medical Executive Committee-at-large members shall be elected.

b. Annual reports shall be made by the President and Secretary-Treasurer of the Medical Staff, Chief Medical Officer and President of the Hospital.

c. Reports from Department and committee chairs may be presented.

The following action may take place at the Semi-Annual meeting and/or the Annual meeting:

a. Medical Staff bylaws shall be amended

10.1.3 **Special Meetings**

Special meetings of the Medical Staff may be called at any time by the Board of Directors, President of the Medical Staff, Medical Executive Committee, or upon written petition of ten (10%) percent of the members of the Medical Staff eligible to vote.

a. Special meetings shall be held at a time and place designated by the President of the Medical Staff but not less than fourteen (14) days after he/she receives a valid request for the meeting.

b. No business shall be transacted at any special meeting except that for which the meeting was called.

10.1.4 **Agenda at Regular Staff Meetings**

The agenda for any regular Medical Staff meeting may include:

a. call to order;

b. correction and approval of minutes of prior regular and special Medical Staff meetings;

c. report of Secretary-Treasurer;

d. report of the President of the Medical Staff;

e. report of the Chief Medical Officer;

f. report of the President of the Hospital;

g. Medical Staff committee and Department reports as indicated;

h. communications;

i. unfinished business;

j. new business; and

k. adjournment.

The order of the above items may be altered at the discretion of the presiding officer.

10.1.5 **Agenda at Special Staff Meeting**

The agenda for any special Medical Staff meeting shall be:

a. call to order;

b. reading of the notes announcing the reason for calling the meeting;

c. transaction of the business for which the meeting was called; and
d. adjournment.

10.2 **Department Meetings**

10.2.1 **Regular Meetings**

Each Department may hold meetings where the professional work of that Department shall be reviewed and issues pertinent to the function of that Department discussed. Scientific and educational programs may be presented.

10.2.2 **Special Meetings**

Special Department meetings may be called by the Chief of the Department, upon petition by ten percent (10%) of the voting members of the Department, the Chief Medical Officer or the President of the Medical Staff.

10.3 **Committee Meetings**

10.3.1 Regular committee meetings shall be held as necessary to accomplish the assigned tasks and to provide the Medical Executive Committee or the President of the Medical Staff information and advice necessary for the proper function of the Medical Staff.

10.3.2 Special meetings may be called by the chair of that committee, upon petition by ten percent of the committee members, the Chief Medical Officer, or the President of the Medical Staff.

10.4 Notice of Meeting

Written notice shall be sent by U.S. Postal Service mail or electronic mail to members of the Medical Staff at least fifteen (15) days prior to the annual meeting and at least five (5) days prior to any special meeting of the Medical Staff. The attendance of a Member at a Staff meeting shall constitute a waiver of notice of such meeting.

10.5 Attendance at Meeting

10.5.1 Attendance in General

a. Active and Senior Medical Staff Members are expected to attend general Staff and appropriate Department, Section and committee meetings. Other Staff Members are encouraged and welcome to attend general Medical Staff and appropriate Department meetings.

b. All general Medical Staff, Department, Section and committee meetings shall be closed to individuals who are not members of the Medical Staff, except by invitation of the presiding officer or a majority of the voting members present at the meeting.

c. Except as otherwise provided in these Bylaws, Department, Section, and committee meetings shall be open to all Medical Staff Members except when a majority of those present and eligible to vote at the meeting decide, or the presiding officer decides, that the meeting shall go into executive session.

10.5.2 Special Appearance

Any Medical Staff Member whose patient's case is scheduled to be presented for discussion at a general Medical Staff, Department, Section, or committee meeting and whose presence at the presentation is deemed appropriate by the meeting chair shall be notified, reasonably in advance of the meeting, that his/her presence is required.

10.6 Minutes of Meetings

10.6.1 The secretary or chair of each meeting shall prepare, or cause to be prepared, minutes of the meeting including a record of attendance and the vote taken on each matter. The minutes shall record the resultant conclusions, recommendations, and actions taken. Minutes shall be authenticated by signature.

10.6.2 A permanent file of minutes shall be maintained in the Medical Staff Administration office.

10.6.3 Upon approval of minutes by Committee members, the minutes may be available for review in the Medical Staff Administration office.

10.6.4 The minutes shall be accessible only to the members of the Department or committee and to those individuals designated by the President of the Medical Staff, Chief Medical Officer or President of the Hospital.

10.6.5 Copies of general Medical Staff and Medical Executive Committee minutes shall be furnished to members of the Medical Staff upon their request.

10.7 Quorum

10.7.1 General Medical Staff Meetings

Quorum. The presence of five percent (5%), in person or by proxy, of the voting Members of the Medical Staff at any regular or special meeting shall constitute a quorum for the election of officers of the Medical Staff and members-at-large of the Medical Executive Committee, and for the amendment of these Bylaws. A quorum for transaction of all other business shall be those voting Members who are present in person or by proxy.

10.7.2 Department and Committee Meetings

The presence of ten percent (10%) of the voting members of a Department or committee at any meeting, but not less than three (3) members, shall constitute a quorum for the transaction of all business unless otherwise specifically permitted by these Bylaws.

10.8 Conduct of Meetings

The rules contained in the latest edition of Robert's Rules of Order Newly Revised shall govern all meetings except when they are inconsistent with these Bylaws, or with rules of order adopted by the Medical Staff. In the event of inconsistency or conflict between Robert's Rules, these Bylaws, or the rules adopted by the Medical Staff, these Bylaws shall prevail.

10.9 **Manner of Action**

Except as otherwise specified, the action of a majority of the voting members present at a meeting at which a quorum is present, shall be the decision of those members present, and except as otherwise specified by these Bylaws, voting by proxy or absentee ballot shall be prohibited.

