

SECTION I: PHYSICIAN RESPONSIBILITIES RELATED TO PATIENT CARE

1. Admission of Patients

- 1.1** The hospital accepts patients for care and treatment by members of its Medical Staff from its service area within the limits of its available resources. Within these guidelines patients are admitted without regard to race, color, creed, sex, national origin, age, or ability to pay.
- 1.2** Only a member in good standing of the active, adjunct or courtesy staff who has been granted admitting privileges may admit patients to the hospital subject to all policies as may be in effect from time to time. General dentists and oral surgeons may admit patients to the hospital as provided under a separate section of those rules and regulations.
- 1.3** At times of full hospital occupancy or of shortage of hospital beds or other facilities and/or personnel, as determined by the Chief Executive Officer, priorities among patients will be based on their medical condition as provided by the attending physician to the Admitting Office. Whenever patients are admitted as an emergency, the attending credentialed physician must provide within eight (8) hours of a patient's admission to the hospital, an admission note which indicates involvement in the immediate care of the patient; and within 24 hours of the admission, sufficient documentation on the chart to justify the emergency admission. The initial assessment/screening of each patient's physical, psychological and social status will determine the need for care and treatment, the type of care or treatment to be provided and the need for any further assessment.
- 1.4** Except in Emergency cases, the attending physician shall arrange for a patient to be admitted during routine hours as specified by the Admitting Office. Ambulatory Surgery patients must comply with hospital policies concerning presurgical laboratory testing, documentation and scheduling.
- 1.5** Except in an emergency, a patient will not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the attending physician requesting such admission. Other required documentation or information specific to the type of admission involved shall be the responsibility of the attending physician. In addition, it is also the responsibility of the attending physician to provide information regarding any source of

significant communicable disease or infection, behavioral characteristics that would disturb or endanger others, and the need for protecting the patient from self-inflicted harm.

2. Child Abuse and Neglect

2.1 Child Abuse and Neglect - Members of the Medical Staff and Graduate Staff shall be responsible for reporting suspected abuse and/or neglect of children as soon as possible to the Child Protective Services, Central Registry for Mandated Reporters. This physician's responsibility is considered to be met if such reporting is carried out by another service, such as the Department of Social Work.

3. Consent

3.1 The attending physician, surgeon, resident or other medical staff member directly involved in the care of the patient is responsible for obtaining consent for anesthesia, surgery, blood transfusions and other invasive or special procedures after conducting and documenting a discussion of relevant risks, benefits, alternatives and expected outcomes of the proposed intervention.

3.2 The attending physician shall devote his best efforts to ensuring that such discussions are conducted in a way that is understandable to the patient or legal representative. The responsible medical staff member shall ensure that an appropriate hospital form documents the signature of the individual performing the intervention, the patient or legal representative, and a legally competent witness. Except in emergency, the medical staff member performing an invasive procedure shall be present when the signatures of the patient (or representative) and witness are obtained. Special consent documents are required for experimental drugs, organ donations, radiation oncology treatments, autopsy, HIV testing and photography.

4. Consultation

4.1 Good medical practice includes the proper and timely use of consultation. The attending physician is primarily responsible for requesting consultation when indicated or required, pursuant to the rules of the hospital. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending physician.

- 4.2** Except as otherwise provided for by the Medical Board, any qualified member of the medical staff with clinical privileges in this hospital may be called for consultation within his/her area of expertise. Generally, a consultant is a recognized specialist in the applicable area of need as evidenced by either certification or by demonstrated competence, training and experience.
- 4.3** Except in an emergency, consultation is indicated in the following situations, but shall not be limited thereto:
- 4.3.1** In cases where the scope of care needed by the patient is beyond the delineated clinical privileges of the practitioner;
 - 4.3.2** In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms;
 - 4.3.3** For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health;
 - 4.3.4** When requested by the patient or his/her family; or
 - 4.3.5** Those situations specifically designated elsewhere in these Rules and Regulations, or in the regulations of the various clinical departments for special care units.
- 4.4** Consultations by physicians, dentists or podiatrists not on Medical Staff must have temporary privileges as defined by Article II, Section 6, Subsection 2 & 3 of the Medical Staff Bylaws, a current New York State license, and evidence of competency, which must be assured by the pertinent Department Chairman (or designee). Such permission must be recorded in the patient's medical record. Whenever possible, the attending physician, dentist, or podiatrist of record or a designee shall be physically present during such consultation.
- 4.5** When requesting a consultation, it is advisable that the attending physician indicate, in writing, the reason for the request and the extent of involvement in the care of the patient expected from the consultant, e.g. "for consultation and opinion only" for consultation, orders and follow-up with respect to a specific problem. The consultant must make and sign a report of his/her findings, opinions and recommendations which reflect an actual examination of the patient and the medical record. Such report shall become part of the patient's permanent

medical record. When operative procedures are involved, the consultation note, except in emergency cases, shall be recorded prior to the operation.

