Rules and Regulations of the Medical Staff

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Revisions approved by the Board of Trustees of Baylor University Medical Center
July 25, 2008

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Preamble

The Rules and Regulations of the Medical Staff are established under the authority of the Bylaws of the Medical Staff and shall be administered and amended as provided thereby. For convenience, they shall be referred to as the Rules and Regulations of the Medical Staff.

Section I DEFINITIONS

The words, phrases and definitions herein unless the context requires otherwise, have the following meanings whenever used in these Rules and Regulations and shall apply regarding patient care activities.

Active Medical Staff means members of the Attending, or Associate Attending Categories of the Medical Staff.

The *Administration* refers to the Chief Executive Officer (CEO) or the CEO's designee(s) who are responsible for managing the day-to-day operations of the Medical Center.

Adverse Action means a peer (professional) review activity which results in reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges or Medical Staff membership in a health care entity.

Applicant means any individual possessing the qualifications for Medical Staff membership specified in these Bylaws who seeks membership to the Medical Staff.

Appointment and Reappointment refers to the process specified herein by which one acquires and retains Medical Staff membership and delineated clinical privileges.

Attending Physician: The Medical Staff member who admits and is responsible for the overall care of the patient, unless the Medical Staff member transfers the care of the patient by means of a doctor's order to another member of the Medical Staff, shall be known as the attending physician. Records, requisitions, and reports shall, at all times, indicate the name of the Medical Staff member who is currently in the role of attending physician.

Board of Trustees means the governing body of Baylor University Medical Center of Dallas.

Certified Registered Nurse Anesthetist (CRNA): An advanced practice registered nurse who provides anesthesia and anesthesia related care and has been granted delineation of services by the Baylor University Medical Center Board of Trustees.

Chairman of the Medical Board is the appointed physician member of the Medical Board who presides at meetings of the Medical Board and Medical Executive Committee of the Medical Board.

Chief Executive Officer (CEO) means the individual designated by the Board of Trustees to manage the performance of Baylor University Medical Center.

Chief of Service or Department Chairman means the head of a Clinical Department, sometimes referred to as a clinical service, who is appointed by the Board of Trustees.

Clinical privileges means the permission granted to an individual physician, Dentist or Licensed Health Practitioner, recommended by the Medical Staff and approved by the Board of Trustees to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the Medical Center.

Co-Attending Physician: The Medical Staff member who treats the patient jointly with the attending physician but who does not assume the primary responsibility for the patient's care. The signature of the co-attending physician will be required on the face sheet of the chart (Attending Physicians Summarized Report) by the time the patient is discharged from the hospital.

Consultant: A consultant is one who, upon request, provides clinical advice to the attending physician or assistant attending physician in the diagnosis and treatment of the patient's illness or injury.

Dentist means any Medical Staff member who has a doctorate in Dentistry and is licensed to practice by the Texas State Board of Dental Examiners.

Department means a division of the Medical Staff composed of members who practice a similar specialty.

A *division* is a subspecialty of a Clinical Department.

Ex Officio means one who serves as a resource person by virtue of an office or position held, but without voting privileges.

HousestaffF: Physicians or dentists who participate in patient care activities at the Medical Center as part of postgraduate medical education programs as defined by the Committee on Medical Education. This includes medical students, interns, residents and fellows.

Medical Center means Baylor University Medical Center, Dallas, Texas.

Medical Staff Member means, unless otherwise expressly limited, any fully licensed physician, dentist, or podiatrist, who is appointed by the Board of Trustees as a member of the Medical Staff of Baylor University Medical Center.

Monitoring committees are those standing committees of the Medical Staff that are responsible for monitoring activities described by the Joint Commission on Accredited of Healthcare Organizations.

Pharmacy and Therapeutics Guidelines: General advice on the implementation and monitoring of drug use or distribution practices. Pharmacy And Therapeutics Guidelines must be approved by the Committee on Pharmacy and Therapeutics sent to each department chief using a transmittal form, and published in the Drug Information section of the Medical Staff Newsletter. Adherence to the guidelines may be reported back to the P&T committee, if requested.

Pharmacy and Therapeutics Standards: Specific, detailed advice on issues regarding medication use. These issues are generally complex or controversial and have important patient-care implications. Pharmacy And Therapeutics Standards must by approved by the Committee on Pharmacy and Therapeutics, reviewed by legal counsel, and sent to the Medical Board for approval. Pharmacy And Therapeutics Standards will be published in the Medical Staff Newsletter. Adherence to the standards must be reported back to the Committee on Pharmacy and Therapeutics.

Pharmacy and Therapeutics Statement: A statement provided for information to medical or other health practitioners. Pharmacy and Therapeutics statements will generally need only the approval of the Committee on Pharmacy and Therapeutics and may be published in the Drug information section of the Medical Staff Newsletter

Physician means any Medical Staff member licensed to practice medicine by the Texas State Board of Medical Examiners.

Podiatrist means any Medical Staff member who is licensed to practice podiatry by the Texas State Board of Podiatry Examiners.

Practitioner means any individual who is a graduate of an approved medical, dental or podiatry school and holds an unrestricted license to practice medicine, dentistry, or podiatry in the state of Texas. This may also refer to Housestaff.

President of the Medical Staff is the elected physician representative of the Medical Staff.

Professional review action pertains to any good faith activity by a professional review body duly authorized by these Bylaws, in the furtherance of quality health care, which is taken based on the competence or professional conduct of an individual physician which affects or may affect the physician's Staff membership or clinical privileges.

Professional review activity means activities undertaken in determining whether a physician may be appointed and/or be granted clinical privileges in this Medical Center, determining the scope or conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.

Professional review body pertains to this Medical Center and the Board of Trustees or any committee of the Medical Center, which conducts professional review activities, and includes any committee of the Medical Staff when assisting the Board of Trustees in a professional review activity.

Year means twelve consecutive months.

The words "work cooperatively with others" as used in Sections 10.3-1(c)(2) and the words "working cooperatively with medical staff members, nurses, medical center administration and other" in Section 10.7(3) includes, but is not limited to, the following:

(1) Physicians must not berate other people who work at the Medical Center;

(2) Gentle and constructive suggestion in a private setting is sometimes appropriate, but scolding; sarcasm; put-downs; profanity; loud, angry or abusive language; and other similar behavior are unacceptable.

(3) It is not permissible to criticize a person because of difficulty in communication caused by such person's native language; such problems should be discussed only with Medical Center Administration or chiefs of service.

(4) Remarks of a sexual nature or reference to a person's ethnic background are not permitted.

Section II ADMISSION AND DISCHARGE OF PATIENTS

Patients shall be admitted and discharged from the hospital only upon orders of a member of the Medical Staff.

At the time the physician requests admission of a patient, an admitting diagnosis, which may be used in initiating routine care of the patient, shall be given to the Patient Access Services.

Physicians admitting a patient should provide to the Patient Access Services any known information that may be necessary to assure the protection of that patient or other patients from those who are a source of danger.

R2.1 Admission to Special Services

R2.1-1 Psychiatric Care

All patients admitted to the psychiatric unit shall have a psychiatric illness as a primary diagnosis, and all patients admitted to the unit shall be attended by a psychiatrist regardless of the reason for admission to the hospital.

Patients moved to the psychiatric unit from another area of the hospital must be formally discharged and then readmitted to the psychiatric unit.

Patients who have a psychiatric illness as the primary diagnosis and as the primary need for treatment should not be admitted other than to psychiatric units.

Patients who are admitted because of suicidal attempts or suspected suicidal attempts may require admission to other services; e.g. surgical service for gunshot wounds, medical service for dialysis in patients with overdoses. These patients require around the clock private attendants if not in the Psychiatric Unit. The type of attendant needs to be designated by the attending physician, i.e. nurse, LVN, sitter, family member. Consultation must be obtained from a psychiatrist on all of these patients and as soon as is medically feasible these patients should be moved to the Psychiatric Unit here or in another hospital if care in a psychiatric unit is deemed advisable. The psychiatrist will be listed as the Attending Physician in all cases admitted to a psychiatric unit and in most instances it will be appropriate to list the referring physician and/or dentist as the co-attending when medical or surgical problems not strictly psychiatric are involved. Private attendants may be discontinued when deemed permissible by the consulting psychiatrist.

R2.1-2 Dental Care

Patients admitted to the hospital for dental care shall be given the same careful medical appraisal as those admitted to other services.

An appropriately credentialed oral and maxillofacial surgeon who admits a patient will complete an admission history and physical examination and assess the medical risks of the procedure to the patient. If indicated by history or in the findings of the physical examination, the patient will be referred for further consultation by an appropriate staff specialist physician.

Patients admitted for other dental treatment will have the portion of the history and physical examination related to their dental problem performed by the attending dentist. The remainder of the history and physical examination and the assessment of medical risk to the patient may be performed by either a credentialed oral and maxillofacial surgeon or Medical Staff Member, when indicated.

R2.1-3 Podiatric Care

Patients admitted to the hospital for podiatric care shall be given the same careful medical appraisal as those admitted to other services. All podiatric patients must be co-admitted by a Medical Staff Member who will be responsible for completing the admission history and physical examination of the patient. A podiatrist will be responsible only for that part of the history and physical examination related to podiatry.

R2.2 Private Attendants for Patients

Private attendants (including, but not limited to, private duty nurses, LVN's, sitters, and family members) are only permitted to sit with the patient and assist the patient with Activities of Daily Living. A private attendant may be obtained upon: (i) order of the attending physician specifying the type of private attendant needed, or (ii) upon request, and at the sole expense of, the patient or the patient's family.

Section III MEDICAL RECORDS

The medical record is the property of the hospital and is maintained for the benefit of the patient, the Medical Staff, and the hospital. The medical record may not be removed without permission of the Director of the Health Information Management Department or in response to subpoena or by statutory authorization.

R3.1 Responsibility

The attending physician shall be entirely responsible for the accuracy and completeness of each medical record which shall include identification data and consent forms, history of the patient, report of the physical examination, diagnostic and therapeutic orders, observations, reports of actions and findings, and conclusions. The ultimate responsibility cannot be delegated to Housestaff, although they can contribute for teaching purposes to the formation of the medical record.

It shall be the responsibility of the attending physician to record a complete history and physical examination for each patient within twenty-four hours after admission and before any interventional or invasive procedure is performed.

R3.2 Minimum Standards for Medical Records

The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. Entries shall contain only pertinent, meaningful observations and information and each entry shall be dated and authenticated. Members of the Medical Staff, as well as authorized allied health practitioners and hospital staff shall record entries in the medical record as appropriate.

R3.2-1 Authentication

Authentication may be by written signatures, initials or computer key. The person utilizing a computer key (electronic signature) must sign a statement that the person alone will use the code for the computer key. This statement is filed in Administration.

Signature stamps are approved for outpatient use only and not for the use in the inpatient medical record. If used in the inpatient medical record, then the signature stamp must be authenticated with an original signature. Acknowledgments for the use of signature stamps will be filed in Medical Staff Services for those physicians who choose to use them. The acknowledgement states that the signature stamp must be in the control of the physician and that they will not allow unauthorized use of the stamp. Signature stamps must include the physician's complete signature and physicians are encouraged to include their dictation code number for ease of reference. Opinions requiring medical judgment should be written, or authenticated, only by individuals who have been granted appropriate clinical privileges and by authorized Housestaff members.

Signature stamps will only be accepted from physicians who are members of the Medical Staff.

R3.3 Reports

R3.3-1 Admission Note

Preferably, at the time of admission, but not later than 24 hours thereafter, a physician admitting progress record shall be completed.

R3.3-2 History and Physical Examination

It is a requirement of the Medical Staff that a current History and Physical be performed on all patients and is considered to be the responsibility of the attending physician. If the History and Physical is performed within 30 days prior to the patient's admission to the Hospital, a durable, legible copy of the report may be used in the patient's medical record, provided the examination was recorded and/or authenticated by a member of the Medical Staff or Housestaff. The attending physician must update the patient's condition since it was last assessed. Any changes that may have occurred since last assessment must be dated, timed and signed in the medical record at the time of the admission or within the first 24 hours. If there are no changes, state "no changes", date, time and sign. This copy must be marked for inclusion in the medical record. If the History and Physical was completed more than 30 days prior to admission, a new history and physical must be completed.

The History and Physical shall reflect a comprehensive history and current physical assessment which shall be recorded by an appropriately credentialed member of the Medical Staff, authorized Housestaff, or by an appropriately credentialed physician assistant or advanced practice nurse approved to do so under the conditions outlined in R 3.3-2 (a)-(d).

Appropriately credentialed Physician Assistants and Advanced Practice Nurses approved to perform admission history and physical examinations will be allowed to do so under the following conditions:

A. Stable pre-surgical patients admitted for elective surgery;

B. Stable patients admitted for elective therapeutic or diagnostic procedure;

C. Non-critical patients admitted from the Emergency Department to Nursing Units if the Emergency Department physician has previously evaluated them. This does not include patients who are admitted to the critical care units.

D. Stable patients admitted directly from the physician's office where the admitting physician has previously evaluated them.

History and Physicals performed under the above conditions must be authenticated and countersigned by the physician within 24 hours.

**Stable: Is defined as a patient who, without concern, could have a surgical, therapeutic or diagnostic procedure delayed for 24 hours or more. Is further defined as a patient whose medical condition would not require admission to a critical care unit.

Each entry shall be labeled appropriately.

- The chief complaint

- Details of the present illness
- All relevant past medical , social and family histories
- The patient's emotional, behavioral and social status when appropriate
- All pertinent (positive or negative) findings resulting from a comprehensive, current assessment of all body systems.
- A statement of the conclusions or impressions drawn from the history and physical
- The goals and treatment plan

A "Check List" physical examination form is acceptable if adequately expanded regarding significant findings as required on the Admitting History and Physical form. Such forms must be approved by the Committee on Medical Records.

Conclusions or impressions drawn from medical history and physical examination are documented.

