

RULES & REGULATIONS

CROUSE HOSPITAL

MEDICAL STAFF

- 1 **ADMISSION AND DISCHARGE OF PATIENTS**
- 1.1 A patient may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.
- 1.2 A physician member of the Medical Staff shall be responsible for medical care and treatment of each patient in the Hospital. Non-physician members of the Medical Staff are responsible for the care and treatment of patients as it relates to their disciplines. Each member of the Staff is responsible for the prompt completeness and accuracy of the medical record, and for the necessary special instructions. The discharging Staff member has the responsibility for transmitting the reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, for more than the usual coverage rotations, a note covering the transfer of the responsibility shall be entered in the progress notes and the order sheet of the medical record.
- 1.2.1 Inpatients of Affiliate Staff members with admitting privileges will be admitted under the name of the Affiliate Staff member and to the joint care of the Affiliate Staff member and a physician member of the Medical Staff. Outpatients may be admitted by an Affiliate Staff member independently, as long as any requirements for histories and physical exams are observed.
- 1.3 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of any emergency, such statement will be recorded as soon as possible.
- 1.4 In any emergency case in which it appears, the patient will have to be admitted to a Hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.
- 1.5 Practitioners admitting emergency cases shall be prepared to justify it to the Executive Committee of the Medical Staff and the Administration of the Hospital,

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that these said emergency admissions were bona fide emergencies. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

- 1.6 A patient to be admitted on an emergency basis, who does not have a private practitioner, may choose to be attended by any willing practitioner on our staff in the applicable department or service in an appropriate category. Where no such selection is made, a member of the Active Staff on duty in the department or service, will be assigned to the patient, on a rotation basis, where possible. The Chief of each department shall provide a schedule for such assignments.
- 1.7 Each practitioner must assure timely, adequate, professional care for patients in the Hospital by being available or having available an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements may result in disciplinary action.
- 1.8 The attending practitioner is required to document the need for continued hospitalization on request of the appropriate committee chair, or that person's designee.
- 1.9 Patients shall be transferred to another institution or provider only after adequate screening for emergent conditions, treatment sufficient to insure a stable transfer (if within the capability of the institution), and appropriate information as to the risks and benefits of transfer.
- 1.10 Patients will be discharged only on a written order of the attending practitioner or designee. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident will be made in the patient's medical record.
- 1.11 In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or the practitioner's designee within a reasonable time and an entry made and signed in the medical record of the deceased before the body will be released. Exceptions will be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to the release of dead bodies will conform to local law.
- 1.12 It shall be the duty of all Staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with the written consent, signed in accordance with State law. All autopsies shall be performed by the Hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete protocol should be made part of the record within two months.

2 MEDICAL RECORDS

- 2.1 The attending member of the Medical Staff shall be responsible for the preparation of a complete, current and legible medical record for each inpatient. The contents of the medical record shall be sufficient to justify the diagnosis, and warrant the treatment and end results. This record shall include identification data, chief complaint, history of present illness, past history, family history, social history, psychiatric history where appropriate, review of systems, physical examination, provisional diagnosis, reports of consultations, reports of laboratory and radiology services, reports of treatment, operative reports, pathology reports, progress notes, final diagnosis, discharge summary or note, autopsy findings and other reports as mandated by New York State Law.
- 2.2 A complete admission history and physical examination shall be recorded within 24 hours of admission by the attending member of the Medical Staff, house staff, or nurse practitioner. The attending member of the Medical Staff must countersign the history and physical examination when it is completed by the house staff or nurse practitioner, unless he or she has completed an attending history and physical. If a complete history and physical has been completed within thirty days prior to an elective or scheduled admission, in the attending physician's office, a durable signed legible copy of the report may be used in the patient's hospital medical record provided there has been no subsequent change or the changes have been recorded at the time of admission, and provided it be placed in the record within 24 hours of admission. Obstetrical records should include all prenatal information. A durable, legible, signed original or reproduction of the office or clinic prenatal record is acceptable. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record. A history and physical examination must be recorded prior to the performance of surgery unless the attending physician states in writing that such delay would be detrimental to the patient. If the history and physical examination are not written by the attending physician, and the patient goes to surgery within 24 hours, the surgeon must write an attending note which can suffice as a preoperative note as well.
- 2.3 Progress notes shall be recorded at the time of observation. They should give a pertinent chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Progress notes shall be written once daily by the attending member of the Medical Staff on all patients in the Hospital who do not meet the qualifications for ALC (Alternate Level of Care). Otherwise, progress notes shall be written by the attending physician or dentist every 72 hours at a minimum or at any time there is a change in diagnosis and/or in the plan of care. Progress notes shall be written every seven days on those patients who have been identified as needing only a skilled nursing level of care. Progress notes shall be written monthly on patients at a custodial level of

