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BAYLOR HEART AND VASCULAR HOSPITAL

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# Rules and Regulations Of the Medical Staff

Approved: 10/02

Revised: 10/06; 9/07, 06/08

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## PREAMBLE

In recognition of the desire of the Medical Staff, Administration, and Board of Managers of Baylor Hamilton Heart and Vascular Hospital to strive for high ideals of humanitarian service to the community through the provision of quality health care, education and research; and in recognition of the need for a Medical Staff organization which can respond effectively and efficiently to changing conditions in order that it can appropriately conduct its responsibilities subject to the ultimate authority of the Board of Managers of this Hospital, the Medical Staff of this hospital hereby formulates these Rules and Regulations, subject to the approval of the Board of Managers of Baylor Hamilton Heart and Vascular Hospital.

## NAME

The official name of this organization shall be the Medical Staff of Baylor Hamilton Heart and Vascular Hospital of Dallas, Texas.

## DEFINITIONS

The words and phrases herein have the following meanings whenever used in these Rules and Regulations, unless the context requires otherwise.

- A. *Active Medical Staff* means members of the Active Category of the Medical Staff.
- B. The *Administration* refers to the President (President) or his designee(s) who are responsible for managing the day-to-day operations of the Hospital.
- C. *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.
- D. *Applicant* means any individual possessing the qualifications for Medical Staff membership specified in Bylaws who seeks membership to the Medical Staff.
- E. *Appointment and Reappointment* refers to the process specified herein by which one acquires and retains Medical Staff membership and delineated clinical privileges.
- F. *Board of Managers* means the governing body of Baylor Hamilton Heart and Vascular Hospital of Dallas.
- G. *Chairman of the Medical Leadership Committee* is the appointed physician member of the Medical Leadership Committee who presides at meetings of the Medical Leadership Committee.
- H. *Chief Executive Officer (CEO)* means the individual designated by the Board of Managers to manage the performance of Baylor Heart and Vascular Hospital.
- I. *Chief of Service or Division Chairman* means the head of a Clinical Division, sometimes referred to as a clinical service, who is appointed by the Board of Managers.
- J. *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 Managers to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the Hospital.
- K. *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.

- L. *Division* means a section of the Medical Staff composed of members who practice a similar specialty.
- M. *Ex Officio* means one who serves as a resource person by virtue of an office or position held, but without voting privileges.
- N. For *editorial consistency*, only masculine word forms and pronouns, such as he or his, are used in these Rules and Regulations when referring to both genders. This use is not intended to express an opinion about the gender of the individuals who may be affected by provisions in these Rules and Regulations.
- O. *Housestaff*: 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.
- P. *Hospital* means Baylor Hamilton Heart and Vascular Hospital, Dallas, Texas.
- Q. *Medical Staff Member* means, unless otherwise expressly limited, any fully licensed physician, dentist, or podiatrist, who is approved by the Board of Managers as a member of the Medical Staff of Baylor Hamilton Heart and Vascular Hospital.
- R. *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.
- S. *Physician* means any Medical Staff member licensed to practice medicine by the Texas State Board of Medical Examiners.
- T. *Podiatrist* means any Medical Staff member who is licensed to practice podiatry by the Texas State Board of Podiatry Examiners.
- U. *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.
- V. *Chairman of the Medical Staff* is the appointed physician representative of the Medical Staff by the Board of Managers.
- W. *Professional review action* pertains to any good faith activity by a professional review body duly authorized by these Rules and Regulations, 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 his Staff membership or clinical privileges.
- X. *Professional review activity* means activities undertaken in determining whether a physician may be appointed and/or be granted clinical privileges in this Hospital, determining the scope or conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.
- Y. *Professional review body* pertains to this Hospital and the Board of Managers or any committee of the Hospital, which conducts professional review activities, and includes any committee of the Medical Staff when assisting the Board of Managers in a professional review activity.
- Z. *Year* means twelve consecutive months.
- AA. The words "working cooperatively with medical staff members, nurses, hospital administration and other" in Section 11.7(3) include, but are not limited to, the following:
- (1) Physicians must not berate other people who work at the Hospital;
  - (2) Gentle and constructive suggestions in a private setting are sometimes appropriate, but scolding; sarcasm; put-downs; profanity; loud, angry or abusive language; and other similar behaviors 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 Hospital Administration or chiefs of service;

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

A.A. An *Incident* means 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, ex. Medication error, etc.