ARTICLE XI. CORRECTIVE ACTION

11.1 **Basis for Corrective Action**

Any Member of the Medical Staff may be subject to corrective action if his/her conduct is:

a. detrimental to patient safety or below the standards of the Hospital and its Medical Staff;

b. disruptive of or adverse to the orderly operation or functioning of the Hospital, the Medical Staff, or patient care, including the inability of the Member to work harmoniously with others;

c. in violation of applicable ethical standards or the Bylaws of the Hospital or of the Bylaws, Rules or Regulations of the Medical Staff including, but not limited to, the quality assessment, risk management and case management programs;

d. indicative of professional incompetence;

e. such that it amounts to a refusal to participate in required Medical Staff or Hospital functions; or

f. impaired by illness, injury, abuse of alcohol, drugs, chemicals, or by any mental or physical disability.

11.2 **Initiating Corrective Action**

Whenever there is reasonable cause to believe that corrective action against a Staff Member may be necessary or advisable a request for corrective action, or, in lieu thereof, a request for an investigation to determine if corrective action is necessary or advisable, may be made by the President of the Medical Staff, the Chief of any Department or Section, the Chair of any standing committee of the Medical Staff, the President of the Hospital, the Chief Medical Officer or by any Officer of the Board of Directors. Any such request shall be in writing and shall be made to the Medical Executive Committee to the attention of the President of the Medical Staff, with copies to the Staff Member, the Chief of the Department to which the Staff Member has been assigned and the Chief Medical Officer, together with detailed information concerning the specific activities, conduct or clinical activities which constitute the grounds for the request. The request may, but need not, state the type of corrective action requested.

11.3 **Medical Executive Committee; Investigation**

At its next meeting following receipt of a request under Section 11.2., the Medical Executive Committee shall consider the request, and, unless it determines that corrective action would not be necessary or advisable, which said determination shall be subject to the approval of the Chief Medical Officer, it shall order an investigation conducted by an ad hoc investigation committee to be appointed by the President of the Medical Staff who shall also appoint the chair of said committee.

The initiation of an investigation shall not preclude the imposition of summary action under Section 11.9.

11.4 **Ad Hoc Investigation Committee**

The ad hoc investigation committee shall consist of at least three Staff Members, and may include the Chief of the Department to which the affected Staff Member is assigned. The President of the Medical Staff shall advise the Staff Member that the Member is the subject of a corrective action investigation; that his/her rights and obligations are as described in this Article XI which should be personally reviewed; and shall advise as to the identity of the Members comprising the ad hoc investigation committee. An investigation by an ad hoc investigation committee shall be considered an administrative matter, and not an adversarial proceeding or a "professional review action" as defined in the Health Care Quality Improvement Act of 1986. A Staff Member who is the subject of an investigation shall be offered the opportunity to meet with the ad hoc investigation committee. Neither the committee nor the Staff Member shall be entitled to have legal counsel present during any meetings or discussions between such Staff Member and members of an ad hoc investigation committee, and the Staff Member shall be advised in writing that any statements made by him/her may be subject to disclosure under New York law.

11.5 **Report of Ad Hoc Investigation Committee**

Upon conclusion of its investigation, the ad hoc investigation committee shall submit a report to Medical Executive Committee and the Chief Medical Officer. Such report shall contain a statement detailing the findings, conclusions and recommendation of the ad hoc investigation committee.

11.6 **Procedure After Report of Ad Hoc Investigation Committee**

11.6.1 Medical Executive Committee. The Medical Executive Committee shall review the report of the ad hoc investigation committee, may interview the affected Staff Member, and may conduct any further investigation it deems warranted. Neither the Staff Member nor the Medical Executive Committee shall have the right to have legal counsel present at the interview of the affected Staff Member, and the Staff

Member shall be advised in writing that any statements made by him/her may be subject to disclosure under New York law.

a. If the Medical Executive Committee determines that one or more of the corrective actions described in Sections 11.7.1(a)-(d) should be imposed, the Medical Executive Committee may impose such corrective action against the Staff Member. In such event, the Staff Member shall not have the right to a hearing as provided in Article XII of these Bylaws, but may submit a written statement to be placed in his/her Quality Assurance file pertaining to the corrective action. All corrective action imposed by the Medical Executive Committee under this Section 11.6.1(a) shall be reported to the Board of Directors.

b. If the Medical Executive Committee determines that one or more of the corrective actions described in Sections 11.7.1(e)-(i) should be imposed, it shall forward its recommendation to the Board of Directors.

11.6.2 Board of Directors. The Board of Directors shall consider the report of the ad hoc investigation committee and the recommendation of the Medical Executive Committee. Subject to the provisions of Section 11.6.3, any recommendation for corrective action submitted to the Board of Directors pursuant to Section 11.6.1 may be approved, modified, or annulled by the Board of Directors in accordance with these Bylaws. If the Board of Directors determines that one or more of the corrective actions described in 11.7.1(e)-(i) should be imposed, then the affected Staff Member shall be notified of the proposed action and of the entitlement to a hearing and procedural rights set forth in Article XII of these Bylaws before any action is taken by the Board of Directors. If the right to a hearing is waived by the affected Staff Member, then the Board of Directors shall take final action which shall become immediately effective.

11.6.3 If the Board of Directors intends to make a decision which is not in accord with the recommendation of the Medical Executive Committee, it shall, through the President of the Hospital, notify the President of the Medical Staff who may request a joint conference of equal numbers of both the Board of Directors and the Medical Executive Committee in order to meet and consider the matter and submit a recommendation to the Board of Directors. The Board of Directors' action on the matter following receipt of such recommendation shall be final and effective immediately, subject to the Staff Member's right to a hearing and other procedural rights set forth in Article XII.

