



RULES & REGULATIONS OF THE MEDICAL STAFF

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DEFINITIONS

BOARD OF DIRECTORS or **BOARD** means the Board of Trustees of Baylor Medical Center at Garland.

CLINICAL PRIVILEGE or **PRIVILEGES** means the permission to render specific diagnostic, therapeutic, medical dental or surgical services.

COMPLETED APPLICATION means that form completely filled out by an applicant for Clinical Privileges and for which all information has been verified by reliable sources.

DENTIST means individual who has been awarded the degree of doctor of dentistry (D.D.S.) or doctor of dental medicine (D.D.M.).

EXECUTIVE COMMITTEE means the executive committee of the medical staff unless specific reference is made to the executive committee of the Board of Trustees.

The pronoun "he" used throughout these bylaws is intended to include either gender. For ease of reading and clarity, "he/she" has been eliminated and "he" should be interpreted as "he/she".

HEALTH STATUS means the state of physical or mental health.

MEDICAL STAFF means the formal organization of all practitioners who are privileged to attend patients in the hospital.

MEDICAL STAFF YEAR means the period from January 1st to December 31st of the same year.

ORAL SURGEON means a practitioner who has successfully completed an accredited post graduate program in oral surgery and, as determined by the organized Medical Staff, is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the surgical procedure the Oral Surgeon proposed to perform.

PHYSICIAN means an individual who has been awarded the degree of doctor of medicine (M.D.) or doctor of osteopathy (D.O.)

PODIATRIST means an individual who has been awarded the degree of doctor of podiatric medicine (D.P.M.).

PRACTITIONER means, unless otherwise expressly limited, any currently licensed individual who is permitted by law and by the hospital to provide patient care services independently without direction or supervision and within the scope of the individual's license and who is granted Clinical Privileges in the hospital at this time, specifically, Physician, Dentist, and Podiatrist.

PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.

PRESIDENT means the individual appointed by the Board to act on its behalf in the overall administrative management of the hospital.

SPECIAL NOTICE means written notification sent by certified mail, return receipt requested.

PREAMBLE

WHEREAS, Baylor Medical Center at Garland is a not-for-profit corporation organized under the laws of the State of Texas; and

WHEREAS, its purpose is to serve as a general acute care hospital providing patient care, education, research; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff is to strive for quality patient care in the hospital, that the Medical Staff must work with and is subject to the ultimate authority of the Board of Trustees, and that the cooperative efforts of the Medical Staff, administration and Board of Trustees are necessary to fulfill the hospital's aims and goals in providing quality care to its patients.

THEREFORE, the Physicians, Dentists, and Podiatrists practicing in this hospital hereby organize themselves into a Medical Staff in conformity with the Medical Staff Bylaws and Rules and Regulations of the Medical Staff.

SECTION 1: INTRODUCTION

The Rules and Regulations of the medical staff will serve as a continuing guide for patient care and medical center services.

SECTION 2: ADMISSION AND DISCHARGE OF PATIENTS

- 2.1 The hospital accepts patients for care and treatment. Exceptions would be those patients requiring stabilization and transfer. Only practitioners granted Medical Staff membership to include clinical privileges shall admit and treat patients as provided in the Medical Staff Bylaws and Rules and Regulations. All Practitioners with authority to admit patients shall be governed by the official admitting policy of the hospital.
- 2.2 A licensed independent practitioner with appropriate privileges shall be responsible for the medical care and treatment, and services of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. There shall be communication among all practitioners involved in a patient's care, treatment, and services. The patient shall be assigned to the service concerned in the treatment of the disease that necessitated admission. A patient requiring admission who has no practitioner shall be assigned to the practitioner on-call for the service to which the illness of the patient indicates assignment. Each department chairman is responsible for providing a schedule of departmental members who will be on call for patients who do not have a physician.
- 2.3 Each patient admitted to the hospital shall receive a baseline history and physical examination in accordance with the bylaws of the medical staff. A physician must see all patients within 24 hours of admission to the hospital. Each patient admitted to the Intensive Care Unit must be seen by a physician within two hours. Hospitalized patients must be seen by the attending physician or his/her call coverage on a daily basis.
- 2.4 Except in the case of emergency admission, no patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated. Such a statement shall be recorded as soon as possible. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission. A copy of the emergency service record shall accompany the patient to the nursing unit.

- 2.5 In any emergency case in which it appears the patient will have to be admitted to the hospital, the practitioner shall when possible, contact the nursing supervisor for appropriate placement.
- 2.6 Each member of the Medical Staff shall name another member of the Medical Staff as an alternate to be called to attend his patients in an emergency when the attending physician is not available or until the attending physician can be present. In case the alternate is not available, the CEO or the Chief of Staff shall have the authority to call the on-call physician or any other member of the staff to attend the patient.
- 2.7 Patients will be admitted on the basis of the following order of criteria:
- (a) Emergency Admissions: Those cases in which a delay of admission might prove hazardous to the patient. These patients require immediate hospitalization and have priority over any and all other classifications of admissions. The Executive Committee may call the practitioner to account for abuse of this privilege;
 - (b) Preoperative Admissions: Those patients scheduled for surgery. If a problem in admitting a patient occurs, the chairman of the department of surgery shall decide the urgency of any specific preoperative admission;
 - (c) Routine Admissions: Those elective admissions for which health will not be endangered by a delay in hospital services.
- 2.8 Patient transfers within the hospital shall be prioritized as follows
- (a) Emergency department to appropriate patient bed;
 - (b) Obstetric patient care area to general care area, when medically indicated;
 - (c) Special care unit to general care unit;
 - (d) Temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible practitioner.

- 2.9 Patients shall be discharged only on order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Practitioners shall abide by the hospital's utilization review plan which is criteria based to include:
- ❖ The appropriateness and medical necessity of admissions
 - ❖ The appropriateness and medical necessity of continued stay
 - ❖ Appropriate use of ancillary services
 - ❖ Participation in discharge planning process
- Significant variances and trending will be reported to the Utilization Review Committee, Medical Staff Quality Improvement Committee, and Medical Executive Committee.

- 2.10 In the event of the death of a patient in the hospital, the patient shall be pronounced dead by the attending practitioner or designee within a reasonable period of time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. The release of bodies from the hospital shall conform to state and local laws and regulations.

SECTION 3: MEDICAL RECORDS

3.1 Required Content

The attending practitioner and other medical staff members, as applicable and clinical staff involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The attending practitioner will be responsible for the medical record requirements. The record will contain adequate information to identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately. The content of the record will be pertinent, accurate, legible, timely, and current.