- care. Progress notes written by the house staff or nurse practitioner will fulfill these requirements if they are countersigned by the attending physician or dentist, indicating concurrence. There shall be a preoperative progress note written by the surgeon within 24 hours prior to surgery and shall be inclusive of the preoperative diagnosis, the indication for surgery and the proposed procedure to be performed. At the conclusion of the procedure a short operative note shall be recorded in the progress notes, giving the diagnosis, operative procedure, surgeon, assistants and any other pertinent information necessary to be immediately available. All progress notes shall be dated and signed.
- 2.4 Operative reports shall be dictated within 24 hours of the conclusion of the surgery. Reports should contain a preoperative and a postoperative diagnosis, a description of the findings, the technical procedures used, the specimens removed, and the name of the primary surgeon and any assistants. The date of dictation and the date of transcription will be recorded on each dictated operative report. The operative report shall be signed by the surgeon. Surgeons who chronically violate this rule may be referred to the Executive Committee.
 - 2.5 Consultation notes shall show evidence of a review of the patient's record by the consultant and pertinent findings on the examination of the patient with the consultant's opinions and recommendations. This report shall be made a part of the patient's record and must be dictated. When operative procedures are involved, the consultant's notes shall, except in emergency situations, so verified on the record, be recorded prior to the operation. If the consultant takes over the management of a patient, a transfer of service form must be completed. The physician who will assume the responsibility of the patient's care must have a written note within the progress notes.
 - 2.6 The attending physician or dentist shall be responsible for the preparation of a complete, current and legible medical record for each outpatient coming for interventional diagnostic or operative procedures. Outpatients are required to have an appropriate history and physical examination, and appropriate laboratory and radiological evaluation sufficient to justify the diagnosis or the procedure being contemplated, and to establish the safety of the procedure for the particular patient.
 - 2.7 The final (principal) diagnosis shall be recorded in full on the face sheet at the time of discharge, or as soon as it is available, by the attending physician, dentist, house staff officer or nurse practitioner without the use of symbols or abbreviations. The principal diagnosis should reflect the condition established after study to be chiefly responsible for occasioning the admission of the patient to the Hospital. All additional diagnoses (including complications) shall also be listed.

All operative and diagnostic procedures shall be listed by the attending physician, dentist, house staff officer, or nurse practitioner on the face sheet. The principal

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operative procedure is identified as the one which was performed for definitive treatment, rather than for diagnostic or exploratory purposes or for the purpose of correcting a complication. The principal procedure should be related to the principal diagnosis.

The face sheet or in lieu of the face sheet, attestation sheet shall be signed by the attending physician or dentist, indicating responsibility for the record.

- 2.8 A discharge summary should be written or dictated at the time of discharge or as soon as possible thereafter, but no later than seven days from the date the record is placed in the attending physician's folder. It shall recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family. Consideration should be given instructions relating to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved". When preprinted instructions are given to the patient or family, the discharge summary should so indicate and a sample of the instruction sheet in use at the time should be on file in the Medical Record Department.

A final progress note may be substituted for the summary in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or family. The dates of dictation and transcription will be recorded on each dictated discharge summary. Each summary shall be signed. All summaries written or dictated by the house staff must be signed by the attending physician or dentist.

- 2.9 All entries in the patient's medical record shall be in ink (blue or black), shall be dated, shall be signed, and the professional status of the author noted. Where reports are signed or authenticated by computer keystroke, only the author of the note may use his/her keystroke.
- 2.10 Written informed consent of the patient is required for the release of medical information to persons not otherwise authorized to review or receive this information.
- 2.11 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and are maintained for the benefit of the patient, the Medical Staff, and Hospital. In the case of a readmission of a patient, all previous records shall be made available for the use of the attending physician. This shall apply whether the patient be attended by the same physician or by another. Unauthorized

