



BAYLOR SPECIALTY HEALTH CENTERS

**BAYLOR SPECIALTY HOSPITAL
And
OUR CHILDREN'S HOUSE AT BAYLOR**

MEDICAL STAFF

**RULES & REGULATIONS
May 23, 2008**

Medical Staff Rules & Regulations
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DEFINITIONS

1. BOARD OF TRUSTEES or BOARD means the Board of Trustees of Baylor Specialty Health Centers.
2. CLINICAL PRIVILEGE or PRIVILEGES means the permission to render specific diagnostic, therapeutic, medical, dental or surgical services specific to the applicable hospital served by the Medical Staff.
3. CONTACTS – A minimum number (as determined by the Board of Trustees) of contacts per appointment period to maintain Active Clinical Staff category. The number of contacts for BSHC is twelve (12).
4. EXECUTIVE COMMITTEE means the executive committee of the medical staff unless specific reference is made to the executive committee of the Board of Trustees.
5. PRESIDENT means the individual appointed by the Board to act on its behalf in the overall administrative management of the hospital.
6. The pronoun "he" used throughout these Rules and Regulations is intended to include either gender. For ease of reading and clarity, "he/she" has been eliminated and "he" should be interpreted as "he/she."
7. HEALTH STATUS means the state of physical or mental health.
9. MEDICAL STAFF means the formal organization of all practitioners who are privileged to attend patients in the hospital.
10. MEDICAL STAFF YEAR means the period from January 1 to December 31 of the same year.
11. PEER, as used for peer review process, means any Physician of at least equal academic and professional standing as the Practitioner whose performance is being reviewed.
12. PHYSICIAN means an individual who has been awarded the degree of doctor of medicine (M.D.) or doctor of osteopathy (D.O.)
13. PRACTITIONER means, unless otherwise expressly limited, any currently licensed individual who is permitted by law and by the hospital to provide patient care services independently without direction or supervision and within the scope of the individual's license and who is granted Clinical Privileges in the hospital.
14. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these Rules and Regulations and in other hospital and Medical Staff policies.
15. SPECIAL NOTICE means written notification sent by certified mail, return receipt requested.

PREAMBLE

WHEREAS, Baylor Specialty Health Centers is a not-for-profit corporation organized under the laws of the State of Texas; and

WHEREAS, its purpose is to operate specialty care hospitals providing multidisciplinary long term rehabilitative care, education, and research; and

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

THEREFORE, the Physicians practicing in this hospital are hereby organized into a Medical Staff in conformity with Bylaws of the Medical Staff.

SECTION I INTRODUCTION

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

SECTION II ADMISSION AND DISCHARGE OF PATIENTS

2.1 All patients admitted to Baylor Specialty Health Centers shall be admitted by members of the medical staff with admitting privileges and all admissions will be governed by the admitted policies and procedures of the hospital.

2.2 A member of the medical staff shall be responsible for the medical care of each patient in the hospital, for the diagnosis and treatment of each patient within the area of his privileges, for the prompt completeness and accuracy of the patient's medical record, for writing orders and supplying special instructions, and for supplying the patient, the patient's family, and any referring or consulting physicians with information regarding the patient's condition and treatment. If the attending physician transfers the patient to the care of another physician, the attending physician must write an order to that effect on the order sheet in the patient's medical record.

2.3 Each patient admitted to the hospital shall receive a baseline history and physical examination in accordance with the bylaws of the medical staff.

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reasons for admission are stated in the patient's record. In the case of an emergency, such statement shall be recorded as soon as possible.

2.4 Each member of the medical staff shall name and notify a qualified member of the medical staff who may be called to attend that member's patients when the practitioner cannot be reached. In the event of failure to name such an associate, or if neither the attending practitioner nor the named associate, nor the medical director of the respective department can be located, the appropriate Chief of Staff shall have the authority to call any member of the medical staff to render interim treatment should this be considered necessary. In the event of an emergency, any member of the medical staff is expected to respond to the request for medical assistance by the nurse in charge of the patient.

2.5 The admitting practitioner will be responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever the practitioner's patients might be a source of danger from any cause.

2.6 Patients will be admitted following the criteria contained in the Admission Standards Policy.

Patients shall be discharged only on order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient or the patient's legal guardian shall be requested to sign a statement releasing the hospital and physicians of any liability as a result of the patient's action. Any refusal to sign this statement shall be documented in that medical record.

- 2.7 It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law.
- 2.8 In the event of the death of a patient in the hospital, the patient shall be pronounced dead by the attending practitioner or his designee within a reasonable period of time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. The release of bodies from the hospital shall conform to state and local laws and regulations.

SECTION III CONSULTATIONS

- 3.1 The attending practitioner is primarily responsible for requesting a consultation from a qualified practitioner who has the appropriate clinical privileges when indicated. A practitioner who has appropriate clinical privileges may be called as a consultant regardless of staff category.

SECTION IV MEDICAL RECORDS

- 4.1 The attending practitioner will be responsible for the preparation of a complete and legible medical record for each patient. This record will include at least the following: (a) identification data (when not available, the reasons will be entered in the record); (b) complete medical history and report of a complete physical examination of the patient; (c) diagnostic and therapeutic orders; (d) evidence of appropriate informed consent (when not obtainable, the reason will be entered in the record); (e) clinical observation, including results of therapy; (f) reports of procedures, tests and the results; (g) conclusions at termination of hospitalization or evaluation/treatment; and (h) provisional and final diagnosis.
- 4.2 A complete history and physical examination report will be written or dictated in all cases by the admitting practitioner or that practitioner's physician assistant, and/or Nurse Practitioner subject to the supervision, or through appropriate delegation by, the admitting practitioner no later than twenty-four (24) hours following the admission of each patient. If the history and physical examination is performed within 30 days prior to the patient's admission to the Hospital, a durable, legible copy of the report may be used in the patient's medical record, provided the examination was recorded and/or authenticated by a member of the Medical Staff or Housestaff. The attending physician must update the patient's condition since it was last assessed. Any changes that may have occurred since last assessment must be dated, time 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 physician must be completed. History and Physician must be dated, timed and authenticated.
- 4.3 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 advance practice nurse approved to do so. The record shall incorporate the chief complaint, details of present illness and relevant information concerning the patient's past history, review of systems, family history, and social history. A physical exam shall reflect a comprehensive, current, physical assessment.