11.7 **Types of Corrective Action**

11.7.1 The types of corrective action shall be:

a. counseling:

b. education;

c. letter of admonition, reprimand, or warning;

d. probation for a specified period and/or specific conditions, which may include concurrent or retrospective review but may not include any other restriction on the exercise of privileges;

e. required supervision or consultation, with specification of circumstances and duration;

f. limitation, modification, suspension, restriction or revocation of privileges with specification of the circumstances and duration;

g. reduction of Medical Staff Category;

h. suspension of appointment, with specification of duration; or

i. revocation of appointment.

11.7.2 The exact nature of and conditions relating to each corrective action shall be specified in the recommendation or action of the Medical Executive Committee or the Board of Directors, as appropriate.

11.7.3 Nothing in these Bylaws shall prevent informal investigations, counseling, education, admonitions, or warnings, by the Department Chief or the Chief Medical Officer or the imposition of counseling, education, letters of admonition, reprimand, or warning or probation for a specified period and/or specific conditions which may include concurrent or retrospective review, but may not include any restriction on the exercise of privileges by the Peer Review Committee, without requesting formal corrective action under this Article XI.

11.8 **Further Action**

11.8.1 Any corrective action specified in Section 11.7.1(a) - (d) shall be executed under the supervision and control of the appropriate Department Chief or the Chief Medical Officer who shall periodically report to the Medical Executive Committee concerning the effect of the corrective action.

11.8.2 If, in his/her sole discretion, the Department Chief or the Chief Medical Officer, as appropriate, concludes that the corrective action imposed on a Staff Member has not had the proper remedial effect, further corrective action may be considered by the process specified in Sections 11.2 through 11.7.

11.8.3 A report of each corrective action imposed and the report to the Medical Executive Committee concerning the effect of the corrective action shall be included in the Staff Member's Quality Assurance file.

11.8.4 If a request for corrective action is found to be without merit after investigation, the Medical Executive Committee shall cause a letter to be placed in the Staff Member's Quality Assurance File stating the conclusions reached.

11.9 Summary Action

11.9.1 Criteria and Initiation

a. Whenever the President of the Hospital**,** the Chief Medical Officer, or a Chief of the Department to which the Staff Member is assigned determines, in his/her sole discretion, there are reasonable grounds to believe the conduct of a Medical Staff Member requires that immediate action be taken against him/her where the failure to take such action may result in imminent danger to the health or safety of any patient, employee, or other person present in the Hospital, the President of the Hospital, the Chief Medical Officer, or the Chief of the Department to which the Staff Member is assigned, shall have the authority to summarily suspend the Member's Medical Staff status and/or suspend, restrict, or limit the exercise of all or any portion of the Staff Member's privileges.

b. Unless the circumstances make it impractical or impossible to do so, prior to the imposition of such summary action, the practitioner shall be given the opportunity to explain his/her conduct and offer reasons why summary action should not be imposed. The summary action shall be effective immediately upon imposition. Notice of the action shall be promptly given to the Staff Member and the Chief Medical Officer and such notice shall set forth the specific activities or conduct which constitute grounds for the summary action. The Chief Medical Officer shall promptly notify the Department Chief, the Chairs of the Credentials Committee, the Medical Executive Committee and Board of Directors, and the President of the Hospital.

11.9.2 Testing; Examination

At the time of summary action, the Staff Member may be required by the person imposing the action or by the Chief Medical Officer to submit to the testing and/or examinations, as specified in Section 3.2.1(b), including testing for drug and alcohol use. Refusal to submit to the testing and/or examinations shall be made part of the record and may be considered by the hearing body.

11.9.3 Patient Coverage

At the time of summary action, the appropriate Department Chief or the Chief Medical Officer shall arrange medical coverage for the patients of the Staff Member who are still in the Hospital. The wishes of each patient shall be considered in the selection of coverage.

11.9.4 **Procedural Rights**

a. Unless the notice of summary action states the action is being imposed pending an investigation requested pursuant to Section 11.2 to determine whether corrective action should be taken, the imposition of summary action shall constitute a request for corrective action and the procedures set forth in Sections 11.3 through 11.8 shall be followed. In the event summary action is imposed pending such investigation, the action shall terminate no later than fourteen (14) days after its effective date unless the Medical Executive Committee, as a result of its investigation, has proposed any of the actions listed in Section 11.7.1(e) – (i), provided this shall not preclude the reimposition of summary action upon a subsequent request, or determination by the Medical Executive Committee, that corrective action be taken. The Staff Member shall not be entitled to the procedural rights afforded by Article XII until such time as the Board of Directors has taken action pursuant to Section 11.6.2, and then only if the action taken constitutes grounds for a hearing as set forth in Article XII, Section 12.1.

b. Within 72 hours after the imposition of summary action, the Medical Executive Committee, or an ad hoc committee thereof, appointed by the President of the Medical Staff, shall convene to consider whether there are reasonable grounds for summary action under Section 11.9.1 and whether to recommend that the summary action be modified or terminated, and may, in connection therewith, request the Staff Member to appear before such Committee. The Medical Executive Committee or ad hoc committee shall immediately make a determination in the matter and forward such determination in writing to the Chairman of the Board of Directors and to the Staff Member. In the event the Medical Executive Committee recommends modifying or terminating the summary action, the Board of Directors, or an ad hoc committee thereof appointed by the Board Chair, shall convene within 72 hours to consider such recommendation. Unless the Board of Directors or ad hoc committee terminates or modifies the summary action, upon recommendation of the Medical Executive Committee, it shall remain in effect, subject to the provisions contained herein, during the pendency of and the completion of the corrective action process and of the hearing procedure under Article XII.