5. Coverage

- 5.1** In order to assure alternate coverage and continuing care, each physician must arrange for timely, adequate professional care of his/her patients in the hospital by being available or designating qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges to care for the patient. Each member of the staff must arrange for coverage during his/her absence for the care of hospitalized patients. The name of the covering physician designated by the attending physician must be readily available from a reliable telephone service operator at all times or indicated in the medical record. Physicians may not “sign out” to the hospital Emergency Department to cover private office patients in their absence. It is the responsibility of the private answering service to contact covering physicians when the attending physician has “signed out”.

6. Discharge of Patients

- 6.1** A patient may be discharged only on the order of the attending physician or assigned resident.
- 6.2** Multidisciplinary discharge planning begins at the time of hospital admission. The physician-of-record or covering designee is solely authorized to discharge patients from the hospital and is responsible for medical aspects of the discharge, including Discharge Instructions and a post-discharge plan. The responsible physician shall (1) record his instructions in the medical record and (2) share these verbally and in writing with the patient and family, addressing at least the following (as relevant to the particular case): an explanation to the patient and family (as applicable) of the patient’s principle diagnoses and medical problems, major findings of tests and investigations, all medications, including any changes from the patient’s admitting medications (i.e. medication reconciliation), diet, activity, self-monitoring, follow-up tests and appointments inclusive of recommended time frames, and specific reasons for seeking urgent care or contacting the physician as they relate to the patient’s known, active medical problems. Consulting physicians play an important collaborative role in discharge planning, but must coordinate their contributions to the overall discharge plan with the physician-of-record or designee.

7. Discharge AMA

- 7.1** In instances where a patient desires to leave the hospital against the advice of the attending physician or without a proper discharge, the attending physician shall be notified and the patient will be requested to sign the appropriate release form. Any minor or individual who cannot legally consent to his/her own care, or is incapable of providing his/her own care shall be discharged only in the custody of a parent, legal guardian, significant other, unless the parent or guardian directs that discharge be made otherwise.
- 7.2** No patient shall be detained in the hospital against his/her will, nor shall a minor under eighteen (18) years of age be detained against the will of his/her parent or legal guardian, except as authorized by law. In no event shall a patient be detained solely for non-payment of the hospital bill or physician statement for medical services. However, it is acceptable to attempt to persuade a patient to remain in the hospital in the patient's own interest. If there is a concern that the patient lacks decisional capacity due to mental illness, or that the patient may be a danger to self or others, the patient may be temporarily detained pending a prompt psychiatric evaluation and determination of the patient's legal rights. If an adult patient lacks capacity for any other reason, and there is no legal guardian or properly designated health care agent, Administration shall be consulted. If a presumptively competent patient insists upon being discharged against the advice of a member of the medical staff or the graduate staff, the patient shall be requested to sign the form entitled "Release for Leaving the Hospital Against Advice". The physician involved is responsible for documenting the facts and circumstances surrounding the act of the patient leaving the hospital against medical advice. In the event the patient refuses to sign the form, the patient's refusal must be documented in the medical record.

8. Emergency Department On-Call Roster

Unless specifically exempted by departmental rules or the Medical Board, each member of the staff is required to serve on the Emergency Department on-call roster and accepts the responsibility for providing care to any patient referred to him/her by the Emergency Department physician on duty. The staff member who is on call, as specified by the published schedule, shall be responsible for providing post Emergency Department care until the medical care for the condition occasioning the Emergency Department visit has been completed. Members of the Medical Staff

are specifically prohibited from either requiring that the patient satisfy any financial obligation in advance of such follow-up care or refusing to provide follow-up care based upon the ability to pay.

9. History and Physical Examination

9.1 For patients undergoing scheduled ambulatory procedures or admitted for scheduled **elective** procedures, a legible H&P must be submitted that was created not more than 30 days prior to, or within 24 hours after, admission and includes the patient's history as it relates to the presenting problem and other history as relevant, physical examination findings, results of relevant investigations, impression, and plan. If the document was created more than 24 hours prior to a planned invasive procedure, the physician must either (1) attest that the patient's condition is unchanged, based upon appropriate reassessment, or (2) indicate any changes in the patient's condition in the medical record. This report must be signed or authenticated, dated and timed prior to surgery or any procedure requiring anesthesia services.