- removal of medical records from the Hospital and/or the Medical Records Department is grounds for suspension.
- 2.12 Free access to all medical records of all patients shall be afforded to members of the Medical Staff (identification must be confirmed) for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved, in advance, by the physician's Department Chief or the Executive Committee of the Medical Staff, as well as the Hospital's Chief Executive Officer or designee. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from medical records of their patient's covering periods during which they attended such patients in the Hospital.
- 2.13 A medical record shall not be permanently filed until it is completed by the responsible member of the Medical Staff or it is ordered filed by the Committee Health Information Management Patient Improvement Council of this Hospital.
- 2.14 Medical Staff members must complete inpatient and outpatient medical records within 14 days from the date of file, or such incomplete medical records will be considered delinquent. If the number of delinquent medical records attributable to a particular Medical Staff member exceeds 30 at any time or if the age of one or more of such delinquent medical records exceeds 30 days from the date of the patient's discharge, the Medical Staff member shall receive a letter indicating noncompliance and requesting the completion of the medical records, and shall be placed on a list of noncompliant Medical Staff members. Each week that the Medical Staff member appears at least once on the list of noncompliant Medical Staff members shall count as a separate occurrence of noncompliance ("Occurrence").
- 2.15 Medical Staff members shall receive written warning letters after their fifth and sixth Occurrence in any rolling 12 month period. Should a Medical Staff member have 7 Occurrences in any rolling 12 month period, he/she will be required to appear before the Medical Staff Executive Committee. This requirement shall be communicated to the Medical Staff member, in writing via certified mail, return receipt requested. Should the Medical Staff member fail to complete all his/her delinquent medical records not later than one week after his/her appearance before the Medical Staff Executive Committee, or should he/she fail to appear before the Medical Staff Executive Committee without acceptable excuse, the Medical Staff member's clinical privileges and Medical Staff membership shall be automatically suspended until all the delinquent medical records are completed. Any Medical Staff member who, for a second time at any point during his/her tenure on the Medical Staff, is found to have 7 Occurrences in any rolling 12 month period shall be deemed to have immediately and automatically resigned from the Medical Staff and voluntarily surrendered his/her clinical privileges.

Any Medical Staff member who resigns under these circumstances shall not be entitled to a hearing or appellate review under Article XI or Article XII of the Bylaws of the Medical Staff. If such individual wishes to have his/her Medical Staff membership and clinical privileges reinstated, he/she must submit a new application for membership and clinical privileges. That application shall be processed in the manner required by Article V of the Bylaws of the Medical Staff.

3 GENERAL CONDUCT OF CARE

- 3.1 A Consent Form, and an authorization form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.
- 3.2 Consent for specific procedures is the responsibility of the attending Medical Staff member responsible for the procedure. Should the actual obtaining of the consent be delegated, the responsibility for informing the patient as to the risks and benefits remains with the Medical Staff member.
- 3.3 All orders for drugs and biologicals shall be in writing. A verbal or telephone order, for drugs or biologicals other than chemotherapeutic agents, shall be considered to be in writing if dictated to a health care professional functioning within his or her scope of practice and signed by the responsible practitioner. All dictated orders shall be signed by the appropriately authorized person to whom dictated and include the name of the dictating practitioner. Verbal or telephone orders for drugs and biologicals require dictating practitioners to authenticate such orders as required by state law.
- 3.4 The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

If the order is to be carried out "stat" it must be so written in the order(s).

The indication(s), all pertinent clinical information, and/or the reason(s) for the procedure must be placed in quotation marks ("") and follow the written order for the procedure: e.g., CXR "chest pain, fever, dyspnea".

All information contained within the quotation marks ("chest pain, fever, dyspnea" in the example above) will then be entered into SMS by the appropriate personnel.

- 3.5 All previous orders are canceled when a patient goes to surgery.

EXCEPTION: Do not resuscitate orders and limited resuscitation orders are not canceled when a patient goes to surgery and do not have to be rewritten post operatively. Such orders may be temporarily rescinded during surgical and other invasive procedures per the policy on "Do Not Resuscitate Orders". If this is done, the order is automatically reinstated post discharge from the recovery area. No order for reinstatement is required. The policy on "Do Not Resuscitate Orders" is included in the Administrative Policy Manual.

EXCEPTIONS are also made for Post Partem Tubal Ligations and for procedures done under local anesthesia. Preoperative orders are not canceled in either of these situations, and do not have to be rewritten.