B.B. 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:

Patient suicide;

Rape or sexual assault;

Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;

Surgery or other procedure on wrong patient or wrong body part;

Retained foreign objects remaining from surgery or other procedure;

Brain or spinal damage.



### 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 House staff. 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.
- 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.

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.

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 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 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 the next calendar day. All progress notes shall be dated, timed and signed by the appropriately credentialed medical staff member.

#### R3.3-5 Focus Charting

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

#### 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 Diagnostic and Therapeutic Orders

Orders shall include any written or verbal communication by individuals granted appropriate clinical privileges and accepted by a hospital-employed, licensed nurse, physical therapist, occupational therapist, clinical dietician, respiratory therapist, pharmacist, or a hospital approved and appropriately credentialed Allied Health Professional..

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 an 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.

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

#### R3.3-8 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.

#### R3.3-9 Pre-Operative Evaluation

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

#### R3.3-10 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 within seven (7) days post procedure. The operative report must be authenticated by the surgeon.

#### R3.3-11 Preanesthesia and Postanesthesia Notes

For anesthetics administered by anesthesiologists or for anesthesia administered by or under the direction of physicians 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 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.

#### R3.3-12 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, estimated blood loss, and the postoperative diagnosis and condition.

#### R3.3-13 Discharge Entries

At the time of the patient's discharge, the Attending Physician's Summarized Report form shall be completed including diagnoses, procedures, dates of procedures. Where final diagnosis remains uncertain until a laboratory or radiology report is available, the physician shall record on the form that the discharge diagnosis is pending. 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.

### R3.3-14 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.
- 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.

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

### 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 Surveys of Medical Records

Surveys, audits or reviews of records at Baylor Heart and Vascular Hospital 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 Administration of the hospital and by the Chief of the Division when, in the opinion of the chief of the principal service, this clearance is desirable.

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 written approval or verification of an exemption by the Medical Leadership Committee, responsible for Professional Standards, 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 Health Information Management Department and current HIPPA guidelines. Studies of procedures or treatment regimens should, unless authorized by the Chief of the Division, 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 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.



- (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 his 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 for the use of restraints on general patient care units are reviewed and approved by the Medical Leadership.

#### R4.4 Standing Orders

Standing orders are approved for use in the Hospital and comply with the standards set forth by Joint Commission. Policies and procedures for use of standing orders are developed and monitored

by the Professional Standards Committee and the Medical Leadership Committee. All new orders will be reviewed and approved by the committees. The committees will review annually standing orders used in the hospital..

## 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 benefits 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 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-BHVH 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 his/her own consent forms;
2. A patient who is divorced (not annulled) or widowed under 18 years of age may sign his/her 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 his/her parents and managing his/her 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 his/her 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 his/her 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 AND SURGERY

### 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 his physician designee is physically present in the Operating Room. 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 Division 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 Medical Leadership Committee.

Operating rooms allocated to the various services shall be held until 48 hours preceding the date of surgery. After that time, following the move-up requests, 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 6 p.m. Saturday elective surgery is based on the availability of staffing. Emergency surgery services will be provided as needed during normal operating hours. 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 the Division.

The first surgical procedure in each room will be posted at 7:30 a.m. A surgeon desiring an earlier time should contact the Team Leader of the respective operating room and the Anesthesiologist. A surgeon desiring a later time will be required to follow the first case posted. 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.

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, he loses the reservation and the next patient scheduled may be moved to that time.

The posting of cases shall be made or canceled by the surgeon or his 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 14.1-1 on Administrative Suspension** ~~Medical Record delinquencies.~~

A surgical operation shall be performed only on consent of the patient or his 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

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 BHVH approved educational program.