11.10 **Automatic Suspension and/or Loss of Membership**

11.10.1 **License**

A Medical Staff Member whose license, registration, certificate or other legal credential authorizing him/her to practice in the State of New York is revoked, or is suspended or is voluntarily surrendered by him, shall no longer be a Member of the Medical Staff. Provided, however, in the event a Staff Member's license suspension be stayed, he/she is placed on probation or is placed on any other form of restriction or limitation, whether or not subject to compliance with any conditions and/or monitoring, the Member's clinical privileges shall be subject to the same restrictions, limitations, conditions and/or monitoring for a period

concurrent with that of the State. The Peer Review Committee shall conduct a review of the conditions surrounding the action taken by the State and shall make a recommendation within thirty (30) days to the Medical Executive Committee as to whether any additional corrective action should be taken under this Article XI.

11.10.2 **Malpractice Insurance**

A Medical Staff Member whose malpractice insurance policy required by these Bylaws is canceled or is not renewed for any reason is immediately and automatically suspended from exercising clinical privileges in the Hospital until such time as proof of malpractice insurance has been received; or for a period of ninety (90) days, after which time the Member shall be deemed to have voluntarily resigned his/her Medical Staff appointment.

11.10.3 **Drug Enforcement Agency (DEA) Number**

A Medical Staff Member whose DEA number is revoked or suspended is immediately and automatically divested of the right to prescribe medications covered by the number. The Chief Medical Officer or Department Chief shall immediately investigate the facts under which the DEA number was revoked or suspended and may request corrective action if warranted under Section 11.1.

11.10.4 **Exclusion from Federal Health Program**

A Medical Staff Member who is excluded from the Medicare, Medicaid or any other federal health program is immediately and automatically suspended from exercising clinical privileges in the Hospital for any patient covered by such program until reinstated in such program. The Staff Member shall present to the Chief Medical Officer a practice plan that shall, in the reasonable judgment of the Chief Medical Officer, assure that the Staff Member will not be involved, directly or indirectly, in the provision of any services to such patients,

11.10.5 **Medical Records**

An automatic suspension of privileges shall be imposed for failure of a Member to complete medical records as required in the Medical Staff Rules and Regulations.

11.10.6 **Failure to Comply with Regulatory Requirements**

Members of the Medical Staff must comply with the requirements established by the various outside regulatory agencies for the exercise of clinical privileges such as, but not limited to, tuberculin testing and annual health reassessments. Failure to comply with these regulations shall result in a suspension of all privileges until compliance is obtained.

11.10.7 **Notice by the Chief Medical Officer**

The Chief Medical Officer shall advise the Medical Executive Committee and the President of the Hospital of each instance of automatic suspension except when suspension is imposed pursuant to Section 11.10.5.

11.10.8 **No Right to Hearing**

The automatic suspension of privileges pursuant to this Section 11.10 shall not be subject to hearing or procedural rights pursuant to Article XII, provided nothing herein shall be construed as precluding a request for corrective action for any of the matters specified in this Section 11.10, other than in Section 11.10.5, and such request shall entitle the Staff Member to any procedural rights to which he/she may be entitled under Articles XI and XII.

ARTICLE XII. HEARING, APPELLATE REVIEW AND FINAL ACTION

12.1 Right to Hearing

The following recommendations or actions shall be defined as adverse actions and shall entitle the Medical Staff Member affected to a hearing as specified in this Article:

a. any corrective action specified in Section 11.**7**.1(e) through 11.**7**.1(i);

b. summary action only as permitted in Section 11.9.4.;

c. denial of appointment;

d. denial of reappointment;

e. denial of requested Category or privileges; or

f. denial of requested advance in Medical Staff Category.

Notwithstanding any other provisions to the contrary, those holding locum tenens privileges under Section 7.2 shall not be entitled to a hearing or procedural rights provided by this Article XII.

Notwithstanding any other provision to the contrary, those applicants denied Medical Staff membership, reappointment or terminated due to an absence of licensure, failure to register the license, or the clinical suspension or termination of membership or reappointment for the absence or loss of malpractice insurance as required by Section 3.3.13, shall not be entitled to a hearing or procedural rights provided by this Article XII.

12.2 Notice of Adverse Action and Right to a Hearing

The Staff Member against whom adverse action has been taken, or is proposed to be taken, shall, within ten (10) days be given special notice by the President of the Hospital or his/her

designee of such action. The notification shall include a copy of this Article XII, and shall state:

a. the adverse action, with reference to the appropriate sections of the Medical Staff Bylaws, Rules and Regulations which are the basis of the action;

b. in the case of corrective action, the charges upon which the adverse action is based in plain and concise statements with sufficient particularity, including a list by number of any patient records in question, to give the Staff Member reasonable notice of the charges;

c. that the Staff Member has a right to a hearing pursuant to this Article XII if he/she requests it;

d. that failure to request the hearing within the time limits imposed by this Article shall constitute a waiver of his/her rights to a hearing and an acceptance of the adverse action; and

e. that all Members of the Medical Staff have consented to submission of all disputes concerning adverse actions taken and all other matters within the scope of these Bylaws to the procedural rights specified in this Article XII as a prerequisite to any other action.

12.3 **Request for or Failure to Request Hearing**

12.3.1 **Request**

The Staff Member shall have thirty (30) days following the receipt of a special notice pursuant to Section 12.2 to submit a written request for a hearing. The request shall be delivered in person or by special notice to the President of the Medical Staff, the President of the Hospital and the Chief Medical Officer.

