BYLAWS, RULES & REGULATIONS OF THE MEDICAL STAFF OF METHODIST HOSPITAL

The following Bylaws, Rules and Regulations of the Medical Staff of Community United Methodist Hospital, Inc. d/b/a Methodist Hospital will comprise of Part II of the Corporate Bylaws of the Methodist Hospital, in Henderson, Kentucky.

THE BYLAWS PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care, education, and research carried out in this Hospital, and that it must assume these responsibilities, subject to the ultimate authority of the Board. Recognizing that the best interests of the patients entrusted to its care are met by cooperative effort, the physicians, oral surgeons and dentists practicing their profession at Methodist Hospital, are hereby organized in conformity with these Bylaws, Rules and Regulations here stated.

ARTICLE I – NAME

The name of this organization shall be the MEDICAL STAFF OF THE COMMUNITY UNITED METHODIST HOSPITAL, INC. d/b/a Methodist Hospital.

ARTICLE II – PURPOSE

Part A:
The purpose of this organization shall be: (1) to secure and maintain a high standard of medical efficiency consistent with the dictates of the medical and legal aspects of the practice of medicine; (2) to provide all patients admitted to this Hospital the best possible care; (3) to provide an effective organization for the scrutiny and evaluation of medical practice in the Hospital so as to make unbiased recommendations to the Board for improvement of medical practice in the Hospital; (4) to provide education and to maintain educational standards for the personnel engaged in or dedicated to the care of sick patients in the Hospital and (5) to provide a means whereby problems of a medical administration nature may be discussed by the Medical Staff and the Board and Administration.

Part B:
The Medical Staff as an integral part of the Methodist Hospital quality and Safety Program, shall meets its duties, responsibilities and take action to further its purpose of providing the best possible care to their patients and provide effective scrutiny and evaluation of medical practices at Methodist Hospital. It is the intent of the Medical Staff to avail itself of the provisions of the Patient Safety and Quality Improvement Act (Act) codified in 42 USC 2996-21-26.

The Medical Staff is voluntarily participating in the Act to ensure that any information, oral, written, electronic, or otherwise, that could improve patient safety, healthcare quality or healthcare outcomes is considered as Patient Safety Work Product. It is the intent that the Medical Staff peer review process is coordinated with the Methodist Hospital quality and safety process for reporting to Patient Safety Organizations and/or is within the Hospital's Patient Safety Evaluation System.

Any information collected, assembled, maintained or is developed or exists separately that is used in the evaluation and/or analysis to improve patient safety, healthcare quality or healthcare outcomes is considered Patient Safety Work Product.

This Article II Part B shall apply to all information collected, assembled, maintained or is developed or exists separately that is used to meet all actions, duties and responsibilities conducted in the furtherance of its purpose pursuant to these Bylaws.

ARTICLE III – DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

(1) Board means the Board of Directors of Methodist Hospital, who has the overall responsibility for the conduct of the Hospital including the Medical Staff;

(2) Executive Director means the Chief Executive Officer of the Hospital;

(3) Executive Committee means the Executive Committee of the Medical Staff unless specifically written Executive Committee of the Board;

(4) Medical Staff means all physicians, oral surgeons, and dentists who are given privileges to treat patients in the Hospital;

(5) Physicians shall be interpreted to include both doctors of medicine and doctors of osteopathy;

(6) Words used in these Bylaws shall be read as the masculine, feminine or neuter gender, and as singular or plural, as the content requires. The captions or headings are for convenience only and not intended to limit or define the scope or effect of any provision of these Bylaws.

(7) Physician's Hospital mailbox should be interpreted to mean that space in the main doctor's lounge dedicated to the distribution of reports and communications from the Hospital to the physician;

(8) Hospital bulletin board is defined as the bulletin board located in the main doctors lounge for the purpose of transmitting general medical staff information; and

(9) Emergency is defined as a medical event that has the potential for causing a disabling and/or dismembering injury to the body or mind, or death.

ARTICLE IV – CATEGORIES OF THE MEDICAL STAFF

All appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board. All appointments to the medical Staff shall be made by the Board, and shall be to one of the following categories of the staff.

ARTICLE IV – PART A: ACTIVE STAFF

The Active Staff shall consist of those physicians and oral surgeons who attend or are involved in the treatment of at least fifty (50) patients per year at the Hospital. Each appointee to the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments. Active Staff appointees shall be entitled to vote, hold office, serve on medical staff committees, and serve as chairmen of such committees. Active Staff appointees shall be required to attend medical staff meetings. Members of the Active Medical Staff shall not be required to be specialists in any particular branch of medicine or surgery.

ARTICLE IV – PART B: ASSOCIATE STAFF

The Associate Staff shall consist of physicians and oral surgeons who will be considered for advancement to the Active Staff. They must attend or be involved in the treatment of at least fifty (50) patients per year at the Hospital. Persons appointed to the Associate Staff shall be entitled to vote, serve on medical staff committees, but not as chairmen of committees and shall be required to attend medical staff meetings. They shall be ineligible to hold office. All new applicants for membership to the Medical Staff shall be considered only after having served on the Associate Staff for a minimum of six (6) months as specified by the Bylaws. ("Refer to Article IX, Part F, Section I, second paragraph, Page 39). They shall be assigned to the Emergency Room roster and shall be required to assume Emergency Room duty on a regular rotation basis with the members of the Active Staff. Application for motion to the Active Medical Staff shall be considered upon the basis of individual merit, skill, and performance of the practice of their profession. No physician or oral surgeon may be appointed to the Active Medical Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

ARTICLE IV – PART C: COURTESY STAFF

The Courtesy Staff shall consist of physicians, oral surgeons and dentists of demonstrated competence qualified for staff appointment who are not eligible for appointment to the Active Staff because they do not intend during each appointment year to admit, or be involved in the care of more than forty-nine (49) patients per year at the Hospital. Courtesy Staff appointees shall have no staff committee responsibilities, may not vote, and may not hold office. They are encouraged to attend staff and department meetings. No physician or oral surgeon may be appointed to the Courtesy Medical Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

ARTICLE IV – PART D: CONSULTING STAFF

The Consulting Staff shall consist of those physician specialists and dentists appointed to the medical staff for the purpose of increasing and/or enhancing the medical serves provided to the patients of the institution. Appointment to the Consulting Staff shall entitle the appointee to admit and/or provide consultative service to patients of the institution. There shall be no limit to the number of patients whom the appointee may admit or in whose care the appointee may be involved. The appointee may not:

(1) Be responsible for providing emergency room coverage;
(2) Be required to serve on medical staff committees;
(3) Be required to attend medical staff committee meetings;
(4) Be entitled to vote on medical staff matters, or
(5) Hold a medical staff office.

To be appointed to the Consulting Staff, the appointee must meet the following criteria:

(1) Have completed a residency training program in his/her medical field approved by the Accreditation Council for Graduate Medical Education of the American Medical Association; and
(2) Be a sub-specialist in one (1) of the following fields:
    (a) Surgery;
    (b) Medicine;
    (c) Pediatrics;
    (d) OB/GYN;
    (e) Radiology, and
(3) Have a permanent residence outside of Henderson County, Kentucky; and
(4) Have active medical staff membership in a hospital other than this institution, accredited by the Joint Commission or certified by the Department of Health and Human Services; and

(5) Not have a personal office, or be an associate or a partner or an employee of a medical corporation which has an office in Henderson County, Kentucky, and
(6) Not be a hospital-based physician.

No physician or oral surgeon may be appointed to the Consulting Medical Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

ARTICLE IV – PART E: EMERITUS STAFF

Medical Staff appointees who have attained the age of sixty-five (65) years shall automatically advance at that time to the Emeritus Staff, unless the Active Medical Staff by two-thirds (2/3) vote of the members present and voting by secret ballot, shall recommend the extension of the appointment for a further period of one (1) year. Such appointees may, if they desire, participate in staff activities assigned by the chairman of their department or the President of the Medical Staff. No member shall be retained on the Active Staff beyond the age of seventy (70) years. Upon reaching Emeritus status, the physician will no longer be required to provide on-call Emergency Room services. Emeritus Staff shall not be required to meet the Department meeting attendance requirements.

The Credentials Committee shall specifically evaluate the mental and physical capabilities of each Emeritus Staff appointee who is either admitting or caring for patients within the Hospital. Recommendations to the Board for continued clinical privileges between ages sixty-five (65) and seventy-five (75) will be based upon such evaluations. Such evaluation will normally occur on an annual basis, but, as in the case of all persons appointed to the Medical Staff, may occur at any time during the appointment year if warranted.

Emeritus Staff appointees who continue to admit and care for patients shall have the same prerogatives that they had previous to attaining Emeritus status, including the right to vote and hold office, if applicable. Upon attaining the age of seventy-five (75), persons on the Emeritus Staff shall no longer have privileges to admit or care for patients in the Hospital and shall automatically be transferred to the Honorary Staff unless an exception for continuing privileges is approved by the Board.

ARTICLE IV – PART F: HONORARY STAFF

The Honorary Staff shall consist of medical staff appointees who have retired from active hospital practice or other physicians or dentists who are of outstanding reputation, not necessarily residing in the community. Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office, but may serve on standing committees if appointed by the President of the Medical Staff, provided he/she agrees to serve in that capacity. Honorary Staff Members may be appointed to special committees, but are not required to attend any Medical Staff meetings.

ARTICLE IV – PART G: CONTRACT PHYSICIANS

The Board shall have the authority to enter into contracts for employment relationships with physicians for the performance of certain services. All physicians functioning pursuant to such contracts or employment relationships, in the performance of clinical medicine, shall attain and maintain staff appointment and clinical privileges, which shall be processed as described in the Medical Staff Bylaws. If a question arises concerning clinical competence or clinical privileges during the term of the contract, that question shall be resolved in the same manner as would pertain to any other appointee to the Medical Staff using the due process procedures of the Medical Staff and Corporate Bylaws. If a modification of privileges or appointment resulting from such action is sufficient to prevent the physician from performing his/her contractual duties, the contract shall automatically terminate except as hereinafter provided.

The Board may enter into Exclusive Personal Service Agreements (e.g. radiology). All physicians functioning pursuant to such Agreements in the performance of clinical medicine shall attain and maintain

staff appointment and privileges which shall be processed as described in the Medical Staff Bylaws. Neither clinical privileges nor staff appointment will survive the termination of a contract or employment nor will termination of those privileges pursuant to termination of contract entitle a physician to any hearing and appeals procedure unless there is a specific provision to the contrary in the contract. In the event that only a portion of a physician's clinical privileges are covered by the Contract or employment, only that portion shall be affected by the expiration or termination of the contract or employment.

Specific contractual or employment terms shall, in all cases, be controlling in the event that they conflict with provisions of the Medical Staff Bylaws.

All physicians contractually required to be members of the active Medical Staff, shall be considered for committee assignment.

ARTICLE V – MEDICAL ASSOCIATES, MEDICAL ASSISTANTS AND PHYSICIAN EXTENDERS

ARTICLE V – PART A: MEDICAL ASSOCIATES

Section 1. Qualifications:

A. Podiatrists, Psychologists, Speech Therapists, Social Workers, Certified Registered Nurse Anesthetists (CRNAs), Physical Therapists, and other classes of health care professionals approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies, and who desire to provide professional services in the Hospital, are eligible to serve as Medical Associates In addition to the previously listed licensed, independent practitioners, perfusion assistances, who may be neither licensed nor specifically certified but have demonstrated expertise and who are under the employment of a perfusion service approved by the Chief of Surgery and the Medical Director of the Hospital, may be credentialed to provide cell saver services.

B. Each such individual shall file an application on a form provided by the Hospital. Each applicant shall be evaluated by the Credentials Committee, which shall recommend to the Executive Committee the scope of practice that the applicant shall be permitted to exercise in the Hospital either in general or limited to a particular case. The Executive Committee shall present to the Board its recommendations for granting of privileges. No individual may be appointed to the Medical Associate Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

C. CRNAs shall be entitled to provide anesthesia services in accordance with applicable laws, rules and regulations of the Commonwealth of Kentucky and subject to the provisions of these Medical Staff Bylaws, Rules and Regulations and delineation of privileges for that individual CRNA.

Section 2. Conditions of Service:

A. Medical Associates shall serve at the discretion of the Board. They may be terminated at will by the Board, and shall not be covered by the due process provisions of these Bylaws or the Corporate Bylaws. However, a Medical Associate shall have the right to appear personally before the Executive Committee to discuss the clinical privileges recommended by that Committee before that recommendation is transmitted to the Board.

B. Medical Associates shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice pursuant to their clinical privileges or clinical privileges specifically granted by the Board. They shall be located within the geographic service area of the Hospital, close enough to fulfill their responsibilities, and to provide timely care for their patients in the Hospital.

C. Medical Associates may not perform history and physical examinations or discharge summaries with the exception of CRNAs and podiatrists. CRNAs and podiatrists may perform history and physical examinations as privileges allow. Each clinical department and/or service shall have the right to designate whether the CRNA shall be supervised in the performance of their delineated privileges.

ARTICLE V – PART B: MEDICAL ASSISTANTS

Section 1. Qualifications:

Categories of health care professionals approved by the Board and who provide services as employees of physicians who are presently appointed to the Medical Staff are eligible to serve as Medical Assistants. This category shall include, but not be limited to social workers, Psychologists, Psychiatric Nurses, and Audiologists. No individual may be appointed to the Medical Assistant Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

Section 2. Selection Procedure:

A. To the extent the Board determines to permit such Medical Assistants to act in the Hospital, the Executive Committee shall recommend to the Board the scope of each such individual's activities with the Hospital.

B. No such individual shall provide services in the Hospital as a Medical Assistant unless and until the Executive Committee has received, on a form approved by the Board, sufficient information about the qualifications of that individual to permit the Executive Committee to recommend the scope of activities the individual will be permitted to undertake in the Hospital. The form shall be prepared by the individual's employer, if appropriate, and signed by both the employer and the individual.

C. The Credentials Committee, on the recommendation of the Chairman of the applicable service, shall recommend to the Executive Committee a written delineation of the scope of activities such Medical Assistant is permitted to undertake in the Hospital. This delineation shall be final with no right of hearing or appeal, provided, however, that the physician seeking to employ the Medical Assistant in the Hospital shall have the opportunity to appear before the Executive Committee and discuss the proposed delineation before any final action is taken on it by the Board. The Medical Assistant may act in the Hospital pursuant to the approved delineation only so long as he/she remains an employee of a physician currently appointed to the Medical Staff.

Section 3. Conditions of Service:

A. Medical Assistants shall serve at the discretion of the Board and may be terminated at will by the Board. Neither the Medical Assistant nor his/her employer shall be entitled to any hearing or appeal upon such termination.

B. Medical Assistants shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff, and may only engage in acts within the scope of practice specifically granted by the Board.

C. Any activities permitted by the Board to be done in the Hospital by Medical Assistants shall be done only under the direct and immediate supervision of his/her employer. However, direct and immediate supervision shall not require the actual physical presents of the employer. Should any Hospital employee who is licensed or certified by the State have any question regarding the clinical competence or authority of the Medical Assistant either to act or to issue instructions outside the physical presence of the employer in any particular instance, such Hospital employee has the right

to require that the individual's employer validate, either at the time or later, the instructions of the Medical Assistant. Any act or instruction of the medical Assistant shall be delayed until such time as the Hospital employee can be certain that that act is clearly within the scope of the Medical Assistant's activities as permitted by the Board. At all times, the employing physician will remain responsible for all acts of any of his/her Medical Assistants within the Hospital.

D. The number of Medical Assistants acting as employees of one (1) physician, as well as the acts they may undertake, shall be consistent with the applicable State statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.

E. It shall be the responsibility of the physician employing the Medical Assistant to provide professional liability insurance for the Medical Assistant in amounts required by the Board that covers any activities in the Hospital, and to furnish evidence of such to the Hospital, so that it can be ascertained that such professional liability insurance covers the activities of the Medical Assistant in the Hospital and such Medical Assistant shall act in the Hospital, only while such coverage is in effect.

ARTICLE V – PART C: PHYSICIAN EXTENDERS

Section 1. Qualifications:

A. Definition: A Physician Extender is a health care worker who is properly licensed by the Commonwealth of Kentucky, whose privileges are subject to all provisions of this Section of the Medical Staff Bylaws hereafter, and any other Sections of the Medical Staff Bylaws, Rules and Regulations where applicable.

B. Qualifications/Guidelines:

(1) A Physician Extender shall be properly licensed by the appropriate and applicable licensure body and shall be credentialed as a Physician Extender by the Medical Staff.
(2) Education/Training: The applicant must possess one (1) of the following educational requirements: R.N.; Licensed APRN; Licensed Physician Assistant; L.P.N.; O.R.T. Certification or Licensed Specialty Technician. The applicant must demonstrate knowledge of sterile technique to the satisfaction of the Supervisor of Surgical Services or designee, if privileges are requested in Surgical Services.
(3) Licensure: The applicant must be licensed by his/her respective Licensure Board in the State of Kentucky.
(4) Departmental Approval: the applicant must be approved by the department in which the Physician Extender will provide services.
(5) Liability Insurance: A Physician Extender must submit proof of his/her professional liability coverage to the Medical Staff Office of Methodist Hospital.
(6) Supervision: To the extent required by law, a Physician Extender shall obtain and provide proof of supervision in the Hospital.
(7) Reappointment: Following initial appointment in accordance with the Medical Staff Bylaws, the applicant must reapply biannually and be approved in the same fashion as members of the Medical Staff.
(8) Rules of Conduct: The Physician Extender shall be governed by the same Rules of Conduct as applies to any member of the Medical Staff.
(9) No individual may be appointed to the Physician Extender Staff until he has served a probationary period of at least six (6) months on the Associate Staff.

ARTICLE V – PART C:

Section 2. Selection Procedure:

A. To the extent the Board determines to permit such Physician Extender to act in the Hospital, the Executive Committee shall recommend to the Board the scope of each such individual's activities with the Hospital. This recommendation shall be in the form of a delineation of privileges specific and unique to that particular Physician Extender.

B. No such individual shall provide services in the Hospital as a Physician Extender unless and until the Executive Committee has received, on a form approved by the Board, sufficient information about the qualifications of that individual to permit the Executive Committee to recommend the scope of activities the individual will be permitted to undertake in the Hospital. The form shall be prepared and signed by the applicant.

C. The Credentials Committee, on the recommendation of the Chairman of the applicable service, shall recommend to the Executive Committee a written delineation of the scope of activities such Physician Extender is permitted to undertake in the Hospital. This delineation shall be final with no right of hearing or appeal.

ARTICLE V – PART C:

Section 3. Conditions of Services:

A. Physician Extenders shall serve at the discretion of the Board any may be terminated at will by the Board. Neither the Physician Extender nor his/her employer shall be entitled to any hearing or appeal upon such termination.

B. Physician Extenders shall not be entitled to the rights, privileges and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board.

C. Any activities permitted by the Board to be done in the Hospital by the Physician Extender shall be done only within that Physician Extender's scope of practice in the Commonwealth of Kentucky and subject to the limitation of privileges. Should any Hospital employee who is licensed or certified by the State have any question regarding the clinical competence or authority of the Physician Extender either to act or to issue instructions has the right to require that the Chief of Staff validate, either at the time or later, the instructions of the Physician Extender. Any act or instruction of the Physician Extender shall be delayed until such time as the Hospital employee can validate the Physician Extender's activities as permitted by the Board.

D. Physician Extender's actions shall be consistent with applicable State statutes and regulations, the Rules and Regulations of the Medical Staff, and the policies of the Board.

E. It shall be the responsibility of the Physician Extender to provide professional liability insurance in amounts required by the Board that covers any activities in the Hospital, and to furnish evidence of such to the Hospital; so that it can be ascertained that such professional liability insurance covers the activities of the Physician Extender in the Hospital and such Physician Extender shall act in the Hospital only while such coverage is in effect.