R3.3-4 Physician Progress Record

This record shall consist of entries by members of the Medical Staff and authorized Housestaff. Progress notes made by the Medical Staff or Housestaff should give a pertinent, chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. Progress notes should be updated daily as the condition warrants by the attending physician or other medical staff member. When a patient is seen by an appropriately credentialed Physician Assistant or Advanced Practice Nurse, the documentation should include the Allied Health Professional's name and credentials (i.e. PA, APN), as well as the name of the responsible practitioner. If progress notes are written by an appropriately credentialed Physician Assistant or Advance Practice Nurse, the practitioner responsible for the Allied Health Professional should co-sign the documentation by the next calendar day. All progress notes shall be dated timed and signed by the appropriately credentialed medical staff member.

R3.3-5 Focus Note

This record shall consist of entries by members of the nursing staff and all other allied health professionals.

R3.3-6 Multi-Disciplinary Progress Record

This record shall include entries by other personnel who are duly authorized through the Medical Staff organization, to make entries in the medical record. However, exceptions may be made for authorization of special departmental progress records where the need for a specially designed form is determined.

R3.3-7 Mental Status Examination

This examination shall be recorded for all patients admitted to the psychiatric division and may be included in the history and physical or progress notes.

R3.3-8 Diagnostic and Therapeutic Orders

Orders shall include any written or verbal communication by individuals granted appropriate clinical privileges and accepted by a Medical Center-employed, licensed nurse, physical therapist, occupational therapist, clinical dietician, respiratory therapist, pharmacist, orthotist or a Medical Center-approved and appropriately credentialed allied health practitioner.

All orders, including verbal orders, must be dated, timed and authenticated within 48 hours by the ordering practitioner or another practitioner who is responsible for the care of the patient.

Telephone or verbal orders given by appropriately credentialed individuals should be used sparingly. All orders must be documented on approved physician order forms.

It is the responsibility of hospital personnel receiving verbal orders to clarify any questions they may have about the order with the physician. Parenteral cytotoxic chemotherapy orders, given via a verbal order, will not be administered until the transcribed order is signed by the attending physicians. . "On-call" orders should specify the date of the procedure.

To reduce the possibility of error in interpreting physician orders, they shall be written legibly and preferably appended with the physician's name and dictating number. Orders must include the name of the drug, dose route, frequency, time/date order written and prescribers' signature. Only

approved abbreviations shall be used. Abbreviations for drug names will not be accepted. Acceptable drug names include: the complete generic name, the brand name, and the element codes from the periodic table. All orders for a drug dose less than one shall have a zero preceding the decimal amount. A trailing zero shall not be used after a decimal. (e.g., 0.25 shall not be written as 0.250) All orders for microgram amounts shall be clearly written as "microgram" (abbreviations, Greek letters, and other conventions are not to be used) to clearly distinguish from milligrams (mg). All orders for units shall be clearly written as "units" (abbreviations and Greek letters are not to be used).

When a patient is seen by an appropriately credentialed Physician Assistant or Advance Practice Nurse, the documentation should include the Allied Health Professional's name and credentials (i.e. PA, APN) as well as the name of the responsible practitioner. If orders are written by an appropriately credentialed Physician Assistant or Advance Practice Nurse, the practitioner responsible for the Allied Health Professional should co-sign orders by the next calendar day.

Questions, which arise, must be clarified by the physician giving the order. Any order questioned by nursing or pharmacy shall be recalculated and checked with the prescribing physician and/or attending physician. Dose clarifications will be rewritten on the order sheet and signed by the prescriber.

R3.3-9 Consultation Reports

Each Consultation Report shall contain a recorded opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record(s). It may be dictated or written in the Physician Progress Record and shall be labeled as a Consultation Report.

R3.3-10 Pre-Operative Evaluation

The responsible practitioner should record and authenticate a pre-operative diagnosis prior to surgery.

R3.3-11 Operative Note and Report

An operative report or other high risk procedure note shall be written immediately after the procedure and include the name of the primary surgeon/proceduralist and procedure(s) performed, findings, specimens removed, anesthesia, estimated blood loss, complications and post-operative diagnosis. A full operative or high risk procedure report with a complete description of the procedure and all above required elements must be written or dictated post procedure. The operative report must be authenticated by the surgeon.

R3.3-12 Preanesthesia And Postanesthesia Notes

For anesthetics administered by anesthesiologists or for anesthesia administered by or under the direction of physicians and/or dentists other than anesthesiologists, the preanesthesia evaluation of the patient shall be recorded on the Anesthesia Record or Physician Progress Record. Documentation should include pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated, the patient's previous drug history, other anesthetic experiences and any potential anesthetic problems.

The recording of post anesthetic visits should include a timed report in the recovery room.

For anesthesia administered by other than a physician, an order for provision of anesthesia by CRNA must be written on the physician order sheet.

R3.3-13 Reports of Actions and Findings

These reports include such items as reports of pathology and clinical laboratory examination, radiology examination, medical and surgical treatment, and any other diagnostic or therapeutic procedures. All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record. Operative Reports should be dictated or written immediately after surgery and should contain a preoperative diagnosis, a description of the findings, the technique used, the tissue removed or altered, and the postoperative diagnosis and condition.

R3.3-14 Discharge Entries

At the time of the patient's discharge, the Attending Physician's documentation shall be completed in accordance with these Rules and Regulations to substantiate treatment rendered and to support patient's condition at discharge. Final diagnoses shall be recorded in full, and without the use of

either symbols or abbreviations. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, are recorded, using acceptable disease and operative terminology that includes topography and etiology, as appropriate. Principal Diagnosis should be the condition established after study to be chiefly responsible for admission. Other Diagnoses should include complications and co-morbidities. Principal Operation should be the procedure performed for definitive treatment or the therapeutic procedure most related to principal diagnosis.

R3.3-15 Clinical Resume

The Clinical Resume (Discharge Summary) is the responsibility of the attending physician and should concisely recapitulate:

- The reason for hospitalization.
- The significant findings.
- The procedures performed and treatment rendered.
- The condition of the patient on discharge stated in measurable terms compared with the condition on admission and with final discharge diagnoses.
- The specific instructions given to the patient and/or family, as pertinent.

A final progress note may be substituted for the Clinical Resume in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries.

The final progress note shall include condition of the patient at the time of discharge and instructions given to the patient and/or family.

When necropsy is performed, a provisional anatomic diagnosis shall be recorded in the medical record within 72 hours, and the complete protocol shall be made part of the record within 60 days unless special studies and/or consultations are necessary and exceed the 60 day limit.

R3.4 Delinquency System

R3.4-1 Procedures

The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave of absence or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section 14 General Provisions and shall be governed by HIM policies and procedures.

R3.5 Standards for Obstetrical Records

Complete prenatal records, including all information contained on the approved American College of Obstetrics and Gynecology form, shall be required on every delivered obstetrical patient. An interim history and an admission physical shall be recorded at time of admission. A Labor and Delivery Note shall be written immediately following delivery, and a Discharge Summary shall be recorded at time of discharge. The information recorded on the Labor and Delivery Record must be authenticated by the attending physician.

The Interim History and Physical on the Maternity Progress Record may be used in lieu of the customary history and physical on undelivered obstetrical cases requiring less than 48 hours of hospitalization.

A routine history and physical shall be required on undelivered obstetrical cases requiring more than 48 hours of hospitalization.

Patients who are admitted for delivery and do not have a maternity record shall have a complete history and physical performed and recorded upon admission on the Admitting History and Physical form.

Patients who are admitted as High-Risk Pregnancy Referrals should have a complete history and physical examination performed and recorded upon admission. Every effort should be made to obtain any prenatal records, which might be available from the referring physician.

R3.6 Standards for Emergency Department Records

A medical record shall be kept for every patient receiving emergency service; it shall become an official hospital record and shall contain:

- Adequate information to identify the patient. This shall include such items as the patient's name, address, age, sex, and party to be notified in the event of an emergency as appropriate, as well as other identifying data.
- Information concerning time of the patient's arrival, means of arrival and by who transported.
- Pertinent history of the injury or illness and physical findings including the patient's vital signs.
- Emergency care given to the patient prior to arrival.
- Diagnostic and therapeutic orders.
- Description of significant clinical, laboratory, and roentgenologic findings.
- Diagnostic impression and treatment given.
- Condition of the patient on discharge or transfer.
- Final disposition, including instruction given to the patient and/or the patient's family, relative to necessary follow-up care.
- Authorization for treatment.

The record shall be authenticated for its clinical accuracy by the physician treating the patient. When a patient is seen by an appropriately credentialed Physician Assistant or Advance Practice Nurse, the documentation should include the Allied Health Professional's name and credentials (i.e. PA, APN) as well as the name of the responsible sponsoring practitioner. The sponsoring practitioner should co-sign orders and documentation timely.

The Department of Emergency Medicine shall maintain a control register which shall contain the name, date and time of arrival and record number of each patient as well as diagnosis, disposition of patient, and name of attending physician and/or dentist. The name of those dead on arrival shall also be entered in the register.

R3.7 Procedures

The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section XVI General Provisions and shall be governed by HIM policies and procedures.

R3.8 Surveys of Medical Records

Surveys, audits or reviews of records at Baylor University Medical Center that do not involve the use or review of patient medical records or other patient-specific health care information shall be subject to clearance by the Chief of Service of which the surveyor is a member and by the chiefs of other services when, in the opinion of the chief of the principal service, this clearance is desirable. The requirements set forth in the Bylaws of the Medical Staff concerning the reviews and approval of research projects must also be met.

Review and approval by the Chief of Service of which the principal author is a member shall be obtained prior to publication or presentation outside the institution.

For any research study, survey, audit, investigation, paper or presentation involving the use or review of patient medical records or other patient-specific health care information, the author, investigator, auditor, or presenter must seek must seek written approval or verification of an exemption by the Institutional Review Board prior to the release of any information. Requests to access, review, and/or use patient medical records or other patient-specific information shall be determined in accordance with the policies of the IRB and the Health Information Management Department. Studies of procedures or treatment regimens should, unless authorized by the Chief of Service, require the permission of the attending physician.

Those individuals not on the Medical Staff who embark on such surveys and reviews shall do so under the sponsorship and direction of a member of the Attending staff.

An IRB approval letter or verification of exemption must be submitted to the Health Information Management Department before a request to access patient medical records or patient-specific information may be processed. Forms requesting permission to access patient records for surveys or research are on file in the Health Information Management Department and must also be completed before a survey or study is undertaken.

Section IV DIAGNOSIS AND THERAPY

R4.1 Drugs and Formulary

Drugs administered to patients in the hospital shall usually be obtained through the hospital pharmacy. Patients may, at times, bring their own drugs into the hospital. The use of such drugs shall be considered acceptable, provided that such drugs are identified by the responsible practitioner, or pharmacist, are legibly labeled for contents, dose, and frequency of administration, are specifically ordered in the patient's medical record comply with self-administration policies approved by the Medical Staff, and this is noted in the necessary notes as self administered.

Before the Institutional Review Board for Human Protection approves a project that requires the use of experimental or investigational drugs, the Medical Staff member performing the research will submit to the Review Board printed material released by the manufacturer of the medication, any additional information concerning side effects, dosage, antidotes, along with the name of the drug and explanation as to how it is to be dispensed. The project will not be approved until such information is provided to the Institutional Review Board for Human Protection.

Before an investigational drug is administered to a hospitalized patient in the Medical Center by nursing personnel:

1. A copy of the Institutional Review Board for Human Protection approved protocol, approval letter and Investigator's brochure must be provided to the Pharmacy Department.
2. A copy of the drug data sheet must be attached to the patient's chart before nursing may administer the investigational drug. A copy of the signed lay consent form must be placed in the patient's chart by the next working day after admission to the Medical Center. If no copy of the drug data sheet and lay consent form is on the chart within the time frames specified, the drug must be administered by the physician.
3. All investigational drugs used in the Medical Center will be stored, labeled, and dispensed by the Pharmacy Department in accordance with rules and regulations of the Texas State Board of Pharmacy.

All information concerning these investigational drugs will be maintained in the Pharmacy and this information will be available for review.

R4.2 Automatic Stop/Renewal Orders

The Medical Staff delegates to the Committee on Pharmacy and Therapeutics the responsibility for the development of policies and procedures for renewing/discontinuing medical orders.

R4.3 Use of Restraints

R4.3-1 General Units

Baylor University Medical Center believes that patients have the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. Restraints will only be used as a last resort, in the least restrictive manner possible and removed at the earliest possible time.

Definitions:

Restraint – Any physical or chemical method of restricting a patient's freedom of movement, physical activity, or normal access to the patient's body, determined necessary to help improve the patient's well-being or to help prevent injury to others.

Physical Restraint – any manual method, or physical or mechanical device, material or

equipment, attached or adjacent to the patient's body that the patient cannot easily remove that restricts freedom of movement or normal access to the patient's body.

Chemical Restraint – the use of any chemical including pharmaceuticals, through topical application, oral administration, injection, or other means, for purposes of restraining a patient and that is not a standard treatment for the patient's medical or psychiatric condition.

Non-emergency Application of Restraint – use of restraint to promote medical/surgical healing.

Emergency Application of Restraint – Use of restraint for behavioral health reasons to manage an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient or others.

Restraints may be initiated by nursing staff by way of the following Medical Board approved protocols:

(a) To promote prevention of falls (non-emergency application);

(b) To promote prevention of removal of invasive lines/tubes (non-emergency application);

(c) To promote prevention of injury to self and others (emergency application).

Note: All restraint use requires a physician order.

A Medical Staff member may also initiate the use of restraints through individual physician order. All orders must include the following:

(a) time limited, PRN orders are not acceptable;

(b) type of restraint to be used;

(c) clinical justification.

For Non-Emergency Application of Restraints:

1. a restraint order by a Medical Staff Member must:

   (a) Be time limited, not to exceed 24 hours. No PRN orders.

   (b) Specify type of restraint

   (c) Include clinical justification

2. If physician is unavailable to issue restraint order, an RN may initiate use of restraint after alternative interventions have been tried and failed.