- 3.6 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These drugs will be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration. The Pharmacy and Therapeutics Committee Approved Manual of Procedures is attached as part of the Hospital Regulations for the use of clinical investigative drugs.
- 3.7 Drugs or procedures are approved for investigational use only through the auspices of the Hospital committee fulfilling the Institutional Review Board Function. Patients admitted, on an emergency basis, who are on an investigational protocol, requiring the use of drugs not approved at this institution will be continued on that protocol, subject to the following conditions: the attending physician files a signed copy of the investigational study consent in the chart and obtains a copy of the investigational protocol as submitted to the approving institution to be filed in the chart as a reference source.
- 3.8 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within the practitioner's area of expertise.
- 3.9 Except in an emergency, consultation is required according to the rules governing consultations in the Approved Procedural Manual of each clinical department.
- 3.10 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant who is a member of the Hospital Medical Staff. Special privileges for Visiting Health Care Providers, not members of the Hospital Medical Staff, may be granted by the Chief of the Department under Section 4.4.3 of the Medical Staff Bylaws and Special Consultative Privileges may be granted by the Chief under Section 4.5 of the Medical Staff Bylaws.

- 3.11 Each patient admitted to the Hospital, as an inpatient or outpatient shall have identified an attending physician.
- 3.12 If a nurse has any reason to doubt or question the care provided to any patient or believe that appropriate consultation is needed and has not been obtained, the nurse is obligated to call this to the attention of the attending physician, and if necessary, the nurse's nursing superior. The report, whether correct or in error, shall be regarded as justified by the Medical Staff. The superior, in turn, may refer the matter to the Director of Nursing Services. If warranted, the Director of Nursing may bring the matter to the attention of the President of the Medical Staff or Chief of the Department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the President of the Medical Staff or Chief of the Department may directly request a consultation.
- 3.13 The approved Hospital Intranet Policy and Procedure Manual is a part of these Rules and Regulations in matters of patient care.
- 3.14 Whenever the primary responsibility for the care of a patient transfers from the service of one Medical Staff member to another, that change in service shall be documented in the chart. The Medical Staff members involved shall communicate relative to the current diagnoses, treatment and patient expectations. It is the responsibility of the transferring physician to notify the patient of the transfer of care. When a change in service occurs, the transferring physician is recommended to dictate an interim summary to that date.

Should a transfer of service become necessary due to conflicting personal values or religious beliefs, it is the responsibility of the then current attending physician to arrange such a transfer. The chief of service may reasonably assist in the arrangements, but no breach in the continuous care of the patient should occur.

4 TEACHING

Reflecting the longstanding policy of this Hospital with respect to medical education, every effort is made to conduct our clinical services in a manner consistent with that of a Teaching Facility. In an effort to ensure high-level quality and experience in the teaching of residents and medical students, all physicians, with faculty appointments, are asked to consider their private patients as part of the teaching service. 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.

4.1 House Staff

- 4.1.1 The resident staff are recruited and accepted by the SUNY Upstate Medical University, as provided by 10NYCRR 405.4(f). Crouse Hospital Assigned residents remain SUNY employees. They are assigned to Crouse Hospital on rotation from the sponsoring program. The responsibility for the maintenance of quality assurance records, and credentialing information rests with the individual program. Information developed relative to credentialing or quality assurance issues will be transmitted by the Chief of the Department or the Chief Medical Officer to the Program and it is expected that the Department will be informed of any problems evident in the Program=s quality assurance effort. Decisions as to promotion or discipline are properly those of the program director. The responsibility of the Chief Medical Officer is to see that those decisions are consistent with the quality assurance effort in this Hospital.
- 4.1.2 The sponsoring program is responsible for maintaining the records to indicate the specific privileging of residents to do specific procedures such as lumbar punctures or the insertion of central lines. The attending staff/faculty will cooperate in this effort by instructing, supervising, and signing off on procedures.
- 4.1.3 Resident patient care activities shall be monitored by the attending staff to insure that residents carry out only those independent activities for which they are credentialed. Other procedures will be done under direct supervision. Supervision during other than normal working hours will be carried out in cooperation with the sponsoring program by the attending staff, or a resident in the last year of his or her training program. Supervision may be documented by a note from the attending in the patient record, a note by the resident documenting discussion with the attending or co-signature by the attending staff of resident=s notes.
- 4.1.4 Residents are responsible for the care of inpatients and outpatients, including the admission, work up, writing orders, continuing management and operating room experience, if appropriate to the discipline, under the supervision of an attending physician, employing progressively greater responsibility consistent with his/her individual growth in clinical experience, knowledge and skill.
- 4.1.5 Orders written by a resident do not require countersignature.
- 4.1.6 Residents are responsible for their professional growth and development, relying on learning acquired during the process of providing patient care. As the resident demonstrates increasing competence, s/he will be granted increasing independence of practice and judgment. Notwithstanding, all decisions made by a resident, at all levels of training, are subject to the supervision and review of the faculty and program director.