ARTICLE VI – PART A: GENERAL

Section 1. Medical Staff Year:

For the purpose of these Bylaws, the Medical Staff year commences on the first (1st) day of January and ends on the thirty-first (31st) day of December.

ARTICLE VI – PART A:

Section 2. Dues:

All Active, Associate, Courtesy and Consulting Staff Physicians and oral surgeons appointed to the Medical Staff shall pay annual staff dues in the amount of $100 per year; due and payable in the amount of $200 before December 31 of each reappointment cycle. (Medical Staff reappointment cycles occur every two (2) years.)

ARTICLE VI – PART A:

Section 3. Bylaws Distribution:

Individuals initially appointed to the Medical Staff and granted clinical privileges shall be provided with a copy of the Bylaws, Rules and Regulations, as well as a written copy of any future amendments to same.

ARTICLE VI – PART B: OFFICERS

The Officers of the Medical Staff shall be the President, Vice President and Secretary-Treasurer. Officers must be appointed to the Active Staff at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

ARTICLE VI – PART B:

Section 1. The President:

The President of the Medical Staff shall be the duly elected representative of the Medical Staff to the Board.

Duties:

A. He/She shall call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

B. Make appointment of Committee Chairmen and members in accordance with provisions of the Bylaws, to all standing, special and ad hoc Medical Staff committees, except the Executive Committee.

C. Serve as an ex-officio member of all Medical Staff committees other than the Executive Committee and the Joint Conference Committee.

D. He/She shall work closely with the Chief of Staff and Executive Director of the Hospital in carrying out all provisions of the Bylaws, Rules and Regulations.

E. He/She shall work closely with the Chief of Staff and the Executive Director of the Hospital to help provide day to day liaison of all Medical Staff matters involving both the Medical Staff and the Board.

ARTICLE VI – PART B:

Section 2. The Vice President:

The Vice President shall:

A. Assume all duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason.

B. Be a member of the Executive Committee of the Medical Staff and of the Joint Conference Committee.

C. Automatically succeed the President when the President fails to serve for any reason.

D. Perform such duties as are assigned to him/her by the President.

Should both the President and the Vice President be unavailable in an emergency, the authority and duties of the President will be temporarily assumed by the Immediate Past President.

ARTICLE VI – PART B:

Section 3. The Secretary-Treasurer:

The Secretary-Treasurer shall:

A. Serve on the Executive Committee and the Joint Conference Committee.

B. Collect staff dues and make disbursements authorized by the Executive Committee or its designees.

C. Keep accurate and complete minutes of all meetings, record attendance, and give notice of all meetings on order of the President and perform such other duties as the President shall assign to him/her.

ARTICLE VI – PART B:

Section 4. Chief of Staff:

A. The Chief of Staff is the professional or clinical head of the Medical Staff and as such, is the duly appointed medical representative to the Medical Staff from the Board. He/She is directly involved with the proper organization and functioning of the Medical Staff of the Hospital.

B. The Chief of Staff shall be nominated by the Executive Committee of the Medical Staff by secret ballot of all newly elected Medical Staff Executive Committee members at their first meeting of the fiscal year. The nomination for Chief of Staff shall be sent to the Board who shall appoint the Chief of Staff. If the Board of Directors rejects this nomination, the Executive Committee of the Medical Staff shall be required to nominate another Chief of Staff, or shall be required to submit a list of two (2) or three (3) names from which the Board may select a Chief of Staff. In the event of controversy between the Board and the Executive Committee of the Medical Staff, the Joint Conference Committee should make every attempt to reach an amicable solution before final appointment is made; however, the final selection of a Chief of Staff shall be the duty of the Board. If the office of Chief of Staff should become vacant before the expiration of a full term, a successor shall be chosen

to fill the unexpired term using the same procedures which were used originally to select the Chief of Staff.

C. The term of office of the Chief of Staff shall be for one (1) year. There shall be no limit to the number of times which an individual may be re-elected to this office. He/She shall not be concurrently the President of the Medical Staff.

D. A Chief of Staff, who is demonstrably unable or unwilling to fulfill his/her duties, or who by his/her conduct brings distress or dishonor upon the Hospital, may be removed from the office by a two-thirds (2/3rds) vote of the members of the Board present at any meeting of the Board acting upon the prior written recommendation of the Joint Conference Committee.

E. The Chief of Staff shall be an ex-officio member of the Joint Conference Committee.

F. The Chief of Staff shall have direct responsibility for the organization and administration of the Medical Staff, in accordance with the terms of the existing Bylaws. In all medical-administrative matters, he/she shall act together with the Executive Director of the Hospital in implementing the adopted policies of the Board.

G. The Chief of Staff shall be responsible to the Board through the Hospital Executive Director for a program to assure high-quality medical care in the Hospital. He/she should be responsible for the processes of supervision, control, and appraisal necessary to assure the standards of medical care affirmed by the Board.

H. The Chief of Staff shall, at the regular meetings of the Board, submit to it a clinical report containing all information relevant to an appraisal of the medical care provided in the Hospital.

I. The Chief of Staff shall convey to the Board the recommendations of the Executive Committee of the Medical Staff respecting appointments and reappointments to the Medical Staff; granting or restricting clinical privileges of individual physicians; disciplinary action against individual physicians; or amendments or additions to the Medical Staff Rules and Regulations. He/She shall, on invitation, advise the Board on these recommendations

J. The Chief of Staff shall be a member, ex-officio, of all committees of the Medical Staff and shall preside at meetings of the Medical Staff Executive Committee. He/She shall be responsible for the proper functioning of all committees of the Medical Staff in accordance with the requirements set forth in the Medical Staff Bylaws and consistent with the policies of the Board in assuring the highest possible control of the standards of medical care in the Hospital.

K. The Chief of Staff shall be responsible for the enforcement of the Medical Staff Rules and Regulations, for implementation of sanctions where these are stipulated for non-compliance and for presentation to the Executive Committee of the Medical Staff of those cases where disciplinary action may be recommended to the Board.

L. The Chief of Staff shall have the authority to temporarily suspend or restrict the privileges of any staff physician in case of extreme and immediate necessity. Knowledge of such action shall be conveyed immediately to the Hospital Executive Director and the Chairman of the Department involved. Such suspensions or restrictions shall be made only to meet emergencies, not for purposes of discipline, and shall prevail only until appropriate action can be taken by the Executive Director or the Board. Where the condition causing the temporary suspension or restriction of privileges is of a temporary nature, the Executive Director may remove the suspension or restriction when to the best of his/her knowledge the condition causing the suspension or restriction ceases to exist. The Board shall be

informed of both the suspension or restriction of privileges and the removal of the suspension or restriction of privileges.

M. When a physician has had his/her hospital privileges restricted or suspended, the Chief of Staff shall arrange for the care of those doctor's patients who are then in the Hospital.

ARTICLE VI – PART B:

Section 5. Election of Officers:

A. If so instructed by the full Medical Staff, at least three (3) months before the scheduled date of the next Medical Staff election, the President shall appoint a Nominating Committee consisting of five (5) Active Staff appointees. The Nominating Committee shall prepare a slate of nominees for each office.

B. Nominations for officers of the Medical Staff may be presented by the Nominating Committee and made from the floor at each annual meeting. The candidates who receive a majority vote, of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken, shall be elected.

The vote shall be by written secret ballot. Each officer shall then serve from the start of the next Medical Staff year for a term of one (1) year or until his successor has been elected.

C. In any election, if there are three (3) or more candidates for an office, and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (2) candidate.

ARTICLE VI – PART B:

Section 6. Removal of Officers:

The Medical Staff by a two-thirds (2/3rds) majority vote, may remove any Medical Staff officer for conduct detrimental to the interests of the Hospital, or if he/she is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of his/her office, providing notice of the meeting at which action takes place shall have been given in writing to such officer at least ten (10) days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his/her own behalf prior to the taking of any vote on his/her removal.

ARTICLE VI – PART B:

Section 7. Vacancies in Office:

If there is a vacancy in the office of the President prior to the expiration of the President's term, the Vice President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Medical Staff shall elect another Active Staff appointee to serve out the remainder of the unexpired term. Such appointment will be effective immediately.

ARTICLE VI – PART C: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Staff Meetings and Committee Appointments:

The Medical Staff at its November meeting shall hold its annual meeting at which officers for the ensuing year shall be elected. All committee assignments and staff appointments shall be made not more than thirty (30) days following the annual meeting.

ARTICLE VI – PART C:

Section 2. Regular Staff Meetings:

The Medical Staff shall hold regular meetings quarterly, on the Hospital premises, for the purpose of reviewing and evaluating service and committee reports and recommendations, and to act on any other matters placed on the agenda by the President. Regular meetings of the Medical staff shall be held on the fourth (4th) Wednesday at 5:30 p.m. in the months of February, May and August, and on the Wednesday, the week prior to Thanksgiving, 5:30 p.m. in the month of November. In the event the fourth (4th) Wednesday, in February, May and August, or the Wednesday, the week prior to Thanksgiving in November, falls on a holiday, the meeting shall be held on the following evening at the same time and place as specified at the regular meetings of the Medical Staff. The annual meeting of the Medical Staff shall be the last, regular quarterly meeting of the year.

ARTICLE VI – PART C:

Section 3. Quorum:

The presence of one-half (1/2) of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff, or its committees. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

ARTICLE VI – PART C:

Section 4. Agenda:

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

(1) Call to order;
(2) Acceptance of the minutes of the last regular and of all intervening special meetings;
(3) Report of the Executive Committee;
(4) Committee reports;
(5) Discussion and recommendations for improvement of the professional work of the Hospital;
(6) Old business;
(7) New business;
(8) Report from the Executive Director, and
(9) Adjournment.

B. The agenda at special meetings shall be:

(1) Reading of the notice calling the meeting;
(2) Transaction of business for which the meeting was called, and
(3) Adjournment

C. All important actions of the Executive Committee shall be included in the Executive Committee‘s report to the Medical Staff at any regular meeting or any special meeting called for the purpose of receiving the Executive Committee’s report.

ARTICLE VI – PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings:

Members of each department may meet monthly but shall meet at least quarterly at a time set by the members of the department to review and evaluate the clinical work of the department; to consider the

findings of ongoing quality assessment activities, and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the Chairman.

ARTICLE VI – PART D:

Section 2. Committee Meetings:

All committees shall meet at least monthly, unless otherwise specified, at a time set by the members of the committee. The agenda for the meeting and its general conduct shall be set by the chairman.

ARTICLE VI – PART D:

Section 3. Special Department and Committee Meetings:

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff; Chief of the Medical Staff; five (5) members of the Active Medical Staff; or upon request of the Board. The procedure for a special called meeting of the Medical Staff shall be by notification of the staff at least five (5) days prior to the meeting. At any special meeting, only the business shall be transacted which is stated in the notice of calling the meeting.

ARTICLE VI – PART D:

Section 4. Minutes:

Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members and the recommendations made. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Executive Committee. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

ARTICLE VI – PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Notice of Meetings:

All meetings of the Medical Staff and regular meetings of Departments and Committees shall be established by the members at the first meeting of the Department or Committee of each new medical staff year. Additionally, notice of each meeting held under these Bylaws shall be given by one (1) of the following ways:

(a) written notice placed in the physician's hospital mailbox not less than five (5) days in advance of such meeting.

(b) Email of the notice not less than five (5) days in advance of such meeting at that email address which is on record in the Medical Staff office.

(c) Written notice mailed by the U.S. Postal Service sent not less than ten (10) days in advance of such meeting.

ARTICLE VI – PART E:

Section 2. Attendance Requirements:

A. Each Active Staff appointee shall be required to attend at least fifty percent (50%) of all regular medical staff meetings and applicable regular department and committee meetings in each year, but is expected to attend all meetings. All members of the Active Medical Staff shall be required to attend at least fifty percent (50%) of each assigned meeting of the Medical Staff, department meetings, or committee meetings to which they are appointed. Attendance records shall be kept at all meetings. Excused absences shall not be counted as attendance. Failure to meet this requirement shall constitute automatic loss of staff privileges. Absences at four (4) consecutive meetings of the Medical Staff, department meetings or committee meetings, shall result in automatic withholding of

privileges from the Active Medical Staff. Upon receipt of a notice from the Medical Staff Secretary, of the violation of this rule, the physician may voluntarily relinquish his/her privileges by informing the Medical Staff Secretary of the same within seventy-two (72) hours after receiving the above notice. Should the physician fail to voluntarily relinquish his/her privileges the physician shall be notified by the Secretary of the Medical Staff that his/her privileges have been withheld. While the privileges are withheld, the physician cannot admit any new patients under his/her name or in another physician's name. The physician, whose privileges are withheld, shall remain responsible for providing care for those patients who are presenting under his/her care either as the attending or consulting physician. Once privileges are withheld, the physician may reapply for admitting privileges in writing, to the Chief of Staff with a copy to the Hospital's Executive Director.

B. Any Medical Staff appointee whose clinical work is scheduled for discussion at a regular department meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meetings the Chairman of the Department shall give him advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall be so stated, shall be given by certified mail, return receipt requested, and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

C. Any member of the Medical Staff may be summoned to attend a staff, department or committee meeting upon written notification ten (10) days in advance of the meeting at which his/her presence is required. The physician so notified may be excused from one (1) meeting, but if so excused he/she must attend the following. His/her failure to attend shall result in automatic loss of staff privileges.

D. Persons appointed to the Consulting and Courtesy categories of the Medical Staff shall be expected to attend and participate in department meetings unless unavoidably prevented from doing so, but shall not be required to do as a condition of continued staff appointment.

E. Persons appointed to the Medical Associate and Physician Extender categories of the medical Staff may attend and participate in Department and clinical meetings of the Medical Staff but shall not have voting privileges nor shall this be considered as a condition of continued staff appointment.

ARTICLE VI – PART E:

Section 3. Rules of Order:

Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

ARTICLE VI – PART E:

Section 4. Voting:

Any individual who, by virtue of position, attends a meeting in more than one (1) capacity shall be entitled to only one (1) vote.

ARTICLE VI – PART F:

Review of Medical Staff Bylaws:

A. The Medical Staff Bylaws, Rules and Regulations shall be reviewed every two (2) years.

B. The Medical Staff Bylaws, Rules and Regulations will be reviewed to reflect the Hospital's current practices with respect to Medical Staff organization and function.

C. All Medical Staff Policies will be reviewed at least every (2) years.

ARTICLE VII – CLINICAL DEPARTMENTS

ARTICLE VII – PART A: CLINICAL DEPARTMENTS

Section 1. Departments of the Medical Staff:

The following Departments are established:

A. Anesthesiology
B. Emergency Medicine
C. Family Practice or General Practice
D. Medicine
E. Obstetrics and Gynecology
F. Pathology
G. Pediatrics
H. Radiology
I. Surgery
J. Orthopedics and Physical Medicine

ARTICLE VII – PART A:

Section 2. Functions of Departments:

A. Each clinical department shall establish its own criteria consistent with the policy of the Medical Staff and to the governing body for the granting of clinical privileges in that department.

B. At the first meeting of each fiscal year, a majority of the members of each clinical department shall determine the frequency (inclusive of a minimum), time and date of the meetings for the coming year. The department shall meet, review and analyze on a group basis the clinical work of the department. The department shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis and shall select cases for presentation at its meetings that will contribute to the continuing education of the members of the department or division. Such presentation should include cases involving deaths or complications; quality assessment; clinical monitors; and such other cases believed to be important, such as those involving patients currently in the hospital with unsolved clinical problems.

C. In discharging these functions, each department and division shall report to the Executive Committee after each meeting detailing its analysis of patient care. Copies of these reports shall be filed with the Executive Committee.

ARTICLE VII – PART A:

Section 3. Department Chairman/Appointed Alternate:

A. The chairman/appointed alternate of each department shall be an appointee to the Active Staff who is qualified by training, experience and administrative ability for the position. The chairman/appointed alternate shall be considered qualified if that person is board certified in a specialty which functions under the clinical department; and if not board certified, shall be deemed equivalently competent by training, experience and administrative ability, which shall be determined by criteria and details considered by the Medical Executive Committee, including that the chairman/appointed alternate shall have a minimum of five (5) years' experience on the Medical Staff of Methodist Hospital.

B. The chairman/appointed alternate of each department shall be elected by the members of the department of the Medical Staff subject to appointment by the Board. The term of the chairman shall be made for a period of one (1) year. There shall be no limited as to the number of times a chairman ca be re-elected.

ARTICLE VII – PART A:

Section 4. Duties of Department Chairman/Appointed Alternate:

The role and responsibility of each department chairman/appointed alternate shall address:

A. Each department chairman shall be a member of the Executive Committee. In the absence of the chairman of the department, the appointed alternate may attend the Executive Committee and have full voting rights. In those situations in which the chairman and appointed alternate of the same department attend a meeting, only the chairman may vote. (Attendance requirements do not apply to the designated alternate.)

B. Responsibility for implementation within the department of actions taken by the Board and the Executive Committee.

C. Reporting and recommending to Hospital management when necessary with respect to matters affecting patient care in the service, including personnel, supplies, special regulations, standing orders and techniques.

D. Clinically related activities of the department.

E. Administratively related activities of the department, unless otherwise provided by the Hospital.

F. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

G. Recommendations to the Medical Staff criteria for clinical privileges that are relevant to the care provided in the department.

H. Recommendations for clinical privileges for each member of the department.

I. Assessments and recommendations to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the Hospital.

J. Integration of the department or service into the primary functions of the Hospital.

K. Coordination and integration of interdepartmental and intradepartmental care, treatment and services.

L. Development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

M. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services.

N. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

O. Continuous assessment and improvement of the quality of care, treatment and services.

P. Maintenance and quality control programs as appropriate.

Q. Orientation and continuing education for all persons in the department or services

R. Recommendations for space and other resources needed by the department or service.

ARTICLE VII – PART A:

Section 5. Removal of Department Chairman/Appointed Alternate:

Removal of a chairman/appointed alternate during his term of office shall be initiated by a two-thirds (2/3rds) majority vote of all active staff members in the department. No such removal shall be effective unless and until it has been ratified by the Executive Committee and the Board.

ARTICLE VII – PART A:

Section 6. Assignment to Department:

A. The Executive Committee shall, after consideration of the recommendation of clinical privileges as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

B. Each family or general practitioner may be granted clinical privileges in any department in accordance with his/her education, training, experience and demonstrated competence. He/She shall be subject to all rules of such department sand shall be under the jurisdiction of each department chairman involved

C. Members of the Family Practice/General Practice Department shall be required to attend the meetings of the Department of Family Practice. They may attend other department meetings if they so desire. They shall have no vote in the election of the chairman in any department other than Family Practice.

ARTICLE VIII – COMMITTEES OF THE MEDICAL STAFF

ARTICLE VIII – PART A: APPOINTMENT

Section 1. Chairmen:

A. All committee chairmen, unless otherwise provided for in these Bylaws, will be appointed by the President of the Medical Staff. All chairmen shall be selected from among persons appointed to the Active Staff.

B. Such appointments will be made by the President of the Medical Staff within thirty (30) days following the annual full-staff meeting, for a term of one (1) year.

ARTICLE VIII – PART A:

Section 2. Members:

A. Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the President of the Medial Staff, no more than thirty (30) days after the annual full staff meeting with no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

B. The Executive Director, the President of the Medical Staff and the Chief of Staff shall be members, ex-officio, on all committees.

C. All appointments of hospital personnel to the Medical Staff committees shall be made by the Executive Director. All Hospital personnel, so named, shall serve on these committees in an ex-officio capacity.

ARTICLE VIII – PART A:

Section 3. Meetings, Reports and Recommendations:

A. Unless otherwise specified in these Bylaws, each committee shall meet at least monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee.