3. an order must be obtained within 12 hours of initiation of restraint.

4. telephone or verbal orders for restraint must be signed by the physician within 24 hours.

5. for each episode of restraint use, a new order is required every 24 hours.

For Emergency Application of Restraints:

1. An RN may initiate use of restraint.

2. An order must be obtained from appropriate Medical Staff Member within 1 hour of initiation of restraint.

3. A face-to-face assessment by a Licensed Independent Practitioner (LIP) must occur within one (1) hour of the initiation of restraints, the purpose of the assessment is to evaluate the patient's condition and the need for continuation of restraints.

4. An order for restraint under emergency application is limited to 4 hours for adults; 2 hours for children and adolescents ages 9 to 17; 1 hour for patients under 9.

5. Upon expiration of the original order, a new order must be obtained from appropriate Medical Staff member, or the Medical Staff member's designee.

6. The Medical Staff member must conduct a face to face re-evaluation of the patient in person at least every 8 hours for patients 18 years of age and older and every 4 hours for patients ages 17 and younger.
7. A consultation with the patient's treating physician must occur as soon as possible (if the restraint is not ordered by the patient's treating physician).
8. A written modification to the patient's plan of care must occur.

The RN may initiate early release trials if the behavior/reason for the restraint has abated prior to the expiration of the time-limited order. Patient care policies and protocols for the use of restraints on general patient care units are reviewed and approved by the Medical Board.

R4.3-2 Psychiatric Unit

Restraint or seclusion on the Psychiatric Unit can only be initiated by an order from a medical staff member in the Department of Psychiatry. Restraint or seclusion may be initiated by the RN in an emergent situation where there is imminent probability of harm to the patient or others; however, the order must be obtained from the psychiatrist within one hour. Specific policies for the use of restraint or seclusion in Psychiatry are approved by the Medical Staff from the Department of Psychiatry and are maintained on the Psychiatric unit for review.

R4.4 Standing Orders

Standing orders are approved for use in the Medical Center and comply with the standards set forth by Joint Commission.

All new orders will be reviewed and approved by the committee. The committee will review annually standing orders used in the special care areas and those in other areas on an appropriate schedule.

Section V INFORMED CONSENT

The physician will direct the process of informed consent.

It is the physician's responsibility to:

1. determine the need for informed consent;
2. determine the decision-making capacity of the patient or appropriate surrogate decision maker;
3. explain the proposed treatment or procedure including risks and alternatives; and
4. obtain the patient's (or surrogate decision maker's) consent;

R5.1 "A-List" Procedures

Those treatments/procedures which require disclosure and consent to specific risks and hazards are referred to as "A-List" Procedures" as defined by the Texas Medical Disclosure Panel. Specific disclosure and consent forms are available for "A-List" treatments/procedures. For "A-List" Procedures, it is the physician's responsibility to obtain the patient's (or surrogate decision-maker's) informed consent to the treatment/procedure prior to performing the treatment/procedure by disclosing to they patient (or surrogate decision-maker) the risks and hazards set forth on the specific "A-List" disclosure and consent form and obtaining (or requesting a nurse to obtain) the patient's (or surrogate decision-maker's) signature on the form. Disclosure and Consent forms for all "A-List" procedures may be obtained at the Medical Center.

R5.2 Non-"A-List" Procedures

Those treatments/procedures, which do not require disclosure and consent, are referred to as "B-List" procedures as defined by the Texas Medical Disclosure Panel. A generic or "blank" disclosure and consent form (Medical and Surgical Procedures: Form 18688) is available for treatments/procedures not identified as "A-List" Procedures. This form identifies general risks and hazards of treatments/procedures. For treatments/procedures not identified as "A-List" Procedures, but that in the physician's judgment require informed consent, it is the physician's

responsibility to obtain the patient's (or surrogate decision-maker's) informed consent prior to performing the treatment/procedure by writing the risks and hazards of the proposed treatment/procedure on the generic disclosure and consent form disclosing such information to the patient (or surrogate decision-maker) and obtaining or requesting a nurse to obtain the patient's (or surrogate decision-maker's signature on the generic disclosure and consent form or documenting the patient's (or surrogate decision-maker's) informed consent in the Physician's Progress Record.

R5.3 Signatures

Generally, informed consent is obtained by the physician prior to or contemporaneously with the treatment/procedure. If there is a delay in treatment or a change in the patient's condition, physicians are encouraged to repeat the informed consent process. Consent forms may be relied upon for a period of time equal to the earlier of: (i) 96 hours after admission to the hospital or (ii) if the consent form is signed prior to admission to the hospital, 90 days from the date of signature.

Signature should be obtained prior to administration of pre-operative or pre-treatment medication which may cause sedation or confusion, unless delay of the procedure would be significantly hazardous to the patient, or in the opinion of the physician or nurse, the patient has the capacity to exercise judgment. If possible, a consent form should not be signed within 3 hours after administration of such a medication.

For a patient who lacks decision-making capacity, the physician should identify the appropriate surrogate decision maker who may be in order of priority:

1. Court-appointed guardian;
2. Agent with Durable Power of Attorney for Health Care;
3. Patient's spouse (includes common law spouse, i.e., a person who resides with the patient and who along with the patient holds himself or herself out to the public as a married couple);
4. An adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision maker;
5. A majority of the patient's reasonably available adult children;
6. The patient's parents;
7. The individual clearly identified by the patient to act for the patient before the patient became incapacitated;
8. The patient's nearest living relative.

For a patient who possesses decision-making capacity and is able to exercise judgment but is physically unable to sign, a responsible adult may sign for the patient. (This signature confirms that the patient is giving the physician consent for the treatment or procedure.) The responsible adult need not be next-of-kin. Any non-BUMC employee may do so.

For patients who are less than 18 years of age, the parent or legal guardian should sign the consent form. Exceptions are as follows:

1. A patient who is married at any age may sign their own consent forms;
2. A patient who is divorced (not annulled) or widowed less than 18 years of age may sign their own consent forms;
3. Unmarried pregnant females may sign for consent of care for any problem related to the pregnancy other than termination of pregnancy;
4. Patient on active duty with the military;
5. Patient 16 years of age or older living apart from the patient’s parents and managing the patient’s own affairs, regardless of source of income.

R5.4 Emergency Situations

If, in the physician's judgment, (i) an adult patient is not able to communicate because of an injury, accident or illness, is unconscious, or otherwise lacks decision making capacity or a minor patient presents without a parent, managing or possessory conservator, or guardian to consent on the minor's behalf, and (ii) the physician believes the patient is suffering from a life-threatening injury or illness, then the patient is deemed to have given implied consent to the emergency treatment/procedure, and the physician may proceed with the treatment/procedure. It is advisable for the physician to document the reason for the emergency treatment/procedure in the Physician's Progress Record.

R5.5 Telephone Consents

If the patient lacks decision-making capacity and the responsible surrogate decision maker is not and will not be present in the hospital to express verbal consent or sign the forms, the physician may obtain consent over the telephone from the surrogate decision maker. The physician should explain the proposed treatment or procedure including the risks and alternatives and should obtain the surrogate's consent over the phone. The physician or nurse must read the consent form to the surrogate and ask if the individual understands and agrees with the form. Telephone consents must have two witnesses; the physician may be the second witness.

Section VI OPERATING ROOMS, SURGERY, AND DELIVERY ROOMS

R6.1 General

Surgeons must be in the immediate operating room vicinity and ready to begin operating at the time of induction. No patient shall receive general anesthesia unless the surgeon or the surgeon's designee is physically present in the Operating Room or Surgery lounge. In any elective procedure of unusual complexity or which is associated with unusual hazard to life, there must be a physician present and scrubbed as first assistant. Each department may designate those procedures, which require a physician as first assistant. A list of such procedures will be supplied by the Chief of the Department and will be maintained in the Department of Surgical Services.

The Scheduled time as it appears on the OR Schedule will be interpreted as follows:

1. General anesthesia - time of induction
2. Epidural anesthesia - time epidural is established
3. Spinal anesthesia - time spinal procedure begins

All members of the surgical team are expected to consider the above factors when planning their arrival time to the OR If any are going to be late, the OR should be contacted 30 minutes prior to late arrival for scheduled procedures.

R6.2 Scheduling of Operating Rooms

The number of operating rooms to be allocated to the various specialty departments shall be determined by the Committee on Surgical Services.

The schedule shall be arranged to permit the fullest utilization of personnel and facilities. Operating room personnel will inform the surgeon and the anesthesiologist of any change and will lend assistance in contacting the parties involved.

When time is not available to schedule a patient in the appropriate room, the posting information shall be entered on the move-up list. Every effort will then be made to work this procedure into the operating room schedule.

The operating room shall be staffed for elective surgery Monday through Friday from 7 a.m. through 11 p.m. Saturday elective surgery is based on the availability of staffing. Emergency surgery services will be provided as needed. Life threatening emergencies will have precedence over all other cases. Bumping of elective procedures by emergency procedures is first negotiated between operating

surgeons. If resolution cannot be reached between the operating surgeons, the decision will be referred to the Chief of Service.

The first surgical procedure in each room will be posted at 7:15 a.m or 7:30 a.m. on days with teaching conferences scheduled until 7 a.m.. A surgeon desiring an earlier time should contact the supervisor of the service and the Anesthesiologist. A surgeon desiring a later time will be required to follow the first case posted in the room allocated to the surgeon's specialty. Every effort will be made to schedule as close as possible to the time requested by the surgeon; however, rooms will not be held for late starts.

A surgeon or anesthesiologist who is late for a 7:15 a.m. or 7:30 a.m. surgical procedure on three occasions in any one calendar quarter will not be permitted to schedule procedures at 7:15 a.m. or 7:30 a.m. for four weeks following the third offense during that particular calendar quarter. Late is defined as a period of time greater than fifteen minutes for either the surgeon or anesthesiologist. The Vice President of Surgical Services will be responsible for maintaining record of surgeon or anesthesiologist late arrivals. If a third offense occurs within the calendar quarter, the four weeks prohibition from early posting will begin on the third Monday following the third offense, thereby permitting the individual concerned to perform surgical procedures already on the schedule.

Surgical procedures scheduled for a time later than 7:15 a.m. by surgeons or anesthesiologists during the time they are in the penalty period may be moved to 7:15 a.m. Such a move may occur in the interest of improving operating room efficiency.

Surgical procedures may be scheduled as far in advance as necessary. The time on the operating room schedule is reserved for the patient rather than for the surgeon. Therefore, if a surgeon cancels a procedure, the surgeon loses the reservation and the next patient scheduled will be moved to that time.

The posting of cases shall be made or canceled by the surgeon or the surgeon's office personnel.

In addition, physicians must adhere to the Rules and Regulations of the Medical Staff, Section III MEDICAL RECORDS on Physical Examination requirements and Section XVI for Administrative Suspension .

A surgical operation shall be performed only on consent of the patient or the patient's legal representative, except in emergencies.

Doctors and other personnel entering the operating rooms or delivery rooms shall wear approved operating apparel.

R6.3 Visitors to the Operating Room, Exclusive of Delivery Rooms

Visitors will be permitted in the Operating Rooms under one of the following categories:

Observation -- May be in the OR itself, but not participate in the care of the patient. Access to the room will be coordinated by the circulating nurse.

Tours -- May tour the department, but may not enter any operating room in which a procedure is underway (case open).

Clinical Participation -- May scrub in and assist in the surgical procedure.

Student/Orientee -- Personnel for whom Operating Room procedure is a part of a BUMC approved educational program.

All visitors to the Operating Rooms must have prior "admission approval." The criteria follow:

Observation -- Written requests by Baylor physicians or employees are to be sent to the Administrator of Surgical Services. State the purpose, visitor's name, affiliation, and duration of visit; i.e. one procedure (indicate patient's name), one week, etc. Once the visit is approved, the appropriate clinical manager will be notified in writing by Administration. In circumstances where standing approval is needed, a written request from the appropriate Chief of Service stating the reason for "standing approval" must be submitted. Once Administrative approval is granted, a biannual reapproval will occur.

Tours -- Approval given by the Vice President, Surgical Services. Written request should be submitted, when possible.

Clinical Participation -- Written requests are to be sent to the Chief of Service from the physician making the request. If the Chief approves, the Chief must request Administrative approval from the Vice President. The request should be sent to Medical Staff Services. If the physician does not hold a Texas license, permission from the State Board of Medical Examiners is necessary. The State Board requires proof of licensure in another jurisdiction, curriculum vitae, and a statement as to the reason for the request. Proof of liability insurance coverage in Texas is also required. These steps must be completed before Administrative approval can be granted.

Student/Orientee -- Approval granted by the Clinical Manager of Operating Room Education during the orientation process.

The following individuals may be approved:

Physicians, Dentists and Podiatrists

The following have had clearance from the OR Education Department:

1) Interns and residents from this and other hospitals
2) Nurses
3) Operating Room technologists
4) Medical, dental, nursing and pastoral care students
5) Technicians from BUMC's Department of Radiology
6) Photographers and medical illustrators employed by BUMC and Baylor College of Dentistry
7) Invited professional cinematographic teams
8) Laboratory technicians
9) BUMC research assistants and Baylor College of Dentistry research assistants
10) Members of visiting organ transplant retrieval teams
11) Technical representatives (allowed in the Operating Room only during that portion of the procedure that their product is being used. They must leave upon completion of that portion of the procedure).
12) Interpreters

The following individuals will not be approved without specific consent from the Chief of Service:

1) Non medical personnel
2) Pre-Med, high school students, or those contemplating medical or paramedical careers
3) Private duty personnel attending the patient

The admission of administratively approved visitors to the Operating Rooms is subject to the further approval of the operating surgeon and anesthesiologist.