12.3.2 **Failure to Request a Hearing**

A Staff Member who fails to request a hearing within the time and in the manner specified in Section 12.3.1 waives the right to a hearing, and this waiver shall constitute an acceptance of the adverse action taken or proposed to be taken

12.4 Hearing Prerequisites

12.4.1 Receipt of Request for Hearing

Upon receipt of a timely request for a hearing, the President of the Hospital shall advise the Chair of the Board of Directors, who shall appoint a hearing body and a presiding officer. The presiding officer shall schedule a hearing to be held not more than sixty (60) days from the date of receipt of the request, and not less than thirty (30) days from issuance of the notice required by Section 12.4.2.

a. The Staff Member shall submit a written response to the charges to the hearing body not less than fifteen (15) days prior to the hearing. The response shall include an answer either admitting or denying each charge and it shall set forth all affirmative defenses to the charges. All charges not denied shall be deemed admitted and no proof shall be required as to the charges admitted.

b. The interval between receipt of a request for hearing and the hearing may be extended by mutual written consent of the parties involved.

12.4.2 Notice of Hearing

At least thirty (30) days prior to the hearing, the Staff Member shall be notified by the Hospital President or his/her designee of the time, place, and date of such hearing. The notice shall:

a. refer to the right of discovery allowed by Section 12.4.3;

b. state that the personal appearance of the Staff Member is required as specified in Section 12.4.4;

c. list the names of those persons who are to comprise the hearing body under Section 12.5.1;

d. identify the person appointed under Section 12.6.3 to represent the Hospital and Medical Staff in the proceeding (the "Hospital Representative"); and

e. list the witnesses expected to offer evidence against the Staff Member, to the extent said witnesses are known.

12.4.3 Right of Discovery

Prior to the hearing and within fifteen (15) days of requesting same in writing, the Staff Member shall be provided copies of all tangible evidence (writings, photographs, etc.) which the Hospital Representative intends to present to the hearing body. Prior to the hearing and within fifteen (15) days of requesting same in writing, the Hospital Representative shall be provided copies of all tangible evidence which the Staff Member intends to present during the hearing, as well as

a list of his/her witnesses. Each party shall furnish the other in a timely manner with copies of evidence and names of witnesses which the party intends to present as evidence and which have been identified after the initial production to the other party. The presentation of evidence or testimony from witnesses' not so furnished shall be allowed at the hearing only at the discretion of the presiding officer of the hearing body.

12.4.4 **Personal Appearance**

The Staff Member is required to appear at the hearing, and if he/she fails to appear without good cause, he/she shall be deemed to have waived his/her rights with the same consequences as provided in Section 12.3.2.

12.5 **Hearing Body**

12.5.1 **Composition**

a. The hearing body which is to conduct the hearing shall be composed of members who:

   i. have no conflict of interest relative to the issues to be reviewed, are not in direct economic competition with the Staff Member, and did not make the request for an investigation or for corrective action;

   ii. shall undertake to render a fair, objective and impartial recommendation based on the material presented during the hearing;

   iii. unless otherwise required by these Bylaws, may, but need not, be physicians on the Medical Staff;

   iv. need not have any prior affiliation with the Hospital; and

   v. have not participated in any stage of the proceedings leading to the adverse action unless, in the sole discretion of the Chair of the Board of Directors, it is impossible to select a representative group.

b. The hearing body shall be appointed by the Chair of the Board of Directors in consultation with the Chief Medical Officer and President of the Medical Staff and shall consist of five (5) members and a presiding officer. A majority of the hearing body shall be physician or dentist members of the Medical Staff.

c. An application to disqualify an individual from participating as a member of the hearing body, for failing to satisfy any of the requirements under paragraph a. of this section, shall be made in writing by the Staff Member, or Hospital Representative, as appropriate, to the Chair of the Board not less than fifteen (15) days prior to the hearing.

d. If any member of a hearing body is unable to serve, or is removed from the hearing body, the Chair of the Board shall appoint a replacement to the hearing body.

12.5.2 **Presiding Officer**

The presiding officer of the hearing body:

a. may, but need not be, a member of the Medical Staff;

b. shall act to maintain decorum and assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence;

c. shall determine the order of procedure during the hearing and shall make all rulings with respect to conduct of the proceedings or the admissibility of evidence; the hearing body by majority vote may overrule the presiding officer with respect to a ruling on the conduct of the proceeding;

d. shall act in an impartial manner; and

e. shall have no voting rights.

12.6 **Conduct of Hearing**

The general conduct of the hearing shall be governed by the following rules.

12.6.1 Normally, all of the hearing body members shall be present during the hearing; however, it is within the hearing body's sole discretion to permit a member to be absent.

12.6.2 The personal presence of the Staff Member is required, as specified in Section 12.4.4, and he/she may be required to testify.

12.6.3 The President of the Hospital, in consultation with the President of the Medical Staff, shall appoint the Chief Medical Officer, another member of Hospital Administration or a member of the Medical Staff to represent the Hospital and Medical Staff at the hearing and to present evidence in support of the adverse action, including the examination of witnesses.

12.6.4 The Staff Member may be accompanied and represented at the hearing by a member of the Medical Staff in good standing, or other person of his/her choice, and by an attorney and may consult with and receive advice from such representative and attorney, but such representative and attorney shall have no right to interrogate witnesses, offer evidence or otherwise actively participate in the proceedings.

12.6.5 The Hospital Representative may have an attorney present and may consult with and receive advice from such attorney, but such attorney shall have no right to

interrogate witnesses, offer evidence or otherwise actively participate in the proceedings.