B. Each committee shall report, with or without recommendation, to the executive committee for its consideration and appropriate action any situation involving questions of the clinical competency, patient care and treatment, or case management of any individual appointed to the Medical Staff.

ARTICLE VIII – PART A:

Section 4. Conflict of Interest:

In any instance where a member of any committee has a conflict of interest in any matter involving another medical staff appointee that comes before the committee, or any instance where a member of the committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter and shall excuse himself/herself from the meeting during that time, although he may be asked to answer any questions concerning the matter before leaving.

ARTICLE VIII – PART B: BYLAWS COMMITTEE

Section 1. Composition:

The Bylaws Committee shall consist of three (3) members of the Action Medical Staff. The Chairman of the Committee shall be appointed by the President of the Medical Staff.

ARTICLE VIII – PART B:

Section 2. Duties:

The duties of the Bylaws Committee shall be:

A. Review the Medical Staff Bylaws at least once every (2) years and to recommend any changes to assure compliance with local, state and federal laws, as well as the Joint Commission requirements;

B. Propose amendments to the Bylaws for approval by the Executive Committee and Full Medical Staff as required by either the Executive Committee or the Full Medical Staff.

ARTICLE VIII – PART B:

Section 3. Meetings, Reports and Recommendations:

The Bylaws Committee shall meet as necessary to fulfill its obligations and shall maintain a permanent record of findings, recommendations and actions, and shall make a report thereof to the Executive Committee.

ARTICLE VIII – PART C: CANCER COMMITTEE

Section 1. Composition:

The membership of the cancer committee is multidisciplinary, representing physicians from diagnostic and treatment specialties and non-physicians from administrative and supportive services. Cancer committee coordinators, who are responsible for specific areas of cancer program activity, are designated each calendar year.

ARTICLE VIII – PART C:

Section 2. Duties:

The Cancer Committee serves as the oversight committee for all cancer related activities within Methodist Hospital. This committee is charged with assuring the appropriate organization, environment and services required to provide optimal cancer patient care and professional education through a comprehensive cancer program designed to meet the requirements of the Joint Commission, the Commission on Cancer of the American College of Surgeons and the Association of the American Medical Colleges.

ARTICLE VIII – PART C:

Section 3. Meetings, Reports and Recommendations:

The Cancer Committee shall meet quarterly and maintain a permanent record of findings, recommendations and actions and shall make a report thereof to the Executive Committee.

ARTICLE VIII – PART D: CASE MANAGEMENT – INFECTION CONTROL COMMITTEE

Section 1. Composition:

The Case Management – Infection Control Committee shall consist of five (5) members of the Active Medical Staff. The Committee and Chairman of the Committee shall be appointed by the President of the Medical Staff. The Director of Case Management, Director of Medical Records, three (3) Case Management nurses, Medical Director and the Executive Director shall be ex-officio members of the Committee.

An Internal Subcommittee shall be formed to advise the Parent Committee. The Subcommittee members shall consist of the following members: the above enumerated ex-officio members of the Parent Committee; Director Nursing or designee; Director of Laboratory; Chief Pharmacist; Director of Radiological Services; Director of Cardiopulmonary Services; Director of Dietary; Director of Surgical Services, Microbiologist; Director of Housekeeping; Director of Physical Therapy; Director of Fiscal Services; and the Director of Anesthesia. The Subcommittee shall meet separately from the Parent Committee and shall function in an advisory capacity to the Parent Committee.

ARTICLE VIII – PART D:

Section 2. Duties:

A. Assure the compliance with the Joint Commission standards relative to Medical Records Services; performance Improvement; Infection Control; and Utilization Review.

B. Control format and forms authorized for use in the medical record.

C. Recommend and/or approve policies and procedures relative to the release of medical information as well as any other policy or procedure relating to the medical record services.

D. Recommend and/or approve retention and microfilming schedules relative to the medical records and medical statistical data.

E. Approve special study requests involving medical records.

F. Recommend the disposition of incomplete medical records due to any reason.

G. Assure the prompt completion of medical records in accordance with the Medical Staff Bylaws Rules and Regulations.

H. To oversee, coordinate and direct quality assurance/risk management activities. (This Committee will work in close association with the Risk Management Committee of the Board).

I. To monitor, evaluate and improve the quality of patient care.

J To monitor hospital-wide performance improvement/risk management activities by evaluating the monthly narrative analysis submitted by the support services.

K. To ascertain if the monitoring actions improve performance standards for the benefit of the patient and institution.

L. To serve as an intermediary for all medical staff departments in resolving quality assurance problems.

M. To discuss the results of Medical Staff reviews conducted by the Case Management Director and make recommendations for action as indicated.

N. Review the following monthly reports with recommendations and/or corrective action taken regarding the following:

(1) Individual nosocomial cases.
(2) Rate of nosocomial infection rate by site.
(3) Nosocomial rate.
(4) Patients in isolation.
(5) Reportable diseases.
(6) Number of nosocomial infections by services or departments.
(7) Nosocomial infections by pathogen.

O. Review infection control procedures of all departments annually and revise as necessary.

P. Review antibiotic susceptibility profile twice yearly and any antimicrobial susceptibility/resistant trend when it occurs.

Q. Review any unusual occurrence in Hospital that pertains to infection control.

R. Request physician members to provide direction regarding decision or problem solving as related to their specific clinical department.

S. Review for appropriate antibiotic usage in an ongoing fashion.

T. Establish and implement isolation policies and procedures.

U. Coordinate the employee health program with infection control.

V. Evaluate ongoing review of all aseptic and sanitation techniques used in the Hospital and proceed with appropriate suggested actions.

W. Instruct personnel on asepsis and responsibility in prevention and control of nosocomial infections.

X. Conduct utilization review monitoring designed to evaluate over-utilization, under-utilization and official use of Hospital resources.

Y. Formulate a written utilization review plan for the Hospital to be approved by the Executive Committee and the Board. Such plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payer requirements.

Z. Evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations on the same to the attending physician and the Executive Committee. (No physician shall have review responsibility for any extended stay cases in which he was professionally involved.)

ARTICLE VIII – PART D:

Section 3. Meetings, Reports and Recommendations

The Case Management – Infection control Committee shall meet at least monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee.

ARTICLE VIII – PART E: CONTINUING MEDICAL EDUCATION AND LIBRARY COMMITTEE

Section 1. Composition:

The Continuing Medical Education and Library Committee shall consist of four (4) members of the Active Medical Staff. The Chairman of the Committee shall be appointed by the President of the Medical Staff. There shall also be a representative of the Nursing Education Department; General Nursing Staff; Case Management – Infection Control Committee; Librarian; and the Director of Medical Records.

ARTICLE VIII – PART E:

Section 2. Duties:

The Continuing Medical Education and Library Committee shall:

A. Provide educational interventions that maintain or improve knowledge in skills of physicians and when appropriate, of other health care professionals in order to maintain and improve a high quality of patient care.

B. Provide monthly seminars and/or lectures on various topics that are related to the needs and deficiencies as identified by various quality assurance activities.

C. Coordinate with the Case Management-Infection Control Committee, nursing staff, Medical Staff and allied staff to meet with primary purpose of achieving high quality patient care.

D. Monitor the effectiveness and results of its actions.

E. Meet the Joint Commission standards, PRO standards to obtain AMA authorization for Category 1 credits.

F. Encourage attendance of allied health professionals at the monthly continuing medical education meetings.

G. Provide and maintain a hospital library with adequate books, journals and audio-visual aids including access to on-line resources.

H. Be involved in community health education.

ARTICLE VIII – PART E:

Section 3. Meetings, Reports and Recommendations:

The Continuing Medical Education and Library Committee shall meet at least quarterly, maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee.

ARTICLE VIII – PART F: CREDENTIALS COMMITTEE

Section 1. Composition:

The Credentials Committee shall consist of no less than three (3) nor more than five (5) members of the Active Medical Staff and shall include a cross-sectional representation of the professional categories of the Medical Staff. The Chairman shall be appointed by the President of the Medical Staff. Service on this Committee shall be considered as the primary Medical Staff obligation of each member of the Committee and other Medical Staff duties shall not interfere. The President of the Medical Staff shall appoint up to five (5) additional members of the Committee for terms of one (1) year, if at any time the continued functions of the Committee are threatened by the inability or unwillingness of any member or members to complete their duties. In addition, the Chief Nursing Officer shall be a member of the Credentials Committee serving in an advisory capacity and reviewing the credentials of advance practice nurses only.

ARTICLE VIII – PART F:

Section 2. Duties:

The duties of the Credentials Committee shall be:

A. To review the credentials of applicants for Medical Staff appointment, reappointments and clinical privileges such credentials to be considered by the committee shall include but not be limited to those items identified in the Medical Staff Rules and Regulations.

B. To make investigations of and interview such applicants as may be necessary.

C. To make recommendations on the same to the Executive Committee in accordance with Article IX of these bylaws.

ARTICLE VIII – PART F:

Section 3. Meetings, Reports and Recommendations:

The Credentials Committee shall meet as often as necessary to accomplish its duties, but at least six (6) times a year and shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee.

ARTICLE VIII – PART G: EXECUTIVE COMMITTEE

Section 1. Composition:

A. The Executive Committee shall consist of the officers of the Medical Staff, the Chairman of each department elected by the Active Medical Staff.

B. The Chief of Staff shall be the Chairman of the Executive Committee.

C. The Executive Director may attend meetings of the Executive Committee and participate in its discussions but without vote.

ARTICLE VIII – PART G:

Section 2. Duties:

The duties of the Executive Committee shall be:

A. To represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the Staff, between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws.

B. To coordinate the activities and general policies of the various services.

C. To receive and act upon Committee reports, and to make recommendations concerning them to the Executive Director and the Board.

D. To implement policies of the Medical Staff that are not the responsibility of the Departments.

E. To provide liaison among the Medical Staff, the Executive Director and the Board.

F. To keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital.

G. To enforce Hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff.

H. To refer situations involving questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any Medical Staff appointees to the Credentials Committee for appropriate action in accordance with Article XI.

I. To be responsible to the Board for the implementation of Hospital's quality assessment plan as it affects the Medical Staff.

J. To determine minimum continuing education requirements for appointees to the Staff.

K. To nominate and recommend annually to the Board of the Hospital a member of the Action Medical Staff to serve as Chief of Staff.

ARTICLE VIII – PART G:

Section 3. Meetings, Reports and Recommendations:

The Executive Committee shall meet at least once each month, or more often if necessary, to transact pending business. The Secretary-Treasurer will maintain reports of all meetings, which shall include the minutes of the various Committees and departments of the Medical Staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the Board routinely as prepared, and the actions of the Executive Committee shall be reported by each Committee of the minutes of meetings to the Staff as a part of the monthly Executive Committee's report. Recommendations of the Executive Committee shall be transmitted to the Board by the Chief of Staff. A copy of the minutes of each Executive Committee meeting will be placed in the physician's Hospital mailbox of each member of the Active Medical Staff.

ARTICLE VIII – PART H: FACILITIES PLANNING COMMITTEE

Section 1. Composition:

The Facilities Planning Committee shall consist of five (5) members of the Active Medical Staff. The Chairman of the Committee shall be appointed by the President of the Medical Staff.

ARTICLE VIII – PART H:

Section 2. Duties:

The Facilities Planning Committee shall evaluate and recommend, in conjunction with Administration, the deletions, changes and/or additions to the facility and equipment for the improvement in patient care.

ARTICLE VIII – PART H:

Section 3. Meetings, Reports and Recommendations:

The Facilities Planning Committee shall meet as necessary to carry out the above duties, and shall maintain a permanent record of findings, recommendations and actions and shall make a report thereof to the Executive Committee.

ARTICLE VIII – PART I: INTENSIVE CARE COMMITTEE

Section 1. Composition:

The Intensive Care Committee shall consist of five (5) members of the Active Medical Staff and shall include a cardiologist and a member of the Department of Surgery. The Chairman of the Committee shall be appointed by the President of the Medical Staff. In addition the following Hospital personnel or their designee shall be members of this Committee: Nursing Supervisor of the Unit; Director of Respiratory Therapy; and the Director of Nursing.

ARTICLE VIII – PART I:

Section 2. Duties:

A. Establish policies for the Unit, including admission, transfer and discharge criteria.

B. Develop and approve all standing orders.

C. Standardize drugs and dosages for code blue protocol.

D. Develop visitation policies.

E. Develop guidelines for nursing staff in the Unit.

F. Monitor quality and appropriateness of care rendered in the unit.

ARTICLE VIII – PART I:

Section 3. Meetings, Reports and Recommendations:

The Intensive Care Committee shall meet at least quarterly, maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee.

ARTICLE VIII – PART J: JOINT CONFERENCE COMMITTEE

THE JOINT CONFERENCE COMMITTEE IS A BOARD COMMITTEE. ANY CHANGE IN THE COMPOSITION, DUTIES, OR OTHER RESPONSIBILITIES OF THE COMMITTEE ADOPTED BY THE BOARD AUTOMATICALLY CHANGES THE LANGUAGE BELOW.

ARTICLE VIII – PART J:

Section 1. Composition:

The Joint Conference Committee shall consist of ten (10) members giving equal representation to the Board of Directors and the Active Medical Staff. The Chairmanship of this Committee shall be vested in the Chairman of the Board who shall not vote except to break a tie. In addition to the Chairman of the Board, the membership shall consist of the Vice-Chairman, Secretary, and the Treasurer of the Board along with the President, Vice-President, Secretary-Treasurer, and the past President of the Medical Staff with the additional members chosen to give equal representation from the Board and the Medical Staff.

ARTICLE VIII – PART J:

Section 2. Duties:

This Committee shall be of a medico-administrative nature and shall constitute the proper median for the interchange of information between the Board and the Medical Staff. The Committee's duties are as follows:

A. Act as an advisory group to the Board concerning recommendations made by the Medical Staff.

B. Interpret official policy of the Board to the Medical Staff.

C. Perform on-going review and follow-up of regulations and requirements for Hospital accreditation.

D. Follow-up for approval requirements as related to Hospital-based programs of health care careers.

ARTICLE VIII – PART J:

Section 3. Meetings, Reports and Recommendations:

The meetings, reports and recommendations of the Joint Conference Committee shall be reported in writing to the Board or to the Board's Executive Committee, and when deemed necessary, also to the Medical Staff as a whole.

ARTICLE VIII – PART K: MEDICAL DIAGNOSTICS & THERAPEUTIC SERVICES COMMITTEE

Section 1. Composition:

The Medical Diagnostics & Therapeutic services Committee shall consist of six (6) members of the Active Medical Staff with one (1) representative from each of the following disciplines: Gastroenterology, Cardiology, Anesthesia, Oncology/Pain, Pulmonary and Surgery. The Chairman shall be appointed by the President of the Medical Staff. In addition, the Director of Diagnostic Services, Operations Manager and Manager of Cardiopulmonary Services shall be members of the Committee. The Chief Operating Officer will be the administrative representative.

ARTICLE VIII – PART K:

Section 2. Duties:

The Medical Diagnostics & Therapeutic Services Committee shall:

(1) Provide medical guidance and coordination for the following departments: Cardiac Cath Lab, Cardiology, Endoscopy (Diagnostic & Therapeutic Center), Neuro/Sleep Lab and Respiratory Therapy.
(2) Define the scope of diagnostic and therapeutic services to be provided within the above areas.
(3) Review and recommend revisions as necessary to the written policies, procedures and/or protocols used within the Diagnostic Services area.
(4) Recommend upgrading of facilities and equipment as needed to assure safe, effective operating of the Diagnostic Services area.
(5) Review, evaluate and recommend quality/performance improvement activities within the Diagnostic Services areas.
(6) Share, evaluate and review new evidence-based recommendations which involve the areas under the Diagnostic Services umbrella.

ARTICLE VIII – PART K:

Section 3. Meetings, Reports and Recommendations.

The Medical Diagnostics & Therapeutic Services Committee shall meet quarterly and shall maintain a permanent record of findings, recommendations and actions, and shall make a report thereof to the Executive Committee.

ARTICLE VIII – PART L: OPERATING ROOM COMMITTEE

Section 1. Composition:

The Operating Room Committee shall consist of the Chairman of the Department of Surgery, who shall serve as Chairman of the Committee; Director of Anesthesia; one (1) general surgeon; one (2) surgeon sub-

specialist; one (1) gastroenterologist and the Chairman of the Department of OB/GYN. In addition, the Director of Surgical Services shall be a member of the Committee.

ARTICLE VIII – PART L:

Section 2. Duties:

The Operating Room Committee shall:

A. Formulate rules and regulations to govern Surgical Services.

B. Review and Recommend for approval applications of physician employees who request operating room privileges.

C. Review all incidents in Surgical Services pertaining to patient care.

D. Review all new policies and procedures within Surgical Services that are pertinent to Committee review.

E. Perform periodic review of all performance improvement issues within Surgical Services.

ARTICLE VIII – PART L:

Section 3. Meetings, Reports and Recommendations:

The Operating Room Committee shall meet quarterly and shall maintain a permanent record of findings, recommendations and actions, and shall make a report thereof to the Executive Committee.

ARTICLE VIII – PART M: PATIENT CARE/EDUCATION COMMITTEE

Section 1. Composition:

The Patient Care/Education Committee shall consist of a Medical Staff appointee from each of the following Departments: Pediatrics, Family Practice, Medicine, Surgery and OB/GYN. The Chairman of the Committee shall be appointed by the President of the Medical Staff. In addition, the Director of Nursing, Director of Dietary, Director of Rehabilitative Services, Case Management Nurse and Executive Director shall be members of the Committee.

ARTICLE VIII – PART M:

Section 2. Duties:

The Patient Care/Education Committee shall provide the following functions:

A. Provide input into and/or approval of policies and procedures from any Department which affect all aspects of patient care and patient education.

B. Provide a forum to discuss, constructively, any kind of patient care or patient education issue such as:

(1) Problems which exist or seem to be developing.
(2) Review patterns of activities that impact patient care, such as census, shift from inpatient to outpatient, hours of operation, flow of patient care across Departments, etc.
(3) Types of services to explore, to offer or delete.
(4) Provide for Medical Staff approval of the contents of the diet manual.

(5) Provide Medical Staff supervision for the provision of care and approval of policies and procedures of the Therapy Services Department.
(6) Provide Medical Staff approval required by the Joint Commission for policies and procedures that would not be covered by other Committees.
(7) Develop patient education programs based on needs as identified by the Committee.
(8) Identification of educational needs of specific target groups and determines appropriate material and resources to carry out the program.
(9) Utilize input from the Case Management group to anticipate patient care and educational needs.
(10) Share activities in patient education with outside agencies and organizations to attempt to prevent duplication of patient educational activities.
(11) Be responsible for establishing Hospital policies and procedures on organ procurement and assure compliance with Kentucky Revised Statutes.
(12) Review and recommend revisions and deletions in the policies and procedures relating to code blue proceedings.
(13) Review and recommend revisions and deletions in the policies and procedures relating to brain death.

ARTICLE VIII – PART M:

Section 3. Meetings, Reports and Recommendations:

The Patient Care/Education Committee shall meet every other month to carry out the above duties, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the Executive Committee.

ARTICLE VIII – PART N: PHARMACY COMMITTEE

Section 1. Composition:

The Pharmacy Committee shall consist of at least three (3) members of the Active Medical Staff. The Chairman of the Committee shall be appointed by the President of the Medical Staff. In addition, the Chief Hospital Pharmacists and the Case Management Director shall be members of the Committee.