The record shall include:

- (a) Identification data
- (b) Personal and family medical histories
- (c) History of present complaint or illness
- (d) Summary of psychosocial needs, appropriate to age and diagnosis
- (e) Physical examination (includes conclusions or impression and treatment plan)
- (f) Diagnostic and therapeutic orders
- (g) Evidence of appropriate informed consent
- (h) Treatment provided
- (i) Progress notes and other clinical observations, including results of therapy
- (j) Special reports, when applicable (such as, clinical laboratory, radiology, radiotherapy, EEG, EKG, consultation, pre-post anesthesia, operative and other diagnostic and therapeutic procedures, etc.)
- (k) Pathological findings
- (l) Final diagnosis without the use of symbols or abbreviations
- (m) Autopsy report (if applicable)
- (n) Advance Directive
- (o) Discharge Summary (includes reason for hospitalization, significant findings, procedures performed, treatment rendered, and instructions to patient and family)

3.2 Assessment, History and Physical

An assessment, appropriate to the level of care the patient is receiving, must be documented on every patient. A complete history and physical examination

report will be documented by the admitting practitioner or that practitioner's physician assistant and in the medical record no later than twenty-four (24) hours following the admission of each patient. A short stay record may be used in lieu of a complete history and physical for those patients who are discharged within 48 hours after admission. A consultation containing a history and physical will also suffice as a formal history and physical.

The history and physical examination must include:

- (A) The chief complaint;
- (B) Details of present illness;
- (C) All relevant past medical, social and family history: the patient's emotional, behavioral, and social; status when appropriate;
- (D) Review of body systems;
- (E) Comprehensive physical examination;
- (F) A statement of the conclusions or impressions drawn from the history and physical;
- (G) Current medications and allergies
- (H) The goals of treatment and the treatment plan.

- 3.2.1 If a qualified member of the hospital's medical staff has obtained a complete history and has performed a complete physical examination 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 hospital medical record along with an update to the patient's condition since it was last assessed. Any changes that may have occurred must be dated, timed and signed in the medical record at the time of admission or within the first 24 hours. If there are no changes, state "no changes", date, time and sign. Every H & P documented prior to admission, must be updated by the attending physician within 24 hours of admission.

In the situation where the patient will undergo a procedure using sedation or anesthesia within the first 24 hours of admission, the update to the patient's condition can be the pre-anesthesia assessment as long as it is documented in the medical record prior to the procedure.

- 3.2.2 Invasive outpatient procedures including but not limited to all scopes, all invasive radiology, all invasive cardiology, arteriograms, percutaneous needle biopsies, myelograms, lumbar puncture, chemotherapy, transfusion of blood products, dialysis, etc. shall have a clinically pertinent history and physical exam. Minimum requirements will include:

- a. Indication for the procedure
- b. Current medications
- c. Allergies
- d. Heart and lung exam
- e. Pertinent lab

Timeframe for completion will be the same as 3.2 – 3.2.1.2

- 3.2.3 The history and physical examination and the results of indicated diagnostic tests are recorded before the operative or other high-risk procedures. In the case of emergencies whereby delays would be life threatening, the timed, dated, and signed Emergency Department assessment with appropriate addenda may serve as an initial history and physical. However, the practitioner will document a complete history and physical examination immediately after the procedure.

3.3 Progress Notes

Progress notes must be recorded daily by the attending practitioner, his coverage, or P.A (must be co-signed by the attending physician within 24 hours). The consulting/operating surgeon must also record daily progress notes during the peri-operative period. The progress note must be dated, timed, signed, and contain the practitioner's dictation number for accurate identification. Progress notes will be recorded with sufficient frequency to 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 and ensure comprehensiveness of the record in the event of transfer of responsibility of care.

3.4 Operative Report

An operative or other high risk procedure progress note is entered in the medical record immediately after the procedure and shall include:

- a. the name of the licensed independent practitioner and assistants
- b. the name of the procedure(s) performed
- c. description of the procedure
- d. findings
- e. estimated blood loss
- f. specimens removed
- g. complications
- h. postoperative diagnosis

A full operative or other high-risk procedure report, to include the details of the procedure, will be written or dictated immediately following the procedure

Immediately following the procedure is defined as "upon completion of the operation or procedure, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver. In addition, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.

The completed operative or other high risk procedure report is authenticated by the licensed independent practitioner and made available in the medical record as soon as possible after the procedure.

In the event a patient's medical record is received in the Health Information Management Department after discharge without a patient's history and physical or a dictated operative report, the Medical Staff member may automatically be suspended.

3.5 Consultation Request and Report

When an attending physician feels a consultation is necessary, an order for the consult will be entered in the order sheets of the patient's chart; the order will include the reason for the consult. (Please refer to section 4.7 for further information regarding consults).

Each consultant's report shall include:

- a. evidence that the medical record was reviewed,
- b. indication that the patient was examined,
- c. consultant's impression and recommendations

When the consultation has a direct relationship to a procedure being performed, the consultation must be present on the medical record prior to the procedure.

3.6 Obstetrical Record

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission (the copy must include the last prenatal visit). An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings since the last prenatal visit.

3.7 Conclusion of Hospitalization

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure, and any additional procedures must be recorded in full, without the use of symbols or abbreviations, dated and signed by the responsible practitioner at the time of discharge of all patients. Final diagnosis and procedures will be recorded in full, without the use of symbols and abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.

3.8 Discharge Summary

A discharge summary shall be written or dictated for every patient who has been admitted to the hospital by the practitioner who is primarily responsible for the patient at the time of discharge. The discharge summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, specific attention should be given to diet, activity, medication, and follow-up. The content of a complete discharge summary and exceptions to the requirement of a complete discharge summary for certain procedures or categories of patients will be periodically recommended and approved by the Executive Committee.

- 3.8.1 When individual patients are seen for minor problems or interventions, and stay less than two days, a final progress note may be substituted for the discharge summary. Normal obstetrical deliveries, and normal newborn infants may contain instead an extended final progress note. A final progress note includes the final diagnoses, which includes sufficient information to justify the diagnosis and warrant the treatment and disposition of the patient at discharge.

3.9 Authentication

All clinical entries into the patient's medical record must be legible, dated, timed, and authenticated by the responsible practitioner. The responsible practitioner will countersign all entries and clinical reports generated by physician assistants or nurse practitioners employed by a physician in accordance to privileges delineated. The practitioner's dictation number must accompany all orders. Only valid, legible orders with dictation numbers will be carried out, all others must be clarified or rewritten.

Opinions requiring medical judgment should be written or authenticated, only by individuals who have been granted appropriate clinical privileges.

3.9.1 Electronic Signature

Electronic signature is approved for inpatient and outpatient medical record usage. Acknowledgments for the use of electronic signature will be filed in the BHCS HIM Department. The acknowledgment states that the electronic personal password must be in the control of the physician and that he/she will not allow unauthorized usage.

3.10 Emergency Room Record

A medical record is maintained on every patient seeking emergency care and is incorporated into the patient's permanent record. The emergency record should include: (a) pertinent history of the illness or injury and physical findings, including patient vital signs; (b) diagnostic impressions; (c) conclusion at the termination of evaluation/treatment, including final disposition of the patient's condition on discharge or transfer and any instructions for follow-up care. The emergency department assessment should be completed prior to discharge or transfer from the emergency department.

3.11 Removal of Records

All medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. In the event of re-admissions of the patient, all previous records will be made available upon request for the use of the attending practitioner. Unauthorized removal of records from the hospital shall constitute valid grounds for suspension of privileges and termination of staff membership, on the recommendation of the Executive Committee.