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

Observation -- Written requests by Baylor physicians or employees are to be sent to the Administrative Director of Clinical 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 Team Leader will be notified by Administration. In circumstances where standing approval is needed, a written request from the appropriate Chief of the Division stating the reason for "standing approval" must be submitted. Once Administrative approval is granted, a biannual reapproval will occur.

Tours -- Approval given by the Administrative Director of Clinical Services. Written request should be submitted, when possible.

Clinical Participation -- Written requests are to be sent to the Chief of the Division from the physician making the request. If the Chief approves, he must request Administrative approval from the 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 Team Leader of Education during the orientation process.

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 the Vascular Surgery Division, and agreed upon by the contracted Pathologist. The exempted specimen should only be those that by

their nature do not permit fruitful examination (e.g. foreign body, incidental rib removal, arthroscopic surgery fragments, 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 his 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 Heart and Vascular Hospital 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 the contracted pathologist, 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 Division of Vascular Surgery, or their designated representative. 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 Body Substance Isolation 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 CATEGORIES OF MEMBERSHIP

### R9.1 Categories

Within the divisions of the Medical Staff, there shall be three categories of membership:

1. Active Clinical
2. Consulting
3. Courtesy
4. Active Community

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

#### R9.1-1 The Active Clinical Staff

The Active Medical Staff shall be in active medical practice and regularly use the hospital to provide patient care. Exceptions may be made for practitioner administrators who are not in active medical practice and for practitioners who by virtue of their medical specialty do not regularly admit patients but conduct the majority of their practice at Baylor.

Members of the Active Clinical Medical Staff shall have full admitting privileges, be eligible for delineated privileges and be able to vote and hold Medical Staff Office as specified in these Bylaws. They shall be expected to serve on Medical Staff committees, regularly attend Medical Staff and division meetings as specified in these Bylaws, and participate in the quality improvement and utilization review process.

#### R9.1-2 Consulting Category

The Consulting Category shall consist of Medical Staff members who are persons recognized for outstanding attainments in medicine, dentistry or podiatry and whose practice in the hospital is limited to consultation. These members shall hold positions in other medical, dental or podiatric facilities, at a minimum, and on active staff at Baylor University Medical Center, and shall be expected to respond to calls for consultation by any member of the Medical Staff. Members of this category shall be eligible for delineated privileges but shall have no admitting privileges and shall not be able to vote on Medical Staff matters or hold Medical Staff office. They shall not be required to serve on Medical Staff committees or attend Medical Staff meetings. However, members in this category shall participate in the quality improvement and utilization review process of the hospital and may be required to make available quality improvement and utilization review results from other health care facilities where members hold membership and exercise clinical privileges. These members must abide by these Bylaws and the Rules and Regulations of the Medical Staff.

#### R9.1-2 Courtesy Category

The Courtesy Category shall consist of Medical Staff members who are members of the active staff of another hospital where he/she actively participates in quality review, evaluation and monitoring activities similar to those required of the Active Clinical staff. Courtesy members must maintain at least one (1) and up to a maximum of 12 contacts per appointment period. This maximum number shall not include patient contacts that occurred when the courtesy staff member is providing call coverage for an active clinical staff member. A courtesy staff member will not be required to come an active clinical staff member because of call-coverage contacts alone.

Members of the Courtesy staff shall have full admitting privileges, be eligible for delineated clinical privileges and vote on matters presented at general special meetings of the medical staff and of the Divisions and committees of which he is a member. A courtesy staff member shall not be eligible to hold office in this Medical Staff organization. Members of the Courtesy staff shall adhere to the responsibilities described in the Medical Staff Bylaws, Section 2.8-2©.

#### R9.1-4 Active Community Staff

The Active Community Staff shall consist of Medical Staff members who do not have patient contacts at the Hospital. Members of this category may not have clinical privileges. Members of the Active Community staff shall adhere to the prerogatives and responsibilities described in the Medical Staff Bylaws, Section 2.8-3(b)(c).