Section VII PATHOLOGY

Tissues removed at operation shall normally be sent to the hospital pathology laboratory for examination, and consultation. Limited categories of specimens may be exempted from this requirement. Exemptions should be established by the Chief of Surgical Department or section, and agreed upon by the Chief of the Department of Pathology. The exempted specimen should only be those that by their nature do not permit fruitful examination (e.g. cataract, orthopaedic appliance, foreign body, incidental rib removal, arthroscopic surgery fragments, and traumatic injured tissue).

Many specimens should be sent for gross examination to establish operative procedure or information for the medical record. Bullets, etc., for legal reasons are given directly in the chain of custody to law enforcement representatives. A record of all tissues and appliances removed during

an operative procedure shall be made in the Operative Record. When sending tissue or appliances to pathology, the surgeon may indicate on the pathology information sheet when gross examination only is desired. A more detailed examination of the specimen may be done if the pathologist considers it indicated. When a specimen is sent to the laboratory, whether intentional or not, it will be considered as a request for examination and at least a gross pathology report will be issued. Therefore, when no examination is desired, or required, the specimen should not be sent to the laboratory.

A complete surgical pathology requisition form will be filled out on all specimens by the surgeon or at the surgeon's direction. This form shall accompany the tissue to the laboratory and include adequate information for the pathology consultation, such as pre and post-operative diagnosis, the nature of the specimen, and sufficient clinical data to assist the proper pathological examination, and to provide the information for justification by the Committee on Surgical Case Review.

R7.1 Major Operations Based on Biopsies Performed Elsewhere

When major surgical procedures are scheduled at Baylor University Medical Center on the basis of a biopsy performed elsewhere, the pathology material from the previous biopsy must be made available for examination and verification of diagnosis by a member of the staff of Baylor's Department of Pathology, and a Baylor pathology report will be placed on the chart prior to the contemplated surgery.

If compliance with this rule will delay surgery in a manner that is harmful to the patient, the rule may be waived for that particular patient by either the Chief of the Department of Surgery or Pathology, or their designated representatives. In such a case, however, the provisions of this rule are still carried out with the least practical delay following the operation.

R7.2 Autopsies

Every member of the Medical Staff should seek to secure autopsy permits on appropriate cases. In certain instances, deaths should be initially reported to the Medical Examiner's office for their scrutiny.

Due to the inherent risk of autopsy material and need for body substance isolation, visitors to the morgue will be limited to selected medical staff and other personnel. All admissions of visitors or observers to the morgue will be subject to the approval of the Director of the Autopsy Service and/or senior pathologist.

Section VIII CONTROL OF INFECTIONS

R8.1 Reporting of Infections

It is the duty of the attending physician to notify the charge nurse if a particular patient has an infection, which is transmissible within the hospital.

The physician should specify the diagnosis so that if any measures beyond Standard Precautions are required, they may be done.

If the physician for some reason is not available to order the isolation and if the nurses become aware of a diagnosis, which requires special isolation, they may isolate the patient until they can consult the physician.

The charge nurse should notify the nurse epidemiologist of the name of the patient and the diagnosis.

If any unusual incidence of infections such as wound infections or urinary tract infections are suspected the physician or the nurses should notify the nurse epidemiologist.

Physicians are urged to report nosocomial infections, which are discovered after the discharge of the patient.

R8.2 Isolation Procedures

The Committee on Infections shall monitor policies and procedures regarding the isolation of patients admitted with infectious diseases and for those patients who develop infectious diseases subsequent to admission.

If any questions arise about the appropriateness of the isolation procedure, the questions may be resolved by discussion with the epidemiologist and/or the physicians of the Infectious Diseases service.

Section IX HOUSESTAFF – INTERNS, RESIDENTS, AND FELLOWS

Baylor University Medical Center (BUMC) housestaff participate in the care of patients under the supervision of credentialed members of the Medical Staff. Rotating housestaff are also under the supervision of credentialed members of the Medical Staff per affiliation agreements between BUMC and the sponsoring entities of graduate medical education. The housestaff shall provide care commensurate with the level of training and competence, under the supervision of credentialed members of the Medical Staff. The supervising practitioner will be present or readily available to supervise the housestaff at all times.

All housestaff shall meet the qualifications for resident eligibility as outlined in the Accreditation Council for Graduate Medical Education's Institutional Requirements Section of the *Essentials of Accredited Residencies in Graduate Medical Education*.

The Chairman of the BUMC Graduate Medical Education Committee (GMEC) shall serve as the liaison for communication between the Graduate Medical Education program and the BUMC Medical Staff Committees and the Board of Trustees regarding the quality of care, treatment, and services and educational needs of the program. The GMEC Chairman will communicate information to the Program Director regarding these issues at the Hospital. The Residency Program Director shall provide the Designated Institutional Official/MEC Chairman with residency review committee citations to ensure compliance.

The competence of individual Housestaff shall be evaluated on a regular basis by assigned members of the Medical Staff and forwarded to the Residency Program Director. The entity sponsoring the residency program, through its Residency Program Director, shall maintain a confidential record of evaluations.

The entity sponsoring each Graduate Medical Education (GME) program is responsible for the selection of Resident physicians, as well as procedures for discipline and dismissal. Rotating Housestaff must show evidence of professional liability insurance coverage provided by the program and hold a Texas license or an institutional permit.

The Supervising physician or designee is ultimately responsible for completion of a patient's medical record.

Section X REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

R10.1 General

In addition to the requirements for Medical Staff Membership set forth in the Bylaws of the Medical Staff, the Medical Staff shall have the authority to include in these Rules and Regulations requirements for Medical Staff membership. Any such additional requirements shall be cumulative and not an alternative to the requirements set forth in the Bylaws.

R10.2 Proximity to Medical Center

Pursuant to Section 3.3-1 (e) of the Bylaws of the Medical Staff, each Member of the Medical Staff in the Active Attending, Active Associate Attending and Courtesy categories, whether provisional or full staff status, must have a medical office within 50 miles of the Medical Center, and be able to travel to the Medical Center from place of residence or medical office within one (1) hour during normal driving conditions.

Individual Medical Staff Departments or Divisions may recommend modifications to these proximity requirements to shorten the distance and driving time if required to meet patient care needs of the Department or Division. Any modification to the proximity requirements for individual Departments or Divisions must be approved by the Medical Board as provided in Section 10.4 (m) of the Bylaws of the Medical Staff.

Section XI MEMBERSHIP

R11.1 Composition of The Medical Staff

The Medical Staff of Baylor University Medical Center shall be composed of practitioners who are selected on the basis of their professional and personal qualifications and for their ability to further the fulfillment of the Medical Center's objectives in patient care, education and research. The Medical Center shall endeavor to maintain a balance among the various specialties required for an outstanding metropolitan medical and referral center. It shall also endeavor to provide for systematic admission of outstanding members in a manner that will assure a continued development of the Medical Staff in future years. Pursuant to the policy of the Board of Trustees, the size of the Medical Staff--the number of practitioners in the Active, Consulting and Courtesy categories shall be related to the capacity of the Medical Center's facilities to serve its patients effectively and meet the needs of the community it serves.

R11.2 Nature of Membership

No practitioner, including those in a medical administrative position, shall admit or provide medical or health-related services to patients in the Medical Center unless the practitioner is a member of the Medical Staff and has been granted clinical privileges in accordance with these Bylaws or unless the practitioner has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

R11.3 Qualifications of Membership

R10.3-1 General Qualifications

To be considered for Medical Staff membership, the applicants:

(a) must possess and provide documentation of their

(1) current licensure

(2) adequate experience, education, and training

(3) current professional competence

(4) good judgment

(5) ability to perform the clinical privileges requested.

(b) must be of such physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care. Applicants may be asked to provide to the Credentials Committee proof of their physical and/or mental health status.

(c) must

(1) adhere to the ethics of their respective professions;

(2) be able to work cooperatively with others;

(3) willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

(d) must maintain in force professional liability insurance (i) that is not less than the minimum amounts, as from time to time may be jointly determined by the Board of Trustees and Medical Board and (ii) that does not exclude from coverage any of the procedures for which the applicant is seeking privileges.

(e) must maintain office and residence within reasonable proximity of the Medical Center as defined by the Medical Staff in the Rules and Regulations to permit timely, continuous patient care.

(f) possess the skills and training necessary to satisfy the patient care, research or educational needs of the community the Medical Center serves.

In addition, applicants for membership shall be evaluated and selected on the basis of:

(a) their potential for enhancing the patient care, education and research programs of the Medical Center

(b) their prospects for providing strong leadership in their respective fields of practice

(c) their willingness to devote time and support to the teaching program and to other Medical Staff activities.

(d) the Medical Center's ability to provide adequate facilities and support services for the applicant's patients.

(e) members of the courtesy category who admit more than 12 patients per calendar year shall be required to fulfill all the responsibilities of active medical staff membership.

R11.3-2 Particular Qualifications

(a) Physicians. An applicant for physician membership in the Medical Staff shall be a graduate of a medical school approved at the time of the issuance of such degree by the Texas State Board of Medical Examiners for licensure and must also hold a valid and unsuspended certificate to practice medicine issued by the State of Texas. At the time of initial appointment, physicians shall (1) be diplomats of a board which is a recognized member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists, or (2) be currently approved to take the examinations of such boards, or (3) shall have completed the approved residency as a prerequisite to become eligible to take such examination as defined by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists or (4) shall have completed the equivalency requirements of such boards as a prerequisite to become eligible to take such examination as defined by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists.

(b) Dentists. An applicant for dental membership in the Medical Staff shall be a graduate of a dental school approved at the time of the issuance of such degree by the Texas State Board of Dental Examiners for licensure and must also hold a valid and unsuspended certificate to practice dentistry issued by the State of Texas.

(c) Podiatrist. An applicant for podiatric membership on the Medical Staff shall hold a DPM degree conferred by a school approved at the time of issuance of such degree by the Council on Podiatric Medical Education of the American Podiatric Medical Association and must hold a valid and unsuspended license to practice podiatry by the State of Texas. Podiatrists shall be board admissible or board certified by the American Board of Podiatric Surgery at the time of initial appointment.

R10.3.3 Exception

Under special circumstances, in order to serve the best interests of the Medical Center, one or more of the above qualification requirements may be waived.

R11.4 Affect of Other Affiliations

No person shall be entitled to membership in the Medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or clinical privileges at another health care facility.

R11.5 Nondiscrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin or any other criterion unrelated to professional ability and judgment, to community need, reasonable objectives of the hospital, or any other requirements set forth in these bylaws.

R11.6 Ethics and Ethical Relations

All members of the Medical Staff shall be governed by high standards of ethical conduct and practice and shall adhere to the ethics of their professions. A member may not receive from, nor pay to, another practitioner, either directly or indirectly, any part of a professional fee under conditions that constitute (1) payment for services not performed by the practitioner or the member, (2) payment for referral of patients or (3) other aspects of fee splitting.

R11.7 Responsibilities of Medical Staff Membership

Membership to the Medical Staff of Baylor University Medical Center is considered a privilege, and with this privilege, there shall be certain responsibilities.

R11.7-1 Basic Responsibilities

Basic responsibilities that apply to all members include:

(1) providing patients with the quality of care meeting the professional standards of the Medical Staff of this Medical Center;

(2) abiding by these Bylaws and the Rules and Regulations of the Medical Staff;

(3) working cooperatively with Medical Staff members, nurses, Medical Center administration and others;

(4) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership;

(5) abiding by applicable Medical Center bylaws, rules and policies;

(6) providing medical care to patients in emergency situations wherever and whenever needed regardless of the member's category of appointment or the patient's ability to pay;

(7) requesting consultation from other specialties as the needs of the patient require, and providing consultation to other medical staff members when requested;

(8) self-reporting any physician health matter, including impairment or substance abuse matters;

(9) self-reporting any investigation, recommendation, limitation, suspension or termination regarding (1) privileges at any other health care facility or (2) license to practice by any state or federal agency as required by these Bylaws;

(10) actively participating in the Medical Center's quality assurance and utilization review activities.

(11) performing other staff obligations as may be established from time to time by the Medical Staff.

(12) to promote and participate in a work environment that is conducive to the well being of patients and Medical Center personnel including an environment that is free of unlawful harassment. Unlawful harassment includes that which is based on race, color, religion, national origin, sex, disability, age, citizenship or harassment which may be considered sexual in nature.

R11.7-2 Additional Responsibilities

Medical Staff members may also be expected to discharge in a reasonable manner the following responsibilities:

(1) serving on Medical Staff Committees.

(2) providing Emergency Department call coverage.

(3) regularly attending Medical Staff meetings and departmental meetings as specified in these Bylaws.

(4) timely response to patients upon admission and ordering appropriate tests and basic treatments when given basic admitting privileges.

(5) preparing and completing in a timely fashion the medical records for all patients to whom the member provides care in the Medical Center.

(6) participating in continuing education programs and aiding in any Medical Staff approved education programs for medical students, housestaff, nurses and other allied health professionals.

R11.7-3 Reporting of Incidents and Sentinel Events

Each member of the Medical Staff has the duty to report timely any incident or Sentinel Event (as defined below)to the chief of service, to the nursing supervisor or to the Director of Quality Assurance. A report is timely if made as soon as is practical after the occurrence, taking into account the patient's immediate need for care, and the need for intervention to prevent further adverse events.

Definitions:

An "incident" is an occurrence that has produced an actual, potential, or perceived injury to a patient, or any practice, premises condition, or product defect that, in the opinion of a reasonably prudent medical practitioner, may produce an injury or significant risk of injury if left uncorrected, including:

1) Medication error
2) A perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams

A "Sentinel Event" is an event that meets one of the following criteria:

1) The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition; or
2) The event is one of the following:
   - i. Patient suicide
   - ii. Infant abduction
   - iii. Rape or sexual assault
   - iv. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;
   - v. Surgery or other procedure on wrong patient or wrong body part;
   - vi. Unplanned, retained foreign objects remaining from surgery or other procedure;
   - vii. Brain or spinal damage;
   - viii. Patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.

Section XII OFFICERS

R12.1 Officers of the Medical Staff

R12.1-1 Identification

The officers of the Medical Staff shall be the President, President-Elect, Immediate Past President, and Secretary.