3.12 Research

Any research project involving the use of medical records must receive approval of the Executive Committee prior to its commencement.

3.13 Incomplete Record

No medical record shall be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff Quality Improvement Committee, ***with the exception of Section 14.3.3.***

3.14 Completion of Records

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.

SECTION 4: GENERAL CONDUCT OF CARE

4.1 Consents:

A general consent form, signed by the patient or on his behalf by the patient's legal guardian, will be executed for every patient at the time of admission. It is the obligation of the practitioner to obtain proper consent before the patient is treated in the hospital.

4.2 Orders:

All patient orders shall be written on the order sheet of the medical record. These orders should be written directly by the attending practitioner. Verbal orders shall be used infrequently. However, when used, they must only be accepted by persons authorized to do so. This includes the following Baylor Medical Center at Garland employees as they apply to their respective departments:

- ❖ Registered Nurse
- ❖ Licensed Vocational Nurse
- ❖ Registered Laboratory personnel
- ❖ Registered Physical Therapist
- ❖ Registered X-ray Technologist
- ❖ Hospital Social Worker
- ❖ Registered and/or Certified Respiratory Therapist
- ❖ Certified Registered Nurse Anesthetist
- ❖ Registered Pharmacist
- ❖ Registered Occupational Therapist
- ❖ Certified Occupational Therapy Assistant
- ❖ Physical Therapy Assistant

Verbal orders must be signed, dated, and timed within 48 hours of order. (Original order requires a date, time, and signature of the person writing the

verbal order. The practitioner signature should have the date and time that the order was authenticated, not the date and time the order was given.)

NOTE: For the 5 year period following 1/26/07, all orders, including verbal orders must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders by hospital policy and in accordance with state law. As of 1/26/07, all orders must be signed by the ordering practitioner.

Orders written by an emergency physician for a patient admitted from the emergency department to the service of a medical staff member are void after twenty-four (24) hours.

- 4.3** The practitioner's orders will be clearly written, both legibly and completely, and will be understandable. The practitioner's dictation number should accompany all orders. Illegible, improperly written, or otherwise not understood orders will not be carried out by hospital personnel until clarified by the practitioner. All previous orders are canceled when patients go to surgery or to a special care unit. Pharmacy will not recognize "blanket order" or resume previous orders.
- 4.4** All drugs and medications administered to patients will be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Services, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions and must be approved by the Baylor Health Care System Institutional Review board and reported to the Patient Care Monitoring Committee and the Executive Committee, and the subject patient or the patient's legal guardian has given written consent for its use. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Federal Drug Administration. Orders for the use of investigational drugs must follow the criteria as outlined in the Baylor Medical Center at Garland Investigational Drug Policy. Those licensed hospital employees as designated in hospital departmental policies and procedures may administer drugs and medications to patients. These include registered nurses, licensed vocational nurses, respiratory technicians, x-ray technicians, special imaging technicians, nurse anesthetists, and pharmacists.

Medication Prescribing Privileging Procedures: The medical staff clinical privileging process includes medication prescription ordering as a granted privilege, when appropriate to the practitioner's license.

All physicians (M.D.'s, D.O.'s, and Oral Surgeons will be granted medication ordering privileges to all classes of drugs with the following restrictions:

Any limitations placed on physicians by the Drug Enforcement Administration (DEA), or state narcotics control bureau, or restricting their ordering of any schedule(s) of controlled substance; or

Any limitations placed on physicians regarding prescribing practices or on the prescribing of certain therapeutic class (es) of drugs as determined by the clinical privileging process.

All dentist and podiatrists will be limited to the classes of drugs appropriate to their practice and licensure board with the restrictions as outlined above. These drugs include pain medications, antibiotics, topical anesthetics and steroids.

Any limitations placed on the dentist or podiatrist by DEA restricting ordering any schedule (s) of controlled substances; or

Any limitations placed on a dentist or podiatrist on a therapeutic class of drug as determined by the clinical privileging process.

- 4.5** Controlled drugs, sedatives, antibiotics, antineoplastics, corticosteroids, and anticoagulant drugs that are ordered without time limitations of dosages will be automatically discontinued after seventy-two (72) hours. If the order expires, it will be called to the attention of the practitioner.

All medication brought into the hospital by a patient must be sent to the Pharmacy for the proper identification. The pharmacist will verify that the medications brought in by the patient are those that the physician has prescribed.

Medications brought in to the hospital by a patient or his family will not be given to the patient during his hospital stay without the express authorization of the attending physician. The physician must write specific instructions as to administration, dosage, and time.

All medications received by the Pharmacy will have a receipt, the original of which will be attached to the patient's chart and the duplicate retained in the Pharmacy

- 4.6** Standing orders may be formulated to the extent permitted by the members of each department and approved by the Executive Committee and may be changed only in the same manner. These standing orders will be followed insofar as proper treatment of the patient will allow and will constitute the orders for treatment until specific orders to the contrary are written, signed and delivered by the attending practitioner. Preprinted orders for individual practitioners may be used, provided they are signed and dated by the attending practitioner for that particular patient. Such orders and/or instructions sheets shall be reviewed and revised every three years.

- 4.7** The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise.

Consultation should be performed within 24 hours of request unless the consult is emergent. If the consult is emergent, it must be made physician to physician. This will not be done by the nursing or clerical staff.

Except in an emergency, consultation is required when patient management requirements exceed the privileges granted to the attending physician, and

- ❖ when the patient is not a good risk for operation or treatment'
- ❖ where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
- ❖ where there is doubt as to the choice of therapeutic measures to be utilized;
- ❖ in unusually complicated situations where specific skills of other practitioners may be needed;
- ❖ in any instances in which the patient exhibits severe psychiatric symptoms (a licensed mental health professional may perform a mental health exam when a psychiatric consult is ordered);
- ❖ when requested by the patient or his family;
- ❖ when required by the policy of a special care unit.

Consultation may be ordered for radiology and pathology services. The attending physician is responsible for providing necessary clinical data for the consult. The ordering staff member may take the necessary data from the order sheet or progress notes. If the information is not documented, the procedure may be canceled. (Please also refer to section 3.5).

4.8 A patient admitted for dental care is the dual responsibility involving the dentist and a physician member of the medical staff.

The dentist's responsibilities are:

- (a) A detailed dental history justifying hospital admission. When a patient is admitted to the emergency department for dental surgery, it is permissible for the emergency department physician to complete a history and physical. If a history and physical is not completed by a physician prior to admission to the operating room, then the anesthesiologist is required to complete the history and physical;
- (b) A detailed description of the examination of the oral cavity and a preoperative diagnosis;
- (c) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and fragments, shall be sent to the hospital pathologist for examination;
- (d) Progress notes as are pertinent to the oral condition;
- (e) Clinical summary and treatment; and
- (f) Written order to discharge the patient.

The physician's responsibilities are:

- (a) Medical history pertinent to the patient's general health;
- (b) A physical examination to determine the patient's condition prior to anesthesia and surgery;
- (c) Supervision of the patient's general health status while hospitalized. Securing the appropriate medical consultations and seeing that a physician follows the course of a patient while in the hospital is the responsibility of the admitting dentist.