ARTICLE VIII – PART N:

Section 2. Duties:

The Pharmacy Committee shall:

(1) Have a plan and systematic process for the monitoring and evaluation of the quality and appropriateness of pharmaceutical patient care services and for resolving identified problems.
(2) Devise and keep current a standard drug formulary based on input from all Medical Staff committees.
(3) Approve new antibiotics for inclusion into the formulary.
(4) Approve all drugs to be included in the IV push list and direct IV list.
(5) Approve all policies involving medication for all departments included in handling medications.
(6) Review all adverse drug reaction reports.
(7) Review all incident reports involving medication.
(8) Review performance improvements policies and reports involving medications.

ARTICLE VIII – PART N:

Section 3. Meetings, Reports and Recommendations:

The Pharmacy Committee shall meet bimonthly, shall maintain a permanent record of findings, proceedings and actions and shall make a report thereof after each meeting to the Executive Committee.

ARTICLE VIII – PART O: SURGICAL CASE REVIEW COMMITTEE

Section 1. Composition:

The Surgical Case Review Committee shall consist of five (5) members of the Active Medical Staff. A pathologist of the Hospital shall be a member.

ARTICLE VIII – PART O:

Section 2. Duties:

The Surgical Case Review Committee shall:

(1) Review, retrospectively, all surgical cases whether a specimen has been obtained or not.
(2) Monitor the trend of practice of surgery.
(3) Review cases which might or might not have met the predetermined criteria.
(4) Carry out performance improvement functions in reference to surgical operative cases.
(5) Review for quality and appropriateness all invasive procedures.

Section 2. Duties of Surgical Case Review Committee in reference to transfusions:

(6) Monitor the indications for transfusion.
(7) Monitor the quality of blood and blood products.
(8) Educate the Medical Staff in the utilization of blood and blood products.
(9) Review all blood reactions.
(10) Cooperate with the blood bank director; blood bank supervisor; blood supplier.
(11) Establish general policies for blood transfusion administration, permits and informed consents, as approved by the Executive Committee.
(12) Carry out performance improvement in reference to blood utilization and transfusion reactions.

ARTICLE VIII – PART O:

Section 3. Meetings, Reports and Recommendations:

The Surgical Case Review Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, of each meeting, to the Executive Committee.

ARTICLE VIII – PART P: TUMOR BOARD

Section 1. Composition:

The Tumor Board shall consist of nine (9) members of the Active Medical Staff. The Chairman shall be a Pathologist. The members shall represent the following specialties: OB/GYN, General Surgery, Surgical Subspecialty, Urology, Oncology, Pulmonology, Radiology and Family Practice/Internal Medicine (2). In addition, a physician in the field of Radiation Oncology will be invited to attend.

ARTICLE VIII – PART P:

Section 2. Duties:

(1) Provide forum for retrospective case presentations of oncology patients.
(2) Provide forum for physician to request review of his/her oncology patient's medical record to recommend management and treatment.
(3) Properly stage the oncology patient's tumor for further management and treatment.

Review of Medical Record will be performed to:

(1) Evaluate timely diagnosis.
(2) Determine if tumor has been staged.
(3) Evaluate treatment or proposed treatment.
(4) Recommend further evaluations.
(5) Recommend CME's based on medical record reviews.

Article VIII – PART P:

Section 3. Meetings, Reports and Recommendations:

The Tumor Board shall meet monthly, maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee.

ARTICLE VIII – PART Q: GRADUATE MEDICAL EDUCATION COMMITTEE (D.O. Residency Committee)

Section 1. Composition:

The Graduate Medical Education committee shall consist of the following members: Administrative Director of the Program; Director of Medical Education; Preceptors of the Continuity Care Clinic; Chief Resident; and two (2) members of the Department of Family Practice selected by the above members. The Chairman of the Committee shall be the Administrative Director of the Program.

Section 2. Duties:

The duties of the Graduate Medical Education Committee shall be to:

(1) Perform quarterly reviews of each resident.
(2) Ensure that the Program is meeting all requirements of the AOA, ACOFP and the Hospital.
(3) Discuss and recommend educational improvements to the Program.
(4) Discuss and recommend actions as necessary relative to complaints involving the Program.
(5) Recommend changes as necessary to improve the educational aspect of the Program.
(6) Evaluate the overall program performance.
(7) Review and discuss each new resident accepted into the Program.
(8) Coordinate annual graduation exercises.

Section 3. Meetings, Reports and Recommendations:

The Committee shall meet monthly, maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Medical Executive Committee.

ARTICLE VIII – PART R: PEER REVIEW COMMITTEE

Section 1. Composition – The Peer Review Committee shall consist of the Vice Chairs of the Clinical Departments of the Medical Staff as established in Article VII Part A: CLINCAL DEPARTEMENTS.

Section 2. Duties – The Peer Review Committee shall meet on an Ad Hoc basis to address matters which are disciplinary in nature.

1. It shall address concerns relating to any matter which may constitute "grounds for action" under Article XI Part C Section 1 of these Bylaws.
2. It shall review, as questions arise, and investigate all information regarding the behavior and clinical competence of persons currently appointed to the Medical Staff, and as a result of such review to make recommendations on the same accordance with Article XI of these Bylaws.
3. The Peer Review Committee shall make recommendations for every matter referred to it to the Executive Committee.

Section 3. Meetings – Reports and Recommendations – The Peer Review Committee shall meet as needed and may be called by the Chief of Staff or any chairman of the Medical Staff Committee for the purpose of addressing any of it duties set forth in Section 2 above.

Note: This shall replace some of the functions of the Credentials Committee which should be limited only to credentialing matters and investigations only to credentialing.

ARTICLE VIII – PART S: CREATION OF STANDING COMMITTEES

The Executive Committee of the Medical Staff, or Full Staff, may, by resolution and upon approval of the Board, without amendment of the Bylaws, establish additional committees to perform one (1) or more staff functions. In the same manner, the Executive Committee, or Full Medical Staff, may, by resolution and upon approval by the Board, dissolve or rearrange committee structure, duties, or composition as needed to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which are not assigned to a standing or special committee shall be performed by the Executive Committee.

ARTICLE VIII – PART T: SPECIAL COMMITTEES

Special committees shall be created, and their members and Chairman shall be appointed by the Chief of Staff or the President of the Medical Staff. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

ARTICLE IX – APPOINTMENT TO THE MEDICAL STAFF

ARTICLE IX – PART A: QUALIFICATIONS FOR APPOINTMENT

Section 1. General:

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board.

ARTICLE IX – PART A:

Section 2. Specific Qualifications:

Only physicians, oral surgeons, dentists and physician extenders who:

(1) Are currently licensed to practice in this state.
(2) Are located within the geographic service area of the Hospital, close enough to provide timely care for their patients.
(3) Possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital.
(4) Can document their:
    (a) Background, experience, training and demonstrated competence.
    (b) Adherence to the ethics of their profession.
    (c) Good reputation and character, including the applicant's mental and emotional stability.
    (d) Ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive quality care, and that the Hospital and its Medical Staff will be able to operate in an orderly manner, shall be qualified for appointment to the Medical Staff.

ARTICLE IX – PART A:

Section 3. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that (a) he/she is licensed to practice any profession in this or any other state (b) he/she is a member of any particular professional organization or (c) he/she had in the past, or currently has, medical staff appointment or privileges in this or another hospital.

ARTICLE IX – PART A:

Section 4. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, color or national origin.

ARTICLE IX – PART B: ASSOCIATE STAFF APPOINTMENT

Section 1. Duration of Initial Associate Appointment:

All initial appointments to the Medical Staff, regardless of the category of the staff to which the appointment is made, and all initial clinical privileges shall be provisional for a period of six (6) months from the date of the appointment, or longer if recommended by the Credentials Committee. During the term of this associate appointment, the person receiving the associate appointment shall be evaluated by the Chairman of the Department or Departments in which he/she has clinical privileges, and by the relevant Committees of the Medical Staff and the Hospital as to his/her clinical competence and as to his/her general behavior and conduct in the Hospital. Associate clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article IX.

ARTICLE IX – PART B:

Section 2. Rights and Duties of Appointees:

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board and shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

ARTICLE IX – PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Information:

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Board upon recommendation of the Executive Committee. These forms shall be obtained from the Executive Director or his designee. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

(1) The names and complete addresses of at least two (2) physicians, dentists or other practitioners as appropriate, who have had recent experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character.
(2) The names and complete addresses of the chiefs or chairmen of each service or department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e. the individuals who served as chairmen or chiefs at the time the applicant worked in the particular department/service). If the number of hospitals the applicant has worked in is great, or if a number of years has passed since the applicant worked in a particular hospital, the Executive Committee and the Board may take into consideration the applicant's good faith effort to produce this information.
(3) Information as to whether the applicant's medical staff appointment or clinical privileges have ever been resigned, denied, revoked, suspended, reduced or not renewed at any other hospital or health care facility.
(4) Information as to whether the applicant has ever withdrawn his application for appointment, reappointment and clinical privileges before final decision by a hospital's or health care facility's governing board.
(5) Information pertaining to the loss of clinical privileges at another institution and whether the applicant's membership in local, state or national professional societies or his/her license to practice any profession in any state, or his/her Drug Enforcement Administration license has been suspended, modified, terminated or voluntarily relinquished. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his/her Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed.
(6) Information as to whether the applicant has currently in force professional liability insurance coverages, the name of the insurance company, and the amount and classification of such coverage.
(7) Information concerning the applicant's malpractice litigation experience.
(8) A consent to release of information from the applicant's present and past professional liability insurance carriers.
(9) Information on the applicant's physical and mental health.
(10) Information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance.
(11) Information the citizenship and visa status of the applicant.
(12) The applicant's signature.
(13) Such other information as the Board may require.

ARTICLE IX – PART C:

Section 2. Undertakings:

The following undertakings shall be applicable to every Medical Staff appointee and applicant for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

(1) An obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility.

(2) An agreement to abide by all bylaws and policies of the Hospital, including all Bylaws, Rules and Regulations of the Medical Staff as shall be in force from time to time during the time he is appointed to the Medical Staff.

(3) A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a thirty (30) days prior to registration or in-patient admission, an update, documenting any changes in the patient's condition, is completed within twenty-four (24) hours after registration or in-patient admission, but prior to surgery or a procedure requiring anesthesia services.

(4) An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff.

(5) An agreement to provide the Hospital, upon request or without request, current information regarding all questions on the application form at any time, new or updated information that is pertinent to any question on the application form.

(6) A statement that the applicant has received and had an opportunity to read a copy of the Bylaws of the Hospital and Bylaws, Rules and Regulations of the Medical Staff as are in force at the time of his/her application, and that he/her has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/her is granted appointment to the Medical Staff or clinical privileges.

(7) A statement of her/her willingness to appear for personal interviews in regard to his/her application.

(8) A statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application, resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff.

(9) A statement that the applicant will:

- (a) Refrain from fee splitting or other inducements relating to patient referral.
- (b) Refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised.
- (c) Refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services.
- (d) Seek consultation whenever necessary.
- (e) Abide by generally recognized ethical principles applicable to his/her profession.
- (f) Provide continuous care for his/her patients in the Hospital.

Each applicant for Medical Staff appointment and reappointment shall specifically agree to these undertakings as part of his/her application.

ARTICLE IX – PART C:

Section 3. Burden of Providing Information:

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. He/She shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information requested by the Hospital, the applicant will be deemed incomplete and will not be processed.

ARTICLE IX – PART C:

Section 4. Authorization to Obtain Information:

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

(a) Immunity. To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications, or documents, recommendations or disclosures involving the individual concerning the following:

(1) Applications for appointment or clinical privileges, including temporary privileges.
(2) Evaluations concerning reappointment or changes in clinical privileges.
(3) Proceedings for suspension or reduction of clinical privileges or for revocation of medical staff appointment or any other disciplinary sanction.
(4) Summary suspension.
(5) Hearings and appellate reviews.
(6) Medical care evaluations.
(7) Utilization review.
(8) Other activities relating to the quality of patient care or professional conduct.
(9) Matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior.
(10) Any other matter that might directly or indirectly have an effect on the individual's competence, on patient care, or on the orderly operation of this or any other hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Hospital and its authorized representatives, and to any third parties.

(b) Authorization to Obtain Information. The individual specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions.

The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

(c) Authorization to Release Information. Similarly, the individual specifically authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care facilities, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

(d) Definitions.

(1) As used in this section, the term "Hospital and its authorized representatives" means the Hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct in the Hospital, the members of its Board and their appointed representatives; the Executive Director or his designees; consultants to the Hospital, the Hospital's attorney and his partners, associates or designees, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials or acting upon his/her application or conduct in the Hospital.

(2) As used in this section the terms "third parties" means all individuals, including appointees to the Hospital's Medical Staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives.

ARTICLE IX – PART C:

Section 5. Medical Member File:

A separate record shall be maintained on each applicant and each staff member shall remain on file in the office of the Medical Staff Secretary.

ARTICLE IX – PART D: CLINICAL PRIVILEGES

Section 1. General:

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual who has been given an appointment to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the Chairman of the Department in which such privileges are south. The applicant shall have the burden of establishing his/her qualifications for and competence to exercise the clinical privileges he/she requests. Recommendations of the clinical Departments in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

It will not be necessary to perform the re-credentialing process on an applicant who reapplies for membership/privileges during the time frame which had been previously granted membership/privileges.

ARTICLE XI – PART D:

Section 2. Focused Evaluations:

In those cases where a practitioner does not have documented evidence of competence in performing a requested privilege/s, OR, when questions arise regarding currently privileged practitioners' ability to provide safe, high quality patient care, a focused professional practice evaluation will be carried out. The purpose of the evaluation is to determine the practitioner's competence as related to the privileges which have been requested or granted. The Chairman of the Department, in which the privilege/s are requested, shall be responsible for performing the evaluation.

The evaluation shall be based on direct observation of the practitioner; medical record review; clinical practice patterns; discussion with other practitioners involved in each patient's care; simulation or external peer review.

In those cases where the practitioner currently possess privileges, the evaluation may be triggered by an abnormal pattern of procedural complications, nosocomial infections, deaths or other untoward events.

The method for establishing the monitoring plan and the duration process shall be determined by the Department Chairman in whose department the privilege is exercised.

ARTICLE XI – PART D:

Section 3. Clinical Privileges for Dentists:

(a) The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairman of the Department of Surgery. A medical history and physical examination for all dental admissions shall be performed and recorded by a physician who holds an appointment to the Medical Staff, and the designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(b) Oral surgeons shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

(c) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

(d) Members of the dental staff shall not be required to attend staff meetings except as specified in the Bylaws.

ARTICLE IX – PART D:

Section 4. Clinical Privileges for Podiatrists:

The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be delineated and recommended to the Board in accordance with the provisions of these Bylaws governing Medical Associates and such policies may be adopted by the Board from time to time. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery. A medical history and physical examination of the patient shall be performed and recorded in the medical record by a physician who holds an appointment to the Medical Staff before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout

the period of hospitalization. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

ARTICLE IX – PART D:

Section 5. Residents and Medical Students:

Residents, in training in the Hospital, shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in the training protocols developed by the Executive Committee.

Medical Students, who are participants in the Methodist Hospital/PCSOM Core Site training program, shall be permitted to exercise only those privileges set out in the approved training protocol.

ARTICLE IX – PART D:

Section 6. Clinical Privileges of Other Medical Associates:

The scope and extent of the clinical privileges which may be awarded to CRNA's, social workers, psychologists, speech therapist, physical therapists and other licensed medical associates shall be delineated and recommended to the Board in accordance with the provisions of these Bylaws governing medical associates, and such policies may be adopted by the Board from time to time. These medical associates may not write orders on hospitalized patients unless otherwise allowed by these Bylaws, Rules or Regulations. A CRNA may utilize medications and perform procedures within the scope of his/her license as long as it is consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws.

ARTICLE IX – PART D:

Section 7. Medical Students, Nursing Students and Physician Assistant Students:

These individuals can write orders under the direct supervision of a preceptor; however, the orders will not be honored by nursing service until the orders are signed by the preceptor.

ARTICLE IX – PART D:

Section 8. Notification of Final Board Action:

Each applicant for initial appointment, reappointment, or with a change of clinical privileges, shall be notified of final Board action by the Executive Director in a written communication.

ARTICLE IX – PART E: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Submission of Application:

The application for Medical Staff appointment shall be submitted by the applicant to the Credentials Committee. It must be accompanied by payment of such processing fees as may be recommended by the Medical Staff and approved by the Board. After receiving references and other information or materials deemed pertinent, the Credentials Committee shall determine the application to be complete. It is the responsibility of the applicant to submit a complete application, including adequate responses from references. An incomplete application will not be processed.

ARTICLE IX – PART E:

Section 2. Initial Credentials Committee Procedure:

Upon receipt of the complete application for appointment, the Credentials Committee shall:

(a) Inform the Chairman of the Department in which the applicant seeks clinical privileges of the pending application, furnish a copy of the application to each Chairman concerned and request recommendations.

(b) Post the name of the applicant on the bulletin board so that each Medical Staff appointee may have an opportunity to submit to the Committee, in writing, information bearing on the applicant's qualifications for staff appointment. In addition, any current medical staff appointee shall have the right to appear in person before the Credentials Committee to discuss, in private and in confidence, any concerns he may have about the applicant.

ARTICLE IX – PART E:

Section 3. Department Chairman Procedure:

The Chairman of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application, and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the Credentials Committee's report. As a part of the process of making this recommendation, the Department Chairman has the right to meet with the applicant to discuss any aspect of his/her application, his/her qualifications and his/her requested clinical privileges.

ARTICLE IX – PART E:

Section 4. Subsequent Credentials Committee Procedure:

(a) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior, and ethical standing of the applicant, and shall determine, through information contained in references given by the applicant, and from other sources available to the Committee, including an appraisal from the Chairman of each Department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for staff category and clinical privileges requested by him.

(b) As a part of this process, the Credentials Committee may require a physical and mental examination of the applicant by a physician or physicians satisfactory to the Committee and shall require that the results be made available for the Committee's consideration.

(c) If, after considering the recommendations of the clinical department concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment and provisional clinical privileges.

(d) As part of the process in making its recommendation, the Credentials Committee shall have the right to require the applicant to meet with the Committee to discuss any aspect of his/her application, his/her qualifications, and his/her clinical privileges.

ARTICLE IX – PART E:

Section 5. Credentials Committee Report:

(a) Not later than 60 days from its receipt of the completed application, provided the necessary information can be obtained, the Credentials Committee shall make a written report and recommendation, with respect to the applicant to the Executive Committee.

(b) If the recommendation of the Credentials Committee is delayed longer than sixty (60) days he Chairman of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee.

(c) The Credentials Committee shall transmit to the Executive Committee the complete application and its recommendation that the applicant be appointed to the Medical Staff, that his/her application be deterred for further consideration, or that he/she be rejected for Medical Staff appointment. The Chairman of the Credential's Committee or his/her designate shall be available to the Executive Committee or any appropriate committee to answer any questions that may be raised with respect to the recommendation.

ARTICLE IX – PART E:

Section 6. Subsequent Action on the Application:

(a) When the recommendation of the Credentials Committee is favorable to the applicant, they shall promptly forward it, together with all supporting documentation, within thirty-five (35) days to the Medical Staff Executive Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.

A favorable recommendation of the applicant by the Medical Staff Executive Committee will be acted upon by the Board of Trustees at its next regularly scheduled meeting which shall not exceed thirty-five (35) days after its receipt. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.

(b) When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed up within thirty-one (31) days by a subsequent recommendation to the Executive Committee for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application for staff appointment.

(c) When the recommendation of the Credentials Committee is adverse to the applicant in respect to either appointment to the staff or clinical privileges requested, it shall be forwarded to the Medical Staff Executive Committee together with all supporting documentation within thirty-five (35) days. The applicant will be notified of the recommendation of the Medical Staff Executive Committee. The Executive Director shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article XII, after which the Executive Director shall forward the recommendation of the Executive Committee, together with the application and all supporting documentation, to the Board.