9.2 For patients admitted for **non-elective** reasons, the admitting physician of record or designee shall create a legible admission note within eight hours after admission outlining the patient's presenting problem and reason for admission, pertinent history, physical findings, results of initial investigations, impression and plan. If this notation is not inclusive of all elements required for an Admitting History and Physical as delineated in this section, a complete and legible H&P must be created within 24 hours after admission and include the patient's chief complaint, details of the present illness, all relevant past medical, social and family history, a review of systems, physical examination findings including, where appropriate, the patient's emotional and behavioral status, results of investigations, and diagnostic impressions. The attending physician must indicate the reason for hospitalization and the diagnostic/therapeutic plan of care. There must be an initial assessment/ screening of each patient's physical, psychological, and social status to determine the need for care or treatment, the type of care or treatment to be provided, and the need for any further assessment.

9.3 If the admission history and physical for an operative or invasive procedure are performed by a physician who is not a member of the hospital's medical staff, the attending physician shall review the history and physical examination and attest to its accuracy by countersigning. Individuals who are not licensed independent practitioners may perform part or all of a

patient's medical history and physical examination under the general supervision of the attending physician. The attending physician shall review and countersign the history and physical examination before the operation or procedure.

9.4 A relevant history and physical examination is required for each patient having surgery.

Except in an emergency, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the H&P has been dictated but is not on the chart at the time of surgery, a written note must be entered into the chart before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done. The condition of the heart and lungs, allergies known to be present, other pertinent information and pathology relating to the patient, and that the history and physical have been dictated are also to be noted. If not recorded, the anesthesiologist shall not allow the surgery to proceed. In cases of emergency, the responsible physician shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed.

9.5 The current obstetrical record must include a complete prenatal record. This may be a durable, legible copy of the attending physician's office record transferred to the hospital before admission, but an interval admission note must be written which includes pertinent additions to the history and any subsequent changes in the physical findings.

9.6 Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry. A qualified physician must do the admission history and physical.

9.7 All patients admitted for Podiatric surgery must have a history and physical examination performed by a physician member of the active medical staff who shall be responsible for the medical care of the patient during his or her stay in the hospital. Such writings shall be recorded on the chart prior to the procedure in the OR. No podiatric surgical procedure will be allowed until the history and physical has been performed. It will be the Podiatric surgeons' significant responsibility to see that that is completed.

10. Indication for Procedure/Surgery

10.1 The determination of the appropriateness of any surgical intervention will be based in part (or at least) on a review of the patient's history, a review of the patient's physical status, a review of diagnostic data, and an assessment including the risks and benefits of the procedure, the anesthesia to be administered, and the risks, benefits, and alternatives of the procedure, including the possible need to administer blood or blood components. Unless impossible due to the patient's condition, the risks, benefits and potential complications associated with the procedure and alternate options are discussed with the patient before obtaining informed consent.

11. Physician Orders

11.1 All orders for the diagnosis and treatment of hospitalized patients must be clear, legible and complete. Orders must be signed or electronically authenticated, dated and timed, by the attending physician, assigned resident or designated alternate. Orders which are illegible or improperly written will not be carried out by the nursing staff.

11.2 Telephone orders for drugs and biologicals shall be used sparingly when the medical staff member is not readily available on-site, and shall not replace an appropriate medical assessment. A registered professional nurse, a pharmacist or a member of the Allied Health Staff can transcribe a telephone order when the order is within the scope of their practice. An order so transcribed may be carried out by the nurse.

11.3 All telephone orders must be authenticated by the prescribing practitioner or designee within 48 hours of issuing the order, unless the order was issued by a physician's assistant which requires authentication by a supervising physician within 24 hours of issuing the order.

11.4 All orders are automatically canceled and discontinued when a patient goes to surgery or is transferred to the OR.

11.5 The hospital formulary which is approved by the Pharmacy and Therapeutics Committee and the Medical Board lists drugs available for ordering from stock. Each member of the medical staff is expected to use the drugs which are available and listed in the formulary as approved by the medical staff. Each patient's medications shall be monitored on an ongoing basis for effectiveness and actual or potential adverse effects or toxicity. Use of investigational drugs

requires prior approval by the Institutional Review Board and must be in full accordance with separate rules and regulations of this committee and consistent with regulations of the FDA.