#### R9.2 Housestaff

The Housestaff shall consist of practitioners who are graduates of a medical school and are pursuing additional training in one of Baylor University Medical Center's organized medical education programs. Such practitioners shall not be considered medical staff members nor shall the term housestaff be considered a category of Medical Staff membership. Such practitioners shall be subject to these Bylaws, Rules and Regulations of the Medical Staff and any other policies and procedures applicable to each respective medical education program while providing medical care in the hospital. The Housestaff shall not be entitled to the procedural rights of Article IX of these Bylaws.

#### R9.3 Modification Of Membership

On its own, upon recommendation from and/or consultation with a Division Chief and Chairman of the Medical Leadership Committee, or pursuant to a request by a member under Section 5.10-11, or upon direction of the Board of Managers forth in Section 8.1-6, the Credentials Committee may recommend a change in the medical staff category of a member consistent with the requirements of these Bylaws.

## Section X OFFICERS

#### R10.1 Officers Of The Medical Staff

##### R10.1-1 Identification

The officers of the Medical Staff shall be the Chairman, who will also act as the Chairman of the Medical Leadership Committee, and the Secretary.

##### R10.1-2 Qualifications

The Chairman and Secretary shall both be members of the 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.

### R10.1-3 Elections

Each year, at its Annual Meeting, the Board of Managers shall elect the Chairman and Secretary of the Medical Staff by majority vote from a slate provided by the Medical Leadership Committee. The Chairman of the Board of Managers may also accept additional nominations at that time prior to the vote by the Board of Managers. Officers of the Medical Staff shall be announced at the annual meeting of the Medical Staff.

### R10.1-4 Term Of Elected Office

Each officer shall serve until the next annual meeting of the Board of Managers or until their successors are chosen unless that officer shall sooner resign or be removed from office at which time a special election will be held at the next scheduled meeting of the Board of Managers to fill the vacancy. The interim officer shall serve until the next Annual Meeting of the Board of Managers or until their successor is chosen unless removed from office for cause.

### R10.1-5 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 appointed or failure to comply with the provisions of Article I of the Bylaws. Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Board of Managers or by recommendation for consideration made by the Medical Leadership Committee. Recall shall be considered at the next scheduled meeting of the Board of Managers. Recall shall require a [majority] vote of the Board of Managers members eligible to vote.

### R10.1-6 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 Chairman or Secretary is vacated during the year, the Board of Managers shall elect a replacement at its next scheduled meeting.

## R10.2 Duties Of Officers

### R10.2-1 Chairman 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 Chairman of the Medical Leadership Committee;
- (c) serving as a liaison between the Medical Staff and the Board of Managers. The Chairman shall attend meetings of and communicate Medical Staff matters to the Board of Managers;
- (d) reporting to the Medical Staff on actions taken by the Medical Leadership Committee;
- (e) serving as an ex officio member of all other staff committees without vote, unless his membership in a particular committee is required by these Rules and Regulations; and
- (f) interacting with the Administration and Board of Managers on matters of mutual concern within the Hospital.

### R10.2-2 Secretary

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

- (a) serving as Secretary of the Medical Leadership Committee;
- (b) attending to all appropriate correspondence on behalf of the Medical Staff;
- (c) calling meetings on the order of the Chairman;
- (d) keeping minutes of all general meetings of the Medical Staff, the Medical Leadership Committee,;

(e) serving in the role of Chairman in the absence of the Chairman until his return or a replacement has been elected; and

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

#### R10.2-3 Medical Staff Representatives

Other representatives of the Medical Staff shall be appointed by the Board of Managers as they become necessary and are mutually agreed upon.

## Section XI DIVISIONS OF THE MEDICAL STAFF

### R11.1 Organization

#### R11.1-1 Clinical Divisions

The Medical Staff shall be divided into clinical divisions. Each division 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 11.6-5

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

### R11.2 Divisions

Divisions are:

- (1) Cardiology; and
- (2) Vascular Surgery

### R11.3 Assignment To Divisions

Practitioners shall be a member of only one division. The Chief of Service of the division shall recommend to the Credentials Committee the clinical privileges to be granted to the practitioner. All practitioners in the division 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 their division only.