4.9 A patient admitted for podiatric care is the dual responsibility involving the podiatrist and a physician member of the medical staff.

The podiatrist's responsibilities are:

- (a) A detailed podiatric history justifying hospital admission. When a patient is admitted to the emergency department for podiatric surgery, it is permissible for the emergency department physician to complete a history and physical. If a history and physical is not completed by a physician prior to admission to the operating room, then the anesthesiologist is required to complete the history and physical;
- (b) A detailed description of the examination of the operative area and a preoperative diagnosis;
- (c) A complete operative report, describing the findings and technique. All tissue removed in surgery will be sent to the hospital pathologist for examination;
- (d) Progress notes as are pertinent to the podiatric condition;
- (e) Clinical summary and treatment; and,
- (f) Upon concurrence of the physician supervising the general condition of the patient, a written order to discharge the patient.

The physician's responsibilities are:

- (a) Medical history pertinent to the patient's general health;
- (b) A physical examination to determine the patient's condition prior to anesthesia and surgery; and,
- (c) Supervision of the patient's general health status while hospitalized. Securing the appropriate medical consultations and seeing that a physician follows the course of a patient while in the hospital is the responsibility of the admitting podiatrist.

4.10 All tissues and foreign bodies removed during a surgical procedure will be examined by a pathologist with medical staff privileges at Baylor Medical Center at Garland and a report of that pathological examination issued, and a signed copy of the report placed in the patient's medical record. Furthermore, a hard copy of this pathology report will be transmitted to the operating surgeon's office. At the discretion of the pathologist, any specimen may be subject to microscopic examination.

There are exceptions to the above requirement. Exception is defined as routinely not to be sent to the pathologist for examination except under the direction of a written or verbal countersigned order of the operating surgeon.

The following specimens are exceptions:

- (a) Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements.
- (b) Foreign bodies, including those such as knives, bullets, etc., given directly to law enforcement officers;

- (c) Scars removed to gain access or for cosmetic purposes, incidental soft tissue fragments, bone fragments, dental tissue, débrided tissue, fingernails, toenails.
- (d) Lipoma of cord, skin tags.
- (e) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.
- (f) Cataracts.
- (g) Teeth, dental fragments.
- (h) Orthoscopic shavings, orthopedic appliances.
- (i) Cartilage from nasal septoplasties, tonsils, adenoids <12 years old (only tissue from patients > 12 years old would be sent). P.E. tubes, foreign bodies of the ear and nose.
- (j) Skin removed for correction of ptosis, fat removed for cosmetic purposes, traumatic and ornamental tattoos.
- (k) Bone spurs, bunions.
- (l) Pacemaker hardware, ribs removed to gain access (except to gain access to cancer), prominent xiphoid.
- (m) Newborn circumcisions skin.
- (n) stones.

4.11 Only hospital employees and practitioners and appropriately credentialed allied health professionals may be present in any of the operating rooms for the purpose of observations during the performance of operations. Consent from the patient will be obtained in writing in advance for all observers. The operating surgeon, anesthesiologist, or the surgical personnel will have authority to have any person not involved in patient care during a surgical procedure removed from the operating room.

4.12 The conduct of a medical staff member will be in accordance with hospital policies and procedures of Baylor Medical Center at Garland for the following:

- (a) Brain death and termination of life support;
- (b) Do not resuscitate orders;
- (c) Adoption;
- (d) Organ and tissue donation;
- (e) Abortions;
- (f) Emotionally ill patients;
- (g) Restraint of patients;
- (h) Smoking; and
- (i) Transfer of patients to other health care facilities.

4.13 Physician Treatment of Self and Immediate Family or Significant Other
Please refer to the most current Policy/Procedure.

SECTION 5: PRACTITIONER BEHAVIOR AND HEALTH ISSUES SUBCOMMITTEE

5.1 Pursuant to Section 12.2.2 (n) of the Rules and Regulations, the Executive Committee has created a subcommittee named "Practitioner Behavior and Health Issues Committee".

- 5.2 The subcommittee shall implement processes and procedures to identify and manage matters of individual behavior and individual health that are separate from the corrective, disciplinary function. The subcommittee shall actively address individual behavioral and health issues involving practitioners and privileged allied health professionals by utilizing the applicable policy:
- ❖ Disruptive Conduct by a Member of the Medical Staff
 - ❖ Practitioner Health and Wellness Policy

SECTION 6: FORMS

- 6.1 Application forms and any other prescribed forms required by the Medical Staff Bylaws or Medical Staff Rules and Regulations for use in connection with staff appointments, re-appointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board of Trustees after considering the advice of the Executive Committee.

SECTION 7: MEDICAL STAFF

7.1 Purpose

The purposes of the Medical Staff are:

To be the formal organizational structure through which (1) the benefits of membership on the staff may be obtained by individual practitioners and (2) the obligations of staff membership may be fulfilled. To serve as the primary means for accountability to the Board of Trustees for the quality and appropriateness of the professional performance and ethical conduct of its members and the allied health professionals and to provide a pattern of medical care delivered in the hospital that is consistently maintained at the level of quality and appropriateness achievable by the state of the healing arts and the resources locally available; To provide a means through which the Medical Staff may participate in the hospital's policy-making and planning process; and To cooperate with medical schools and other educational institutions in graduate, postgraduate, and continuing education programs, and to support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

7.2 Responsibilities of the Medical Staff

The responsibilities of the Medical Staff, to be fulfilled through the actions of its officers, departments, and committees, include:

- (a) To implement, conduct, report and recommend to the Board of Trustees specific activities:
- 1) The quality and appropriateness of patient care provided by all individuals with clinical privileges authorized to practice in the hospital;

- 2) Appointments, reappointments, staff category and department assignments, clinical privileges, and corrective action;
 - 3) Establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of medical care within the hospital;
 - 4) The quality and efficiency of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review, evaluation and monitoring activities;
- (b) To initiate and pursue corrective action with respect to practitioners, when warranted;
 - (c) To develop and administer amendments to and seek compliance with the bylaws, rules and regulations of the staff and other hospital policies;
 - (d) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs; and
 - (e) To exercise the authority granted by the bylaws as necessary to adequately fulfill the foregoing responsibilities.

SECTION 8: MEDICAL STAFF MEMBERSHIP

All matters regarding initial appointment, reappointment, and privileges are set forth and governed by the Medical Staff Bylaws. The Rules and Regulations of the Medical Staff shall be part of the Medical Staff Bylaws, except that they may be amended or repealed at any regular meeting of the Executive Committee at which at least fifty percent (50%) of the committee members are present and without previous notice. Such change shall become effective when approved by the Board of Trustees.