ARTICLE IX – PART F: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary Clinical Privileges for Applicants:

In extraordinary situation, when necessary, to avoid undue hardship to the applicant, the Executive Director may, upon the basis of verified information then available which may reasonable be relied upon as to the licensure, competence, character, ethical standing, proof of alternate coverage, and malpractice insurance coverage of the applicant, and after consulting with the Chief of Staff or Chairman of the Department concerned, may grant temporary admitting and clinical privileges to an applicant for a specific time period not to exceed thirty (30) days, provided that his/her application has been determined to be complete. In exercising such privileges, the applicant hall act under the supervision of the Chairman of the Department or his/her designee from the Department in which he/she has requested primary privileges. If all requested

information, referable to the applicant has not been received, and, after appropriate review, temporary privileges may be extended for another thirty (30) days by the same mechanism for the granting of the original temporary privileges.

When a physician has made application for Active Medical Staff membership and temporary privileges have been granted for a specific time period, this time period will be applied to the six (6) month probationary period required for Associate/Active staff.

ARTICLE IX – PART F:

Section 2. Special Requirements:

Special requirements of supervision and reporting may be imposed by the Chairman of the Department concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Executive Director or his designee upon notice of any failure by the individual to comply with such specific conditions.

ARTICLE IX – PART F:

Section 3. Locum Tenens:

The Executive Director may grant an individual serving as a locum tenens, for a person holding an appointment to the Medical Staff, temporary admitting and clinical privileges to attend patients of that appointee for a period not to exceed fifteen (15) days. This shall be done in the same manner and upon the same conditions as set forth in Section 1 of this Part, provided that the Executive Director shall first obtain such individual's signed acknowledgement that he/she has received and had an opportunity to read copies of the Hospital and Medical Staff Bylaws Rules and Regulations which are then in force, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. The individual serving as locum tenens must also complete a request for clinical privileges form and must have in force and effect professional liability insurance in an amount acceptable to the Hospital.

ARTICLE IX – PART F:

Section 4. Termination of Temporary Clinical Privileges:

(a) The Executive Director, or in his absence, his designee, may at any time, after asking for a recommendation from the Chief of Staff or the Chairman of the Department responsible for the individual's supervision, terminate an individual's temporary admitting privileges. Clinical privileges shall then be terminated when the physician's in-patients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed by the Executive Director, Chairman of the Department, or Chief of Staff, and such termination shall be immediately effective.

(b) The appropriate Department Chairman or, in his/her absence the Chief of the Medical Staff, shall assign a Medical Staff appointee the responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial, nor termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

(d) Temporary privileges shall be automatically terminated at such time as the Executive Committee recommends unfavorably, with respect to the applicant's appointment to the staff, or at the Executive Committee's discretion, shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.

ARTICLE IX – PART G: EMERGENCY CLINICAL PRIVILEGES

(a) In an emergency involving a particular patient, a physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to act in such emergency using all necessary facilities of the Hospital including calling for any consultation necessary or desirable.

(b) Similarly, in an emergency involving a particular patient, a physician currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising clinical privileges not specifically assigned to him.

(c) When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he/she does not request such privileges, the patient shall be assigned by the Chief of the Medical Staff or his/her designee to an appropriate person currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

ARTICLE IX – PART H: EMERGENCY LIP CLINICAL PRIVILEGES

When an emergency management plan is implemented by the Hospital, and the organization is unable to meet immediate patient needs, volunteer LIP's (Licensed Independent Practitioner) may be granted emergency (temporary) privileges as desired below.

During a disaster, the following may grant emergency privileges:

Executive Director
Medical Director
Chief of the Medical Staff

Any of the above noted individuals may designate a designee to act in their absence.

The granting of emergency privileges will be made on a case by case basis. At no time will any of the above identified individuals be required to grant privileges to any individual LIP.

The credentials verification process will begin as soon as the disaster situation is under control and will be performed in the same manner and with the same requested content for granting other temporary privileges.

In granting these emergency privileges, the individuals noted above should review any of the following available information about the LIP in question. Emergency privileges may be granted upon presentation of any of the following:

(1) Current hospital photograph.
(2) Current photograph issued by a state, federal or regulatory agency.
(3) Current license to practice, granted by a federal, state or regulatory agency.
(4) ID individual LIP is a member of Disaster Medical Assistant Team (DMAT).

(5) ID indicating LIP has been granted authority to render patient care in an emergency circumstances by a federal, state or municipal entity.

(6) Personal (first-hand) knowledge of the LIP's identify presented by a current Medical Staff member.

Any LIP granted privileges under the above circumstances shall act in accordance with the Medical Staff Bylaws and be answerable to the Board of Directors through either the Chief of the Medical Staff or the Medical Staff Department Chairman in which his/her privileges were granted.

ARTICLE X – GENERAL OBLIGATION OF THE MEDICAL STAFF

ARTICLE X – PART A: EMERGENCY ROOM COVERAGE ROTATION

The Medical Staff shall be responsible for the professional care of all patients entering the Hospital without a professional attendant and shall provide, at all times, rotation of medical services for all emergency patients who report to the emergency room of the Hospital for care.

The rotation for the emergency care shall be prepared in the Administrative offices, unless a request is made by physicians in a specialty group to prepare their own schedules. In those cases, the schedule will be prepared by the physicians in that specialty group and presented then to the administrative offices, and upon approval by the Executive Director, shall be distributed in the usual fashion to the staff physicians in the Emergency Department. Failure of any duties shall be reported to the Executive Committee of the Medical Staff for consideration and recommendation.

ARTICLE X – PART B: NAMING A PHYSICIAN ALTERNATE

Each member of the Medical Staff shall name another member of the Medical Staff who may be called to attend his/her patients in case of an emergency or in the event of his/her absence. An Alternate Designee form will be signed and kept on file in the Medical Staff Office.

If a physician agrees to cover another physician, either as "Alternate Designee" or by agreement, it is the responsibility of the covering physician to provide care for the patient or to locate another physician to care for the patient. In the event this responsibility is not carried out, the physician, who agreed to cover, will be asked to appear before the Executive Committee and explain his/her actions.

The Chief of Staff shall do all in his power to call a physician on emergency duty or any physician on the Active Staff if he considers it necessary for the welfare of the patient.

ARTICLE X – PART C: CLINICAL SPECIALISTS RESPONSIBILITY TO THE EMERGENCY ROOM

Certification of clinical specialty or limitation of practice shall not excuse any physician as a member of the Active Medical Staff who admits a patient from participating in the emergency duties of the Hospital.

ARTICLE X – PART D: PROCEDURE FOR REAPPOINTMENT

Section 1. Application:

Each current appointee who wishes to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. The reappointment application shall be submitted to the Executive Director or his designee at least two (2) months prior to the expiration of the appointee's then current appointment. Failure to submit an application and payment of the $200 staff dues by that time will result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current medical staff year. An applicant for reappointment to the Medical Staff, or a request

for revised clinical privileges, will be acted upon by the Credentials Committee, provided all necessary information can be obtained, within sixty (60) days of receipt of the application or request.

A favorable recommendation referable to the applicant or request for revised clinical privileges by the Credentials Committee will be acted upon by the Medical Staff Executive Committee at its next regularly scheduled meeting which shall not exceed thirty-five (35) days after which the recommendation was forwarded from the Credentials Committee.

A favorable recommendation referable to the applicant or revised clinical privileges by the Medical Staff Executive Committee will be acted upon by the Board of Trustees at its next regularly scheduled meeting which shall not exceed thirty-five (35) days after which the recommendation was forwarded from the Medical Staff Executive Committee. Reappointment, if granted, shall be for a period of not more than two (2) years with one-half (½) of the staff appointed in even numbered years and the other half (½) in odd numbered years. If an application for reappointment is filed and the Board has not acted on it prior to the expiration of the appointee's current appointment, the appointee's current appointment and clinical privileges shall continue in effect until such time as the Board acts on the reappointment application.

ARTICLE X – PART D:

Section 2. Factors to be Considered:

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon such appointee's:

(a) Ethical behavior, clinical competence, and clinical judgment in the treatment of patients.
(b) Attendance at Medical Staff meetings and participating in staff duties.
(c) Compliance with the Hospital and Medical Staff Bylaws, Rules and Regulations and policies.
(d) Behavior in the Hospital, his/her cooperation with medical and hospital personnel as it relates to patient care or the orderly operation of this Hospital, and his/her general attitude toward patients, the Hospital and its personnel.
(e) Use of the Hospital's facilities for his patients.
(f) Physical and mental health.
(g) Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications.
(h) Satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies.
(i) Other relevant findings from the Hospital's quality assessment activities.

ARTICLE X – PART E: PENALTY FOR VIOLATION OF BYLAWS AND RULES AND REGULATIONS

Any physician on the Medical Staff who has been dismissed from the staff three (3) times in one (1) year due to violations of the Rules and Regulations or Bylaws, shall lose his admitting and clinical privileges for a period of two (2) weeks without retribution. It shall be his/her responsibility to provide for another physician to admit and provide care for his/her patients during that period of time. Following that two (2) weeks period, he/she shall be allowed to reapply for full privileges as provided by Article IX of these Bylaws.

ARTICLE X – PART F: ETHICS/CODE OF CONDUCT

The principle ethics of the American Medical Association shall govern the professional conduct of the members of the Medical Staff. The Medical Staff shall be expected to conduct themselves in accordance with the requirements of nationally recognized hospital and medical standardizing agencies and the members of the Medical Staff shall pledge themselves that they will not receive from nor pay to another physicians, osteopath, or dentist, either directly or indirectly, any part of fees received for professional

services. The same principles of ethics shall apply to the dentists in accordance to or with the Code of Ethics of the American Dental Association.

ARTICLE X – PART G: EMERGENCIES

In case of an emergency, the physician attending a patient shall be expected to do all his/her power to save the life of the patient including the calling of such consultations that may be available or indicated.

ARTICLE XI – ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE XI – PART A: REAPPOINTMENT

Section 1. Department Procedure:

(a) No later than six (6) weeks prior to the end of the current appointment period of all Medical Staff members will be issued a reappointment form. This form shall include information pertaining to, but not limited to, privileges and staff status desired for the coming year as well as information pertaining to the loss of clinical privileges at another institution and whether the applicant's membership in local, state or national professional societies or his/her license to practice any profession in any state, or his/her Drug Enforcement Administration license has been suspended, modified, terminated or voluntarily relinquished. The Medical Staff Office shall send to the Credentials Committee the list of those appointees desiring reappointment. The Credentials Committee shall then in turn transmit to the Chairman of the Department a current list of all appointees who have clinical privileges in that department together with the clinical privileges each then olds, accompanied by copies of their applications.

(b) The reappointment forms shall request information on the applicant's physical and mental health.

(c) No later than fifteen (15) days after he/she receives the application, the Chairman of the Department shall transmit to the Credentials Committee the list of individuals recommended for reappointment in the same medical staff category with the same clinical privileges they then hold. In addition, the Chairman shall submit individual recommendations and the reasons therefor, for any changes recommended in staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not.

(d) Recommendations for increase or decrease of clinical privileges shall be based upon:

(1) Relevant recent training.
(2) Observation of patient care provided.
(3) Review of the records of patients treated in this or other hospitals.
(4) Results of the Hospital's quality assessment activities.
(5) Other reasonable indicators of the individual's continuing qualifications for the privileges in question.

ARTICLE XI – PART A:

Section 2. Recredentialing Process-PI

The Department Chairman shall issue a signed statement that he/she has used performance improvement data as a part of the recredentialing process for the recommendation of the applicant and shall further supply this to the Credentials Committee.

ARTICLE XI – PART A:

Section 3. Credentials Committee Procedure:

(a) The Credentials Committee, after receiving recommendations from the Chairman of each departments, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from hospital management for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuring appointment period.

(b) The Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Committee either as part of the reapplication process or during the appointment period to aid in determining whether clinical privileges should be granted or continued and make results available for the Committee's consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee, shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(c) The Credentials Committee shall prepare a list of persons currently holding appointment who are recommended for reappointment without change in staff category and clinical privileges. Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be handled individually.

(d) The Credentials Committee shall transmit its report and recommendations to the Executive Committee. The Executive Committee shall then make its recommendations to the Board in time for the Board to consider reappointments at its final scheduled meeting in each reappointment cycle. Where non-reappointment, non-promotion of an eligible current appointee, or further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article XII. The Chairman of the Credentials Committee or his/her designee shall be available to the Executive Committee to answer any questions that may be raised with respect to the recommendation.

ARTICLE XI – PART A:

Section 4. Meeting with Affected Individual:

If, during the process of a particular individual's reappointment, it become apparent to the Credentials Committee or its Chairman that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairman of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation, and ask him if he desires to meet with the Committee prior to any final recommendation by the Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the Committee shall indicate as part of its report to the Executive Committee whether such a meeting occurred.

ARTICLE XI – PART A:

Section 5. Procedure Thereafter:

Any recommendation by the Executive Committee denying reappointment, denying a requested change in staff category or clinical privileges shall entitle the affected individual to the procedural rights provided in Article XII. The Executive Director shall then promptly notify the individual of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article XII, after which the Board shall be given the Committee's final recommendation and shall act on it. If for any reason the application for reappointment has not been finally acted on by the Board prior to the end of the appointment year, the then current appointment and clinical privileges shall continue until final action on the application is taken by the Board.

ARTICLE XI – PART B: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

Section 1. Application for Increased Clinical Privileges:

Whenever, during the term of his/her appointment to the Medial Staff, an individual desires to increase his/her clinical privileges, he/she shall apply in writing to the Executive Committee on a form approved by the Board. The application shall state in detail the specific addition clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. This application will be transmitted by the Executive Director to the Credentials Committee and by it to the appropriate department. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application if the request is made at that time.

ARTICLE XI – PART B:

Section 2. Factors to be Considered:

Recommendations for an increase in clinical privileges made to the Board shall be based upon:

(1) Relevant recent training.
(2) Observation of patient care provided.
(3) Review of the records of patients treated in this or other hospitals.
(4) Results of the Hospital's quality assessment activities.
(5) Other reasonable indicators of the individual's continuing qualifications for the privileges in question.

The recommendation for such privileges may carry with it such requirements for supervision or consultation for such period of time as is deemed necessary.

ARTICLE XI – PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

Section 1. Grounds for Action:

Whenever, on the basis of information and belief, the Chief of Staff, the Chairman of a Department, the Chairman or a majority of any Medical Staff Committee, the Chairman of the Board or the Executive Director has cause to question that a violation of the Hospital Bylaws, these Medical Staff Bylaws and/or Rules and Regulations may have occurred based upon one or more of the following:

(a) The clinical competence of any Medical Staff appointee.

(b) The care or treatment of a patient or patients or management of a case by any Medical Staff appointee.

(c) The known or suspected violation by any Medical Staff appointee of applicable ethical standards, the Model Medical Staff Code of Conduct, or the Bylaws, Policies, Rules and Regulations of the Hospital or its Board or Medical Staff, including, but not limited to the Hospital's quality assessment, Risk Management and utilization review programs.

(d) Behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others, of the matter shall be addressed to the Credentials Committee making specific reference to the activity or conduct which gave rise to the request.

(e) Harassment. Harassment is defined as verbal or physical harassment that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, national origin, age, disability, marital status, citizenship or any other characteristic protected by law and is prohibited by this policy. Reports of verbal or physical actions that has the purpose or effect of creating an intimidating, hostile or offensive work environment or has the purpose or effect of unreasonably interfering with an individual's work performance or otherwise adversely affects an individual's employment opportunities will be investigated.

Harassing conduct includes, but is not limited to: epithets or name calling, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written or graphic material that denigrates or shows hostility or aversion toward an individual or group that is placed on walls or elsewhere exhibited on Hospital premises.

(f) Sexual Harassment. Sexual harassment is defined, as in the Equal Employment Opportunity Commission Guidelines, as unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature.

All circumstances will be investigated by the Credentials Committee or Peer Review Committee as appropriate under these Bylaws.

ARTICLE XI – PART C:

Section 2. Investigative Procedure:

The Credentials Committee shall meet as soon after receiving the request as practicable and if, in the opinion of the Credentials Committee:

(a) The request for investigation contains information sufficient to warrant a recommendation, the Credential Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the appointee; or

(b) The request for investigation does not at that point contain information sufficient to warrant a recommendation, the Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or if it is deemed necessary, appoint an Investigating Committee.

(1) This investigating Committee shall consist of three (3) persons, who are members of the Active Medical Staff. This Committee shall not include partners, associates, or relatives of the affected individual or of any members of the Credentials Committee.

(2) The Credentials Committee, its subcommittee, or the Investigating Committee, if used, shall have available to them the full resources of the Medical Staff and the

Hospital to aid in their work, as well as the authority to use outside consultants as required.

(3) The individual, with respect to whom an investigation has been requested, shall have an opportunity to meet, with the Investigating Committee before it makes its report. At this meeting, but not as a matter of right in advance of it, the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Credentials Committee.

(4) If a subcommittee or Investigating Committee is used, the Credentials Committee may accept, modify, or reject the recommendation it receives from that Committee.

ARTICLE XI – PART C:

Section 3. Suspension of Privileges:

At any time during the investigation, the Credentials Committee, with the approval of the Executive Director, may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of Hospital patients. It shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation shall be completed within thirty (30) days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.

ARTICLE XI – PART C:

Section 4. Procedure Thereafter:

(a) In acting after the investigation, the Executive Committee may:

(1) Issue a written warning
(2) Issue a letter of reprimand;
(3) Impose terms of probation;
(4) Impose a requirement for consultation;
(5) Recommend reduction of clinical privileges;
(6) Recommend suspension of clinical privileges for a term;
(7) Recommend revocation of staff appointment; or
(8) Recommend that no action is justified.

(b) Any recommendation by the Executive Committee for reduction of clinical privileges, for suspension of clinical privileges for a term of fourteen (14) days or more after the Credentials Committee acts or for revocation of staff appointment shall entitle the affected individual to the procedural rights provided in Article XII. Such a recommendation shall be forwarded to the Executive Director who shall promptly notify the affected individual by certified mail, return receipt requested. The Executive Director shall then hold the recommendation until after the individual has been deemed to have waived his right to a hearing. The Executive Director shall then forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The Chairman of the Executive Committee or his designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

(c) If the action of the Credentials Committee is less severe than reduction of clinical privileges or suspension of clinical privileges for a term of a month or more, or revocation of staff appointment, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made to the Board through the Chief of Staff, and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges; suspend clinical privileges for a month or more; or revoke staff appointment; it shall so notify the affected individual, through the Executive Director and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article XII.

(d) The Chairman of the Credentials Committee shall promptly notify the Executive Committee in writing of all requests for action regarding an individual received by the Credentials Committee and keep the Executive Director and Executive Committee fully informed of all action taken in connection therewith.

ARTICLE XI – PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1. Grounds for Summary Suspension:

(a) The Chief of Staff, the President of the Medical Staff, the Chairman of a Department, the Executive Director, or in his absence his designee, or the Chairman of the Board shall each have the authority to summarily suspend all or any portion of the clinical privileges of a medical staff appointee or other individual whenever such action is in the best interest of patient care or safety or the continued effective operation of the Hospital or whenever such individual has violated the Bylaws, Rules, Regulations and Policies of the Hospital or Medical Staff. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

(b) Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Executive Director or, in his absence his designee and the Chief of the Medical Staff, and shall remain in effect unless or until modified by the Executive Director or the Board.

ARTICLE XI – PART D:

Section 2. Credentials Committee Procedure:

Any person who exercises his/her authority under Section 1 of this Part to summarily suspend clinical privileges shall immediately report his/her action to the Chairman of the Executive Committee to take further action in the matter. At that point the Committee shall take such further action as is required in the manner specified under Part C of this Article. The summary suspension shall remain in force after the appropriate Committee takes responsibility unless and until modified by that Committee or the Executive Director or until the matter that required the suspension is finally resolved.