R12.1-2 Qualifications

The President, President-Elect, and the Immediate Past President shall be members of the Attending Category. The Secretary shall be a member of the Associate Attending Category. Officers of the Medical Staff must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

Chiefs of Service are not eligible for election to these offices but a Medical Staff officer who is appointed chief of a service may hold both positions while completing the elective office.

R12.1-3 Nominations and Nominating Committee

Each year, by September 1, the President of the Medical Staff shall develop a slate of candidates for positions on the Nominating Committee. The Committee shall consist of three members from the Attending Category and two from the Associate Attending Category. The President shall propose the slate of candidates consisting of at least six members from the Attending Category and four from the Associate Attending Category.

This slate and a ballot shall be mailed to each member of the Attending or Associate Attending Category. These members shall vote for the name of three nominees from the Attending Category and two from the Associate Attending Category and mail the ballot to the Secretary of the Medical Staff. The Secretary of the Medical Staff shall tabulate all ballots and shall certify the election. One of the three elected Attending Category members shall be designated as Chairman of the Committee by the President of the Medical Staff.

The Committee shall maintain a confidential record of its proceedings and report to the President of the Medical Staff. Prior to the first meeting of the Committee, the chairman shall obtain a list of persons who have been officers in the past several years as well as other information the Committee may need. The Committee shall meet as often as necessary to discuss the past performance in Medical Staff assignments and activities of members under consideration for officers. The Nominating Committee shall nominate one or more nominees for the offices of President-Elect and Secretary. The slate of nominees for the various offices shall be delivered to voting members of the Medical Staff at least two weeks prior to the annual meeting.

Further nominations from the floor shall be recognized if the nominee is present and consents.

The Nominating Committee shall also propose a slate of candidates for the three elected representatives to the Medical Board and the elected delegate to the Medical Staff Section of the American Medical Association and Texas Medical Association.

R12.1-4 Elections

Officers of the Medical Staff shall be elected at the annual meeting of the Medical Staff. Nominees shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Board shall decide the election at its next meeting or a special meeting called for that purpose.

R12.1-5 Term of Elected Office

Each officer shall serve until the next annual meeting or until their successors are chosen unless that officer shall sooner resign or be removed from office. At the end of a term, the President of the Medical Staff shall automatically assume the office of Immediate Past President and the President-Elect shall automatically assume the office of President of the Medical Staff. The Secretary of the Medical Staff shall serve a two-year term.

R12.1-6 Recall of Officers

A Medical Staff officer may be recalled from office based upon a failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office to which elected or failure to comply with the provisions of Sections 3.3-1 and 3.7 of these Bylaws. Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Medical Board or by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff Officers who actually cast votes at the special meeting in person or by mail ballot.

R12.1-7 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. If the office of President is vacated during the year, the President-Elect is elevated to that office and shall serve as President for the remainder of the unexpired term in addition to the full term as President -Elect. If the offices of President-Elect and/or Secretary are vacated, a replacement shall be elected as soon as feasible to serve the remainder of the term. The President-Elect would serve the next year as President. A slate of nominees shall be developed by the previous election's Nominating Committee and voting shall take place by mail ballot.

Should the office of the Immediate Past President be vacated, it shall remain unfilled until the next following election.

R12.2 Duties of Officers

R12.2-1 President of the Medical Staff

The duties of the President of the Medical Staff shall include, but not be limited to:

(a) calling, presiding at, and being responsible for the agenda at all general meetings of the Medical Staff;

(b) serving as a member of the Medical Executive Committee of the Medical Board and Medical Board;

(c) serving as a liaison between the Medical Staff and the Board of Trustees. The President shall attend meetings of and communicate Medical Staff matters to the Board of Trustees;

(d) reporting to the Medical Staff on actions taken by the Medical Executive Committee of the Medical Board and Medical Board;

(e) serving as an ex officio member of all other staff committees without vote, unless membership in a particular committee is required by these Bylaws; and

(f) interacting with the Administration and Board of Trustees on matters of mutual concern within the Medical Center.

R12.2-2 President-Elect

The duties of the President-Elect shall include, but not be limited to:

(a) assuming all duties and authority of the President in the absence of the President;

(b) serving as Program Chairman for the general meetings of the Medical Staff;

(c) serving as a member of the Medical Executive Committee of the Medical Board and Medical Board;

(d) attending the meetings of the Board of Trustees;

(e) serving as an alternate delegate to the Medical Staff Section of the American Medical Association and Texas Medical Association; and

(f) performing such other duties as the President may assign or as may be delegated by these Bylaws, or by the Medical Board.

R12.2-3 Immediate Past President

The duties of the Immediate Past President shall include, but not be limited to:

(a) serving as a member of the Medical Executive Committee of the Medical Board and Medical Board; and

(b) performing such other duties as the President may assign or as may be delegated by these Bylaws, or by the Medical Board.

R12.2-4 Secretary

The duties of the Secretary shall include, but not be limited to:

(a) serving as Secretary of the Medical Executive Committee of the Medical Board and Medical Board;

(b) attending to all appropriate correspondence on behalf of the Medical Staff;

(c) calling meetings on the order of the President;

(d) keeping minutes of all general meetings of the Medical Staff, the Medical Executive Committee of the Medical Board and Medical Board; and

(e) serving as Treasurer of the Medical Staff if there are funds to be accounted.

R12.2-5 Medical Staff Representatives

Representatives of the Medical Staff shall include the three elected at-large representatives to the Medical Board and the elected delegate to the Medical Staff Section of the American Medical Association and Texas Medical Association. These representatives shall be elected at the same time and in the same manner as the elected officers of the Medical Staff. At-Large Representatives to the Medical Board shall serve a term of two years. The elected delegate to the Medical Staff Section of the American Medical Association and Texas Medical Association shall also serve a two-year term and may serve up to three consecutive two year terms.

Section XIII DEPARTMENTS OF THE MEDICAL STAFF

R13.1 Organization

R13.1-1 Clinical Departments and Divisions

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have clinical services under the direction of a Chief of Service. The Chief of Service shall be selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6-5. A department may be further divided, for the purpose of development or strengthening the subspecialty, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division head selected and entrusted with the authority, duties and responsibilities specified in Section 10.7-5.

Proposals to realign, rename, create, eliminate, or modify departments and divisions must first be presented and approved by a majority vote of the members of the departments present at a regular or specially called meeting for that purpose. Proposals shall then be presented to the Medical Board and the procedures outlined in Section XII shall apply.

R13.1-2 Multidisciplinary Departments

Multidisciplinary Departments may be established for fields of medicine that require formally coordinated clinical relationships and evaluation among several clinical specialties on a continuing basis. Except for its Chief of Service, each person appointed to a Multidisciplinary Department shall also hold a primary appointment in another department and shall be subject to the standards and requirements of both departments. The same procedure shall be used for the appointment to the Multidisciplinary Department as for appointment to the primary department. Any person designated to head that person’s specialty's section or division within the Multidisciplinary Department shall have such designation approved by the Chiefs of both that person’s primary department and the Multidisciplinary Department, and shall follow the procedure for appointment described in Section 10.7-2. Such person may also hold a similar position in that person’s primary department.

The purpose of establishing a Multidisciplinary Department is to maintain a clinical service and to conduct educational programs and research in its specialized area.

R13.2 Departments

Departments and multidisciplinary departments are:

(1) Anesthesiology and Pain Management

(2) Children Services

(3) Colon and Rectal Surgery

(4) Emergency Medicine

(5) Family Practice

(6) Internal Medicine

(7) Neurological Surgery

(8) Obstetrics and Gynecology

(9) Oncology

Secondary appointment (Primary appointment through another department)

(a) Division of Medical Oncology and other Internal Medicine Sub-specialties

(b) Division of Radiation Oncology and Diagnostic Radiology

(c) Division of Surgical Oncology

(d) Division of Gynecologic Oncology

(e) Division of Oncologic Pathology

(10) Ophthalmology

(11) Orthopaedic Surgery

(12) Otolaryngology

(13) Pathology and Clinical Pathology

(14) Physical Medicine and Rehabilitation

(15) Plastic and Reconstructive Surgery

(16) Psychiatry

(17) Radiation Oncology

(18) Radiology

(19) General Surgery

(20) Thoracic and Cardiovascular Surgery

(21) Urology

R13.3 Assignment to Departments and Divisions

With the exception of multidisciplinary departments, practitioners shall be a member of only one department known as the primary department. The Chief of Service of the primary department shall recommend to the Credentials Committee the clinical privileges to be granted to the practitioner. All practitioners in the department are subject to the rules and regulations of the department and to the authority of the Chief of Service.

Practitioners may apply for clinical privileges in departments other than their primary department. In these instances, the practitioner's application must also be evaluated and subsequent recommendations as to the granting of such privileges given by the Chief(s) of Service in the other department(s) in which clinical privileges are requested. Such recommendation(s) will be sent to the Chief of Service in the primary department who will forward them along with the Chief's own recommendation to the Credentials Committee.

R13.4 Functions Of Departments

Under the responsibility of its Chief of Service, each department shall perform certain functions. The Chief of Service may assign the responsibility for the accomplishment of specific functions to a departmental committee or to a department member(s). Such committees or member(s) shall perform delineated functions pursuant to these Bylaws.

The general functions of each department shall include:

(a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Center's Quality Assurance Plan. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. These criteria may be based upon procedures performed, outcomes, medication usage, blood usage, medical records, mortality rates, utilization management, meeting attendance and/or risk-management data. Patient care reviews shall include the clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

(b) recommending to the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department, and determining the circumstances when consultation or management by a physician or other qualified licensed independent practitioner is required in granting and delineating clinical privileges;

(c)evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;

(d) conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice and regarding use of clinical practice guidelines for use in improving processes;

(e) reviewing and evaluating departmental adherence to Medical Staff policies and procedures, as well as sound principles of clinical practice;

(f) determining the circumstances where a medical history and physical examination performed by a licensed independent practitioner who is not a physician must be confirmed by a qualified physician;

(g) coordinating patient care provided by the department's members with nursing and ancillary patient care services.

(h) submitting written reports to the Medical Board, through the Committee on Professional Standards, concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Medical Center;

(i) meeting at least quarterly, or more often at the discretion of the chief, for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and Staff functions;

(j) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it;

(k) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

(l) accounting to the Medical Board for professional and Medical Staff administrative activates within the department;

(m) formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Medical Board.

R13.5 Functions of Divisions

Subject to approval of the Medical Board, each division shall perform the functions assigned to it by the Chief of Service of the respective department. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privileges delineation, and continuing education programs. The division shall transmit regular reports to the Chief of Service on the conduct of its assigned functions.

R13.5-1 Divisions are:

Department of Internal Medicine

(1) Division of Allergy and Immunology

(2) Division of Cardiology

(3) Division of Dermatology

(4) Division of Gastroenterology

(5) Division of Endocrinology and Metabolism

(6) Division of General Internal Medicine

(7) Division of Infectious Disease

(8) Division of Nephrology

(9) Division of Neurology

(10) Division of Medical Oncology and Hematology

(11) Division of Pulmonary Medicine

(12) Division of Rheumatology

Department of Surgery

(1) Division of Dentistry

(2) Division of Transplant Surgery

(3) Division of Trauma Surgery

(4) Division of Vascular Surgery

Department of Family Practice

(1) Division of Podiatry

Department of Children Services

(1) Division of Neonatology

(2) Division of General Pediatrics

R13.6 Department Heads (Chiefs Of Service, Assistant Chief Of Service, And Secretary)

R13.6-1 Qualifications

Each department shall have a Chief of Service, Assistant Chief of Service, and Secretary who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical services covered by the department. In addition, a Chief of Service should be certified by the appropriate specialty board, have demonstrated leadership qualities, be a strong supporter of Baylor University Medical Center and be active in education, both for medicine and for allied fields. Under special circumstances, in order to serve the best interests of the Medical Center, one or more of the above requirements may be waived. Candidates for Chief of Service who are not board certified must demonstrate competence comparable to individuals with board certification.

R13.6-2 Terms Of Office

Chiefs of Service in departments primarily engaged in private practice (non-contracted Chiefs of Service), Assistant Chiefs of Service, and departmental Secretaries shall be appointed by the Board of Trustees for terms of one year. Contracted full-time or part-time Chiefs of Service shall be appointed on a continuing basis by the Board of Trustees, subject to the terms of the contract between the individual and the Medical Center.

R13.6-3 Selection

(a) Non-Contracted Chiefs of Service

Chiefs of Service for each clinical department shall be chosen by the Board of Trustees from a slate of three (3) candidates selected for consideration by the Officers of the Medical Staff. The Officers of the Medical Staff shall determine the three candidates from a list of nominees (not to exceed 10) submitted to the Officers by the Department based on the recommendations of the Active Staff Members of the Department made at a scheduled Department meeting or a special meeting called for that purpose. Clinical departments with less than ten members on the Active Staff may submit the names of all Active Staff members for consideration. If any clinical department fails to submit a list of nominees by October 31, the Officers of the Medical Staff may select a slate of three candidates without input from the Department.

(b) Contracted Chiefs of Service

Contracted Chiefs of Service shall be appointed by the Board of Trustees, with advice from the appropriate departments of the Medical Staff. The Board of Trustees shall establish procedures for securing the advice and shall also establish formal means of having the incumbent's professional and administrative qualifications evaluated periodically by the incumbent’s peers, which may include evaluation by the departmental Advisory Committee.

(c) Assistant Chiefs of Service and Secretaries

On an annual basis, the Chief of Service shall recommend to the Medical Board members for appointment to the Assistant Chief of Service and Secretary positions. The Medical Board shall review these candidates and make its recommendation to the Board of Trustees, which shall make the final decision.