SECTION 9: HOUSE STAFF

The house staff shall consist of individuals who are graduates of a medical school or are pursuing additional training through accredited or approved medical education programs at this hospital or another allied health facility. Family Medicine Residents and Medical Students are considered "House Staff" and are supervised as outlined in the *Policy for Supervision of Family Medicine Residents and Medical Students*. Such individuals shall not be considered medical staff members nor shall the term house staff be considered a category of medical staff membership; however, they shall be subject to the Rules and Regulations of the Medical Staff, departmental rules and regulations and any other policies and procedures applicable to the medical education program while providing medical care in the hospital. The house staff will attend meetings of the staff and the department for which he is assigned and participate in medical staff committees to which he may be appointed as a non-voting member. Since they are not members of the medical staff, the house staff shall not be entitled to any procedural rights afforded by the bylaws including, without limitation, any due process rights. House staff will be supervised as set forth in the Rules and Regulations and/or Policies and Procedures.

SECTION 10: STAFF CLINICAL DEPARTMENTS

10.1 Organization of Departments

The Medical Staff shall be organized in the following Departments:

Department of Anesthesiology
Department of Emergency Medicine
Department of Family Medicine
Department of Internal Medicine
Department of Obstetrics/Gynecology
Department of Pediatrics
Department of Radiology and Pathology
Department of Surgery

Each Department shall have a chairman who shall be elected and have the qualifications, duties, and responsibilities as set out in Sections 11.2.2 and 11.2.3 of these rules and regulations.

10.2 Future Departments

When deemed appropriate and consistent with the provisions of Section 10.5, the Executive Committee and the Board, by their joint action, may create, eliminate, subdivide, or combine departments.

10.3 Assignment to Departments

Each member of the staff shall be assigned membership in one primary department, but may be granted membership and/or clinical privileges or specified services in another department. The exercise of clinical privileges or the performance of specified services within any department shall be subject to the rules and regulations of that department and the authority of the department chairman. A staff member, meeting the qualifications of an active-clinical or courtesy staff member, with privileges in more than one department shall vote only in the department in which he holds primary privileges, but shall be entitled to attend meetings of any department in which he holds privileges.

10.4 Functions of Departments

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

- (a) Participate in the quality and utilization programs for the purpose of reviewing and evaluating the quality of care within the department. Each department shall review all clinical work performed under its jurisdiction whether or not a particular practitioner whose work is subject to such review is a member of that department.
- (b) Establish guidelines for the granting of clinical privileges within the

- department and submit the recommendations required regarding the specific privileges each staff member or applicant may exercise;
- (c) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state of the art and to findings of review, evaluation, and monitoring activities;
 - (d) Monitor, on a continuing and concurrent basis, adherence to: (1) staff and hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; (4) programs designed to promote patient and employee safety;
 - (e) Coordinate the patient care provided by the department's member with nursing and ancillary patient care services and with administrative support services;
 - (f) Submit written reports to the Executive Committee on a regularly scheduled basis concerning: (1) findings of the department's review, evaluation, and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital; and (3) such other matters as may be requested from time-to-time by the Executive Committee.
 - (g) Meet regularly for the purpose of receiving, reviewing, and considering findings of the quality/utilization management program and the results of the department's other review, evaluation, and monitoring activities and of performing or receiving reports on other department and staff functions; and
 - (h) Establish such committees as are necessary to perform the functions outlines in (A), (B), (E), and (F) and establish such committees or other mechanisms as are necessary to perform the other functions outlined in this section, elsewhere in the bylaws, or assigned to it.

10.5 Modifications in Clinical Organization Unit

In creating, eliminating, subdividing, or combining departments, or any other clinical organization units that may exist or be contemplated, the following guidelines shall be followed.

- (a) **Creation:** A sufficient number of practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these rules and regulations, and the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions.
- (b) **Elimination:** The number of practitioners available is no longer adequate enough and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions.
- (c) **Combination:** The union of two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions. In all instances of modification, the hospital's written plan of development as currently being

implemented and any constraints or mandates imposed by external planning authorities shall also be considered.

10.6 Department Meetings

Each department will meet as needed and will conform in its proceedings and actions with relevant provisions of Section 13.

SECTION 11: OFFICERS

11.1 General Officers and Other Officers of the Medical Staff

11.1.1 General Officers of the Staff

- (a) Chief of Staff
- (b) Vice Chief of Staff
- (c) Secretary

11.1.2 Other Officials of the Staff

Other officials of the staff may include a medical director, department chairman, a director of medical education, academic chiefs, and such other officials as may be selected pursuant to these rules and regulations. To the extent that any such officials perform any clinical function, he must become and remain a member of the staff. In all events, he is subject to the bylaws, rules and regulations, and all other lawful policies of the hospital.

11.1.3 Qualifications

General officers must be members of the active-clinical staff for a period of three (3) years, in good standing, at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The chief of staff, vice chief of staff, and secretary must be physicians with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience, and ability to direct the medico-administrative aspects of hospital and staff activities.

11.1.4 Nominations

The nominations committee shall be composed of two previous past chiefs of the medical staff and three members of the active-clinical staff, voted on and elected by the Executive Committee. The committee will recommend one or more qualified nominees for chief of staff, vice chief of staff, secretary, and three (3) representatives-at-large to the Medical Staff Executive Committee. Members of the nominating committee are ineligible to be a nominee for any of these positions. A statement from the

chairman of the nominating committee will be included with the recommendations stating that each nominee has agreed to stand for election to office. The Medical Executive Committee will review and approve the Nominations Committee report and forward to the general Medical Staff for a vote at the September Semi-annual meeting. Nominations of additional candidates for each office may be made from the floor at the meeting at which the voting for officers occurs.

11.1.5 Election

Election of each of the general officers and the three representatives-at-large (“elected officers”) shall be made by a separate majority vote for each. Only staff members accorded the prerogative to vote for general staff officers shall be eligible to vote. A nominee shall be elected upon receiving a majority vote on the first ballot. In the event of a tie vote; the results will be forwarded to the Board of Trustees for resolution.

11.1.6 Term of Elected Office

Each elected officer shall serve a two-year term, commencing on the first day of the Medical Staff Year following his election. Each elected officer shall serve until the end of his term and until a successor is elected, unless he shall resign or be removed from office.

11.1.7 Removal of Elected Officers

Except as otherwise provided, removal of an elected officer may be initiated by the Board acting upon its own initiative or by a majority vote of the staff members accorded the prerogative to vote present at the general Medical Staff Semi-Annual meeting duly convened pursuant to these rules and regulations. Removal may be based upon, but not limited to, failure to perform the duties of the position held as described in these rules and regulations or mental and/or physical impairment.

11.1.8 Vacancies in Elected Offices

- (a) If there is a vacancy in the office of chief of staff, the vice chief of staff shall become chief of staff and serve out the remaining term.
- (b) A vacancy in the office of the vice chief of staff shall be filled by the secretary.
- (c) A vacancy in the secretary office shall be filled at the next general medical staff meeting following the general mechanism outlined in Sections 13.1.1.
- (d) The Executive Committee shall fill vacancies in any of the three positions of representatives at large.
- (e) Vacancies in any department chair position shall be filled by immediate vote of the medical staff members having primary privileges in such department. The Executive Committee shall have power to appoint a replacement if the department fails to hold such vote.