12.6.6 Prior to the hearing, and preferably after the exchange of information required under Section 12.4.3, the Presiding Officer shall, at a date and time determined by him, meet with the Staff Member, his/her representative and attorney, and the Hospital Representative and attorney to discuss the order of procedure and to resolve any open procedural issues.

12.6.7 For the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, the hearing body, at its sole discretion, may recess the hearing to any date and time stated at the time of recess, and reconvene without additional notice.

12.6.8 A stenographic record of the hearing shall be made by a stenographic reporter. The reporter shall be instructed to transcribe the record as soon as possible and supply each party and the hearing body with a copy of the transcript of proceedings, and the cost of such transcript, as well as the cost of the stenographer's services, shall be paid for equally by the Hospital and the Staff Member.

12.6.8 The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter may be admitted, regardless of its admissibility as evidence in a court of law. It shall be the obligation of the Hospital Representative to present appropriate evidence in support of the adverse recommendation or decision, but the Staff Member shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

12.6.9 During the hearing, each party shall have the right to:

a. call and examine witnesses;

b. cross-examine witnesses on any matter relevant to the issues;

c. introduce exhibits or memoranda concerning any relevant issue which shall become a part of the hearing record;

d. rebut any evidence submitted; and

e. submit a written statement at the close of the hearing in accordance with Section 12.7.1.

12.6.10 Oral evidence shall be taken only under oath.

12.6.11 Each party offering into evidence an exhibit which is received by the hearing body as part of the record, shall at the time the exhibit is offered supply the other party with a duplicate of it.

12.6.12 In reaching a determination, the hearing body may officially take notice of any technical or scientific matter relating to the issues under consideration. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party may request that a matter be officially noticed or seek to refute the officially noticed matters.

12.6.13 The hearing body shall be entitled to ask questions of any witness, including the Staff Member, and to consider any relevant material on file in the Hospital, including material in the Quality Assurance file of the Staff Member, the report of the ad hoc investigating committee, the recommendation of the Credentials Committee or any other body or person that may have considered the matter, and other relevant information that can be considered pursuant to the Medical Staff Bylaws in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

12.6.14 All materials in the Hospital files which are considered by any hearing body member must be identified for the record. If any member of the hearing body is requested on behalf of the hearing body to review materials on file in the Hospital which are too voluminous for consideration by the hearing body as a group, or to make any special investigation of matters related to the issues, the report of that review or investigation shall be made in writing and shall become a part of the hearing record. The hearing body shall have sole discretion in determining when an examination of relevant Hospital records or material other than those presented in the hearing itself, or a special investigation, is appropriate.

12.7 **Conclusion of Hearing; Report and Recommendation**

12.7.1 Upon conclusion of the presentation of oral and written evidence, and the completion of any review of Hospital records or files or any special investigation ordered by the hearing body, the hearing shall be closed and the parties shall be offered the opportunity, at that time, to submit written statements. If either party advises that it wishes to submit a statement, the Presiding Officer shall specify a date by which either or both parties must submit statement(s). Such statement(s) shall be delivered or mailed to the Presiding Officer who shall then furnish a copy of any statement submitted by a party to the other party.

12.7.2 Within fifteen (15) business days of the submission of written statements as provided in Section 12.7.1 or, in the event no written statements are submitted, within fifteen (15) days of the closing of the hearing, the hearing body shall deliberate outside the presence of the Staff Member and Hospital Representative and make a written report of its findings and recommendation based on majority vote, setting forth in a concise manner the reasons for its recommendation, and shall forward its report and recommendation by special notice to the Staff Member with a copy to the Hospital Representative, the President of the Hospital, the Chief Medical Officer and the President of the Medical Staff. No member of the hearing body may vote by proxy.

12.8 **Appellate Review and Final Decision**

12.8.1 Upon receipt of the hearing body's report and recommendation, the President of the Hospital shall forward a copy of same to the Chair of the Board of Directors. The Board shall make the final decision in the matter, subject to the Staff Member's opportunity for an appellate review of the hearing body's findings and recommendation. The purpose of Appellate Review is to give the individual the opportunity to apply for an impartial review of the hearing which resulted in an adverse decision against him. At the same time as they are furnished with the hearing body report and recommendation, both parties to the hearing shall be notified by the Hospital President or his/her or her designee of the Staff Member's right to apply for appellate review. This notice shall state:

a. that the Staff Member may apply for appellate review as specified in this Section 12.8;

b. that failure to apply for appellate review within the time limits shall constitute a waiver of the right to do so; and

c. that the Staff Member shall be notified of the date, time, place and procedure for appellate review.

12.8.2 Both parties shall have access to the hearing record, including the hearing transcript and all evidence that was considered by the hearing body in making its decision. In the event the Staff Member wishes to have an Appellate Review of the hearing body's findings or recommendation, he/she shall submit to the Board a written statement in his/her own behalf in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement shall be specified.

This written statement may cover any matters raised at any step in the procedure to which the review is related. Such written statement shall be submitted to the Board of Directors through the President of the Hospital, and shall be provided to the Hospital Representative, within seven (7) days after receipt of the notice referred to in Section 12.8.1. A statement in response may be submitted by the Hospital

Representative, and shall be provided to the Board and to the Staff Member within fifteen (15) days after receipt of the notice referred to in Section 12.8.1.

12.8.3 Upon receipt of the Staff Member's statement, the Board Chair shall appoint an appellate review body which shall consist of at least three (3) members of the Board, at least one (1) of whom shall be a physician, and none of whom shall have served on the hearing body.