R13.6-4 Removal

A Chief of Service may be removed by the Board of Trustees after consultation with the Medical Board and the department's Advisory Committee*, if applicable*. Contracted Chiefs of Service may be removed from office as determined in the contract between the individual and the Medical Center, or based upon a failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office to which elected or failure to comply with the provisions of Sections 3.3-1 and 3.7 of these Bylaws. Non-Contracted Chiefs of Service may be removed from office based upon a failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office to which elected or failure to comply with the provisions of Sections 3.3-1 and 3.7 of these Bylaws.

R13.6-5 Vacancies

Vacancies in department heads/division chiefs occur upon the death or disability, resignation, or removal of the department head/division chief, or the loss of their membership in the Medical Staff. If the position of section chief/division head is vacated during the year, the Assistant Chief is elevated to that position and shall serve as Chief for the remainder of the unexpired term subject to approval by the Board of Trustees.

In the event that the position is not filled by the Assistant Chief, for any reason, an interim appointment shall be made by the Board of Trustees until such time that the division or department can select a permanent chief through the process described in 10.6-3 or 10.7-2.

R13.6-6 Duties

(a) Each Chief of Service shall have the following authority, duties and responsibilities, and the Assistant Chief of Service, in the absence of the Chief of Service, shall assume all of them and shall otherwise perform such duties as may be assigned:

(1) act as presiding officer at departmental meetings and provide appropriate minutes of such meetings;

(2) assure that the departmental functions in Section 10.4 are carried out;

(3) responsible to the Medical Board for all professional, clinical and administrative activities within the department;

(4) monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Board;

(5) develop and implement departmental programs, policies and procedures for retrospective patient care review, on-going monitoring of practice, credentials review and clinical privilege delineation, medical education, utilization review, and quality assurance;

(6) be a member of the Medical Board, and give guidance on the overall medical policies of the Medical Staff and Medical Center and make specific recommendations and suggestions regarding the department;

(7) recommend to the Credentials Committee department membership appointments and reappointments, as well as clinical privilege delineations;

(8) recommend criteria for membership and clinical privilege delineation;

(9) recommend and cooperate in corrective action with respect to persons with clinical privileges in the department when necessary;

(10) endeavor to enforce the Medical Staff bylaws, rules and regulations and policies within the department;

(11) cooperate with other departments and implement within the department appropriate actions taken by the Medical Board or its designee;

(12) participate in every phase of administration of the department, including cooperation with other departments, as well as the nursing service and the Administration in matters such as personnel, supplies, space, special regulations, standing orders, techniques, and off-site sources for patient care services not provided by the department or organization;

(13) direct and participate in medical education programs in the department and provide support to such programs throughout the Medical Center;

(14) encourage and monitor research in the department;

(15) perform such other duties commensurate with the office as may from time to time be reasonably requested.

(b) Secretaries shall be responsible for maintaining appropriate minutes and other records of departmental meetings, as well as fulfilling other functions that may be requested by the Chief of Service.

R13.7 Division Heads

R13.7-1 Qualifications

Each division shall have a head who shall be a member of the Active Medical Staff and a member of the division which the person is to head, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

R13.7-2 Selection

The Chief of Service over the respective division shall recommend to the Medical Board persons for appointment. The Medical Board shall review the recommendation and make its own recommendation to the Board of Trustees, which shall make the appointment.

R13.7-3 Term of Office

Each Division Head shall serve for a term of one year or until the end of the year after appointment.

R13.7-4 Removal

A Division Head may be removed by the Board of Trustees after consultation with the Chief of Service and the Medical Board for failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office, or failure to comply with the provisions of Sections 3.3 – 1 and 3.7 of the Medical Staff Bylaws.

R13.7-5 Duties

(a) act as presiding officer at division meetings and ensure that appropriate minutes are kept;

(b) assist in the development and implementation, in cooperation with the Chief of Service, of programs to carry out the patient care quality review, and evaluation and monitoring functions assigned to the division;

(c) monitor the clinical work performed in the division;

(d) conduct investigations and submit reports and recommendations to the Chief of Service regarding the clinical privileges to be exercised within the division by members of or applicants to the Medical Staff;

(e) direct and participate in the medical education programs of the Division Head's specialty and department, as well as medical education programs in other departments;

(f) encourage research in the division;

(g) cooperate with other departments and divisions, and perform such other duties commensurate with the office as may be requested by the Chief of Service or Medical Board or its designee.

R13.8 Departmental Advisory Committees

Each department may have an advisory committee to assist the Chief of Service in carrying out the duties of the department. Such advisory committees shall also be available to the Board of Trustees and the Administration for counsel on departmental matters.

Its composition and responsibilities may vary by department based on the needs of the Chief of Service. The method of selection of members shall be departmental specific.

Among the matters that may be referred to the committee are:

(1) evaluation of applicants for appointment or reappointment;

(2) recommendations for clinical privilege delineation; and

(3) organization of the department or its patient care, education or research programs.

The Chief of Service shall retain the ultimate authority and responsibility to make the decisions and carry out the duties with which the Chief is charged in the Medical Staff Bylaws.

Section XIV COMMITTEES

R14.1 Designation

Medical Staff committees shall include but not be limited to, the General Meetings of the Medical Staff as a committee of the whole, meetings of departments, meetings of committees established under this Section, and meetings of special or ad hoc committees created by the Medical Board pursuant to this Section or by departments pursuant to Sections 10.4 (j). The committees described in this Section shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Board or departments to perform specified tasks. Each committee shall have the authority to appoint subcommittees to perform studies on subjects within its jurisdiction. Unless otherwise specified, the chairman, vice-chairman, and members of all committees shall be appointed by the Medical Board based on recommendations provided by the Committee on Committees. Members may be removed by the Chairman of the Medical Board subject to consultation with and approval by the Medical Board. Medical Staff committees shall be responsible to the Medical Board through the Medical Executive Committee of the Medical Board.

R14.2 General Provisions

R14.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of two years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

R14.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Medical Center, suffers a loss or significant limitation of clinical privileges, or if any other good cause exists, that member may be removed by the Medical Board.

R14.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Board.

R14.2-4 Confidentiality of Information

Records and proceedings of all committees of the Medical Staff shall be confidential pursuant to Section XIV.

R14.3 Medical Board

R14.3-1 Composition

The Medical Board shall be composed of:

(a) Chiefs of Service of the Departments of Anesthesiology and Pain Management, Colon and Rectal Surgery, Dentistry, Emergency Medicine, Family Practice, Internal Medicine, Neurological Surgery, Obstetrics and Gynecology, Oncology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Children Services, Physical Medicine and Rehabilitation, Plastic and Reconstructive Surgery, Psychiatry, Radiology, Radiation Oncology, General Surgery, Thoracic and Cardiovascular Surgery and Urology;

(b) The President of the Medical Staff;

(c) The President-Elect of the Medical Staff;

(d) The Immediate Past-President of the Medical Staff;

(e) The Secretary of the Medical Staff;

(f) The Chairman of Committee on Medical Education;

(g) The Chairman of the Committee on Professional Standards;

(h) The Baylor Health Care System Board of Trustees Medical Staff representative;

(i) The elected delegate to the medical staff section of the American Medical Association and the Texas Medical Association;

(j) Three elected representatives of the Medical staff with two of the three being members of the Active Clinical category and one representative from the Department of Internal Medicine. All three will serve terms of two years;

(k) The Chief Executive Officer and/or designee(s) shall attend each meeting as non-voting members and shall serve as a liaison officer between the Board of Trustees and the Medical Board, and;

(l) Directors of the Divisions of Cardiology, Dermatology, Gastroenterology, General Internal Medicine, Infectious Disease, Nephrology, Neurology, Medical Oncology and Hematology, Pulmonary Medicine, Rheumatology in the Department of Internal Medicine and Directors of the Divisions of Transplant Surgery and Vascular Surgery in the Department of Surgery.

The same person holding two or more of the positions qualifying for Medical Board membership shall serve with one vote.

R14.3-2 Officers of the Medical Board

The Officers of the Medical Board shall be the Officers of the Medical Staff. Medical Executive Committee Medical Executive Committee

R14.3-3 Duties

The duties of the Medical Board shall be to:

(a) Serve as advisory board to the Medical Executive Committee. The Chairman shall report to the Medical Executive Committee, ,

(b) Participate in the development and evaluation of Medical Staff and Medical Center policies, practices, and plans as appropriate,

(c) Receive reports from Administration and provide feedback as appropriate,

(d) Obtain and report feedback regarding Medical Staff activities to and from Medical Staff constituents on an ongoing basis.

R14.3-4 Meetings

The Medical Board shall meet as often as necessary at the call of its chairman but at least quarterly. It shall maintain a record of its proceedings.

R14.4 Medical Executive Committee

R14.4-1 Composition

The Medical Executive Committee shall be composed of the following voting members:

(a) President of the Medical Staff;

(b) President-Elect of the Medical Staff;

(c) Immediate Past-President of the Medical Staff;

(d) Secretary of the Medical Staff;

(e) Chief of Anesthesiology and Pain Management;

(f) Chief of Emergency Medicine;

(g) Chief of General Surgery;

(f) Chief of Internal Medicine;

(g) Chief of Obstetrics and Gynecology;

(h) Chief of Radiology;

(i) Chief of Pathology;

(j) Chairman, Committee on Graduate Medical Education;

(k) Chairman, Committee on Professional Standards;

(l) Three additional members shall be elected from the general membership of the Medical Board and shall serve two-year terms. The Officers of the Medical Staff shall serve as the Nominating Committee. A paper ballot with a slate of six nominees shall be submitted to each member of the Medical Board in October of alternating years. The three nominees with the highest number of votes submitted shall be elected to serve. In considering these nominees, efforts will be made to balance the representation.;

(k) Non-voting members shall include representatives from Administration.

R14.4-2 Officers of the Medical Executive Committee

The officers of the Medical Executive Committee shall be the Officers of the Medical Staff.

R14.4-3 Duties

The duties of the Medical Executive Committee shall be to:

(a) Act on all matters on behalf of the self-governing, organized Medical Staff, without requirement of subsequent approval by the Medical Staff, subject to any limitations imposed by the Medical Staff Bylaws or these Rules and Regulations;

(b) Recommend actions to the Board of Trustees on matters relating to the delivery of medical care and medical staff functions;

(c) Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Practice Councils, and make recommendations to the Board of Trustees;

(d) Exercise final authority over the activities of and policies adopted by the Medical Staff, Departments, Committees and Clinical Practice Councils;

(e) Appoint chairmen and members to all standing committees of the Medical Staff, and to special committees as may be required to carry out the duties of the Medical Staff;

(f) Designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the Medical Executive Committee and the Medical Staff;

(g) Keep the Medical Staff abreast of JCAHO accreditation, regulatory and other professional standards or requirements;

(h) Ensure bi-directional communication with the Medical Staff;

(i) Review the Bylaws, Rules and Regulations and policies of the Medical Staff at least once a year and recommend any changes to the Board of Trustees;

(k) Establish structures of the Medical Staff to accomplish the following:

a. Review of credentials and delineation of clinical privileges of individuals;

b. Quality assurance/utilization review activities;

c. Termination of Medical Staff membership and fair hearing procedures;

d. Other matters relevant to the operation of an organized medical staff.

(l) Review the clinical competency and qualifications of all Practitioners and make recommendations to the Board of Trustees on appointment and reappointment to the Medical Staff, assignment to Departments and delineation of clinical privileges.

(m) Investigate any suspension or limitation of a member's clinical privileges or request investigation to determine the need for professional review as outlined in Article 3 of the Medical Staff Bylaws.

(n) Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all Medical Staff members including the initiation of and participation in Medical Staff corrective actions or review measures when warranted.

R14.4-4 Meetings

The Medical Executive Committee shall meet as often as necessary at the call of its Chairman, but at least bi-monthly it shall maintain a confidential record of its proceedings and report to the Board of Trustees..

R14.5 Committee on Committees

R14.5-1 Composition

The Committee on Committees shall be composed of four members of the Active Medical Staff and the officers of the Medical Staff. The secretary of the Medical Staff shall serve as chairman. Active Medical Staff members shall serve a staggered three-year term, with one new member to be appointed by January 1 of each year by the Chairman of the Medical Executive Committee.

R14.5-2 Duties

The duties of the Committee on Committees shall be to:

(a) Recommend persons to be appointed to all standing committees of the Medical Staff and to present these recommendations to the Medical Board,

(b) Develop recommendations for appointments to the Medical Executive Committee and Credentials Committee and report these recommendations to the Medical Executive Committee,

(c) Develop recommendations for vacancies that may occur in any Committee and develop recommendations for appointment for new Committees that may be formed during the year. Report these recommendations to the Medical Board.

R14.5-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.6 Credentials Committee

R14.6-1 Composition

The Credentials Committee shall be composed of at least ten members to include nine members from the Active Medical Staff and one representative of the Board of Trustees. Members shall serve three-year terms and may serve multiple terms. Three Medical Staff Members shall be appointed each year in the same manner as with other standing Committees of the Medical Staff to ensure continuity. The representative of the Board of Trustees shall be chosen each year by the Chairman of the Board of Trustees. Members shall be chosen on the basis of the ability to perform their duties and make recommendations in the best interest of patient care. A Chairman of the Committee shall be chosen each year by the Medical Executive Committee. Representatives from the Administration shall also attend as non-voting members.

R14.6-2 Duties

The duties of the Credentials Committee shall be to:

(a) Review and evaluate the qualifications of each practitioner applying for reappointment and the granting or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments,

(b) Submit required reports and information to the Board of Trustees on the qualifications of each practitioner applying for reappointment or particular clinical privileges including recommendations

with respect to reappointment, membership category, department affiliation, clinical privileges, and special conditions,

(c) Investigate, review, and make recommendations on matters referred by the Medical Executive Committee Medical Executive Committee regarding the qualifications, conduct, professional character, or competence of any applicant or medical staff member,

(d) Submit monthly reports to the Medical Executive Committee concerning the Committee's recommendations to the Board of Trustees regarding membership reappointments, clinical privilege delineations and status of pending applications and other activities of the Committee.

R14.6-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee and the Medical Staff.