11.1.9 Duties of General Officers

(a) Chief of Staff

The chief of staff shall serve as the chief medical officer of the hospital and chief administrative officer of the staff. As the principal elected official of the staff, the chief of staff shall:

- (1) Be responsible for the organization and conduct of the medical staff;
- (2) Aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the medical staff;
- (3) Communicate and represent the opinions, policies, concerns, needs, and grievances of the medical staff to the Board of Trustees, the president, and other officials of the staff;
- (4) Be responsible for the enforcement of the medical staff bylaws, rules and regulations, and other policies, for implementation of sanctions where indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
- (5) Call, preside at, and be responsible for the agenda of all general meetings of the medical staff;
- (6) Serve as chairman of the Executive Committee, and as an ex officio member without vote of all other staff committees;
- (7) Serve as an ex officio member of the Board of Trustees;
- (8) Be accountable to the Board of Trustees, in conjunction with the Executive Committee, for the quality and appropriateness of clinical services and performance within the hospital and for the effectiveness of the quality/utilization management program;
- (9) Develop and implement, in cooperation with the department and committee chairmen, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and quality assessment;
- (10) Appoint the staff representatives to staff the hospital committees, unless otherwise expressly provided by these rules and regulations or hospital bylaws, policies, or procedures;
- (11) Serve as the spokesman for the staff in its external professional and public relations.

(b) Vice Chief of Staff

The vice chief of staff shall be responsible for overseeing the review and revision of the medical staff bylaws, rules and

regulations, and applicable policies. He shall be a member of the Executive Committee, and in the absence, temporary or permanent, of the chief of staff, he shall assume all the duties and have the authority of the chief of staff. He shall perform such additional duties as may be assigned to him by the chief of staff, the Executive Committee, or the Board of Trustees.

(c) Secretary

The secretary shall be a member of the Executive Committee and an ex officio member without vote of all other staff committees. His duties shall be to oversee the following:

- (1) Proper notice is given of all staff meetings on order of the appropriate authority;
- (2) Perform such other duties as ordinarily pertain to his office.

11.2 Department Officers

11.2.1 Department Chairman

- (a) **Qualifications:** Each department chairperson shall have been a member in good standing of the active staff for a period of three (3) years, shall have demonstrated ability in the clinical areas covered by the department, and be willing and able to faithfully discharge the functions of his office.
- (b) **Election:** Except for those chairmen who have contracts to act in the capacity of department chairman entered into by the hospital with the approval of the Executive Committee, department chairman shall be elected through majority vote of the medical staff in such department. Notice will be given to department members 14 days prior to the election. Nominations to be forwarded in writing to the department chairman prior to the meeting. Nominations will be accepted from the floor within the department meeting. Results of elections for department chairmen will be forwarded to the Medical Executive Committee for approval. In the event of a tie vote, the results will be forwarded to the Executive Committee for resolution; the chairman of the department in question must abstain from voting. Election for department chairman shall occur prior to September 1st of each election year.
- (c) **Term of Office:** Department chairman shall serve a two-year term coinciding with the term of the elected chief of staff. Department chiefs shall serve until the end of the succeeding Medical Staff Year and until his successor is chosen, unless he shall resign or be removed from office.
- (d) **Removal:** Removal of a department chairman from office may be made by the Board of Trustees, acting upon its own initiative, or upon the recommendation of the Executive Committee, or by a two-thirds majority vote of the medical staff members of such department.

11.2.2 Duties

Each Department Chairman shall serve as an advocate to his department:

- (a) Be accountable to the Executive Committee and to the chief of staff for all professional, administrative, and quality review functions within his department;
- (b) Develop and implement departmental programs, in cooperation with the chief of staff and consistent with the provisions of the bylaws for credentials review and privileges delineation, continuing medical education, and quality/utilization management;
- (c) Be a member of the Executive Committee, give guidance on the overall medical policies of the hospital, and make specific recommendations and suggestions regarding his own department;
- (d) Appoint such committees as are necessary to conduct the functions of the department;
- (e) Enforce the hospital and medical staff bylaws, rules and regulations, and policies within his department, including the initiation of collegial intervention, oversight of clinical performance, and recommending consultations to be provided or to be sought when necessary;
- (f) Implement within his department, actions taken by the Executive Committee and by the Board of Trustees;
- (g) Collaborate with the nursing service and the hospital administration in matters affecting patient care including personnel, supplies, special regulations, standing orders, and techniques;
- (h) Act as presiding officer at all department meetings or appoint a designee to preside in his absence; and
- (i) Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the chief of staff, the Executive Committee, the President, or the Board of Trustees.

11.3 Additional Officers

The Board of Trustees may, after considering the advice and recommendations of the Executive Committee, appoint additional practitioners to the medical administrative positions within the hospital to perform such duties as are prescribed by the Board of Trustees, or as defined by the bylaws or amendments thereto. To the extent that any such officer performs any clinical function, he must become and remain a member of the staff. In all events, he must be subject to the bylaws and to the other policies of the hospital, except to the extent so provided by the Board of Trustees. The immediate past chief of staff shall be a member of the Executive Committee and may perform such other advisory duties as are assigned to him by chief of staff, the Executive Committee, or the Board of Trustees.

SECTION 12: COMMITTEES AND FUNCTIONS

12.1 Designation, Structure and Function

12.1.1 Composition and Appointment

Committees will be standing and special as may be from time to time necessary and desirable to perform the functions of the staff required by these rules and regulations or necessarily incidental thereto. All committee chairmen and members, other than the Executive Committee, will be appointed by the chief of staff and approved by the Executive Committee. The president will appoint all hospital personnel, other than staff members, to serve on committees. The chief of staff will appoint staff members to hospital-wide committees if requested by the president. Appointment of any medical staff member to any hospital committees will be made according to bylaws, rules and regulations, and established policies and procedures of the hospital and of the staff.

12.1.2 Duties

All committees will:

- (a) Maintain a record of attendance at their meetings;
- (b) Maintain a record of their proceedings; and
- (c) Submit timely reports of their activities and copies of the minutes of their meetings to the Executive Committee.

The standing committees will be organized to assume delegated authority for the oversight of medical staff functions.

12.1.3 Term of Appointment

Committee appointment will be for two (2) years to coincide with the term of the chief of staff, unless otherwise specified by these rules and regulations. A medical staff member serving on a staff committee may be removed by a majority vote of the Executive Committee.

12.1.4 Vacancies

Unless otherwise specifically provided, vacancies on any staff committee will be filled in the same manner in which original appointment to that committee is made.

12.1.5 Meetings

A staff committee established to perform one or more of the staff functions required by these rules and regulations will meet as often as necessary to discharge its assigned duties.

12.2 Executive Committee

12.2.1 Composition

The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff (chief of Staff, vice chief of staff, secretary), immediate past chief of staff, vice president of medical affairs (VPMA), the chairman of each department, the chairman of each standing committee, director of the Family Medicine Residency Program, and the three elected representatives-at-large. The chief of staff of the medical staff by virtue of his office shall be the chairman of the Executive Committee.