ARTICLE XI – PART D:

Section 3. Care of Suspended Individual's Patients:

Immediately upon the imposition of a summary suspension, the appropriate Department Chairman or, in his/her absence, the Chief of the Medical Staff, shall assign to another individual with appropriate clinical privileges responsibility for the care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered by

the Department Chairman in the selection of a substitute. It shall be the duty of the Chief of the Medical Staff and the Department Chairman to cooperate with the Executive Director in enforcing all suspensions.

ARTICLE XI – PART E: OTHER ACTIONS

Section 1. Action by State Licensing Agency:

Action by the appropriate state licensing board or agency reducing, revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of all hospital clinical privileges as that date, until the matter is resolved and the license restored. In the event of a reduction, revocation or suspension of any individual's professional license by the appropriate state licensing board; that individual shall immediately notify the Medical Staff office of the reduction, revocation or suspension. Failure to so notify the Medical Staff office may result in the summary suspension of all or any portion of the clinical privileges of said individual.

ARTICLE XI – PART E:

Section 2. Failure to be adequately insured:

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, the appointee's clinical privileges shall be voluntarily relinquished as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

ARTICLE XI – PART E:

Section 3. Failure to Attend Meetings or Satisfy Continuing Education Requirements:

1. Failure to attend meetings as required in these Bylaws Rules and Regulations or failure to complete mandated continuing education requirements imposed by the Kentucky State License Agency shall be considered a voluntary relinquishment of Medical Staff appointment and shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically considered by the Executive Committee when making its recommendations for reappointment and by the Board when making its final decisions.

2. Any individual whose reappointment has been refused for these reasons shall be entitled to meet with a Committee to be designated by the Board before final action is taken. This meeting with the Board Committee shall be conducted under the procedural rules provided in these Bylaws.

3. If reappointment is refused by the Board, the individual shall be eligible to reapply for staff appointment and the application shall be processed in the same manner as if it were an initial application.

ARTICLE XI – PART E:

Section 4. Procedure for Leave of Absence:

(a) Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Board.

(b) Requests for leaves of absence shall be made to the Chairman of the Department in which the individual applying for leave has primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The Department Chairman shall transmit the request together with his/her recommendation to the Credentials Committee which shall make a report and a recommendation and transmit it to the Executive Committee. The Executive Committee shall transmit its recommendation to the Board for final approval.

(c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Executive Committee summarizing his professional activities during the leave of absence. The individual shall also provide such other information as may be required by the Hospital at that time. Final approval will be given by the Board.

(d) In acting upon the request for reinstatement the Board may approve reinstatement either to the same or a different staff category, and may recommend limitation or modification of the clinical privileges to be extended to the individual upon reinstatement.

ARTICLE XII – HEARING AND APPEAL PROCEDURES

ARTICLE XII – PARTY A: INITIATION OF HEARING

An applicant or an individual holding a Medical Staff appointment shall be entitled to a hearing whenever a recommendation unfavorable to him has been made by the Executive Committee regarding those matters enumerated in Part B, Section 2 of this Article. In the event the Board should determine to reject a favorable recommendation by the Executive Committee regarding any of those matters, the affected individual shall also be entitled to a hearing before the Board enters a final decision. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital Corporation, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out. Accordingly, the hearing shall be conducted in as informal a manner as possible, subject only to the rules and procedures set forth in these Bylaws.

ARTICLE XII – PART B: THE HEARING

Section 1. Notice of Recommendation:

(a) When a recommendation is made which, according to these Bylaws, entitles an individual to a hearing prior to a final decision of the Board on that recommendation, the affected individual shall promptly be given notice by the Executive Director, in writing, return receipt requested. This notice shall contain a statement of the recommendation made, "the reasons for the recommendation, and the right to request a hearing on the recommendation. Additionally, the notice shall contain a summary of the rights in the conduct of the hearing."

(b) Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing by the Hearing Panel hereinafter referred to, said request being made by written notice to the Executive Director. In the event the affected individual does not request a hearing within the time and in the manner herein above set forth, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

ARTICLE XII – PART B:

Section 2. Grounds for Hearing:

No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

(a) Denial of initial Medical Staff appointment;
(b) Denial of requested advancement in Medical Staff category;
(c) Denials of Medical Staff reappointment;
(d) Revocation of Medical Staff appointment;
(e) Denial of requested initial clinical privileges;
(f) Denial of requested increased clinical privileges;
(g) Decrease of clinical privileges;
(h) Suspension of total clinical privileges for a term of a month or more.

ARTICLE XII – PART B:

Section 3. Unappealable Actions:

Neither voluntary or automatic relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirements, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Executive Committee or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

Section 4. Notice of Hearing and Statement of Reasons:

The Executive Director shall schedule the hearing and shall give notice, in writing, return receipt requested to the person who requested the hearing of its time, place, date and list of witnesses expected to be called by the Medical Staff or Hospital at the hearing. The hearing shall begin within thirty (30) days. This notice shall contain a statement of the reasons for the recommendation as well as the patient records and information supporting the recommendation. This statement and the patient records and information it contains may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and his/her counsel have sufficient time to study this additional information and rebut it.

ARTICLE XII – PART B:

Section 5. List of Witnesses:

If either party, by notice, requests a list of witnesses, then each party within ten days of such request shall furnish to the other a written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may at any time during the course of the hearing be changed, provided that notice of the change is given to the other party.

ARTICLE XII – PART B:

Section 6. Hearing Panel:

When a hearing is requested, the Executive Director acting for the Board and after considering the recommendations of the Chief of the Medical Staff and the Chairman of the Board, shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The majority of the Panel shall be

composed of Medical Staff appointees who shall not be in economic competition with the physician involved and shall not have actively participated in the consideration of the matter involved at any previous level or physicians not connected with the Hospital or a combination of such persons. Such appointment shall include designation of the Chairman. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

ARTICLE XII – PART B

Section 7. Failure to Appear:

Failure without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

ARTICLE XII – PART B:

Section 8. Postponements and Extensions:

Postponements and extension of time beyond any time limit set forth in these Bylaws may be requested by anyone, but shall be permitted only by the Hearing Panel or its Hearing Officer on a showing of good cause.

ARTICLE XII – PART B:

Section 9. Deliberations and Recommendations of the Hearing Panel:

Within twenty (20) days after final adjournment of the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Hearing Officer shall render a recommendation accompanied by a report, which shall contain a concise statement of the reason justifying the recommendation made and shall deliver such report to the Executive Director.

ARTICLE XII – PART B:

Section 10. Disposition of Hearing Panel Report:

Upon its receipt, the Executive Director shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Board for further action. He shall also send a copy of the report and recommendation, return receipt requested, to the individual who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, a copy of the report of the Hearing Panel shall be delivered by the Executive Director to the Committee for informational purposes.

ARTICLE XII – PART C: HEARING PROCEDURE

Section 1. Representation:

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He/She shall inform the Executive Director in writing of the name of that person at least ten (10) days prior to the date of the hearing. The Executive Director shall appoint a person, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine the cross-examine witnesses at the hearing.

ARTICLE XII – PART C:

Section 2. Hearing Officer:

(a) The Executive Director may appoint any attorney at law as Hearing Officer. Such Hearing Officer may not be legal counsel to the Hospital. He/she must act as a prosecuting officer, or as an advocate for either side at the hearing. He/she may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but he/she shall not be entitled to vote on its recommendations. He may thereafter continue to advise the Board on the matter.

(b) If no Hearing Officer has been appointed, the Chairman of the Hearing Panel shall be the Hearing Officer.

(c) The Hearing Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He/she shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he may be advised by legal counsel to the Hospital. In all instance, he shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Hearing Officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board.

ARTICLE XII – PART C:

Section 3. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

ARTICLE XII – PART C:

Section 4. Rights of Both Sides:

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the person requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. Further, the physician shall have a right to submit a written statement at the close of the hearing.

ARTICLE XII – PART C:

Section 5. Admissibility of Evidence:

This hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

ARTICLE XII – PART C:

Section 6. Official Notice:

The Hearing Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidenced admitted on official notice.

ARTICLE XII – PART C:

Section 7. Basis of Decision:

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(a) Oral testimony of witnesses;
(b) Memorandum of points and authorities presented in connection with the hearing;
(c) Any information regarding the person who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
(d) Any and all applications, references and accompanying documents;
(e) All officially noted matters;
(f) Any other evidence that has been admitted.

ARTICLE XII – PART C:

Section 8. Burden of Proof:

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

(a) The Board or the Executive Committee, whichever recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in his/her support.
(b) After the evidence has been submitted by both side, the Hearing Panel shall recommend in favor of the Board unless if finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

ARTICLE XII – PART C:

Section 9. Attendance by Panel Members:

Recognizing that it may not be possible for all members of the Hearing Panel to be present continually at all sessions of the panel, since it is necessary to conduct a hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Hearing Panel are not present at all times. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. Consequently, no quorum of the Hearing Panel shall be required in order to continue the hearing. The vote shall be by majority of those appointed to the Hearing Panel.

ARTICLE XII – PART C:

Section 10. Adjournment and Conclusion:

Upon the adjournment of the hearing, the physician involved has the right to:

(1) Receive the written recommendation of the presiding officer including a statement of the basis of the recommendations; and
(2) To receive a written decision of the healthcare entity, including a statement of the basis for the decision.

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

ARTICLE XII – PART D: APPEAL

Section 1. Time for Appeal:

Within ten (10) days after the affected individual is notified of an adverse recommendation from the Hearing Panel or Board Committee modifying a recommendation of a hearing panel which was not appealed in a manner adverse to the individual, he/she may request an appellate review. The request shall be in writing, and shall be delivered to the Executive Director either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved, and it shall thereupon become final and immediately effective.

ARTICLE XII – PART D:

Section 2. Grounds for Appeal:

The grounds for appeal from an adverse recommendation shall be that:

(a) There was substantial failure on the part of the Executive Committee, Hearing Panel, or Board Committee, whichever recommendation is the subject of the appellate review, to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or

(b) The above recommendations were made arbitrarily, capriciously, or with prejudice; or

(c) The above recommendations were not supported by the evidence.

ARTICLE XII – PART D:

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than twenty (20) days, nor more than forty (40) days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

ARTICLE XII – PART D:

Section 4. Nature of Appellate Review:

(a) The Chairman of the Board shall appoint a Review Panel composed of not less than three (3) persons either members of the Board or other, including but not limited to reputable persons outside the Hospital, or any combination of the same, to consider the record upon which the pending recommendation was made.

(b) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he/she was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel.

(c) Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the Review Panel may allow each party or his/her representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board.

(d) The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

ARTICLE XII – PART D:

Section 5. Final Decision of the Board:

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Chairman of the Executive Committee, in person or by certified mail.

ARTICLE XII – PART D:

Section 6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

ARTICLE XII – PART D:

Section 7. Right to One Appeal Only:

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one (1) appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Executive Committee or Hearing Panel, or a combination of acts of such bodies. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff to an applicant or revoke or terminate the Medical Staff appointment, and clinical privileges of a current appointee, that individual may not again apply for Medical Staff appointment or clinical privileges at this Hospital unless the Board provides otherwise. However, nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of an appointee to apply for

reappointment and clinical privileges after the expiration of five (5) years from the date of such Board decision unless the Board provides otherwise on its written decision.

ARTICLE XIII – AMENDMENTS TO THE BYLAWS

(a) All proposed amendments to these Bylaws may be initiated by either the Full Medical Staff or the Executive Committee. The proposal shall be submitted by the Bylaws Committee in writing and read, if so desired, by either of the above bodies when the proposal is submitted. There shall be a lapse of thirty (30) days before the amendment is next considered, and this consideration shall be made by the Full Medical Staff. The amendment shall require a two-thirds (2/3) majority vote of those active medical members present and voting. The amendment(s) shall become effective when approved by the Board;

(b) The Executive Committee shall have the power to adopt such amendments to the Bylaws which are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, due to punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent, if not disapproved, by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption,

(c) These Bylaws Rules and Regulations shall not be amended unilaterally by either the Medical Staff or the Board.

ARTICLE XIV – ADOPTIONS

These Bylaws of the Medical Staff, which constitute Part II of the Corporate Bylaws of Methodist Hospital, are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and henceforth, all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws. They shall therefore be incorporated in the Corporate Bylaws of the Community United Methodist Hospital, Inc. d/b/a Methodist Hospital, Henderson, Kentucky.

Chairman, Board of Directors	President, Medical Staff
Secretary, Board of Directors	Secretary, Medical Staff
Executive Director	Chief of Staff

RULES AND REGULATIONS OF THE MEDICAL STAFF

Section 1. Statement

Medical Staff Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws and shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

Section 2. General

(a) Acceptance of a member of the Medical Staff of Methodist Hospital, in Henderson, Kentucky, shall automatically constitute an agreement by that member to abide by the Rules and Regulations of the Medical Staff and be governed by the Corporate Bylaws of the Hospital.

(b) Unprofessional and unethical conduct or violation of the Rules and Regulations of this staff shall constitute grounds for expulsion from the Hospital. Any member so charged shall have the opportunity of appearing before the Executive Committee of the Medical Staff in accordance with the procedures set forth in these Bylaws.

(c) Physicians admitting private patients in this Hospital shall be responsible for giving information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient that is to be admitted.

(d) The attending physician shall be held responsible for preparation of the complete medical record for each patient. This record shall include identification data, complaint, personal history, past history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisions diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or a discharge note and autopsy findings when available.

(e) Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsies shall be performed without the proper written consent. All autopsies shall be performed by the Hospital pathologist or by a physician delegated to this responsibility.

(f) All non-private or medical indigent patients shall be attended by members of the Active Staff and any patient who is admitted to the Hospital who has no attending physician shall be assigned to a member of the Active Staff on duty or shall be properly assigned to a member of the Department to which the illness of the patient indicates assignment.

(g) Members of the Medical Staff shall encourage consultations. In case of charity patients, any physician, osteopath or dentist shall give his/her services free. A consultant shall record his/her findings and recommendations, which shall form a part of the patient's record.

(h) Each member of the Medical Staff or his/her alternate, shall see all of his/her patients once a day and a daily, meaningful process note will be written. However, the final progress note may be written at any time within twenty-four (24) hours of discharge.

Only physicians can write orders with the following exceptions:

(1) Physician Extenders – as noted in Article V, Part C.
(2) Medical Students, Nursing Students and Physician Assistant Students – as noted in Article IX, Part D, Section 6
(3) Medical Associates as it relates to podiatrists and CRNAs, as noted in Article V, Part A, Section 1 and Section 2.

(i) General Privileges:

(1) Unless otherwise limited by these Bylaws or Medical Staff Rules and Regulations, the Physician Extender may provide such services as allowed by the Kentucky law and Physician Extender's particular scope of practice.

(a) Make rounds for the Physician Employer.
(b) Examine the patient after the initial examination has been performed by the Physician Employer.
(c) Transcribe orders and make progress note entries which are dictated by the Physician Employer and countersigned within 24 hours of the entry.
(d) An individual who has gone through a formal training program as a Physician Assistant (PA) or Advanced Registered Nurse Practitioner (ARNP) and is licensed by his/her respective licensure board, may perform and dictate history and physical examinations and dictate discharge summaries on behalf of his/her Physician Employer.

(2) Inspect wounds and change dressings.
(3) Remove sutures.
(4) May assist on surgical cases where an M.D. assistant is not required, provided Surgical Services privileges are requested and the conditions of Article V, Part B are met.

The term assisting allows the Physician Extender to perform the following duties as directed by the Physician Employer.

(a) Provide retraction.
(b) Manage special instrumentation.
(c) A physician assistant, who has been certified through an approved program in which the applicant was taught skin closure, and who is licensed as a physician assistant by the Kentucky Board of Medical Licensure, may close the skin and subcutaneous tissue as long as the surgeon employer is in the operating suite.

A Physician Extender not trained or licensed as a physician assistant by the Kentucky Board of Medical Licensure, may be granted privileges to close skin and subcutaneous tissue provided the individual can provide proof of one of the following:

(a) Training as a first assistant in a certified training program.
(b) Five (5) years' experience in performing this procedure in a Joint Commission approved institution.
(c) Attendance at a seminar of three (3) hours, devoted completely to wound closure.

STIPULATION: Extender must be supervised for ten (10) cases prior to granting this privilege.

(d) Assist in set up, preparation and clean-up of the procedure.
(e) Assist in instrumentation in a cooperative effort with the Operating Room staff.

(5) Arrange the admission of patients under direct instructions from the Physician Employer.
(6) Give certain routine instructions to the patient as advised by the Physician Employer (i.e. discharge instructions for post hospital care).
(7) **THE GRANTING OF PRIVILEGES TO PERFORM SERVICES BY THESE INDIVIDUALS SHALL IN NO WAY RELIEVE THE COLLABORATIVE PHYSICIAN FROM PERFORMING HIS/HER DUTIES AS OUTLINED IN SECTION II. PART H OF THE RULES AND REGULATIONS OF THE MEDICAL STAFF BYLAWS.**
(8) Departments specific privileges:

(a) May put on initial case under the direct supervision of the Physician Employer. May change a cast.
(b) May set up traction.
(c) Assist in placement of Steinman Pins. May remove Steinman Pins.

(j) Special Privileges: Special privilege requests shall be submitted to the department involved for recommendation. Special privileges shall be recommended on an individual basis by the department to which the privileges apply, but shall not be recommended unless the applicant can demonstrate special training and/or additional educational experiences to warrant such approval.

(k) Restrictions: Physician Extenders, excluding licensed ARNPs and PAs **MAY NOT**:

(1) Do patient chart (medical record) work, except for transcribing orders and progress notes which must be countersigned by the Physician Employer within 24 hours of entry.
(2) Perform nor dictate/record initial history and physical examinations.
(3) Dictate/record discharge summaries.
(4) Replace qualified assistants in surgery as specified by the Surgical Services Rules and Regulations.
(5) Assume the primary care of a patient nor substitute for an absent Physician Employer.

(l) Special Requirements for Physician Extenders in Surgical Services: All Physician Extenders who desire privileges in Surgical Services must make an appointment with the Director of Surgical Services or designee to ensure that the applicant has sufficient knowledge of sterile technique to perform duties in Surgical Services. Following the interview, the applicant will be given a tour of Surgical Services and in those cases, when indicated, an orientation session to Surgical Services will be arranged to the convenience of the applicant. A locker will be assigned to the applicant.

(m) Special requirements for Physician Extenders in the Emergency Department: A licensed PA or ARNP, employed the group contracted to deliver emergency services, may perform duties as established by diagnostic and treatment protocol. During those times in which the licensed PA or ARNP performs these duties under protocol, it is specifically understood that a physician member, of the group contracted to perform emergency services, shall be on duty and performing services in the Emergency Department and available for consultation as needed by the PA or ARNP (See Med. Staff P&P Protocols).

(n) Emergency Room Physicians:

(1) Will respond to all “Code Blue” calls;
(2) Will see all patients who present to the Emergency Room except in the event the private physician has been contacted by the patient prior to arrival to the Emergency Room and the private physician contacts the Emergency Room advising of this prior arrangement;
(3) Will admit all patients under a designated physician who will treat or be responsible for follow-up care.

(o) A special roster of on-call physicians of all clinical departments and their subdivisions will be posted in the Emergency Room.

(p) The maximum time acceptable for response, by a physician or oral surgeon member of the Medical Staff to an Emergency Room physician’s request for help in evaluation and/or treating an Emergency Room patient, shall be thirty (30) minutes.

(q) A medical screening examination is defined as the process to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency exists.