4.1.7 Residents are responsible for conduct consistent with the Policies and Procedures of the Hospital, while at the Hospital, including respect for patients' rights and confidentiality and observation of appropriate infection control practices.

4.1.8 The number of hours of on-duty assignment, including on-call duty in the Hospital during night shift hours, shall be subject to the limitations defined in applicable New York State regulations (See 10 NYCRR 405.4(b)(6)).

Residents may not work in any outside employment that would cause them to exceed the hour limitations described in applicable regulations. Any resident who accepts outside employment is required to notify the chief of the department as well the chairman of the academic department. The hours worked shall be reported to the Program and included in the limitations stated above. Chiefs shall be alert to signs of resident fatigue and provide for appropriate relief. Disciplinary action, if that is appropriate, will be determined by the Program.

4.2 Medical Students:

Medical students may be assigned as clinical clerks, or in the capacity of elective externships. When in patient contact situations, students shall be identified as such. The attending staff is urged to spend as much time with students as possible and to review the Histories and Physicals done by students on their patients, with appropriate comment. Students are expected to attend all of the conferences normally scheduled by the Academic Departments as well as those at Crouse Hospital. Students clearly require greater supervision than residents, and any orders written must be countersigned by a resident (R-2 or above) or the attending physician. Exceptions to this rule are: emergency blood work, venous and arterial, emergency chest or abdominal x-ray, emergency ECG, initial IV fluid therapy and glucose administration in documented hypoglycemia. Problems involving demeanor and conduct of students will be referred to the Chief of Service. Procedures appropriate to medical students with out direct supervision are:

- Phlebotomy
- Peripheral IV access
- Electrocardiogram
- Vital capacity determination
- History & Physical Examination with rectal

Medical Students may take histories, perform complete physical examinations and enter the findings in the Hospital chart only with prior approval of a member of the Attending Staff. Chart entries must be countersigned within twenty-four (24) hours by a member of the Attending Staff. Procedures may be performed by medical students under the direct supervision of a member of the Attending Staff. If the supervising physician is other than the physician attending the patient, the permission of the physician attending the patient must be obtained.

5 CLINICAL SERVICES

The approved Manual of Procedures of Anesthesiology, Family Medicine, Internal Medicine, Laboratory Services, Medical Imaging, and Nuclear Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pediatrics, Psychiatry General Surgery, and Urology, are considered to be a part of these Rules and Regulations. These complement the Surgical Suite approved Manual and the Obstetrical Suite approved Manual of Procedures.

6 EMERGENCY SERVICES

The Approved Manual of Procedures of the Emergency Services Department is considered to be a part of these Rules and Regulations. It constitutes the proper mode of action for all emergency services and conduct of the Hospital during a disaster.

For the normal operation of the Emergency Department:

6.1 All members of the active Medical Staff must be available for coverage of the Emergency Department, in their particular area of expertise, on a rotation basis as a condition of Medical Staff membership. Exceptions may be granted by Department Chiefs in accordance with written policy, and as long as coverage of the Emergency Department is not jeopardized.

6.2 Physicians on call for the Emergency Department must be available to respond to the Emergency Department within a reasonable period of time, appropriate to the patient's medical condition, as determined by the Medical Executive Committee. If required by the ED physician, it is the on call physician's responsibility to come to the ED to evaluate and/or treat the patient.

A resident physician, acting on the behalf of the attending may satisfy this obligation. The resident functions under the direction of the on-call physician. The on-call physician will be available to assist the resident and will be responsible for the resident's activities and for co-signing resident notes. The on-call physician is responsible for the follow-up of patients seen by the resident, unless other follow-up is arranged.

6.3 Unless other appropriate arrangements that are acceptable to the patient are made, the on-call physician is responsible for the appropriate outpatient follow-up.

6.4 Patients may not be sent to physician's offices or other facilities for evaluation or treatment unless stabilized, or facilities for the evaluation and/or treatment are not available in the Hospital. In these cases the risks and benefits of transfer must be

explained and documented for the patient, and certified by the attending physician.