12. Physician of Record

12.1 All patients, ambulatory or inpatient will be attended by a mutually consenting practitioner of his/her choice to perform the care required, provided said practitioner is a member of the Medical Staff and has appropriate clinical privileges and is properly credentialed. A private patient who has no personal physician may request a physician who is a member of the Medical Staff and who has appropriate clinical privileges. When no such request is made and the patient requests assistance in obtaining a physician, the hospital shall assign a member of its Medical Staff, based on the Emergency Department on-call roster, consistent with the patient's condition, except for cases requiring General Adult Medicine or Pediatrics in which case the patient will be assigned to the hospitalist service. The physician-of-record or covering designee shall be responsible for the medical care and treatment of each patient in the hospital at all times, for the overall coordination of patient care, the prompt completion and accuracy of those portions of the medical record for which they are responsible, for discharge planning and for communication of the patient's condition and plan of care to the patient, agent or family as applicable.

13. Transfer of Care

13.1 When primary responsibility for a patient's care is transferred from the admitting or attending physician to another staff member, a note covering the transfer of responsibility and acceptance of the same should be entered on the order sheet and progress notes.

SECTION II: PHYSICIAN RESPONSIBILITIES RELATED TO MEDICAL RECORD DOCUMENTATION AND CONTENT

1. The attending physician and other Medical Staff members, including residents, involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The content of the medical record shall be pertinent, accurate, legible, timely and current. It shall include (a) patient identification and demographic data; (b) personal and family medical histories; (c) description and history of present complaint and/or

illness; (d) physical examination; (e) diagnostic orders; (f) evidence of appropriate informed consent; (g) information generated through the analysis of assessment data which is integrated in daily progress notes to identify and prioritize the patient's needs for care and treatment; (h) special reports, when applicable, such as laboratory, radiology, EEG, EKG, consultation, pre- and post-anesthesia evaluation, operative and other diagnostic and therapeutic procedures; (i) pathological findings; (j) final diagnosis; (k) all discharge instructions given to the patient, and/or, when appropriate, his/her family, and includes appropriate education and training to expand knowledge of the patient's illness and treatment needs and to learn skills and behaviors that promote recovery and improve outcomes; (l) autopsy report, when available; (m) nursing assessments, nursing plans for care, documentation of nursing care provided and results.

2. Pertinent progress notes must be recorded at the time of observation and must be sufficient to support continuity of care by explaining the physician's findings, working diagnoses and plan of care. Frequency of progress notes shall be determined on a departmental basis but shall be entered at least once daily.
3. Operative and special procedure reports must contain, as applicable, a detailed account of the findings, technical procedures used, specimens removed, postoperative diagnosis, and the name of the primary performing practitioner and any assistants. If the operative report is dictated and not immediately transcribed, the responsible physician must enter a comprehensive operative progress note in the medical record immediately after completing the procedure which provides sufficient and pertinent information for use by any other physician who is involved in the care of the patient. All tissues, foreign bodies, artifacts and prosthesis removed during a procedure, except those specifically excluded by policy, shall be properly labeled, packaged and sent to the hospital pathologist, who shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.
4. A discharge summary must be recorded for all patients, except those with problems of a minor nature requiring less than 48 hours hospitalization; normal newborn infants and patients having uncomplicated vaginal deliveries. To affect planned and coordinated care and treat-

ment plans and the rehabilitation that may be necessary after discharge, the discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care. The discharge instructions should facilitate patient/family understanding of the patient's health status, health care options, and the consequences of the treatment options selected. If no instructions were required, a record entry must be made to that effect.

5. All clinical entries in the patient's medical record must be accurately dated, timed, and individually authenticated.
6. All original patient medical records, including images, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute or with the permission of the Chief Executive Officer. Copies of records may be released only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof is considered to be a serious violation of hospital policy.
7. The medical records of discharged patients shall be completed within thirty (30) days of such discharge.

SECTION III: PHYSICIAN RESPONSIBILITIES RELATED TO HOSPITAL POLICY AND PROCEDURE

1. Advance Directives

- 1.1 Advance directives include but are not limited to health care proxy, consent to do not resuscitate (DNR) orders, and living will. Members of the medical staff shall comply with all applicable statutory and regulatory requirements. All members of the medical staff shall protect and support the patient's rights to formulate health care proxies and other advance directives.

2. Autopsy and Organ Procurement

- 2.1 It is the responsibility of every member of the Medical Staff to secure autopsies whenever possible.