### R11.4 Functions Of Divisions

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

The general functions of each division 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 division. The number of such reviews to be conducted during the year shall be as determined by the Hospital's Quality Improvement Plan. The division shall routinely collect information about important aspects of patient care provided in the division, 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 division, regardless of whether the member whose work is subject to such review is a member of that division;

(b) recommending to the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the Division, *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 division;

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

(e) reviewing and evaluating division 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 division's members with nursing and ancillary patient care services.

(h) submitting written reports to the Medical Leadership Committee, 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 division and the hospital;

(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 division'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 Leadership Committee for professional and Medical Staff administrative activities within the division;

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

## R11.5 Division Chief of Service

### R11.5-1 Qualifications

Each division shall have a Chief of Service who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical services covered by the division. In addition, a Chief of Service should be certified by the appropriate specialty board, have demonstrated leadership qualities, be a strong supporter of Baylor Heart and Vascular Hospital and be active in education, both for medicine and for allied fields. Under special circumstances, in order to serve the best interests of the Hospital, 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.

### R11.5-2 Terms Of Office

Chiefs of Service in divisions primarily engaged in private practice shall be appointed by the Board of Managers for one year terms. They may serve successive terms at the choice of the Board of Managers.

#### R 11.5-3 Removal

A Chief of Service may be removed by the Board of Managers after consultation with the Medical Leadership Committee. 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 Article I of the Bylaws.

#### R 11.5-4 Vacancies

Vacancies in division chiefs occur upon the death or disability, resignation, or removal of the division chief, or the loss of their membership in the Medical Staff. If the position of division chief is vacated during the year, the Board of Managers shall appoint a new chief for the remainder of the term at its next regular Board of Managers meeting. The Medical Leadership Committee may choose to appoint an interim chief if necessary to oversee the division until the Board has met and taken action, if necessary.

#### R 11.5-5 Duties

(a) Each Chief of Service shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned by the Medical Leadership Committee or the Board of Managers:

- (1) act as presiding officer at division meetings and provide appropriate minutes of such meetings;
- (2) assure that the division functions in Section 11.4 are carried out.
- (3) responsible to the Medical Leadership Committee for all professional, clinical and administrative activities within the division..
- (4) monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by members with clinical privileges in the division through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the division by the Medical Leadership Committee;
- (5) develop and implement division 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 improvement.
- (6) be a member of the Medical Leadership Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the division.
- (7) recommend to the Credentials Committee division 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 division when necessary.
- (10) endeavor to enforce the Medical Staff bylaws, rules and regulations and policies within the division;
- (11) cooperate with other divisions and implement within the division appropriate actions taken by the Medical Leadership Committee or its designee.
- (12) participate in every phase of administration of the division, including cooperation with the other division, 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 division or organization

- (13) direct and participate in medical education programs in the division and provide support to such programs throughout the Hospital.
- (14) encourage and monitor research in the division;
- (15) be responsible for maintaining appropriate minutes and other records of departmental meetings,
- (16) perform such other duties commensurate with the office as may from time to time be reasonably requested.

## Section XII COMMITTEES

### R12.1 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 divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Medical Leadership Committee pursuant to this Article or by divisions pursuant to Sections 11.4 (I). The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Leadership Committee or divisions 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 Board of Managers. Members may be removed by the Chairman of the Medical Leadership Committee subject to consultation with and approval by the Medical Leadership Committee. Medical Staff committees shall be responsible to the Medical Leadership Committee.

### R12.2 General Provisions

#### R12.2-1 Terms Of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of 2 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.

#### R12.2-2 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 Hospital, suffers a loss or significant limitation of clinical privileges, or if any other good cause exists, that member may be removed by the Medical Leadership Committee.