- 6.5 An attending physician who has arranged to meet a patient in the ED for emergency evaluation and/or treatment has an obligation to be there within a reasonable period of time following notification of the patient's arrival and appropriate to the patient's condition. Failure to achieve that goal places an obligation on the Emergency Department physicians to evaluate the patient.
- 6.6 Physicians on call for the ED may not delay or refuse to care for any patient because of that patient's financial status.
- 6.7 The physician listed as on-call for the ED is responsible for the coverage. If coverage is not readily available, the listed physician will be subjected to disciplinary action. During the course of a two-year credentialing cycle, the first occurrence will result in a review at the Peer Review Committee and a letter placed in the physician's Quality Assurance file. The second occurrence may result in formal corrective action, including possible termination of privileges.

7 NEWBORN AND PREMATURE NURSERIES

The Approved Manual of Procedures for the Newborn and Premature Nurseries is considered to be a part of these Rules and Regulations.

8 SPECIAL CARE UNITS

The Approved Manual of the Coronary Care, Intensive Care, Newborn Intensive Care, and any newly established intensive care units are considered to be a part of these Rules and Regulations.

9 PHYSICAL THERAPY SERVICE

The Chief of Orthopedics or a physiatrist, shall be designated as the Medical Director of Physical Therapy Services and shall work in conjunction with the Program Director of this department.

10 COMMITTEES

- 10.1 In addition to the Standing Committees listed in the Bylaws, other Standing Committees of the Medical Staff shall be:

10.2 PEER REVIEW COMMITTEE

- 10.2.1 Membership: The Committee shall be chaired by a physician appointed by the President of the Medical Staff and shall consist of the President of the Medical

Staff and five clinically experienced members of the Active Medical Staff also appointed by the President. The Committee may invite any other member of the Medical Staff or Affiliate Staff for their expertise at any meeting. In addition, a physician member of the Board of Trustees, and the Chief Quality Officer, and the Director of Risk Management shall be invited. The appropriate Department Chief shall be invited to any meeting where the performance of a specific staff member is to be discussed. Non-attendance of a Department Chief shall not be a reason to postpone discussion.

10.2.2 Meetings: The Committee shall meet as frequently as necessary.

10.2.3 Charge: The Committee shall review all clinical issues where a Committee or Department Chief feel adverse information should be placed in the quality assurance file of a Medical Staff member. The Committee may choose to review patient care or clinical issues referred from the Quality Improvement Office or gleaned from other Committee minutes. The Committee shall recommend the policies as to what information shall be included in the quality assurance files and coordinate Medical Staff investigations, including those involving outside supervisory agencies.

10.2.4 Reporting: The minutes of each meeting shall be reviewed at the Medical Staff Executive Committee meetings.

10.3 PRACTITIONER HEALTH COMMITTEE

10.3.1 Membership: Membership of the Practitioner Health Committee (PHC) shall be appointed by the Medical Executive Committee. The PHC shall consist of three (3) members, at least one of whom shall be a psychiatrist. The Medical Executive Committee shall appoint one of the PHC members to serve as Chair of the PHC.

No Medical Staff member concurrently having a Medical Staff disciplinary role shall serve on the PHC. No member of the PHC shall concurrently serve on the Medical Executive Committee or Credentials Committee. If a PHC member is the subject of an investigation by the PHC, such person shall not participate in the investigation or determination of the matter and a substitute member will be appointed by the Medical Executive Committee.

10.3.2 Meetings: The PHC shall meet as necessary to perform its responsibilities, but not less than annually, and shall maintain a record of its proceedings. The meeting records shall be submitted to the Chief Medical Officer within fifteen (15) days of the meeting.

10.3.3 Charge: The PHC shall develop and implement general guidelines for dealing with Practitioner Staff Members who may be suffering from a physical, psychiatric, emotional behavioral impairment or substance abuse problem such

that the impairment or problem may affect the member's ability to practice his profession and/or otherwise appropriately function in a hospital setting.

The guidelines developed by the PHC shall be for the purpose of helping an affected member recover from his impairment, protecting the patients of the member, protecting the integrity and credibility of the Hospital, and assisting the Hospital in meeting its obligations to its patients, other members of the Medical Staff, and Hospital personnel.