2.2 It is the duty of the member of the Medical Staff who has been caring for a patient who has died to request permission for a postmortem examination in certain circumstances. The following criteria identify deaths in which an autopsy should be performed:

- i)** All fetal deaths greater than 20 weeks gestation; all stillbirths or neonatal deaths.
- ii)** All cases in which the death was an unexpected result of the patient's clinical condition.
- iii)** All cases in which a definitive diagnosis had not been established (e.g. a suspected cancer patient without a tissue diagnosis).
- iv)** All inpatient cases referred to the medical examiner in which the medical examiner has declined to perform an autopsy.
- v)** Any case which the clinician deems would be of educational value or fulfill a specific consultative function (e.g. genetic counseling, Alzheimer's Disease research).

2.3 The retrieval of transplantable organs and tissues as required by both federal and state regulations affecting organ procurement is the responsibility of the attending physician with the assistance of the hospital's nursing staff. The hospital is a member of the Organ Procurement and Transplantation Network established under law and abides by its rules and regulations.

3. Deaths

3.1 In the event of a hospital death, the deceased shall be pronounced dead by the attending physician, designee or credentialed registered nurse as soon as possible. The attending physician or his on-call designee is responsible for notifying the next of kin in a timely fashion.

3.2 Reporting of deaths to the Medical Examiner's office shall be carried out when required by, and in conformance with applicable statute.

3.3 The death certificate must be signed by the attending physician or on-call designee unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner.

3.4 The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff. In the Medical Examiner's case, the body may not be released to any other than Medical Examiner personnel or to police

officers, except upon receipt of an “Order to Release Body” form issued by the Medical Examiner.

4. DNR

- 4.1** All members of the medical staff shall comply with all applicable laws and regulations regarding do not resuscitate (DNR). The attending MD is required to document a patient’s eligibility and consent for DNR on the patient’s medical record and/or hospital designated DNR form.

5. Patient Access to Medical Records

- 5.1** A patient may, upon proper written request, have access to all information contained in his/her medical record, unless access is specifically restricted by the attending physician for medical reasons or is prohibited by law.

6. Performance Improvement/Quality Management

- 6.1** It is incumbent upon every practitioner to participate in the performance improvement program, which has been established to meet or exceed the all applicable regulatory standards, reduce avoidable errors and harm to patients, improve adherence to evidence-based practices, ensure timely intervention and efficient resource utilization, and generally promote clinically excellent and patient-centered care.
- 6.2** In the event that a member of the medical staff is notified of a quality citation by the State PRO, such information must be reported immediately to the Quality Management Department in order to carry out appropriate interventions on the practitioner’s behalf and possible hospital-related appeals to avoid unnecessary sanctions.
- 6.3** Safe Medical Device Reporting - The members of the Medical Staff will comply with the hospital’s Medical Device Reporting Program which was established to identify medical device-related incidents in order to initiate corrective action and comply with the reporting requirements of the Safe Medical Devices Act of 1990. Members of the medical staff shall report any such potentially reportable incidents to the Quality Management Department.

7. PHI Confidentiality and Security

- 7.1** All members of the professional staff and allied health staff shall maintain the confidentiality of their patient’s records and respect the confidentiality of the records of all patients of the

hospital. They shall not access any patient information through paper records, the hospital's information systems and/or patient databases unless required to access such information in connection with their obligation to provide medical care to the patient or for bona fide research or educational purposes consistent with preserving the confidentiality of patient information.

- 7.2** All members of the Medical and Allied Health Staff shall comply with all hospital and Health System policies and procedures addressing the management and protection of PHI, and all laws and regulations regarding patient confidentiality and PHI.

8. Regulatory and Statutory Requirements

- 8.1** Members of the Medical Staff shall comply with all applicable statutory and regulatory requirements under federal, state and local laws, including but not limited to the NYS Hospital Code and The Joint Commission, the hospitals' malpractice prevention program, the quality assurance program and the incident reporting program which are required by law. All members of the staff shall afford patients their rights in accordance with provisions of state law.

SECTION IV: ALLIED HEALTH PROFESSIONALS

- 1.** Allied Health Professionals (AHP) who are members of the hospital staff or who may have been granted specific responsibilities for the care of the patient by the attending physician may write orders only to the extent, if any, specified in their delineation of privileges developed by the Medical Staff and consistent with the scope of services for which they are credentialed and have received training. Any authorized order by an AHP must be countersigned by the responsible supervising physician within twenty-four hours.
- 2.** In those instances when an attending physician determines that the services of an AHP, not available from the hospital, are required for his/her patient, that physician is responsible for ordering and monitoring the provision of the needed services by qualified appropriately credentialed individuals. In all cases, the attending physician is ultimately responsible for the

management of the case and the care of the patient. The Medical Board shall monitor compliance with established criteria relative to the use of AHPs not employed or affiliated with the hospital.