An emergency screening exam shall be conducted on every patient who presents for emergency treatment, or for active labor by a physician, unless the Medical Staff, either directly, or through the appropriate Committee of the Medical Staff authorizes other qualified medical personnel (i.e. R.N., L.P.N., Physician Assistant) through protocol, policy or procedure approved by the Medical Staff.

In the case of an emergency medical condition, all physicians with Medical Staff privileges shall be qualified to stabilize a patient by utilizing their medical judgment, independent knowledge, and if necessary, through consultation with other Medical Staff members.

(r) The following ER philosophy and protocols are approved by the Medical Staff.

(1) ER Philosophy
(2) Protocols
    (a) Scheduled Patient
    (b) Medical Screening Exam
    (c) Evaluation of Obstetrical Patients

(s) History and physical examinations may only be performed by physicians, physician assistants and advanced registered nurse practitioners that hold current hospital privileges or a physician who is licensed in the State of Kentucky and is a member in good standing on staff at a Joint Commission, or CMS or AOA approved hospital.

ER PHILOSPHY

1. It is the policy of Methodist Hospital to accept and treat within its capabilities every patient, without regard to race, national origin, sex, religion, type of illness, physical or mental capabilities or ability to pay. Treatment shall not be delayed in order to obtain payer source information.

2, In no event shall a different level of care be provided to any patient based upon race, national origin, sex, religion, type of illness, physical or mental capabilities or ability to pay.

3. The Emergency Department is designed, equipped and staffed to provide prompt, courteous and competent treatment to every patient who presents to the Department. Medical and nursing personnel are on duty twenty-four (24) hours a day, with other professional services available immediately or within a reasonable period of time.

4. The purpose of the Emergency Department is:

   A. To provide care of individuals with acute medical or surgical emergencies;

   B. To provide personalized care in a manner that enables the patient and his/her significant others to view the Emergency Department experience as a positive interaction with the health care system. This is to be accomplished without compromising good standards of care while upholding the moral and ethical principles of care in emergency medicine.

   C. To integrate fully with the other disciplines of the Hospital and with the surrounding community, including all aspects of disaster planning, and

   D. To provide pre-hospital care by serving as a base station for approved ambulance care units.

ER SCHEDULED PATIENT

Certain out-patient procedures may be performed in the Emergency Department or shall gain entry to the Hospital through the Emergency Department without the patient being considered an emergency visit.

General Information:

1. Physicians having Medical Staff privileges at Methodist Hospital may schedule certain non-emergency out-patient procedures, examinations or evaluations with the Emergency Department, primarily as an entry point to the Hospital and for convenience of the patient.

2. The physician will either call the Emergency Room nurse and give a phone order for treatment or the patient will present with a written order for all scheduled procedures, examinations or evaluations.

3. Scheduled cases are not considered an emergency and do not require the Emergency Room physician to see and perform a medical screening examination unless the patient presents with symptoms unrelated to the scheduled visit. If there is a question as to the condition of a patient, an appropriate medical screening exam shall be performed.

4. Emergency Room records are not used for scheduled cases.

5. Examples of possible scheduled procedures are:
   •Patients who are to receive physician ordered injection or an IV of less than one (1) hour duration.
   •Persons presenting for Work Track rechecks.

•Appointment with attending physician to be seen at the Hospital.

Procedure:

1. Patient is seen by the Emergency Room screen nurse and assigned to an available room and primary nurse.

2. The patient is registered by the Emergency Room clerk, using the appropriate patient type, service code, admitting type and source code.

3. The primary nurse will perform a nursing evaluation and record the patient's chief complaints, allergies and vital signs on the interdisciplinary progress note. All interventions by the Emergency Room nurse or the attending physician will also be recorded on the progress note.

4. If during the nurse evaluation, it is determined conditions exist which are in addition to those the patient presented for, the Emergency Room physician will see the patient and the attending physician will be notified without delay for approval or determination of payer source. The patient record should then be converted to a full Emergency Room record and logged as such.

5. Discharge instructions will be provided to the patient on release from the area.

6. Work track recheck patients will be given an appointment time to return when released after the initial visit.

7. The patient information is to be entered into the "Scheduled Out-Patient" log and **NOT** the Emergency Room log unless the procedure in paragraph 4 above is implemented.

Medical Screening Exam:

Every person who requests emergency treatment shall have the right to receive an appropriate medical screening exam and treatment for their condition within the capabilities of Methodist Hospital including routinely available ancillary services and if necessary, available on-call physicians. An emergency medical screening exam is a process, the details of which depend upon the individual circumstances and may consist of a history or physical or utilization of any routinely available ancillary tests and if necessary, available on-call physicians, necessary to reach the determination as to whether an emergency medical condition exists.

An emergency medical screening condition is defined as a medical condition manifesting itself by acute systems of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

> Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part of with respect to a pregnant woman who is having contractions.

Procedure:

The emergency medical screen exam shall be conducted by a physician unless other medical personnel are qualified within the scope of their license to make an assessment of the patients as authorized by the Medical Staff through its Bylaws or Rules and Regulations.

Individuals shall initially see an Emergency Department Registered Nurse who shall triage and initiate a screen exam which shall consist of an assessment of the patient's condition within the scope of the Nurses license and training and further as authorized by any Medical Staff approved protocols. The screening exam shall be concluded by the Emergency Room physician utilizing such consultation with other physicians who specialize in clinical areas which are deemed necessary in his/her clinical judgment to determine whether an emergency medical condition exists. In the presentation of a woman complaining of active labor, she shall be taken directly to the OB unit to be assessed in accordance with the established protocol in OB.

Evaluation of Obstetric Patients

All pregnant patients who present to the Obstetric Department either directly or from the Emergency entrance will be screened by a registered nurse specially trained in Labor and Delivery. The nurse will have completed orientation to Labor & Delivery and demonstrated competency in care and assessment of the antepartum, intrapartum and post partum patient.

For the patient who presents with complaint of contractions:

1. Place in labor bed.
2. Determine frequency of contractions.
3. Assess fetal heart rate.
4. Determine dilation.
5. Determine estimated date of delivery and gravity.

For patients who are in late active labor transition or second stage and delivery is expected in a short period, the patients physician is to be contacted immediately. The patient, who does not have a physician will be attended by the physician on call. Refer to schedule On Call physician for walk-ins. Begin preparations for delivery, which include but not limited to, notification of Nursery and Neonatologist if appropriate. Prepared Delivery area. Continue Maternal and Fetal Assessment per unit procedure. Admission of Labor patient as time permits, may be completed after delivery but before transfer to post partum.

Patients in early labor will have a complete screening prior to delivery, fetal status: heart rate, assessment, position, gestation. Maternal Status: status of labor, cervical effacement, dilation, station, membranes, vital signs, deep tendon reflexes if B/P elevated, documentation of frequency, intensity and duration of contractions and uterine relaxative. Maternal health history: risk identification, blood type and RH, hepatitis status, drug and alcohol use. Maternal and family support systems. Sociocultural background and economic needs identify support persons, level of childbirth preparation.

Document screening assessment, discuss plan of care with patient and family. Notify physician of patient screening within one (1) hour of admission. The patient, who does not have a Physician, will be attended by the Physician on call; refer to schedule On Call Physician for walk-ins.

For patients who present with complaint of vaginal bleeding:

1. Place in labor bed.
2. Assess fetal status.
3. Assess for pain and amount of bleeding.
4. Assess vital signs.
5. Determine estimated date of delivery.

If screening parameters are within normal limits, continue with complete screening assessment. If screening reveals heavy bleeding, pain, abnormal fetal heart or unstable vital signs, the patient's physician is to be contacted immediately. The patient who does not have a Physician will be attended by the Physician on call: refer to On Call Physician for walk-ins.

For the patient who presents with complaint of HA, backache, lower abdominal pain, pressure, low fetal movement or generalized discomfort:

1. Place in labor/testing room.
2. Do complete screening assessment per OB Policy & Procedures.
3. For the patient with urinary tract symptoms, obtain clean catch urine specimen for evaluation.
4. Notify the patient's Physician within one (1) hour of admission to the unit. The patient who does not have a Physician will be attended by the Physician on-call. Refer to schedule On Call Physician for walk-ins.

Section 3. Admissions

(a) The Hospital shall admit patients suffering from all types of disease for which it is capable of providing care and further will render emergency treatment to the degree possible for those cases which it cannot provide ongoing care.

(b) All elective surgical patients, with the exception of same day surgery patients, are to be admitted to the Hospital no later than 4:00 p.m. on the day prior to the scheduled operation. The only exception to the rule will be as specified in the Surgical Rules and Regulations.

Section 4. Orders

(a) All verbal/telephone orders may be taken from any member of the Active, Associate, Courtesy or Consulting Medical Staff by the Hospital personnel as follows:

1. Nursing: R.N. or L.P.N.
2. Cardiopulmonary Services: Respiratory Therapist
3. Home Medical Equipment: Respiratory Therapist
4. Radiology: Radiologist
   Technologist
   Radiologist designee
5. Pathology: Pathologist
   Technician
   Pathologist designee
6. Rehabilitative Services: Physical Therapist
   Occupational Therapist
   Speech Language Pathologist
7. Pharmacy: Pharmacist
   Nursing Supervisor
8. Dietary: Registered Dietitian
9. Social Worker: Discharge order (including diet/activity orders, D/C peripheral IV/Foley catheters, etc.; transportation orders; therapy orders (PT, OT, Speech therapy, etc.); Referrals to DSS, agency referrals (Home Health, Hospice, TCU, etc.), Equipment orders: Oxygen orders.

All verbal orders must be signed within twenty-four (24) hours by a Medical Staff member.

The Hospital personnel receiving the verbal/telephone order shall record in the medical record the time, date, type order (p.o. or v.o.), physician's name, and the first initial and last name and title of the person taking the order.

(b) Standing orders shall be formulated either by the Full Medical Staff, Executive Committee, or the appropriate committees of the Medical Staff. They can be changed only by mutual consent of the Medical Staff or its committees. These orders shall be signed by the attending physician and shall become a permanent part of the patient's record.

(c) A Physician may obtain consent from a patient who has received a pre-anesthetic analgesic, sedative or anesthetic agent provided that immediately prior to signing the consent and after evaluation of the patient the Physician who is to perform the procedure documents in the patient's medical record the following:

1. The patient is oriented to time, place and person; and
2. The risks, potential benefits and alternatives of the procedure have been explained to the patient by the Physician and that the patient indicated he/she understands; and
3. In the Physician's opinion, the patient is mentally capable of comprehending everything explained in (2.) above.

If this is not documented in the medical record, patients who have received sedation must wait a minimum of three (3) hours before signing an operative consent for an elective procedure.

(d) Automatic stop orders apply to:

1. Parenteral Class II narcotics after seven (7) days unless a specific period of time is designated in the order that initiated the administration of the drug.

(e) When a patient is transferred to a different level of care, the Physician giving the transfer order is to review and either, approve or delete all previous orders.

(f) All orders pertaining to a patient moved to Surgical Services shall be cancelled upon arrival in Surgical Services. Post-procedurally, a Physician may reinstitute the previous orders or write new orders.

Section 5. Records

All documentation and entries in the Medical Record, both paper and electronic, must comply with the applicable Methodist Hospital Medical Staff Bylaws and Rules and Regulations requirements for quality, content and timely completion.

(a) A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

For medical H & P examination that was completed within thirty (30) days prior to registration or in-patient admission, an update, documenting any changes in the patient's condition, is completed within twenty-four (24) hours after registration or in-patient admission, but prior to surgery or a procedure requiring anesthesia services.

Each Physician's performance will be reviewed quarterly. Failure to meet this requirement on 90% of admissions will result in withholding emergency and elective admitting privileges. Upon receipt of a notice from the Medical Staff Secretary, of the violation of this rule, the Physician may voluntarily relinquish his/her privileges by informing the Medical Staff Secretary of the same within seventy-two (72) hours after receiving the above notice. Should the Physician fail to voluntarily relinquish his/her privileges, the Physician shall be notified by the Secretary of the Medical Staff that his/her privileges have been withheld. While privileges are withheld, the Physician cannot admit any new patients under his/her name or in another Physician's name. The Physician, whose privileges are withheld, shall remain responsible for providing care for those patients who are presently under his/her care either as the attending or consulting physician. Once privileges are withheld, the Physician may reapply for admitting privileges, in writing to the Chief of Staff with a copy for the Hospital's Executive Director. Except in a case of emergency, all patients for surgery shall have the history and physical examination performed and either recorded or dictated prior to the time stated for the operation. In those cases in which the history and physical examination has been dictated but is not present on the patient's chart, the attending physician must record in his progress notes all pertinent information deemed necessary for the welfare of the patient. If the history and physical has not been recorded, any elective surgical procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

The only except to performing complete history and physical examinations within twenty-four (24) hours of hospital admission is as follows:

(a) When a complete history and physical examination has been performed within seven (7) days of admission, a durable, legible copy of this report may be used in the patient's hospital medical record, provided there have been no subsequent changes.

(b) All records are the property of the Hospital. Records shall not leave the Hospital without a court order, subpoena or statute.

(c) In case of readmission, all previous records shall be available for the use of the attending physician. This shall apply whether this patient is a private or charity patient and whether he is attended by the same Physician or by another Physician.

(d) Free access to medical records of patients shall be afforded to staff physicians in good standing for treatment purposes only and consistent with preserving the confidentiality of the personal information concerning the individual patients in accordance with the provisions of HIPAA and Methodist Hospital confidentiality policies.

(e) Surgical operations shall be performed only with the consent of the patient or his/her legal representative e, except in a case of extreme emergency.

(f) All operations performed shall be fully described by the operating surgeon and recorded on the patient's chart.

(g) A medical record will be considered delinquent thirty (30) days after discharge. (**EXCEPTION:** The medical record must be completed in its entirety within fifteen (15) days following the patient discharge from a licensed psychiatric unit – **STATE LAW**.)

Failure to complete any medical record within the above time frame will result in the physician being given a notification by the Medical Records Department of a pending temporary interruption of hospital privileges related to new patients. If the physician fails to complete

the delinquent records within the subsequent seven (7) calendar days, then he/she will have their hospital privileges temporarily interrupted (by Hospital Administration) immediately, and without further notice (other than the letter of confirmation of the temporary interruption). A physician's temporary interrupted privileges shall be automatically reinstated immediately upon completion of delinquent records. Any Physician so suspended shall not admit any new patients under his/her own name or in another Physician's name. The Physician so suspended, however, shall remain responsible for providing care for those patients who are presently under his/her care either as the attending Physician or as a consultant.

(h) All Physician's entries into a patient's medical record shall be authenticated with the written or electronic signature, as applicable on the original document by the Physician making the entry, with the exception of verbal orders by partners/associates, provided an agreement has been signed and is on file in the Medical Records Department. The entries shall include:

•H & P
•Progress Notes
•Discharge Summary
•Consultation Report
•Operative Procedure Report
•Informed Consents

(i) The patient shall be discharged from the Hospital only upon written order of a member of the Medical Staff. The discharge summary will be performed within seven (7) days after discharge. For this reason, the chart will be placed in the attending Physician's chart box within three (3) to five (5) days after discharge. If the chart is removed for any reason before the discharge summary is completed, notice of removal, location of chart and remaining time for completion shall be prominently displayed in the box.

Section 6. Diagnostic Facilities

(a) A laboratory shall be provided in the Hospital to insure as complete a service as possible. The Hospital pathologist shall be responsible for all work required to be performed in the laboratory and for all reports on this work. He shall be available to the operating room department whenever an immediate diagnosis is required to guide a surgeon in his operating.

(b) Diagnostic x-ray facilities shall be provided within the Hospital to insure as complete an x-ray diagnostic service as possible. All work shall be performed under the direction of a qualified radiologist. All x-ray reports are to be fully recoded and signed by the radiologists. All patients shall receive prompt service, that all requests shall be completed and returned no later than twenty-four (24) hours after their receipt.

Section 7. Consultation and Tissue Examination

(a) Consultation by qualified Physicians who are members of the Medical Staff are required on the following surgical procedures prior to surgery:

(1) Uterine curettage or other procedures, by which a known or suspected pregnancy may be interrupted.
(2) All cases in which, according to the judgment of the Physician, the patient is not a good risk for surgery or in which the diagnosis is obscure.

(b) All tissues removed by operations shall be sent to the Hospital pathologist who shall make such examination that he/she may consider necessary to arrive at a diagnosis. His/her report is to be fully recorded and signed and made a part of the patient's chart.

Section 8. Miscellaneous

(a) Drugs to be administered to the patient in the Hospital should meet the standards of the United State Pharmacopoeia. National Formulary, new and non-official remedies, with the exception of drugs for bona fide and clinical investigation with specified drugs that the Hospital pharmacy cannot provide.

(b) The Hospital shall maintain a Medical Library. Funds for the procurement of books and journals for this Library shall be obtained by requiring each staff member to pay dues, the amount of which is to be determined by the Active Medical Staff.

Section 9. Peer Review Policies

Definition

Peer Review is defined as the evaluation of an individual M.D./D.O.'s; Oral Surgeons; and other Licensed Independent Practitioner's (LIP) professional performance.

Purpose

To ensure the Medical Staff of Methodist Hospital assesses the professional performance of Licensed Independent Practitioners who have been granted clinical privileges utilizing the information for the purpose of improving patient care.

Goals

Seek to improve quality of care rendered by individual LIP's.

Identify areas in which performance improvement can be enhanced.

Monitor LIP's clinical privileges.

Analyze data in a fashion which can demonstrate trends.

Policy

All Peer review material shall be considered privileged and confidential and in accordance with Hospital and Medical Staff By-Laws; State & Federal Laws and regulations pertaining to confidentiality and nondiscoverability.

Provider specific information will be provided to an involved LIP in any situation which in the opinion of the Medical Executive Committee the information should be provided.

Provider specific information will be utilized in credentialing and re-credentialing processes, and as appropriate in performance improvement activities.

All provider specific and performance improvement information which concern an LIP will be kept in a safe, locked file. This information shall include:

Utilization Review and Performance Improvement data.

Sentinel Events

Significant incidents and near misses.

LIP specific correspondence regarding any performance improvements, credentialing, or re-credentialing information.

All peer review information shall be available only to authorized individuals who may have a legitimate need to know the information based upon their respective responsibilities either as Medical Staff Leaders or Hospital Employee, with the access to information limited to the extent necessary to carry out their assigned responsibilities. Authorized individuals are as follows:

Medical Staff Officers, including Chairmen of Departments

Members of the Medical Executive Committee

Medical Director

Hospital Risk Manager

Hospital Director of Case Management

Medical Staff Secretaries and member of the Case Management to the extent which this information is necessary for re-credentialing processes.

Accrediting Body surveyors (State Lic.; HCFA; Joint Commission)

Individuals with legitimate purposes as determined by the Hospital Board of Directors or its Legal Counsel.

No copies of peer review documents will be created nor distributed unless authorized by Hospital management or Hospital policy.

Circumstances Requiring Peer Review

Peer Review will be performed in the following circumstances:

Re-credentialing
Deaths
Adverse outcomes
Sentinel Events where applicable
Monitors/studies, when Physician is outlier

Peer Review shall be conducted by peers who have been granted privileges equal to or more than the practitioner in question. In the case of an M.D. or D.O. a peer is another person who is licensed as an M.D. or D.O. A peer of a licensed independent practitioner (LIP), is a practitioner who is licensed the same as the LIP.

Peer Review on Physician Assistants may be conducted as determined by the Medical Staff and the institution as these individuals are employees of, and under the direct supervision of the Medical Staff Members.