In furtherance of its duties, the PHC shall have the following primary functions:

provide education about member health and impairment recognition; facilitate diagnosis, treatment, and rehabilitation of members who may be suffering from potentially impairing conditions; and enhance prevention of physical, psychiatric and emotional illness of members.

The PHC shall serve as a resource to members on the Medical Staff who, because of physical, psychiatric or emotional illness, or substance abuse issues, may be in need of assistance and/or monitoring to regain optimal functioning and to provide competent patient care.

The PHC shall act as an advisor to the Medical Executive Committee, Hospital Administration and individual Department Chairs regarding impairment concerns about particular members and general issues of member health maintenance and illness/impairment recognition and prevention.

The PHC shall also serve as a resource in educating the Hospital community and Medical Staff members about prompt and appropriate treatment of illness and problems associated with illness and impairment in members and health maintenance of members.

10.3.4 Reporting: The PHC shall determine the credibility of each referral, complaint, allegation, or concern expressed to the PHC. The individual who suspects a member of being impaired must give an oral or, preferably, a written report to the Chief Medical Officer or the Chair of the PHC. The report must be factual and shall include a description of the incident(s) that led the individual to the belief that a member may be impaired. The individual making the report does not need to have proof of the impairment, but must state the basis that led to the suspicion of impairment.

Upon notification of a suspected member impairment, the PHC Chair shall promptly advise the Medical Executive Committee, Chief Medical Officer and any applicable Department Chair in instances of a member presenting clear or likely jeopardy to safe patient care or the failure of a member to cooperate with the evaluation recommended by the PHC.

The Chair of the PHC shall periodically report, but not less than annually, to the Medical Executive Committee on the PHC activities. Such report shall maintain the confidentiality of any Members involved and include at least the following:

- number of members that have been assisted by the PHC;
- the types of assistance being rendered by the PHC;
- any trends identified by the PHC from such assistance;
- any recommendations of the PHC concerning the assistance being given.

11 DISRUPTIVE BEHAVIOR

11.1 Purpose: To establish a process for investigating and responding to allegations of disruptive behavior lodged against members of the Medical Staff and Crouse Hospital assigned residents as an alternative to or as a preliminary step before the process of imposing other forms of corrective action pursuant to the Medical Staff Bylaws. This process is an option only; it is not required. On a case-by-case basis, authorized parties may choose to proceed according to this process in advance of (and in hopes of avoiding) the corrective action process or authorized parties may choose to simply respond to incidents through the corrective action process (including, but not limited to summary suspension).

11.2 Policy: It is the policy of the Crouse Hospital Medical Staff that disruptive behavior by its members or by Crouse Hospital assigned residents serves to compromise the quality of patient care and calls into question the competence of such practitioners in delivering health care services. Therefore, disruptive behavior will be subject to investigation and appropriate response pursuant to this policy and/or pursuant to the corrective action process described in Article XI of the Medical Staff Bylaws.

For purposes of this policy and the Medical Staff Bylaws, "Disruptive" behavior shall be defined as any behavior that is judged to interfere or disrupt the working environment of the Hospital, including, but not limited to, any form of abusive behavior directed toward colleagues, patients, other healthcare workers, or visitors; any form of intimidation; sexual harassment; juvenile behavior; lying, cheating, or stealing, especially when involving a patient record; any form of fighting.

11.3 Procedure:

11.3.1 Reporting: Any individual may confidentially report any disruptive behavior to the Nurse Manager of the unit where incident occurred, any member of the Medical Staff Executive Committee, or the Chief Medical Officer (CMO).

This report should be in writing and include the date and time of the incident, a brief description of the incident and details of the disruptive behavior. The individual to whom the incident is reported shall document the facts of the reported incident on the standard Incident Report Form.

11.3.2 Investigation: The Chief of the Department, along with the Chief Medical Officer will be responsible for overseeing the investigation of each incident. The Chief of the appropriate department shall conduct the initial investigation of the incident after the notification to the staff member. If the incident involves the Chief of the Department, the Chief Medical Officer shall conduct the initial investigation. If the Chief of the Department or the Chief Medical Officer finds that there is a basis for the complaint, he/she has the option of following the steps described in this policy or instituting Corrective Action pursuant to Article XI of the Medical Staff Bylaws (including, but not limited to summary suspension). If the primary investigator (Chief of the Department or the Chief Medical Officer) finds there is no basis for the complaint, he/she will produce a letter to that effect, describing his/her investigation and conclusion in this regard. The original of that letter will be maintained in an appropriate fashion that safeguards such information but also makes it available for review, as appropriate. All reports pursuant to paragraph 1 above, all decisions to follow the progressive response outlined in this policy, all decisions to pursue corrective action pursuant to Article XI of the Medical Staff Bylaws, and/or copies of all letters concluding an investigation that are produced pursuant to this paragraph 2 shall be reported to/shared with the Chief Medical Officer, who shall monitor the application of this policy to all reported incidents.