12.2.2 Duties

The duties of the Executive Committee shall be to:

- (a) Represent and act on behalf of the staff, subject to such limitations as may be imposed by these rules and regulations;
- (b) Receive and act upon reports and recommendations from the departments, committees, and officers of the staff concerning the findings of the quality/utilization management program and other quality maintenance activities and the discharge of their delegated administrative responsibilities;
- (c) Approves the activities and policies adopted by the staff, departments, and committees;
- (d) Recommend to the Board all matters relating to appointments, and clinical privileges;
- (e) Account to the Board and to the staff for the overall quality and appropriateness of patient care in the hospital;
- (f) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating and pursuing corrective action, when warranted in accordance with these rules and regulations;
- (g) Make recommendations on medico-administrative and hospital management matters to the Board through the chief of staff;
- (h) Inform the medical staff of the accreditation status of the hospital;
- (i) Identifying community health needs and implementing programs to meet those needs;
- (j) Conduct an ongoing review of the bylaws, rules and regulations, policies/procedures and act upon all matters pertaining to them;
- (k) Submit recommended bylaw changes to the medical staff pursuant to Section 15;
- (l) Arbitrate any conflict in the interpretation of the documents specified in item J above;
- (m) Resolve conflict of interest matters that arise with or pertain to medical staff members;
- (n) Establish a subcommittee or appoint an individual to assist with interventions and to monitor the recovery of impaired practitioners and/or deal with practitioner behavior issues. No member of the

- committee will vote on matters concerning an impaired physician from such committee members same department;
- (o) Recommend to the Board of Trustees all matters pertaining to corrective action; and
 - (p) Will review and approve the election of department chairmen.

12.2.3 Meetings

The Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

12.3 Medical Staff Quality Improvement Committee

12.3.1 Composition

The committee will be composed of the vice president of medical affairs (VPMA), those active-clinical medical staff members deemed appropriate by the chief of staff and representation from appropriate hospital departments.

12.3.2 Duties

The duties of the committee shall be to:

- (a) Collaborate with the hospital in planning a systematic, organization-wide approach to designing, measuring, assessing, and improving its performance;
- (b) Provide for coordinated patient safety program;
- (c) Measure key activities as designated by regulatory agencies, the Board of Trustees, Executive Committee, or as identified through quality improvement processes;
- (d) Assess performance variation and determine appropriate action as defined in the Peer Review Plan;
- (e) Physician performance profiles are trended and analyzed based on patterns, both sustained and outliers indicating a need for further evaluation through chart review. Physician specific data is considered at the time of reappointment;
- (f) Review and evaluate medical records to determine that they are compliant with the Rules and Regulations;
- (g) Approve the utilization management plan that is appropriate to the hospital and that meets the requirements of law and any appropriate accreditation agencies; and
- (h) Perform other related duties as directed by the Executive Committee and/or the Board of Trustees.

12.3.3 Meetings

The Medical Staff quality improvement committee will meet as needed and will conform in its proceedings and actions with relevant provisions of Section 13.

12.4 Credentials Committee

12.4.1 Composition

The committee will be composed of those medical staff members appointed by the chief of staff. The chief of staff, at his discretion, may appoint other members on an ad hoc basis.

12.4.2 Duties

The duties of the credentials committee are to:

- (a) Screen applications in accordance with the procedures set forth in the credentials manual
- (b) Review and evaluate the qualifications of each applicant at initial appointment, reappointment, modification of appointment, or modification of clinical privileges, and, in connection therewith to obtain and consider the recommendations of the appropriate departments;
- (c) Submit reports on the qualifications of each applicant for staff membership or particular clinical privileges. Such reports shall include recommendations with respect to appointment, staff category, department affiliation, clinical privileges, and special conditions attached thereto;
- (d) Investigate, review and report on matters, including the clinical or ethical conduct of any practitioner, health or behavioral issues, assigned or referred by: the Board of Trustee, Medical Staff Leadership, Medical Staff, or hospital staff. No member of the committee will vote on matters concerning an impaired physician from such committee member's same department;
- (e) 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 poses risk of harm to patients, that information may be referred for corrective action;
- (f) Recommend criteria and procedures for evaluations of Medical Staff and other individuals applying for Clinical Privileges; and
- (g) Perform specific tasks as may be directed by the Executive Committee.

12.4.3 Meetings

The credentials committee will meet as needed and will conform in its proceedings and actions with relevant provisions of Section 13.

12.5 Patient Care Monitoring Committee

12.5.1 Composition

The committee will be composed of active-clinical members of the medical staff who represent the areas of infection control, pathology, intensive care, operating room, obstetrics, gynecology; and one (1) representative from each of the hospital departments of administration, medical records, nursing services, and quality management; and a registered pharmacist and dietitian; and such other active medical staff members deemed appropriate by the chief of staff.

12.5.2 Duties

The duties of the patient care monitoring committee are to monitor, measure, and improve processes:

- (a) Use of blood and blood components;
- (b) Use of medications;
- (c) Monitor dietary and nutritional matters;
- (d) Maintain surveillance over the hospital infection control program;
- (e) Perform other related duties, which may be directed by the Executive Committee.
- (f) Review and approve all forms, which are utilized in the medical record.

12.5.3 Meetings

The Patient Care Monitoring Committee will meet quarterly and more often as needed and will conform in its proceedings and actions with the relevant provisions of Section 13

12.6 Ethics Committee

12.6.1 Composition

There will be an ethics committee composed of active-clinical members of the medical staff, a member of the clergy, a member from social services department, a legal representative, nursing service representatives, a lay member, and representatives from administration and quality assurance.

12.6.2 Duties

The duties of the ethics committee will be to:

- (a) Make available educational opportunities and materials regarding medical ethics for the medical staff, hospital employees, limited health professional staff, and the community;
- (b) Provide consultation on ethical issues as requested by the medical staff, limited health professional staff, hospital staff, patients, and their families;
- (c) Evaluate and make recommendations regarding medical staff policies, which relate to ethical issues.

12.6.3 Meetings

The ethics committee will meet as needed and will conform in its proceedings and actions with relevant provisions of Section 13.

12.7 Bylaws Committee

12.7.1 Composition

There will be a Bylaws committee composed of the officers of the medical staff (chief of staff, vice chief of staff, and secretary), the chairman of the Credentials committee, the chairman of the Medical Staff Quality Improvement Committee, the Director of Quality & Risk Management, the Manager of Medical Staff Services and representation from Administration. The vice chief of staff shall be the chairman of the Bylaws committee.

12.7.2 Duties

A standing committee of the staff shall review the medical staff bylaws annually. Such responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner.

12.7.3 Meetings

The Bylaws committee will meet as needed and will conform in its proceedings and actions with relevant provisions of Section 13.

12.8 Authority to Delegate

Any committee formed by or pursuant to authority granted in these rules and regulations shall have the authority to adopt mechanisms and procedures to carry out such committee's duties, including the authority to create and/or appoint subcommittees or ad hoc committees, or consult with or seek assistance from any individual, and to delegate to any such subcommittee, ad hoc committee or individual any of the duties and responsibilities which are to be performed by such committee.