#### R12.2-3 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 Rules and Regulations is removed for cause, a successor may be selected by the Medical Leadership Committee.

#### R12.2-4 Confidentiality Of Information

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

### R12.3 Medical Leadership Committee

#### R12.3-1 Composition

The Medical Leadership Committee shall be composed of:

- (a) Chiefs of Service of the Divisions of Cardiology and Vascular Surgery;

- (b) The Chairman of the Medical Staff
- (c) The Medical Directors of the Noninvasive Labs
- (d) Other leaders of the Medical Staff as may be identified by the Medical Leadership Committee
- (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 Managers and the Medical Leadership Committee.

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

#### R 12.3-2 Officers Of The Medical Leadership Committee

The Officers of the Medical Leadership Committee shall consist of a Chairman and a Secretary. The Chairman and Secretary shall be elected annually by the Board of Managers. The Chairman and Secretary of the Medical Staff shall serve as the Chairman and Secretary of the Medical Leadership Committee.

#### R 12.3-3 Duties

The duties of the Medical Leadership Committee shall be to:

- (a) Represent and act on behalf of the Medical Staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these Rules and Regulations,
- (b) Develop, implement, and coordinate the professional and organizational activities, policies, rules and regulations, and bylaws of the Medical Staff,
- (c) Receive and act upon reports and recommendations from Medical Staff divisions, committees, and assigned activity groups,
- (d) Recommend actions to the Board of Managers on matters relating to the delivery of medical care,
- (e) Establish structures of the Medical Staff to accomplish the following:
  - (1) Review of credentials and delineation of clinical privileges of individuals.
  - (2) Quality improvement/utilization review activities.
  - (3) Termination of Medical Staff membership and fair hearing procedures.
  - (4) Other matters relevant to the operation of an organized medical staff.
- (f) Participate in the development and evaluation of Medical Staff and Hospital policies, practices, and plans as appropriate,
- (g) 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,
- (h) Oversight of the Medical Education Program affiliation with Baylor University Medical Center to ensure ongoing maintenance of the medical education process quality and ensure appropriate oversight is sustained through involvement in the Baylor University Medical Center Medical Staff credentialing activities as appropriate,
- (i) Ongoing oversight and review of the Baylor Health Care System Institutional Review Board as it relates to research and protocol in the application and use of the IRB at BHVH,
- (j) Designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the Medical Leadership Committee and the Medical Staff,

(k) Oversight and responsible to fairly and appropriately manage any and all issues of physician health as it may affect their individual behavior and the ultimate impact on their responsibilities and oversight of high quality patient care;

(l) Report to the Medical Staff annually activities of the previous year.

#### R12.3-4 Meetings

The Medical Leadership Committee shall meet as often as necessary at the call of its chairman but at least monthly. It shall maintain a confidential record of its proceedings and report to the Medical Staff and the Board of Managers.

### R12.4 Credentials Committee

#### R12.4-1 Composition

The Credentials Committee shall be composed of at least 5 members to include members from the Active Medical Staff and one representative of the Medical Leadership/Board of Managers. Members shall serve three-year terms and may serve up to three consecutive three-year 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. 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 Committee from those members who have served at least one year on the Committee. Representatives from the Administration may also attend as non-voting members.

#### R12.4-2 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 divisions,

(b) Submit required reports and information to the Board of Managers on the qualifications of each practitioner applying for reappointment or particular clinical privileges including recommendations with respect to reappointment, membership category, division affiliation, clinical privileges, and special conditions,

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

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

#### R12.4-3 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 Staff and Board of Managers.

### R12.5 Screening Committee

#### R12.5-1 Composition

The Screening Committee shall be composed of at least 5 members of the Active Medical Staff. Members shall serve 3-year terms and may serve up to 3 consecutive 3-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.

### R12.5-2 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 Managers on the qualifications of each practitioner applying for initial Medical Staff Membership.
- (c) Investigate, review, and make recommendations on matters referred by the Medical Leadership Committee regarding initial Medical Staff appointment.
- (d) Submit monthly reports to the Medical Leadership Committee concerning the Committee's evaluation and recommendations regarding initial membership appointments, status of pending applications and other activities of the Committee.