R14.7 Screening Committee

R14.7-1 Composition

The Screening Committee shall be composed of at least five members of the Active Medical Staff. Members shall serve three-year terms and may serve up to three consecutive three-year terms. Member's terms shall be staggered to ensure continuity. A Chairman of the Committee shall be chosen each year by the Committee from those members who have served at least one year on the Committee. Members shall be chosen on the basis of the ability to perform their duties and make recommendations in the best interest of patient care.

R14.7-2 Duties

The duties of the Screening Committee shall be to:

(a) Review and evaluate the qualifications of each practitioner applying for initial appointment to the Medical staff and, in connection therewith, obtain and consider the recommendations of the appropriate departments.

(b) Submit required reports and information to the Board of Trustees on the qualifications of each practitioner applying for initial Medical Staff Membership.

(c) Investigate, review, and make recommendations on matters referred by the Medical Executive Committee regarding initial Medical Staff appointment.

(d) Submit monthly reports to the Medical Executive Committee concerning the Committee's evaluation and recommendations regarding initial membership appointments, status of pending applications and other activities of the Committee.

R14.7-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Board of Trustees and the Medical Staff.

R14.8 Cancer Center Executive Committee

R14.8-1 Composition

The Cancer Center Executive Committee shall be composed of at least fourteen members to include:

(a) Director of the Cancer Center, Chairman;

(b) Chairman of the Cancer Center Medical Committee, Vice-Chairman;

(c) Chief Executive Officer of the Medical Center;

(d) Vice-President responsible for the Cancer Center;

(e) Administrative Director for the Cancer Center;

(f) Chief of Service for Internal Medicine;

(g) Chief of Service for General Surgery;

(h) Chief of Service for Pathology;

(i) Chief of Service for Oncology;

(j) President of the Baylor University Medical Center Foundation, and;

(k) Representative from the Baylor University Medical Center Board of Trustees.

Other members shall be appointed for one or two year terms upon recommendation of the Director of the Cancer Center.

R14.8-2 Duties

The duties of the Cancer Center Executive Committee shall be to:

(a) Provide continuing direction for the planning, operation, and evaluation of all Cancer Center programs, services, and related activities,

(b) Ensure existing activities and newly developed programs are consistent with the overall policies of the Medical Center and that they are coordinated within this framework.

R14.8-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.9 Cancer Center Medical Committee

R14.9-1 Composition

The Cancer Center Medical Committee shall be composed of the Director and Administrative Director of the Cancer Center and at least ten members of the Medical Staff chosen so as to reflect the interest of the Oncology Service, as well as those of the entire Medical Staff. The multidisciplinary membership representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services shall meet the standard set by the American College of Surgeons Commission on Cancer. If requested by the Committee on Committees, membership recommendations will be made jointly by the Chairman and the Director of the Cancer Center.

R14.9-2 Duties

The duties of the Cancer Center Medical Committee shall be to:

(a) Develop, implement, and monitor oncology clinical activities in the Medical Center.

(b) Study, evaluate, and monitor quality of patient care and integrated management through:

(1) Site-specific Oncology Committees,

(2) Development of clinical protocols,

(3) Outreach activities,

(4) Other areas as designated by the Director of the Cancer Center and agreed to by the Committee Chairman.

(c) Promote optimal integration of medical, surgical, and radiotherapeutic management of cancer patients throughout the Medical Center, its affiliated hospitals, and with referring practitioners in outlying communities,

(d) Serve in an advisory capacity to the Director of the Cancer Center in other matters relating to planning, operation, and evaluation of selected Cancer Center programs.

R14.9-3 Meetings

The committee shall meet as often as necessary at the call of its chairman but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Cancer Center Medical Executive Committee and to the Medical Executive Committee.

R14.10 Committee on Infections

R14.10-1 Composition

The Committee on Infections shall be composed of at least ten members of the Medical Staff, as well as the Medical Director of the Employee Health Clinic. Non-voting members shall include representatives from the Microbiology Laboratory, Epidemiology, Administration, and Nursing. Representatives from

other departments of the Medical Center involved in infection evaluation and control may be invited on a consultative basis as non-voting members.

R14.10-2 Duties

The duties of the Committee on Infections shall be to:

(a) Develop a hospital-wide infection control program and maintain surveillance over the program,

(b) Develop a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytical review of such data, and follow-up activities,

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques,

(d) Recommend educational activities for Medical Staff members and for Medical Center employees to maintain awareness of the potential problems of infection and to emphasize the importance of strict adherence to techniques of preventing the spread of infection,

(e) Develop written policies defining special indications for isolation requirements,

(f) Act upon recommendations related to infection control received from the Medical Executive Committee, departments and other committees,

(g) Review antibiotic sensitivities of organisms specific to this facility,

(h) Initiate and coordinate any control measure or studies for the immediate protection of patients or personnel and recommend measures for prevention and control of infection.

R14.10-3 Meetings

The Committee on Infections shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and shall report to the Medical Executive Committee.

R14.11 Committee on Institutional Ethics

R14.11-1 Composition

The Committee on Institutional Ethics shall be composed of at least six members of the Medical Staff, four nurses, one Chaplain, one Medical Center Attorney, two Staff Social Workers, two Administrators, and four community representatives.

R14.11-2 Duties

The duties of the Committee on Institutional Ethics shall be to:

(a) Develop guidelines for consideration of bioethical issues in patient care,

(b) Develop and implement procedures for the review of such issues,

(c) Develop and/or review institutional policies regarding such issues,

(d) Upon request, conduct prospective and retrospective review of cases for the evaluation of bioethical policies,

(e) Consult with concerned parties to facilitate communication and aid conflict resolution,

(f) Provide education to the Medical Center staff, patients, and the community on bioethical matters.

R14.11-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.12 Committee on Graduate Medical Education

R14.12-1 Composition

The Committee on Graduate Medical Education shall be composed of at least sixteen members to include Chiefs of Service, or their designated representative, from Colon and Rectal Surgery, Internal Medicine, Surgery, Obstetrics and Gynecology, Pathology, Physical Medicine and Rehabilitation, and Radiology, as well as Chiefs of Service from departments having joint residency programs through

arrangements with other hospitals. The Committee has allotted three (3) voting positions for housestaff members. Other positions on the Committee shall be filled by members from the Medical Staff at large. The Chairman of the Committee shall be the Director of Medical Education. Non-voting members shall include representatives from Administration and the Director of the Outpatient Clinic.

R14.12-2 Duties

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

(a) Evaluate and approve all residency and fellowship programs,

(b) Recommend policies, procedures, and programs to the Chiefs of Service and the Medical Executive Committee,

(c) Develop plans for new programs,

(d) Evaluate the qualifications of and selection of candidates for residency and fellowship programs,

(e) Monitor the skills demonstrated and care rendered by participants including but not limited to, residents, medical students, fellows, and attending physicians serving as faculty in graduate medical education programs,

(f) Advise the Administration and the Director of Medical Education on any aspect of administering residency, fellowship, or other medical education programs,

(g) Advise the Director of the campus library regarding acquisitions that will enhance medical education.

R14.12-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.13 Committee on Medical Records

R14.13-1 Composition

The Committee on Medical Records shall be composed of at least eight members of the Medical Staff. Non-voting members shall include representatives from Administration, Nursing, and Health Information Management.

R14.13-2 Duties

The duties of the Committee on Medical Records shall be to:

(a) Review and evaluate medical records or a representative sample of medical records to determine that they:

(1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered (clinical pertinence),

(2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the Medical Center,

(b) Evaluate reports on timeliness of entries and completion of records against provisions of the rules and regulations and recommend action for cause and frequency of delays.

(c) Review and make recommendations for Medical Staff and Medical Center policies and Rules and Regulations relating to completion, filing, indexing, storage, destruction, and availability of medical records, including statistical data.

(d) Approve abbreviations, forms, and formats.

(e) Provide liaison with Medical Center administration and medical records personnel on matters relating to medical records practices.

R14.13-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and shall report to the Medical Executive Committee.

R14.14 Committee on Medical Nutrition

R14.14-1 Composition

The Committee on Nutrition and Dietary Services shall be composed of at least seven members of the Medical Staff. Non-voting members shall include representatives from Administration and the Nutrition and Dietary Department.

R14.14-2 Duties

The duties of the Committee on Nutrition and Dietary Services shall be to:

(a) Evaluate and approve standard therapeutic diets available in the Medical Center,

(b) Create guidelines for enteric nutrition and hyperalimentation,

(c) Establish criteria for usage and selection of products,

(d) Monitor and evaluate the nutritional needs of patients,

(e) Disseminate nutritional and dietary information,

(f) Evaluate and make recommendations when requested on general patient food services provided in the Medical Center.

R14.14-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman but at least annually. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.15 Committee on Pharmacy and Therapeutics

R14.15-1 Composition

Committee on Pharmacy and Therapeutics shall be composed of at least seven representatives from the Medical Staff and a representative from the Department of Pharmacy. Non-voting members shall include representatives from Administration and Nursing.

R14.15-2 Duties

The duties of the Committee on Pharmacy and Therapeutics shall be to:

(a) Assist in the formulation of professional practices, policies, and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs and diagnostic testing material in the hospital, including antibiotic usage,

(b) Advise the Medical Staff and the Department of Pharmacy on matters pertaining to the choice of available drugs,

(c) Make recommendations concerning drugs to be stocked in-patient care areas,

(d) Develop and review periodically a formulary or drug list for use in the Medical Center,

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Medical Center and approve the addition of such drugs or preparations to the formulary,

(f) Review formally approved protocols relating to the use and control of investigational or experimental drugs and of research in the use of recognized drugs which are under the direction of the Institutional Review Board for Human Protection and approve the storage and dispensation methods of such drugs,

(g) Review untoward drug reactions and recommend changes in prescribing methods to medical staff departments where indicated,

(h) Monitor and evaluate prescribing of major classes of drugs used, their prophylactic, therapeutic, and empirical use, and ensure appropriate, safe, and effective prescribing of such drugs.

R14.15-3 Meetings

The Committee shall meet as often as necessary at the call of its chairman but at least quarterly. It shall maintain a confidential record of its proceedings and shall report to the Medical Executive Committee.

R14.16 Committee on Professional Health

R14.16-1 Composition

The Committee on Professional Health shall be composed of at least four members of the Medical Staff, one Allied Health Professional, and one Senior Administrator. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee. The Chairman has discretion to appoint other members on an ad hoc basis to consider specific cases.

R14.16-2 Duties

The duties of the Committee on Professional Health shall be to:

(a) Receive and evaluate reports related to the health, well-being, or impairment of Medical Staff members and Allied Health Professionals and investigate such reports,

(b) Establish a subcommittee or appoint an individual to assist with interventions, refer to the appropriate resources for the diagnosis and treatment of the condition or concern and to monitor the recovery of impaired Medical Staff members and Allied Health Professionals, until the rehabilitation or any disciplinary process is complete,

(c) Maintain all activities in a confidential manner; however, in the event information received by the Committee demonstrates that the health or known impairment of a medical staff member or Allied Health Professional poses risk of harm to patients, that information may be referred for corrective action,

(d) Consider general matters related to the health and well-being of the Medical Staff and Allied Health Professionals and, with approval of the Medical Executive Committee, develop educational programs or related activities,

(e) Review and recommend policy changes to the Medical Executive Committee utilizing the established Baylor Policy on Impaired Professionals,

(f) Advise individual members of the Medical Staff and Allied Health Professionals concerning matters involving impairment, and assist and monitor members of the Medical Staff and Allied Health Professionals who self-refer for health or impairment issues,

(g) Educate the Medical Staff, Allied Health Professionals, and Hospital personnel about illness and impairment recognition issues,

(h) Report to the Medical Executive Committee if a Medical Staff member is unable to safely perform the Medical Staff privileges granted, or to the Committee on Allied Health Professionals and to the Medical Executive Committee if an Allied Health Professional is unable to safely perform the scope of practice and delineation of services granted, so that appropriate action may be initiated.

R14.16-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman. It shall provide the Medical Executive Committee with minutes and a brief annual report edited to protect confidentiality.

R14.17 Committee on Physician Relations

R14.17-1 Composition

The Committee on Physician Relations shall be composed of at least three members of the Medical Staff, a representative from the Administration, and a representative from the Department of Nursing. Non-voting members may be added as indicated by an incident being considered.

R14.17-2 Duties

The duties of the Committee on Physician Relations shall be to:

(a) Evaluate behavior that can be disruptive to the quality of patient care and the spirit of teamwork between practitioners and the Medical Center personnel,

(b) Review circumstances when acts, words, or deeds begin to affect the ability of others to accomplish their jobs free of harassment,

(c) Evaluate complaints brought forth by patients, physicians, medical center employees or other individuals concerning a member(s) of the medical staff that cannot be resolved by the Chief of Service,

(d) Make recommendations to the Medical Executive Committee, which may include recommendations involving corrective action or sanctions.

R14.17-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.18 Committee on Professional Standards

R14.18-1 Composition

The Committee on Professional Standards shall be composed of at least twelve members of the Medical Staff to include the following individuals or a designee who is actively involved in Quality improvement activities:

(a) Medical Director(s) of the Center of Quality Care and Coordination Department;

(b) Chairman of the Committee on Surgical Case Review;

(c) Chairman of the Committee on Medical Records;

(d) Chairman of the Committee on Pharmacy and Therapeutics (to include expertise in Drug Usage Evaluation);

(e) Chairman of the Committee on Transfusions;

(f) Chairman of the Committee on Infections, and;

(g) Chairmen of Medical Staff Department Quality Assurance Committee for the Departments of Internal Medicine, General Surgery, Obstetric and Gynecology, Orthopaedic Surgery, Anesthesiology and Pain Management, Children Services and Emergency Medicine.

Non-voting members shall include the Chairman of the Interdisciplinary Quality Assurance Committee or a designee, and representatives from Administration, Center of Quality Care and Coordination, Medical Staff Services, Risk Management, and Nursing.