3. AHPs shall not be deemed members of the Medical Staff, which is limited to physicians, dentists, and podiatrists, but shall be organized for administrative purposes only into an Allied Health Professions Adjunct Staff.
4. An application for specified services by any AHP shall be submitted and processed in the same manner provided for physicians requesting clinical privileges. With the approval of the Medical Board and the Board of Trustees, the President may be delegated the authority to take action for them on any such applications from specified categories of AHPs. Terms of appointment and reappointment of AHPs to the AHP Adjunct Staff shall not exceed two years and shall in no event extend beyond the last day of the next succeeding hospital year. Reappointment shall be subject to the same reappointment process as is specified in Article III of the Medical Staff Bylaws. In the event of adverse recommendations and/or actions regarding the appointment, reappointment, and/or privileges of AHPs, they shall not be deemed entitled to the right of hearing and appellate review set forth in Article VI of the Medical Staff Bylaws, which procedures are limited to the Medical Staff.
5. Only AHPs holding a license, certificate, or other legal credential as required by New State Law who:
 - (i) document their experience, background, training, demonstrated ability, physical mental health status, with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the Hospital; and
 - ii) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others; and
 - (iii) in the event that they engage in the care and treatment of patients, shall provide evidence of professional liability insurance coverage shall be eligible to provide speci-

fied services in the hospital. Such services shall be under the supervision or direction of a physician member of the Medical Staff (except as otherwise expressly provided by resolution of the pertinent Clinical Department and approved by the Medical Board and the Board of Directors). Where appropriate, the Medical Board may establish particular qualifications required of members of a specific category of AHPs, provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable law.

6. AHPs shall be individually assigned to the Clinical Department appropriate to their professional training as determined at the time of appointment by the Medical Board.
7. An AHP may write orders only to the extent that such individual has been privileged to do so by his/her Department Chairman under guidelines established by the Medical Board, and as appropriate in accordance with new York State laws, rules and regulations (including a written practice agreement where required by such laws, rules or regulations). In the event that New York State laws, rules or regulations require that the AHP practice in accordance with a written practice agreement, such practice agreement shall be approved as to form by the Medical Board. Nothing contained in these Rules and Regulations shall permit an AHP to write orders beyond the scope of the AHP's license, certificate or other legal credential.
8. AHPs who engage in the care and treatment of patients shall provide for the continuous care for their patients.
9. AHPs shall be subject to the Hospital Bylaws, the Medical Staff Bylaws and all applicable Hospital, Medical Staff, and Department rules, regulations, policies and procedures.
10. Each AHP shall be required to furnish to the hospital, on an annual basis, evidence of current health status of sufficient scope to assure that the AHP is free from health impairments which pose potential risks to patients or personnel or which may interfere with the performance of duties.

SECTION V: SUPERVISION OF GRADUATE STAFF

1. The Medical Board shall delegate to the Department Chair responsibility for developing and implementing written policies and procedures which set forth a clear set of principles governing medical practice within their respective departments by graduate trainees, including guidelines on circumstances requiring supervision and consultation in accordance with requirements of state and federal laws and regulations.
2. Members of the graduate staff must be supervised by the attending physician or dentist of record or a designee. The attending physician or dentist is responsible for countersigning the history and physical written by a member of the graduate staff. Further documentation in the medical record must evidence the level of involvement by the attending physician or dentist of record. Merely countersigning the notes written by a member of the graduate staff is not sufficient documentation of the attending's involvement and supervision.
3. The Medical Board shall delegate to the department Chair responsibility for monitoring patient care services provided by graduate trainees to assure provision of quality patient care services within the scope of privileges granted to such trainees and responsibility for assuring corrective measures and/or disciplinary action when such services provided exceed the scope of privileges granted.
4. Post graduate trainees are given patient care responsibilities commensurate with their individual level of training, credentialing, experience and capability as determined by the chiefs of the respective clinical departments. In all matters of an individual patient's care, the attending physician is always responsible for the performance of residents. Physical examinations, daily visits, orders, progress notes, recording of histories or other assigned medical care responsibilities performed by residents does not replace the attending physician's ultimate responsibility for the care of each patient.

Section VI: CORRECTIVE ACTION PROCEDURES FOR MEDICAL STAFF

Except as provided otherwise elsewhere in the Medical Staff Bylaws and these Rules and Regulations, the procedures set forth in this Section VI shall apply whenever corrective action has been requested under Article V of the Medical Staff Bylaws. Unless otherwise defined in these Rules and

Regulations, all capitalized terms in this Section VI shall have the same meaning as in the Bylaws of the Medical Staff.