### R12.5-3 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 Managers and the Medical Staff.

## R12.6 Committee On Infections

### R12.6-1 Composition

The Committee on Infections shall be composed of at least 5 members of the Medical Staff, as well as the Infection Control physician who shall act as its Chairman. Non-voting members may include representatives from Epidemiology, Administration, and Nursing. Representatives from other departments of the Hospital involved in infection evaluation and control may be invited on a consultative basis as non-voting members.

### R12.6-2 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 hospital acquired 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 Hospital 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 Leadership 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.

### R12.6-3 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 Leadership Committee.

## R12.7 Committee On Institutional Ethics

### R12.7-1 Composition

The Committee on Institutional Ethics shall be composed of at least 5 members of the Medical Staff, two nurses, one Chaplain, one Medical Center Attorney, 1 Administrators / team leaders, and two community representatives.

### R12.7-2 Duties

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

- (a) Develop guidelines for consideration of bioethical issues in patient care in response to issues raised within the organization or by the committee,
- (b) Develop and implement procedures for the review of such issues when appropriate,
- (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 when asked as appropriate,
- (f) Provide education to the hospital staff, patients, and the community on bioethical matters as issues arise.

### R12.7-3 Meetings

The Committee shall meet as often as necessary at the call of its Chairman on an as needed basis. The Chairman of the Medical Staff shall appoint the Chairman of the committee from the Medical Leadership Committee when needed. The Committee shall maintain a confidential record of its proceedings and report to the Medical Leadership Committee.

## R12.8 Committee On Medical Records

### R12.8-1 Composition

The Committee on Medical Records shall be composed of at least 5 members of the Medical Staff. Non-voting members shall include representatives from Administration, Nursing, and Medical Records.

### R12.8-2 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 Hospital,

- (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 Hospital 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 Hospital administration and medical records personnel on matters relating to medical records practices.

#### R12.8-3 Meetings

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

### R12.9 Committee On Nutrition And Dietary Services

#### R12.9-1 Composition

The Committee on Nutrition and Dietary Services shall be composed of at least 5 members of the Medical Staff. Non-voting members shall include representatives from Administration, nursing and the Nutrition and Dietary Department.

#### R12.9-2 Duties

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

- (a) Evaluate and approve standard therapeutic diets available in the Hospital,
- (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 Hospital.

#### R12.9-3 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 Leadership Committee.

### R12.10 Committee On Pharmacy And Therapeutics

#### R12.10-1 Composition

Committee on Pharmacy and Therapeutics shall be composed of at least 5 representatives from the Medical Staff and a representative from the Pharmacy Department. Non-voting members shall include representatives from Administration and Nursing.

#### R12.10-2 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 Pharmacy Department 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 Hospital,
- (e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital 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.

R 12.10-3 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 Board.

R12.11 Committee On Professional Standards

R 12.11-1 Composition

The Committee on Professional Standards shall be composed of at least 5 members of the Medical Staff to include the following individuals or a designee who is actively involved in Quality improvement activities:

- (a) Medical Director of Quality Care and Coordination
- (b) Chairman of the Committee on Medical Records
- (c) Chairman of the Committee on Pharmacy and Therapeutics (to include expertise in Drug Usage Evaluation)
- (d) Chairman of the Committee on Infections
- (e) Chairmen of Medical Staff Divisions

Non-voting members shall include representatives from Administration, Quality Care and Coordination, Medical Staff Services, Risk Management, and Nursing.

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

R 12.11-2 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 of the Medical Staff are disseminated to the Medical Staff members of each clinical division and appropriate action is taken on these findings.