12.8.4 The appellate review body shall review the record of the hearing, and may remand the matter to the hearing body for the taking of further evidence. In the event of such remand the appellate review body shall adjourn its proceedings until the hearing body has submitted a supplemental report and recommendation and the parties have had a reasonable opportunity to modify their statements under Section 12.8.2. The Staff Member and Hospital Representative shall each have the right to personally appear before the appellate review body, and make oral argument. Each party may have legal counsel present and may consult with and receive advice from counsel but such counsel shall have no right to actively participate in the proceedings. At the conclusion of oral argument, if any, the appellate review body may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the parties.

12.8.5 **Appellate Review Report**

Within fifteen (15) days after the appellate review hearing is closed, the appellate review body shall issue a written report of its decision and recommendations to the Chair of the Board of Directors, and forward it by special notice to the Staff Member and to the Chief Medical Officer, the President of the Medical Staff and the President of the Hospital.

12.8.6 **Standards for Review by the Appellate Review Body**

While the appellate review body may recommend rejection, in whole or in part, of the decision of the hearing body, it may not recommend that the decision be rejected solely because the appellate review body disagrees with the decision. The appellate review body shall not recommend rejection of the findings or recommendation of the hearing body unless the Staff Member established by clear and convincing evidence that:

a. the decision could not have been reached under any rational evaluation of the evidence i.e., the determination is arbitrary, unreasonable or capricious;

b. the decision was the result, in whole or in part, of fraud, prejudice, or other gross impropriety; or

c. the individual's rights were violated by prejudicial error(s) of the hearing body or its presiding officer.

12.8.7 Within thirty (30) days after receipt of the appellate review body's report and recommendation or, if there has been no appellate review, within thirty (30) days after receipt of the hearing body's report and recommendation, the Board of Directors shall schedule a date to review same and to make its final decision in the matter. The Board shall review the entire record of the proceedings including, as applicable, the recommendation of the Credential's Committee, recommendation of the Medical Executive Committee, report and recommendation of the ad hoc investigation committee, report and recommendation of the hearing body, and report and recommendation of the appellate review body. The Board may, but need not, review the transcript of the hearing and may remand the matter to the hearing body for the taking of further evidence. In the event of such remand, the Board shall postpone its decision until the hearing body has submitted a supplemental report and recommendation and the parties have had a reasonable opportunity to provide written statements to the Board in response to such supplemental report The Board of Directors shall make its final decision in writing and copies of the decision shall be immediately forwarded by the President of the Hospital to the Staff Member, President of the Medical Staff and Chief Medical Officer. The final decision of the Board of Directors shall be effective immediately and shall not be subject to further review, except as stated in Section 12.8.9.

12.8.8 Notwithstanding any other provision in these Bylaws to the contrary, the revocation or denial of appointment or re-appointment to the Medical Staff or the revision or suspension of the Staff Member's clinical privileges shall not be final until approval by the Board of Directors.

12.8.9 If the decision of the Board of Directors is substantially in accord with the recommendation of the Medical Executive Committee, then the decision of the Board of Directors shall be final. If the Board of Directors intends to make a decision which is not substantially in accord with the recommendation of the Medical Executive Committee it shall, through the President of the Hospital, notify the President of the Medical Staff who may request a joint conference of equal numbers of both the Board of Directors and the Medical Executive Committee in order to meet and consider the matter and submit a recommendation to the Board of Directors. The Board of Directors' action on the matter following receipt of the recommendation shall be final and effective immediately.

12.9 **General Provisions**

12.9.1 Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee or by the Board of Directors, or by any or all of such parties. The hearing review procedure shall not be deemed to be concluded until all the steps provided in this Article XII have been completed or waived.

12.9.2 In the event the President of the Medical Staff, Chief of the Department to which the Staff Member has been assigned, President of the Hospital, Chief Medical Officer, or Chair of the Board of Directors are unavailable, or otherwise unable to perform any of their duties required under Article XI or XII, then such duties shall be performed by the person holding the position next in order of priority (e.g. Vice President of the Medical Staff) or by the designee of such unavailable person.

12.9.3 In the event that either the President of the Medical Staff, Chief Medical Officer, Department Chief, Section Chief, or Chair of a standing committee is the subject of a request for corrective action or investigation under Section 11.2, and therefore disqualified from performing any of his/her duties under Article XI or XII, the Chair of the Board of Directors, in consultation with the President of the Hospital and, if he/she is not the subject, the President of the Medical Staff, shall appoint another member of the Medical Staff to fulfill such duties.

ARTICLE XIII. CONSENTS, IMMUNITY, AND RELEASES

13.1 Authorizations and Consents

Each individual who applies for initial appointment to the Medical Staff or who applies for reappointment or renewal of such status, or any Licensed Health Care Professional employed by the Hospital or any individual who exercises or exercised the prerogatives of Medical Staff membership automatically authorizes and consents that:

a. the Hospital, the Medical Staff, and their authorized representatives may investigate and compile, as well as act upon, data concerning his/her professional qualifications, clinical competency, behavior, character, mental and emotional status, physical health, ethics, and any other data related to ability to render effective health care;

b. the Hospital, Medical Staff, and their authorized representatives may consult any hospital, medical facility, individuals, organizations, groups, records, or documents that may have information which may be material to evaluating him/her and consents to the release of information by these sources;

c. the individual shall consent to the testing and examinations specified in Section 3.2.1(b), if requested and in the manner specified in the Section and shall permit disclosure of any findings; and

d. the Hospital, Medical Staff, and their authorized representatives may provide other hospitals, with any credentialing information which the Hospital may have concerning the individual.

13.2 Confidentiality of Information

Information, with respect to any individual, collected, submitted or prepared by any representative of this Hospital or any health care facility, medical association, or licensing board, for the purpose of achieving and maintaining quality patient care shall be confidential and shall not be disseminated to anyone nor used in any way except as provided in these Bylaws or by law.