In general, Peer Review is conducted by the following Committees:

Medical Staff Departments
Medical Executive Committee
CM/Infection Committee
SCR/Transfusion
Pharmacy/Therapeutics
Credentials Committee
Intensive Care Committee

In any case where the possibility of a pre-determined bias or in the event of a conflict of interest, the membership of any of the above committees may be altered by appointment and/or removal of any members by the President of the Medical Staff. The change in Committee membership shall be only for the specific purposes of performing peer review on the specific LIP in question. In the final consideration the MSEC will consider minority opinions as well as the opinion of the LIP under review.

In special/specific circumstances a Peer Review panel may be appointed by the Medical Executive Committee. This appointed Committee will act under the direction of the Medical Executive Committee. Upon the completion of the investigation and filing of a report with the Medical Executive Committee, the appointed Committee will disband.

All peer review activities are to be performed in a reasonable time frame. In this situations in which a Medical Staff member's privileges are to be modified by reduction or terminated the Peer Review will be performed as specified in the Medical Staff By-Laws as denoted in the re-credentialing process.

In those cases determined to be a "Near Miss or Sentinel Event", the immediate review will be performed within seventy-two (72) hours of identification of the event. In case of a sentinel event, review and action will be determined following completion of a root-cause analysis. The responsibility for the review; rests with the clinical medical staff department in which the event occurred; the Medical Executive Committee; and the Board of Directors.

Circumstances requiring External Peer Review

An external Peer Review Panel may be requested when one (1) of the following conditions exists:

1. When there is an insufficient number of Medical Staff Peers to perform a review.

2. The internal peer review panel is unable to reach a conclusion on the matters pending.

3. In any situation in which a majority of the internal review committee members feel they lack the expertise to perform the review.

An individual who is under surveillance or discussion by a Peer Review Panel shall have an opportunity to meet with the Panel for purposes of answering questions from the panel; providing explanations of findings, and for purposes of answering questions from the panel; providing explanations of findings, and for discussing the facts with Panel as if necessary.

Section 10. Physician Health

Methodist Hospital and its Medical Staff shall design and provide educational programs which addresses prevention of physical, psychiatric or emotional illness of individual members of the Medical Staff, and foster confidential diagnosis, treatment and rehabilitation of those individual members who may suffer from potentially impairing conditions.

The process for insuring the above conditions are attained shall include:

Education of the Medical Hospital staffs about illness and impairment recognition issues specific to physicians.

Self-referral by a physician or referral by Hospital staff.

Referral to appropriate sources for diagnosis and treatment of the condition.

Expect as limited by law, ethics, or when patient safety is threatened, confidentiality of the Physician shall be maintained.

The credibility of a complaint, concern, or allegation about a Physician will be evaluated.

The affected Physician and the safety of his/her patients will be monitored until the rehabilitation is complete.

During the rehabilitation process should it be learned the Physician is providing questionable or unsafe patient treatment, the Chief of the Medical Staff will be immediately informed.

The purpose of the above process is to assist a Physician to retain or regain optimal professional functioning, which aids in patient protection. At any time during the diagnosis, treatment or rehabilitation should it be determined an individual Physician is unable to safely perform the privileges granted to her/him, the matter will be reported to the Chief of the Medical Staff for appropriate corrective action. This corrective action will include strict adherence to reporting requirements of either the state or federal government.

Section 11. Code of Conduct

The MODEL MEDICAL STAF CODE OF CONDUCT as copyrighted by the American Medical Association is hereby adopted as the standard of conduct for members of the Medical Staff. Each member of the Medical Staff shall sign an acknowledgement indicating they have read and agree to conduct themselves in accordance with the standards as set forth therein.

The procedure for complaints set forth in the AMA MODEL MEDICAL STAFF CODE OF CONDUCT shall not apply. Instead, the following procedure shall be followed to address any complaint of violation of this Article X, Part F: Ethics (See attached).

1. Initial Meeting:

(a) If the parties involved are members of the Medical Staff, they are encouraged to conduct a face to face meeting in a productive professional environment with the goal of reaching an amicable resolution. During the face to face meeting, the parties shall:

(1) Use this Code of Conduct as a reference.
(2) If needed, use Medical Staff leadership to help facilitate the discussion.
(3) If clinical care and/or process deficiencies have been identified during this meeting, those will be forwarded to the appropriate Medical Staff department for consideration.

(b) If the parties involved include non-Medical Staff members, the recommended face to face meeting will also include the Director of the affected Hospital employee's department.

2. Unresolved Issues:

(a) If the complaint of violation of this Article X, Park F, Ethics, is not resolved using the process in paragraph 1 of this Article, the Medical Staff member, Hospital employee or Hospital Department Director, shall file a written report which will be sent to the Medical Staff office. The Medical Staff office will distribute this report to the Chief of Staff, the Chairman of the appropriate committee of the Medical Staff involved and the appropriate department and/or committee of the Medical Staff. Additionally, a copy shall be sent to the Chief Executive Office of Methodist Hospital.

(1) If the complaint involves a Methodist Hospital employee, the Chief Executive Officer or his designee shall meet with the affected parties and develop a plan for appropriate counseling and intervention including, but not limited to any appropriate disciplinary action.

(2) If the complaint involves a non-employed member of the Medical Staff, the Chief of Staff along with the Chairman of the appropriate department shall meet with the affected parties and develop a plan for appropriate counseling and intervention including but not limited to any appropriate disciplinary action.

3. Grounds for Action:

In the event the process set forth in paragraph 1 and 2 above fail to result in an acceptable resolution, the matter will be considered Grounds for Action and the process set forth in Article XI, Part C, herein shall be followed.

Section 12. Amendments

Particular rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee and/or Full Medical Staff at any regular or special meeting provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee and/or Full Staff fourteen (14) days before being voted on and further provided that all written comments on the proposed changes by persons holding the current appointments to the Medical Staff are brought to the attention of the Executive Committee and/or Full Staff before the change is voted upon changes in the rules and regulations shall become effective only when approved by the Board.

Section 13. Medical Futility in End of Life Care

When further intervention to prolong the life of a patient become futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the Physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance. This may interrupt satisfactory decision-making and adversely affect patient care, family satisfaction and physician-clinical team functions.

To assist in fair and satisfactory decision-making about what constitutes futile intervention, the following seven (7) steps should be included in such a due process approach to declaring futility in specific cases.

1. Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy and physician on what constitutes futile care for the patient and what falls within acceptable limits for the physician, family and possibly also the institution.
2. Joint decision making should occur between patient or proxy and physician to the maximum extent possible.
3. Attempts should be made to negotiate disagreements if they arise and to reach resolution within all parties' acceptable limits with the assistance of consultants as appropriate.
4. Involvement of an institution committee such as the Ethics Committee should be requested if disagreements are irresolvable.
5. If the institutional review supports the patient's position and the Physician remains unpersuaded, transfer care to another Physician within the institution may be arranged.
6. If the process supports the Physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought; and, if done, should be supported by the transferring and receiving institution.
7. If transfer is not possible, the intervention need not be offered.

Section 14. Medical Staff Appointment, Re-Appointments, Clinical Privileges

The following items will be required to be submitted for initial Medical Staff appointment

- Copy of Driver's license
- Photo (JPEG) this will be attached to your delineation of privileges as a identifier
- Copy of all Certificates and Diplomas, i.e. Board Cert, ACLS, BLS, Moderate Sedation, etc.
- Copy of social security card
- Copy of COI
- Copy of DEA
- Copy of Medical License
- Copy of Immunization Record
- Criminal Background Check
- Excluded Provider Registry
- Release
- Health Status Questionnaire
- Alternate Designee

The following items will be required to be submitted for the Medical Staff Reappointment:

- Copy of Driver's license
- Release
- Health Status Questionnaire
- Alternate Designee

In the event any information comes to the attention of the Medical Staff Office during the reappointment or credentialing process with information that may have a negative or adverse impact, the applicant shall be notified of the information and given an opportunity to respond prior to the Credentials Committee meeting.

Section 15. Surgical Rules and Regulations

The Surgical Rules and Regulations are hereby made an official part of the Rules and Regulations of the Medical Staff Bylaws.

RULES AND REGULATIONS FOR PROCEDURES PERFORMED IN SURGICAL SERVICES

Surgical Services is defined as a department of Methodist Hospital, composed of offices, lounges, storage rooms and operating rooms located on the first (1st) floor of the Hospital, accessible from the main corridor. The operating rooms are utilized for the performance of the following procedures:

Pre-admission testing
Admission of Out-patients for Preoperative Preparations
Endoscopy
Laser
Major Surgery
Minor Surgery
Pathology
Post-Anesthesia Recovery
Step-Down Recovery

The services provide for the following:

Equipment and supplies for surgical procedures in the fields of General Surgery, OB/GYN, Orthopedics, Urology, Ophthalmology, ENT, Oral Surgery/Dentistry, Podiatry, Endoscopy, Neurology and Pulmonology.

Equipment and supplies for performing diagnostic procedures and peri-operative nursing for all patients experiencing surgical intervention/diagnostic procedures.

Any Physician who is granted privileges to perform procedures in Surgical Services must be either board certified or have completed an approved residency in a surgical field recognized by the Accreditation Council of Graduate Medical Education of the American Medical Association, or by the American Dental Association or by the American Podiatric Association with the following exceptions:

1. An internist or medical subspecialist may use an operating room for the purposes of performing those procedures which he/she has been granted privileges to perform in this institution.

2. A general/family practice physician may use an operating room for the purpose of performing those procedures which he/she has been granted privileges to perform in this institution.

3. A general dentist may use an operating room for the purpose of performing those general dental procedures which he/she has been granted privileges to perform in this institution.

All patients who undergo surgery or other invasive procedures which require general, spinal, regional block anesthesia, that in the manner used, may result in the loss of the patient's protective reflexes shall be rendered services in accordance with these policies. For the purposes of these policies, invasive procedures include, but are not limited to, percutaneous aspirations, biopsies and endoscopic examinations.

The terms operating surgeon and physician as used in these policies shall be synonymous.

SECTION I. General Major Anesthesia Cases

This section shall apply to patients experiencing surgical intervention within Surgical Services who are to receive regional, spinal, or general anesthesia and specifically to those patients who are to receive sedation/medication which the attending physician will be unable to administer.

A. Scheduling:

1. Elective Procedures

a. Elective cases will be scheduled on first-come, first serve basis.

b. It is the responsibility of the operating surgeon to provide an assistant in any case in which an assistant is necessary, irrespective of whether the case may have begun as a diagnostic or therapeutic procedure. An M.D. assistant is not mandatory but at the physician's discretion.

c. Elective scheduled cases will not begin before 7:30 a.m. unless there is mutual concurrence between Surgical Services and the operating surgeon.

d. The patient will be in the operating room, ready for the anesthetic administration at 7:30 a.m.

e. Anesthesia personnel will be in the operating room and be prepared to begin anesthesia administration at 7:30 a.m.

f. The operating surgeon must be in the Surgical Services Department before the patient's anesthesia is begun, irrespective of the time of day. Further, in those cases where an Operating Surgeon has determined an assistant is necessary, the assistant must be physically present in the Hospital before the anesthesia is begun.

2. Emergencies:

Emergencies will:

a. Be scheduled at the discretion of the operating surgeon.

b. Interrupt the daily surgical schedule if the operating surgeon attending the emergency patient determines the interruption to be necessary.

c. Be performed in the first available operating room, if urgent.

B. Admissions:

All patients, irrespective of admission status or procedures to be performed, must be admitted allowing sufficient time, as determined by Surgical Services/Nursing Services, for their preoperative preparation, prior to the scheduled time of the procedure.

All patients, other than in-patients, should be "pre-admitted," in order that the Physician can evaluate the necessary preoperative studies prior to the day of admission.

C. Chart Requirements:

1. Elective Procedures:

The following requirements must be met by 7:00 a.m. on the morning of the scheduled procedure:

a. A consent for the procedures signed by the patient or his/her legal representative.

b. A recording of the history and pertinent physical findings or a progress note entry stating the following information about the patient:

1. A history and pertinent physical has been dictated
2. Surgical Diagnosis
3. Known or suspected allergies
4. General condition
5. Surgical risks
6. Intent and/or expected benefit of proposed procedure.

2. Emergency Procedures:

Chart requirements for emergency procedures are the same as for elective procedures; however, in extreme emergencies, the case may proceed when the chart requirements have not been met, provided that prior to the patient being taken to Surgical Services, the operating surgeon enters on the progress note the following information:

a. The chart requirements that have been deleted, and
b. Any delay to meet the chart requirements would be detrimental to the patient's wellbeing.

D. Cancellations:

An elective-scheduled surgical case will be canceled for the following reasons:

1. Failure to complete chart requirements by 7:00 a.m. on the date of a scheduled 7:30 a.m. case.
2. Absence of the Physician and/or M.D. physician assistant by 7:30 a.m. on the date of a scheduled 7:30 a.m. case, unless Surgical Services is notified of an anticipated late arrival by the Physician or the assistant, in which case a fifteen (15) minute grace period will be allowed.
3. "To Follow" cases, when the Physician cannot be located, and there is insufficient time to allow the case to be performed at the end of the day's regular schedule.

E. Anesthesia:

1. All anesthesia administered in the Surgical Services area will be in accordance with the Medical Staff approved Policies and Procedures of the Department of Anesthesia.
2. All patients identified in the general policy statement will be monitored by the Department of Anesthesia. Anesthesia personnel will be responsible for administration of all drugs and/or anesthetic agents administered in Surgical Services, other than agents being used as either IV analgesics or local anesthetics which may be administered by the operating surgeon.
3. All postoperative patients will be accompanied to the Recovery Room/Step Down Recovery Room by the individual responsible for the patient's anesthesia.

4. Anesthesia shall be provided by a member of the Medical Staff and shall be either an anesthesiologist, CRNA or other Medical Staff member as authorized by these Bylaws, Rules and Regulations, subject to the following conditions:
   a. The procedure is within the scope of the CRNA's delineation of privileges.
   b. The procedure is within CRNA's scope of practice.
   c. The procedure is within the scope of the designation by such clinical department and/or service as to whether the CRNA shall be supervised in the performance of their delineated privileges.

F. Specimens:

All specimens, including any/all foreign bodies, will be sent to the Pathology Laboratory, except as provided in the "Specimen Deletion Policy" of the Surgical Services Master Policy and Procedure Manual.

G. "To Follow" Cases:

1. Only approximate times can be given for "to follow" cases.
2. Surgical Services will notify the operating surgeon when the patient is to receive the pre-medication in "to follow" cases. The surgeon must indicate that he/she will be available to perform the procedure at the indicated time.
3. In a case which does not require a pre-medication, Surgical Services will contact the operating surgeon approximately fifteen (15) minutes prior to the anticipated time that the procedure will begin.
4. When the operating surgeon is notified by Surgical Services of the proposed time for the anticipated procedure to begin, and the operating surgeon indicates that he/she will be unavailable and cannot be available within fifteen (15) minutes of the anticipated time, the case will be canceled. Should sufficient time be available at the end of the regular operating schedule, the case may be "added on" at the end of that day's schedule.
5. In the event a regularly scheduled case is canceled, an attempt will be made to move the first "to follow" case to the canceled case's place. Should there be difficulty in moving the first "to follow" case into the place of the canceled, the list of "to follow" cases will be exhausted before another previously unscheduled case scan be scheduled as a replacement.

H. Operating Surgeon's Responsibility:

The operating surgeon is responsible for:

1. Notifying his/her surgical assistant of the scheduled time of the procedure, at least one (1) day in advance of the date the procedure is to be performed.
2. Notifying Surgical Services of the possible assistants name at least one (1) day in advance of the date the procedure is to be performed.
3. Having his/her assistant available at the appropriate time for the scheduled procedure.
4. Assuring that his/her non-physician assistant has undergone the proper credentialing process by the medical staff and has been granted privileges to act as a physician assistant.
5. Making his/her (operating surgeon's) identify known to the patient and/or his/her (patient's) family prior to the patient being brought to Surgical Services for the scheduled procedure.
6. Making the preoperative diagnosis known to Surgical Services and to the Anesthesia Services.
7. Assuring that the proper preoperative evaluation studies have been requested allowing time for the performance and interpretation prior to the patient being brought to Surgical Services.

8. Observing all policies relating to:

    a. Sterile technique
    b. Wearing apparel
    c. Infection control
    d. Any other policy of Surgical Services which is relevant to the Physician.

9. All operative notes shall be dictated by the operating surgeon within 24 hours of the completion of the surgical procedure.
10. Entering a brief operative note in the progress notes of the patient's chart, stating at least:

    a. Preoperative diagnosis
    b. Post-operative diagnosis
    c. Operative procedure
    d. Estimated blood loss
    e. Assistant's name
    f. Condition of the patient on leaving the Operating Room
    g. Operating surgeon's name

11. Provide direction of the CRNA when anesthetics are not administrated by an anesthesiologist.

I. Medical Students, Interns and Residents:

1. A medical student in a non-formal rotation may enter the Surgical Services operating rooms in the capacity as an observed if he/she is invited by the operating surgeon. He/she may not participate in the surgery.
2. A medical student in a formal, who has completed a medical school rotation in surgery, and who is knowledgeable in sterile technique to the satisfaction of the Surgical Services Supervisor, and who is covered by surgical liability insurance by his/her training institution, may scrub and act as an assistant in surgery for cases which do not require an M.D. assistant, or in the role of a second assistant.
3. An intern or resident in a formal training program may perform in Surgical Services as stipulated in Article IX, Park D, Section 4, of the Medical Staff Bylaws, Rules and Regulations.

Interns and residents in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in the training protocols developed by the Executive Committee.

SECTION II: Local IV/Analgesic Cases

This section applies to patients who receive either local anesthesia, or to patients who receive IV sedation/analgesic/medication.

A. Scheduling:

Scheduling will be the same as stated above in Section I, Item A, of these Rules and Regulations.

B. Admission:

The patient's admission may occur on the date of the procedure, as long as sufficient time is allowed to properly prepare the patient before the scheduled time of the procedure.

C. Chart Requirements:

1. A consent form for the procedure must be signed by the patient or his/her legal representative.
2. Relevant history and physical findings will be recorded by the operating surgeon.
3. The recording of a procedure note following the procedure.

D. Patient Monitoring:

All patient identified in this Section (II) of these Rules and Regulations will be monitored by a registered nurse employed in Surgical Services, provided the procedure is performed during normal working hours (Mon.-Sat. – 7:30 a.m. – 3:00 p.m.). At all other times, the patient will be monitored by the Department of Anesthesia.

Procedure for Registered Nurse Monitoring:

1. Blood pressure, pulse and respiration will be taken and recorded on admission to the Operating Room and every fifteen (15) minutes thereafter, until the procedure is completed.
2. Oximetry:

    a. The monitor lead will be applied to earlobe/index finger.
    b. Unit calibration will be verified.
    c. Digital readings will be recorded at fifteen (15) minute intervals.
    d. The physician/operating surgeon will be informed verbally if digital oxygen saturation readings reach a level of less than 90%, or the systolic blood pressure reaches a level of less than 100 or greater than 180.

3. Oxygen will be administered to the patient as ordered by the operating surgeon.
4. IV fluids will be started if ordered by the physician/operating surgeon.
5. A member of the Department of Anesthesia will be responsible for all monitoring of the patient should the operating surgeon feel that EKG monitoring is necessary. The Anesthesia Department will be notified should the physician/operating surgeon feel EKG monitory is necessary.

E. IV Medications:

Intravenous medications will be administered by either an M.D. or a member of the Department of Anesthesia or by a Surgical Services Registered Nurse.

The Executive Committee shall have the power to adopt such amendments to the Rules and Regulations as are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or express. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the Executive Director and posted on the Medical Staff bulletin board for fourteen (14) days.

ADOPTIONS OF RULES AND REGULATIONS

These Rules and Regulations of the Medical Staff are adopted and made effective upon approval of the Board superseding and replacing any and all previous Medical Staff Rules and to the requirements of these Bylaws.