1. Request for Hearing

1.1 A practitioner who has received notice of a request for corrective action as set forth in Subsection 5.1.2(A)(vii) through (xi) of Article V of the Medical Staff Bylaws, notice of summary action, or an adverse recommendation on an application for appointment or reappointment to the Medical Staff, and who desires a hearing before a Hearing Committee with respect to such request, action or recommendation, shall do so by submitting a written request for a hearing to the Chairman of the Medical Board. Such written request shall be submitted by overnight delivery service or personal delivery within thirty (30) days of his/her receipt of notice of the request, action or recommendation. If the practitioner fails to request a hearing within such time limitation, or to appear at the time set for the hearing, he or she shall be deemed to have waived the right to a hearing, as set forth in Subsection 5.1.6 of the Medical Staff Bylaws.

1.2 If a Medical Staff member is subject to corrective action at both the Hospital and one or more other System Hospital(s) where he/she also has clinical privileges, and the corrective actions at the hospitals are based on substantially the same facts, then the practitioner shall be entitled to request one (1) hearing, the final determination of which shall apply at all the hospitals. The hearing and any appeal therefrom shall be requested at, and shall be conducted in accordance with the Medical Staff Bylaws and the Rules and Regulations of the hospital where the principal facts occurred. If the principal facts occurred at a non-hospital location or at more than one hospital, the hearing shall be requested at the hospital designated by the practitioner as his/her primary hospital in his/her most recent application for appointment or reappointment. All issues relating to the corrective action at all hospitals shall be presented at the hearing and any subsequent appeal.

2. CHALLENGES TO THE COMPOSITION OF THE HEARING COMMITTEE. Any challenge by the practitioner to any member of the Hearing Committee pursuant to Subsection 5.1.5 shall be made in writing to the Chair of the Hearing Committee no less than fifteen (15) days prior to the date of the Hearing. If the challenge is regarding the Chair of the Hearing Committee, it shall be made by the practitioner to the Chief Executive Officer of the Hospital.

3. Conduct of the Hearing

3.1 Not less than five (5) business days prior to the hearing, the practitioner and the Hospital shall simultaneously exchange (i) a list of witnesses, including experts, that each intends to call at the hearing, together with a brief statement describing the subject matter of each witness' testimony and the relevance thereof to the issues in the hearing; and (ii) copies of all exhibits that they propose to introduce as evidence at the hearing. If necessary, such exchange may be supervised by the Chair of the Hearing Committee. Thereafter, neither party may call any additional witness or offer any additional exhibit without the permission of the Chair of Hearing Committee upon a showing of good cause as to why the witness or exhibit could not have been identified prior to the start of the hearing, such as, for example, where rebuttal evidence is offered to respond to the practitioner's evidence. The exchange of witness lists and exhibits shall be without prejudice to either party's right to object to a witness or exhibit at any time on any proper ground. If feasible, however, such objections should be stated and resolved prior to the start of the hearing. Prior to the exchange of the witness lists and exhibits as described above, the practitioner and the Hospital shall enter into a written and signed agreement, in form and substance satisfactory to the Hospital, that ensures the protection of the confidentiality of all quality assurance, peer review and protected health information used by either party in the course of the hearing and any subsequent internal Hospital reviews and appeals and administrative or judicial proceedings.

3.2 In consideration of the sensitive nature of the physician-patient relationship, neither the practitioner nor the Hospital may call a patient, past or present, to testify on his/her or its behalf at the hearing, or offer as evidence any written or oral patient statement solicited or obtained for the purposes of the hearing. A statement shall not be deemed to have been solicited or obtained for the purposes of the hearing if the statement caused, in whole or in part, the corrective action, or was obtained in the course of investigating whether corrective action should be requested or taken.

3.3 Witnesses may be permitted to testify remotely only upon a showing of good cause as to why the witness is unable to be present and a determination by the Chair of the Hearing Committee that such remote testimony will not unfairly prejudice the other party or impede the Hearing Committee's ability to evaluate the testimony. Remote testimony shall not be

permitted if (i) the witness is to be examined or cross-examined with respect to the content or authenticity of documents and/or images, or (ii) video of the witness is not available, unless the Chair determines that the absence of video would not unfairly prejudice the other party or impede the Hearing Committee's ability to evaluate the testimony. When remote testimony is permitted, it shall be the obligation of the party calling the witness to make all technological arrangements, and bear the expense thereof, as may be necessary for the transmission, receipt and broadcast of the testimony in a manner that ensures that all participants in the hearing are able to hear and view (unless the Chair determines that video is not required) the witness.