13.3 Immunity from Liability

13.3.1 For Action Taken

Neither the Hospital nor any representative of the Hospital or Medical Staff shall be liable for any action taken or statement or recommendation made in good faith within the scope of his/her duties or for the release of such information as authorized by these Bylaws or by law.

13.3.2 For Providing Information

No representative of the Hospital or Medical Staff and no third party shall be liable for damages or other relief by reason of providing information, including otherwise confidential or privileged information, to a representative of the Hospital or to any other hospital, medical association, or licensing board concerning a potential, actual, or prior Medical Staff Member.

13.4 Activities and Information Covered

13.4.1 Activities

The confidentiality and immunity provided by this Article XIII shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health related institution's or organization's activities concerning, but not limited to:

a. applications for appointment, clinical privileges, or specified services;

b. periodic reappraisals for reappointment, modification of appointment, clinical privileges, or specified services;

c. corrective action, including summary action;

d. hearings and appellate reviews;

e. patient care audits and/or evaluations;

f. utilization reviews; or

g. other hospital, department, service, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.4.2 **Information**

The acts, communications, reports, recommendations, disclosures, release of information and other information referred to in this Article XIII may relate to an individual's professional qualifications, clinical ability, behavior, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

13.5 **Releases**

Each individual who becomes subject to these Bylaws shall, upon request of the Hospital and by way of addition to the requirements of these Bylaws, execute general and specific releases in accordance with the tenor and import of this Article XIII in favor of the individuals and organizations specified in Section 13.3 above, 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 State and/or federal law.

13.6 **Cumulative Effect**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protection provided by law and not in limitation thereof.

ARTICLE XIV. GENERAL PROVISIONS

14.1 **Medical Staff Rules and Regulations**

Subject to the approval of the Board of Directors, the Medical Executive Committee shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Medical Staff Member in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, and they may be amended or repealed by the Medical Executive Committee. Such changes shall be approved by the Board of Directors. In any case where there is a conflict between the Rules and Regulations and the Medical Staff Bylaws, the principles delineated by the Medical Staff Bylaws shall take precedence with final interpretation to be made by the Medical Executive Committee.

14.2 Department Rules and Regulations

Subject to the approval of the Medical Executive Committee and the Board of Directors each Department shall formulate rules and regulations for the conduct of its affairs and discharge of its responsibilities. Such rules and regulations shall be approved by the Medical Executive Committee and shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, the Corporate Bylaws of the Hospital or other policies of the Hospital. These Department rules and regulations shall become part of the Bylaws and Rules and Regulations of the Medical Staff. Members of the Department shall have access to the Departmental rules and regulations, and shall be advised of any modifications thereof.

14.3 Medical Staff Dues

The Medical Executive Committee shall have the power to set the amount of annual dues for each category of Medical Staff membership and to determine the manner of expenditure of funds received. Delinquency in payment of such dues, payable July first, beyond November first of that same year shall result in suspension of the Member until payment of dues, provided that failure to pay within six (6) months of such suspension shall result in the Member being deemed to have resigned from the Medical Staff.

14.4 Rights and Responsibilities

These Bylaws, as adopted or amended, do not create a contract, but rather a system of mutual rights and responsibilities between Members of the Medical Staff and the Hospital, to which the Medical Staff and the Hospital intend to be bound.

ARTICLE XV. ADOPTION AND AMENDMENT OF BYLAWS

15.1 Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and authority to formulate and adopt the Medical Staff Bylaws and amendments to them. The Medical Staff shall recommend their approval to the Board of Directors and when approved by the Board of Directors they shall become effective and shall become part of the Corporate Bylaws of the Hospital. In the event that the Medical Staff shall fail to exercise its foregoing responsibility and authority and after special notice from the Board of no less than thirty (30) days, including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending the Medical Staff Bylaws. In that event, Medical Staff recommendations shall be considered by the Board of Directors during its deliberations and actions.

15.2 **Mechanism for Adoption, Amendment, or Repeal**

15.2.1 Medical Staff Bylaws may be adopted, amended, or repealed by an affirmative majority vote of the Medical Staff Members eligible to vote at a general Medical Staff meeting at which a quorum is present.

a. The proposed Bylaws shall be reviewed and endorsed by the Medical Executive Committee at the last monthly meeting held prior to the general Medical Staff meeting.

b. All voting Medical Staff Members shall be notified in writing of the pending vote, and provided with a synopsis of the proposed amendments, by U.S. Postal Service mail or electronic mail at least fifteen (15) days prior to the meeting at which the vote is to occur.

c. The changes approved by the Medical Staff shall become effective upon an affirmative vote of the Board of Directors.

15.2.2 If the Board of Directors proposes to amend the Bylaws or change amendments proposed by the Medical Staff, the Board of Directors and the Medical Executive Committee shall confer in an effort to agree upon the proposed amendments or changes no less than thirty (30) days before the Board of Directors approves the amendments.

15.3 **Notification of Bylaws Changes**

Written copies of approved changes in the Bylaws, Rules and Regulations or policies of the Medical Staff shall be posted on the Hospital's website and shall be provided to any Member of the Medical Staff upon his/her request.

15.4 **Adoption**

Approved by the
Medical Staff Executive Committee
May 7, 2024

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MARIA CICIARELLI, M.D.

Approved by the Medical Staff
June 25, 2024

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MARIA CICIARELLI, M.D.
President, Crouse Medical Staff

Approved by the
Board of Directors
July 11, 2024

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SETH E. KRONENBERG, M.D.
President & CEO, Crouse Hospital