- (b) Refer priority problems for assessment and corrective action to the appropriate Division or Committee,
- (c) Keep informed on standards of the Joint Commission on Accreditation of Healthcare Organizations and other regulatory agencies as they are published,
- (d) Monitor results of quality improvement and utilization review activities throughout the Hospital:
  - (1) Review of standards and procedures as they apply to clinical care and safety of patients,
  - (2) Recommend to the Medical Leadership Committee studies that should be performed by other Committees having jurisdiction over clinical standards,
  - (3) Recommend additional Quality Improvement 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 Hospital.
- (e) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of hospital 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 Hospital's case management system.
- (g) Review the Quality improvement Plan and the Utilization Review Plan annually.
- (h) Submit regular reports to the Medical Leadership Committee on the quality of medical care provided, quality review activities conducted, and utilization of resources and facilities in the Hospital.

#### R12.11-3 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 Leadership Committee and Board of Managers.

## Section XIII MEETINGS

### R13.1 Meetings

#### R13.1-1 Annual Meeting

There shall be an annual meeting of the Medical Staff each year. The program shall be determined by the Chairman of the Medical Staff. Notice of this meeting shall be given to the members at least 30 days prior to the meeting.

#### R13.1-2 Regular Meetings

There shall be meetings of the Medical Staff on an as needed basis. Notice of the meetings shall be given to the members at least [30] days prior to the meeting.

#### R13.1-3 Agenda

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

- (a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) administrative reports from the Chairman of the Medical Staff and the Administration;

- (c) voting on proposed changes to these Rules and Regulations when required by the Bylaws;
- (d) reports by responsible officers, committees and divisions 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.

#### R13.1-4 Special Meetings

Special meetings may be called at any time by the Chairman of the Medical Staff or upon the written request of [40%] of the members of the Active Medical Staff. Such members requesting a meeting shall first consult with the Chairman of the Medical Leadership Committee as to the purpose and need to call a special meeting. Called special meetings shall be scheduled by the Chairman within [30] days after receipt of such request. No later than 30 days prior to the meeting, notice shall be mailed or delivered to the members of the Active 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.

#### R13.2 Committee And Division Meetings

##### R13.2-1 Regular Meetings

Except as otherwise specified in these Rules and Regulations, the chairmen of committees, Chiefs of Service, and Division Chiefs 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.

##### R13.2-2 Special Meetings

A special meeting of any Medical Staff committee or division may be called by the chairman thereof, Chief of Service, Medical Leadership Committee, or Chairman of the Medical Staff.

#### R13.3 Quorum

##### R13.3-1 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.

##### R13.3-2 Division And Committee Meetings

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

#### R13.4 Manner Of Action

Except as otherwise specified, the action of a majority of the members present and voting at all division 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 Rules and Regulations. 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 a majority of the members entitled to vote.

R13.5 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 Administration for inclusion in each committee's minute's binder. Summaries of the minutes of standing Medical Staff committees shall be forwarded to the Medical Leadership Committee for review and whatever action warranted.

R13.6 Attendance Requirements

R13.6-1 Regular Attendance

It is expected that each member of the Active Staff and Consulting shall attend:

- (a) As many of the regular meetings of the Medical Staff as possible with intentions to attend at least 50%;
- (b) As many of all meetings of each division, and committee of which he is a member as possible with the intention to attend at least 50%.

R13.6-2 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, divisions, or committees. When a member's practice or conduct is scheduled for discussion at a 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 [7] 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 he was given such notice, unless excused by the Medical Leadership Committee upon a showing of good cause, shall be a basis for corrective action.

R13.6-3 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 XIV GENERAL PROVISIONS

R14.1 Administration 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.*

*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 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. 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 Reinstate**

*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 XV

## AMENDMENT TO THE RULES AND REGULATIONS

The Rules and Regulations of the Medical Staff and division rules and regulation shall be amended as specified in the Rules and Regulations 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 and hospital administration.

## Section XVI

## 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 Leadership Committee for adoption in such areas of the Hospital. New or revised policies and procedures approved by the Medical Leadership Committee and Board of Managers will be communicated to Medical Staff members.

## History of Review and Revision:

10/24/2002

02/02/2004

03/2005

08/29/2005

9/07

06/19/2008