11.3.3 Progressive Response to Disruptive Behavior. If the Chief of the Department chooses to proceed according to this Policy (as opposed to commencing corrective action pursuant to the Medical Staff Bylaws) the Chief will take the following steps:

a. Counseling. The Chief shall counsel the practitioner and ensure that he or she is fully aware of this policy. The Chief shall also inform the practitioner that further discipline or corrective actions may occur if he/she exhibits any further incidents of inappropriate behavior. All incidents requiring counseling will result in the Chief drafting a letter regarding the counseling that both he/she and the practitioner shall sign. This letter will be maintained in an appropriate fashion that safeguards such information but also makes it available for review, as appropriate.

b. Referral to Chief Medical Officer. Any subsequent incident of alleged disruptive behavior will be referred to the Chief Medical Officer, who will then investigate the subsequent incident with the help of the Chief of the Department. The Chief Medical Officer may choose to counsel the practitioner or may choose to

initiate Corrective Action pursuant to Article XI of the Medical Staff Bylaws (including but not limited to summary suspension). Should the Chief Medical Officer choose to counsel the practitioner, he/she shall document such counseling in a letter, which shall be signed by the practitioner and maintained in an appropriate fashion that safeguards such information but also makes it available for review, as appropriate in tracking and trending file in Quality Assurance Department.

c. Alternative Referrals. The Department Chief and the Chief Medical Officer shall have the option, at any point following the investigation, of recommending that the practitioner be evaluated by and/or seek counseling, enter into a contract with or otherwise participate in an independent entity, such as the Committee on Physicians' Health or programs offering psychological counseling, stress and/or anger management, alcohol and chemical dependency treatment, interpersonal skills development, etc., as an appropriate component of responding to such physician's or allied staff member's disruptive behavior. In addition, the Chief of the Department and/or the Chief Medical Officer may recommend that the practitioner participate in appropriate educational or training programs, as warranted by the disruptive behavior.

11.3.4 Referral for Corrective Action. At any point following the investigation of an initial or subsequent incident, the Chief of the Department or the Chief Medical Officer may refer the matter for Corrective Action pursuant to Article XI of the Medical Staff Bylaws, including, but not limited to, instances when a practitioner refuses to participate in any way in the progressive response described in Paragraph 3 above.

11.3.5 Review of Information upon Application for Reappointment. Any information related to the investigation and response to a complaint of disruptive behavior will be available to the Credentials Committee, the Medical Staff Executive Committee and the Board of Trustees, for consideration at the time of a practitioner's re-appointment. All such information shall be maintained in an appropriate fashion that safeguards such information but also makes it available for review, as appropriate.

11.3.6 Objections or Complaints by Practitioner under Investigation. At any time during the investigation or response to a report of alleged disruptive behavior by a practitioner, he or she may request the Chief Medical Officer, the President of the Medical Staff, and/or the Chief Executive Officer of the Hospital to intercede, if he/she feels the investigation of or response to the alleged incident of disruptive behavior is not being conducted in a fair or objective manner, and/or is not being conducted in accordance with this policy. The Chief Medical Officer, President of the Medical Staff and/or the Chief Executive Officer will review such

complaints and report on his/her review to the full Medical Staff Executive Committee. The Medical Staff Executive Committee will be the final arbiter on whether or not the investigation of an incident of alleged disruptive behavior is commencing fairly, objectively, and in accordance with this policy.

12. CONTINUING MEDICAL EDUCATION

Each member of the Medical Staff will attest in writing to completing 25 Category I Continuing Medical Education Credits annually at the time of reappointment.

13. ADOPTION; AMENDMENTS

**Amendments Adopted by the
Medical Staff Executive Committee
December 5, 2006**

_____, 2010

**JAMES MILLS, MD
President, Crouse Medical Staff**

**Approved by the
Board of Directors
January 11, 2007**

_____, 2010

**PAUL J. KRONENBERG, MD
President & CEO, Crouse Hospital**