- 3.4** The practitioner must be present at the hearing, and, subject to the limitations set forth in paragraphs a), b) and c) above, both the practitioner and the Hospital shall be entitled to present relevant evidence and witnesses on his/her or its behalf, to question witnesses appearing on behalf of the other party, and to submit a written statement following the close of the hearing; provided, however, that neither the practitioner nor the Hospital may present a patient as a witness at the hearing. A record of the hearing shall be made by such method as shall be determined by the Chair of the Hearing Committee. Such hearing shall not be open to the public and documents and testimony shall be maintained in strict confidence by all participants and witnesses, consistent with Article 28 of the Public Health Law. The hearing shall not be subject to any formal rules of evidence or procedure, and the Hearing Committee may permit the presentation of evidence and witnesses subject to such restrictions and limitations as it may impose and as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. There shall be no right to pre-hearing discovery. Rulings with respect to evidence and witnesses shall be made by the Chair of the Hearing Committee. A majority of the members of the Hearing Committee shall constitute a quorum. The practitioner and the Hospital each may elect to be represented at the hearing by legal counsel. At its option, the Hearing Committee also may be advised by legal counsel, provided that the attorney appointed to advise the Hearing Committee is not the same attorney as the attorney representing the Hospital before the Hearing Committee. The Hearing Committee, through its Chair, shall make such additional rules as it deems necessary to ensure a fair and

expeditious handling of the matter. Following the conclusion of the Hearing, both parties may submit simultaneously a written statement to the Hearing Committee.

4. Appellate Review Committee

If a practitioner requests appellate review pursuant to Subsection .1.8 of the Medical Staff Bylaws, the Board of Trustees shall appoint an Appellate Review Committee composed of three (3) members of the Board of Trustees. A Chair of the Appellate Review Committee shall be appointed by the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as that person did not request the corrective action or otherwise take part in a prior proceeding on the same matter. For purposes of the appellate review, both parties shall have access to the recommendation and record of the Hearing Committee, the decision of the Medical Board, and all other material that was considered by the Hearing Committee in making its recommendation, unless any such material is otherwise exempt from disclosure by law.

5. Appeal Process

Unless the Chair of the Appellate Review Committee authorizes a different schedule, the party requesting appellate review shall submit his/her or its written statement setting forth in full the grounds for the appeal and the reasons in support thereof to the Appellate Review Committee and to the opposing party within twenty (20) days after the date of receipt by the Board of Trustees of the request for appellate review. The opposing party shall submit a responsive statement within twenty (20) days of receipt of the appealing party's statement. After receiving both statements, the Chair of the Appellate Review Committee shall schedule a date, time and place for the appellate review and shall give written notice of the schedule to the parties. The date of the appellate review shall not be more than twenty (20) days from the date that the Appellate Review Committee received the opposing party's statement, unless agreed to by the Chair of the Appellate Review Committee and all parties. The Appellate Review Committee shall review the record created at the Hearing Committee, the statement of appeal, and the responsive statement for the purpose of determining whether the decision of the Medical Board had a rational basis. The Chair of the Appellate Review Committee may, in his or her sole discretion, allow oral argument or accept additional written evidence, subject to a foundational showing that such evidence could not have been made available at the hearing in the exercise of reasonable diligence. New or additional

matters not raised at the hearing, nor otherwise reflected in the record, shall not be introduced at the appellate review unless the Appellate Review Committee, in its sole discretion, decides to consider such new matters.

6. Summary Action and Proceedings

Notice of a summary suspension or restriction of a practitioner's clinical privileges shall be given to the practitioner personally or sent by overnight delivery service as soon as practicable.

7. Withdrawal of Corrective Action

Any request for corrective action, including a summary action, may be withdrawn by the person requesting or imposing it at any time prior to the consideration of the matter by the Hearing Committee. Notice of such withdrawal shall be provided to the affected practitioner by the person or body withdrawing it.

8. Alternate Medical Coverage

Immediately upon any termination, limitation or suspension of a practitioner's Medical Staff membership or any termination, limitation or suspension of his or her clinical privileges, either under Article III or Article V of the Medical Staff Bylaws and this Section VI of the Rules and Regulations, the Department Chair, Chairman of the Medical Board, the Medical Director, or the Chief Executive Officer of the Hospital shall each have authority to arrange for alternate medical coverage for the practitioner's patients still in the Hospital. The wishes of the patients concerned shall be considered in the selection of an alternate practitioner.

Reviewed/Approved:

Medical Staff Meeting

Medical Board Meeting

Board of Directors: March 25, 2014

Revised and Edited: March 2014

By: Michael B. Grosso, MD

Sr. Vice President Medical Affairs and Quality