SECTION 13: MEETINGS

13.1 Semi-Annual Meetings

13.1.1 Regular Meetings

Regular semiannual meetings of the Medical Staff will be on the fourth Tuesday of February and September, at 6:00 p.m. The day and time of regular semiannual meetings may be changed by the Executive Committee, provided that the Medical Staff is given thirty (30) days notice of the change.

The order of business at any regular meeting will be determined by the chief of staff and will include at least:

- (a) Presentation and acceptance of minutes of last regular meeting and all special meetings held since the last regular meeting;
- (b) Administrative report from the President, reports and recommendations from the chief of staff, committees, and departments which have such reports for the general staff;
- (c) The election of officers and representatives at large, when required by these rules and regulations;
- (d) Recommendations for improving patient care and safety I; and
- (e) New Business.

13.1.2 Special Meetings

Special meetings of the medical staff may be called at any time by the chief of staff, the Board of Trustees, the Executive Committee, or within thirty (30) days after receipt of a written request of at least twenty percent (20%) of the members of the medical staff accorded the prerogative to vote. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be given to medical staff members at least seven (7) days before the time set for the meeting by registered letter, return receipt requested.

13.2 Committee Meetings

13.2.1 Regular Meetings

A staff committee established to perform staff functions required by these rules and regulations will meet as often as necessary to discharge its assigned duties. Committees provide the time and frequency for regular meetings and no notice shall then be required.

13.2.2 Special Meetings

A special meeting of any committee may be called at the request of, the chairman thereof, the Board of Trustees, or the chief of staff, within fifteen (15) days after receipt of a written request of at least forty percent (40%) of the committee's members. No business will be transacted at any special meeting except that stated in the meeting notice.

13.3 Department Meetings

13.3.1 Regular Meetings

Departments shall meet at least once each calendar quarter when called by the department chairman. Departments provide the time for holding regular meetings and no notice shall then be required.

13.3.2 Special Meetings

A special meeting may be called at the request of the Board of Trustees, the chief of staff, the department chairman, or will be called by the department chairman within fifteen (15) days after receipt of a written request of at least ten percent (10%) of the department's staff members accorded the prerogative to vote. No business will be transacted at any special meeting except that stated in the meeting notice.

13.4 Attendance Expectations

13.4.1 Semi-Annual Meetings

All medical staff members are expected to attend at least fifty percent (50%) of all meetings.

13.4.2 Committee Meetings

Medical staff members appointed to serve as members of any committee are expected to attend at least fifty percent (50%) of all meeting of the committee. Failure to meet these attendance goals may be grounds for removal from membership on the committee. Excused absences may be granted.

13.4.3 Department Meetings

Medical staff member are expected to attend at least fifty percent (50%) of all meetings of the department to which they are assigned.

13.5 Provisions Common to all Meetings

13.5.1 Quorum and Voting

- (a) **Semi-Annual Meetings**
The presence of those members of the medical staff accorded the prerogative to vote at any regular or special meeting shall constitute a quorum for the transaction of all business. Only eligible medical staff members are allowed to vote.
- (b) **Committee and Department**
The medical staff members appointed to a committee and staff members accorded the prerogative to vote present at a department meeting will constitute a quorum and be allowed to vote at any meeting.
- (c) **There will be no proxy voting allowed.**

13.5.2 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a

committee or department by a writing setting forth the action so taken signed by each member entitled to vote thereat.

13.5.3 Minutes

Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. A permanent file of minutes of each meeting will be maintained by Medical Staff Services and to the extent not privileged or confidential, made available to members of that committee or department.

SECTION 14: GENERAL PROVISIONS

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

14.1. ADMINISTRATIVE SUSPENSION OR REVOCATION

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.

14.1.1 The Administrative 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 14.1.1A 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 elective and/or 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 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. Repetitious Infractions

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.

14.1.2 Notification of Practitioner Suspension or Reinstatement

A. Notification to Suspend

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. Notification to Reinstatement

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.

14.3.3 Reporting to Texas Medical Board for Failure to Complete Medical Records

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 15: ALLIED HEALTH PROFESSIONAL SERVICES

The Executive Committee may recommend to the Board of Trustees the granting of clinical privileges to allied health professionals, including, but not limited to, psychologists, physicians' assistants, and nurse practitioners, based upon investigation and evaluation of the education, training, experience, and demonstrated ability and judgment of individuals requesting privileges as allied health professionals, according to procedures established in the Allied Health Manual or other document approved by the Board of Trustees. A recommendation by or on behalf of the executive committee to not grant privileges to an applicant for privileges as a allied health professional, or to suspend, to terminate, or to discontinue such privileges, or such a decision by the board, will not give rise to any procedural rights set forth in the bylaws, unless otherwise specifically provided in the Allied Health Manual or other document approved by the board. All allied health professionals will be under the supervision of a physician active-clinical medical staff member who will be responsible for the performance of each of these individuals.

SECTION 16: REVISIONS, MODIFICATIONS AND AMENDMENTS

These Medical Staff Rules and Regulations may be amended, revised, modified or repealed by action of the Medical Staff Executive Committee as provided for in the Medical Staff Bylaws.

SECTION 17: MISCELLANEOUS

17.1 PATHOLOGY:

Autopsy Criteria* It is the policy of the Medical Staff to encourage the seeking of autopsy permission for deaths based on clinical criteria.

The following conditions serve as a basis for requesting autopsy:

- (a) Deaths in which autopsy may help to explain unknown and unanticipated medial complications to the attending physician.
- (b) All deaths in which the cause of death is not known with certainty on clinical grounds.
- (c) Cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or public regarding the death.
- (d) Unexpected or unexplained deaths occurring during any dental, medical, or surgical diagnostic procedures and/or therapies.
- (e) Deaths of patients who have participated in clinical trials approved by institutional review boards.
- (f) Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction.
- (g) Natural deaths that are subject, to be waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospitals; deaths occurring with 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- (h) Deaths resulting from high-risk infectious and contagious diseases.

- (i) All obstetric deaths.
- (j) All neonatal and pediatric deaths.
- (k) Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.
- (l) Deaths known or suspected to result from environmental or occupational hazards.

These are criteria for requesting autopsies, not criteria for conducting medico-legal death investigations.

Autopsies will be performed only with the documentation of proper consent. Data from autopsies will be used as a source of clinical information in quality assessment and improvement activities.

The mechanism for documenting permission to perform an autopsy is defined. The chaplain services are involved with obtaining the proper autopsy permit. At the time of death, the chaplain consults with the medical staff and family concerning the desire for an autopsy, need for medical examiners clearance, and desire for tissue donation. If an autopsy is desired, the chaplain obtains the written permission from the next of kin as defined on the autopsy permit form (see attached) with listing of limitation of performing the autopsy.

There is a system of notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed. The autopsy resident will notify the attending practitioner before each autopsy to obtain significant clinical history and to ask if the clinician had any specific questions to be addressed at the time of the autopsy. The clinician should be notified when the autopsy will be performed and invite him and his house staff to observe if desired.

* Criteria based on recommendations of the College of American Pathologists Autopsy Committee

17.2 SURGERY

All patients scheduled for surgery shall enter the hospital at such a time as to allow completion of appropriate preoperative procedures prior to surgery.