The Chairman of the Committee shall be a member of the Medical Executive Committee.

R14.18-2 Duties

The duties of the Committee on Professional Standards shall be to:

(a) Establish systems to identify potential problems in patient care by:

(1) Review of records of Medical Staff meetings to monitor that the quality and appropriateness of patient care is being provided by all individuals with clinical privileges and that the information is processed to be used for credentialing and reappointment.

(2) Assure that reports of the Monitoring Committees of the Medical Staff are disseminated to the Medical Staff members of each clinical service and appropriate action is taken on these findings.

(b) Refer priority problems for assessment and corrective action to the appropriate Department or Committee,

(c) Keep informed on standards of the Joint Commission on Accreditation of Healthcare Organizations and other outside agencies as they are published,

(d) Monitor results of quality assurance and utilization review activities throughout the Medical Center:

(1) Review of standards and procedures as they apply to clinical care and safety of patients,

(2) Recommend to the Medical Executive Committee studies that should be performed by other Committees having jurisdiction over clinical standards,

(3) Recommend additional quality assurance and utilization review activities or modifications of existing activities,

(4) Develop recommendations for policies, procedures, and programs to improve the care and safety of patients throughout the Medical Center.

(e) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Medical Center, lengths of stay, discharge practices, use of medical center services and related factors which may contribute to the effective utilization of services.

(f) Obtain, review, and evaluate information and raw statistical data obtained or generated by the Medical Center's case management system.

(g) Review the Quality Assurance Plan and the Utilization Review Plan annually.

(h) Submit regular reports to the Medical Executive Committee on the quality of medical care provided, quality review activities conducted, and utilization of resources and facilities in the Medical Center.

R14.18-3 Meetings

The Committee shall meet as often as necessary at the call of its chairman but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee and Board of Trustees.

R14.19 Committee on Surgical Services

R14.19-1 Composition

The Committee on Surgical Services shall be composed of at least the Chiefs of Service for all surgical departments, the Chief of Anesthesiology, or their designated representative, and an Administrative representative of Surgical Services.

Non-voting members shall include representatives from Administration and other representatives from the Department of Surgical Services. The Chief of General Surgery shall serve as Chairman.

R14.19-2 Duties

The duties of the Committee on Surgical Services shall be to:

(a) Evaluate and recommend policies and procedures affecting surgical facilities and services,

(b) Evaluate and recommend allocation and utilization of surgical facilities and services,

(c) Recommend to the Medical Executive Committee, rules and regulations necessary for safe and effective use of surgical facilities and services,

(d) Report problems regarding quality assurance and patient safety to the Medical Executive Committee,

(e) Develop recommendations regarding post anesthesia care facilities,

(f) Recommend actions to be taken in solving interdepartmental surgical problems.

R14.19-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and report to the Medical Executive Committee.

R14.20 Committee on Transfusions and Tissue

R14.20-1 Composition

The Committee on Transfusions and Tissue shall be composed of at least seven representatives of the Medical Staff, which shall include the Medical Director of the Baylor University Medical Center Blood Bank. Non-voting members shall include representatives from Nursing, IV Therapy, Baylor University Medical Center Blood Bank, Department of Surgical Services, Department of Anesthesiology Department of Pharmacy and Administration.

R14.20-2 Duties

The duties of the Committee on Transfusions and Tissue shall be to:

(a) Evaluate the appropriateness of cases in which patients were administered transfusions, including the use of blood and blood components collected and infused in the perioperative setting, which are referred by departmental quality assurance committees and recommend further action where indicated,

(b) Evaluate confirmed significant adverse reactions to transfusions, including transfusions of blood products collected and infused in the perioperative setting, and tissue implantations, including cellular-based transplant products,

(c) Develop, approve, and review policies and procedures relating to the distribution, handling, use and administration of blood and blood components, including blood components collected and infused in the perioperative setting, and tissues, including cellular-based transplant products,

(d) Review the adequacy of transfusion services, perioperative transfusion services and tissue services,

(e) Promote continuing education in transfusion therapy for medical staff, health care personnel, and the public.

R14.20-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman but at least quarterly. It shall maintain a confidential record of its proceedings and shall report to the Medical Executive Committee.

Section XV MEETINGS

R 15.1 Meetings

R15.1-1 Annual Meeting

There shall be an annual meeting of the Medical Staff, which shall be held in November of each year. The program shall be determined by the President of the Medical Staff. Notice of this meeting shall be given to the members at least thirty days prior to the meeting.

R15.1-2 Regular Meetings

There shall be four regular meetings of the Medical Staff. These meetings shall be held in February, May, September, and November with the meeting in November also constituting the annual meeting. Notice of the meetings shall be given to the members at least thirty days prior to the meeting.

R15.1-3 Agenda

The order of business at a meeting of the Medical Staff shall be determined by the President of the Medical Staff. The agenda shall include insofar as feasible:

(a) administrative reports from the President of the Medical Staff and the Administration;

(b) election of officers when required by these Rules and Regulations;

(c) voting on proposed changes to these Rules and Regulations when required by these Rules and Regulations;

(d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

(e) old business; and

(f) new business.

R15.1-4 Special Meetings

Special meetings may be called at any time by the President of the Medical Staff or upon the written request of ten percent of the members of the Active Medical Staff. Such members requesting a meeting shall first consult with the President of the Medical Staff and Chairman of the Medical Executive Committee as to the purpose and need to call a special meeting. Called special meetings shall be scheduled by the President within thirty days after receipt of such request. No later than thirty days prior to the meeting, notice shall be mailed or delivered to the members of the Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

R15.2 Committee and Department Meetings

R15.2-1 Regular Meetings

Except as otherwise specified in these Bylaws, the chairmen of committees, Chiefs of Service, and Division Heads may establish the times for the holding of regular meetings. The chairmen shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

R15.2-2 Special Meetings

A special meeting of any Medical Staff committee, department or division may be called by the chairman thereof, Chief of Service, Medical Executive Committee, President of the Medical Staff, or by written request of one-third of the current members, eligible to vote, but not less than five members.

R15.3 Quorum

R15.3-1 Regular Medical Staff Meetings

Except as otherwise specified, the action of a majority of the total of those Active Medical Staff members who vote at any regular or special meeting shall constitute the action of the group. A majority shall be defined as one member over half of the total of those Active Medical Staff members who are present and voting and any members who may have submitted written ballots.

R15.3-2 Department and Committee Meetings

The presence of one over half of the voting members shall be required for all departmental and committee meetings to constitute a quorum.

R15.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at all department and committee meetings at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged in writing setting forth the action so taken which is signed by at least [two thirds] of the members entitled to vote.

R15.5 Minutes

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and actions taken on significant matters. A confidential copy of the minutes shall be signed by the presiding officer of the meeting. All original minutes shall be forwarded to the Department of Medical Staff Services. Summaries of the minutes of standing Medical Staff committees shall be forwarded to the Medical Executive Committee for review and whatever action warranted. By December of each year, each standing committee of the Medical Staff shall submit to the Medical Executive Committee an annual report of its activities of the past year.

R15.6 Attendance Requirements

R15.6-1 Regular Attendance

It is expected that each member of the Active Staff will attend:

(a) At least fifty percent (two) of the regular meetings of the Medical Staff;

(b) At least fifty percent of all meetings of each department, division, and committee of which they are a member; and

(c) Each member of the Consulting and Courtesy Category shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

R15.6-2 Absence from Meetings

Any member to be absent from any Medical Staff, department, division, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. There is no system for excuses or making up absences; however; the Medical Executive Committee may rule on individual cases. Unless excused for good cause by the presiding officer of the department, division, or committee, or the Secretary for Medical Staff regular meetings, failure to meet the attendance requirements may be

grounds for removal from such committee or corrective action, including termination of Medical Staff membership.

R15.6-3 Special Attendance

At the discretion of the chairman or presiding officer, individuals other than members and non-voting members may be asked to attend meetings of the Medical Staff, departments, divisions, or committees. When a member's practice or conduct is scheduled for discussion at a department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least [seven] days prior to the meeting and shall include the time, place, and general indication of the issue involved. Failure of a member to appear at any meeting with respect to which the member was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

R15.6-4 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to the Sturgis Standard Code of Parliamentary Procedure; however; technical or non-substantive departures from such rules shall not invalidate actions taken at such a meeting.

Section XVI GENERAL PROVISIONS

R16.1 Administrative Suspension or Revocation

NOTE: System Standardized language – may not be changed w/o prior approval

The purpose of this section is to establish an enforcement mechanism for physician and house staff suspension processes. This section addresses the processes for any administrative suspension of medical staff privileges authorized under the Medical Staff Bylaws, including such reasons as: medical record delinquency; lapse or suspension of medical license, Drug Enforcement Agency (DEA) Certification, Department for Public Safety (DPS) Registration, or professional liability insurance; failure to respond to requests for information; or repetitious infractions.

16.1-1 The Administration Suspension as provided in the Medical Staff Bylaws is as follows:

A. Expiration of Licensure, DEA, DPS and/or Professional Liability Insurance

Upon expiration of licensure, DEA, DPS or professional liability insurance the practitioner is immediately prohibited from providing patient care, which includes, but is not limited to: elective and emergency admissions, admission scheduling, consultative and treating privileges, surgery or invasive procedure scheduling, elective anesthesia scheduling, voting and office-holding prerogatives until such document(s) is updated and verified.

B. Failure to Respond to Requests for Information

Practitioners suspended for failure to respond to requests for information related to expiration of licensure, DEA, DPS or professional liability insurance may be prohibited from providing patient care (as defined in section 1.1 above). Failure to respond to other requests for information will be addressed as defined in Section 3.3-5 of the Medical Staff Bylaws.

C. Failure to Complete Medical Records

Practitioners shall be denied scheduling privileges for elective admissions, surgery or invasive procedure and/or elective anesthesia (with the exception of in-house patients), as well as voting and office-holding prerogatives, for failure to complete medical records within twenty-one (21) days from the time the medical records were first made available to the practitioner. In addition, the practitioner's membership and clinical privileges may be suspended for failure to complete medical records for three (3) weeks in a row from availability until such records are completed. Suspended practitioners providing operative procedures on an in-house patient(s) or currently treating an in-house patient(s), may continue to treat that in-house patient(s). Future admission and surgical scheduling will be denied until the practitioner is removed from suspension for failure to complete medical records.

C.1. Extended Leave or Vacation

It is the practitioner's responsibility to notify the Health Information Management Department at the respective facility if

a leave or vacation is planned that exceeds three (3) weeks. In the event the leave extends unexpectedly past three (3) weeks, the Health Information Management Department will initiate the process to file the charts as permanently incomplete.

D. ***<u>Repetitious Infractions</u>***

Practitioners suspended under any definition of administrative suspension will be addressed as defined in Section 3.3-7 (Repetitious Infractions) in the Medical Staff Bylaws.

16.1-2 ***<u>Notification of Practitioner Suspension or Reinstatement</u>***

A. ***<u>Notification to Suspend</u>***

The process for notification to suspended practitioners and appropriate hospital personnel is defined in Medical Staff Services and Health Information Management Policy and Procedures.

B. ***<u>Notification to Reinstate</u>***

Upon receipt of current documentation for licensure, DEA, DPS, professional liability insurance, or other requested documentation and completion of all incomplete medical records, the practitioner's clinical privileges may be reinstated as defined in facility specific Medical Staff Services and Health Information Management Policy and Procedures.

16.3-3 ***<u>Reporting to Texas Medical Board for Failure to Complete Medical Records</u>***

If a practitioner leaves the facility either voluntarily or involuntarily and does not complete their medical records within sixty (60) days, the medical records may be filed as permanently incomplete and the practitioner may be reported to the Texas Medical Board by the MEC.

Section XVII CONFIDENTIALITY, IMMUNITY AND RELEASES

R17.1 Authorization and Conditions

By applying for or exercising clinical privileges within this Medical Center, an applicant:

(a) authorizes representatives of the Medical Center and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff; and

(c) acknowledges that the provisions of this Section are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Medical Center.

R17.2 Confidentiality of Information

R17.2-1 General

Records and proceedings of all Medical Staff committees in this Medical Center, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of departments and divisions, meetings of committees established under Section XI, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

R17.2-2 Breach of Confidentiality

Inasmuch as the delivery of quality patient care, effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other Medical Center, professional society, licensing, or state or federal authority, is outside appropriate standards of conduct of this Medical Staff and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate, and such conduct shall be considered in the granting or removal of clinical privileges or prerogatives of Medical Staff membership.

R17.3 Immunity from Liability

R17.3-1 For Action Taken

Each representative of the Medical Staff and Medical Center shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Medical Center.

R17.3-2 From Providing Information

Each representative of the Medical Staff and Medical Center and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Medical Center concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provides services at this Medical Center.

R17.4 Activities and Information Covered

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

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) peer review organizations.

R17.5 Releases

Each applicant or member shall, upon request of the Medical Staff or Medical Center, execute general and specific releases in accordance with the express provisions and general intent of this Section. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Section

Section XVIII AMENDMENT TO THE RULES AND REGULATIONS

The Rules and Regulations of the Medical Staff and department rules and regulation shall be amended as specified in Article IX of the Bylaws of the Medical Staff.

New or revised Rules and Regulations shall be published for members of the Medical Staff, and shall be compiled and maintained in a convenient form readily available for reference in Medical Staff Services.

Section IXV PATIENT CARE POLICIES

In addition to these Rules and Regulations of the Medical Staff, other policies and procedures relating to the provision of patient care may be presented to the Medical Executive Committee for adoption in such areas of the Medical Center. New or revised policies and procedures approved by the Medical Executive Committee and Board of Trustees will be communicated to Medical Staff members.

History of Review and Revision:

6/1998

11/17/1998

11/16/1999

3/21/2000

7/18/2000

9/19/2000

8/21/2001

1/21/2003

3/18/2003

9/30/2003

05/18/2004

01/17/2006

04/17/2007

05/15/2007

07/25/2008