- 4.4 Progress notes will be recorded at a minimum every seventy-two (72) hours to give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment and ensure comprehensiveness of the record in the event of transfer of responsibility of care.
- 4.5 Diagnostic and therapeutic orders shall include those written by individuals granted appropriate clinical privileges. All orders, including verbal orders, must be dated, timed and authenticated promptly by the ordering practitioner or another practitioner who is responsible for the care of the patient. Telephone or other oral orders given by appropriately credentialed practitioners should be used sparingly and may be accepted and written by a licensed nurse, physical therapist, respiratory therapist, occupational therapist, speech language pathologist, pharmacist, dietitian, orthotist or an approved and appropriately credentialed allied health practitioner.

A physician agent (preferably R.N.) may transmit a telephone order to designated hospital employees. It is the responsibility of hospital personnel receiving such an order to clarify any questions they may have about the order with the physician. Telephone or other oral order designated as "Stat" or "urgent" shall be authenticated by the responsible practitioner within 24 hours. All other telephone or oral orders shall be authenticated by the responsible practitioner at the next hospital visit.

To reduce the possibility of error in interpreting physician orders, they shall be written legibly and appended with the physician's name and dictating number. The Hospital Do Not use Abbreviation list shall be followed. Questions, which arise, must be clarified by the physician giving the order.

- 4.6 Operative Note and Report – An operative report or other high risk procedure note shall be written immediately after the procedure and include the name of the primary surgeon/proceduralist and procedure(s) performed, findings, specimens removed, anesthesia, estimated blood loss, complications and post-operative diagnosis. A full operative or high risk procedure report with a complete description of the procedure and all above required elements must be written or dictated post procedure. The operative report must be authenticated by the surgeon.
- 4.7 Preanesthesia and Postanesthesia Notes – For anesthetics administered by anesthesiologists or for anesthesia administered by or under the direction of physicians and/or dentists other than anesthesiologists, the preanesthesia evaluation of the patient shall be recorded on the Anesthesia Record or Physician Progress Record. Documentation should include pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated, the patient's previous drug history, other anesthetic experiences and any potential anesthetic problems. The recording of post anesthetics visits should include a timed report in the recovery room.
- 4.8 Each new consultation report should contain a written opinion by the consultant that reflects, where appropriate, an actual examination of the patient and the patient's medical record. A written opinion signed by the consultant must be included in the medical record.
- 4.7 Reports of actions and findings shall include such items as reports of pathology and clinical laboratory examination, radiology examination, medical treatment, and any other diagnostic or therapeutic procedures.
- 4.8 All clinical entries into the patient's medical record will be accurately dated, timed and authenticated by the responsible practitioner. All entries and clinical reports generated by physician assistants or nurse practitioners employed by a physician will be countersigned by the responsible practitioner in accordance to privileges delineated.
- 4.9 At the time of chart completion, the Discharge Summary shall include diagnoses, procedures, and dates of procedures. All relevant diagnoses established by the time of discharge 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.

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

- 4.10 A discharge summary shall be written or dictated for every patient who has been admitted to the hospital by the practitioner who is primarily responsible for the patient at the time of discharge. The discharge summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, as pertinent.
- 4.11 All medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with hospital policy. Unauthorized removal of records from the hospital shall constitute valid grounds for suspension of privileges and termination of staff membership, on the recommendation of the Executive Committee.
- 4.12 The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave of absence or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section 14 General Provisions and shall be governed by HIM policies and procedures.

SECTION V DIAGNOSIS AND THERAPY

- 5.1 Drugs administered to patients in the hospital shall be obtained through the hospital pharmacy. Patients may, at times, bring their own drugs into the hospital. Provided, however, the use of such drugs shall be considered acceptable, provided that such drugs are identified by the responsible practitioner, or pharmacist, are legibly labeled for contents, dose, and frequency of administration, are specifically ordered in the patient's medical record comply with the self-administration policies approved by the Medical Staff, and this is noted in the necessary notes as self administered.
- 5.2 All drugs must be reordered at least every 30 days, including controlled substances.
- 5.3 A Medical Staff member may initiate the use of restraints through individual physician order. Such orders must include the following:
 - a. Time limit, not to exceed 24 hours. PRN orders are not acceptable.
 - b. Type of restraint to be used;
 - c. Reason for restraint;
 - d. When restraint is to be used (specified episode)Nursing staff may initiate early release trials if the behavior/reason for the restraint has abated prior to the expiration of the time-limited order.
- 5.4 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.

SECTION VI CONTROL OF INFECTIONS

- 6.1 It is the duty of the attending practitioner to notify the appropriate clinician if a particular patient has an Infection, which is transmissible within the hospital. The practitioner should specify the diagnosis so that if any measures beyond Standard Precautions are required they can be implemented. If the practitioner 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 with the practitioner. The 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,

is suspected, the practitioner or the nurses should notify the nurse epidemiologist. Physicians are urged to report nosocomial infections, which are discovered after the discharge of the patient.

SECTION VII REVISIONS, MODIFICATIONS AND AMENDMENTS

These Medical Staff Rules and Regulations may be amended, revised, modified or repealed by action of the medical staff Executive Committee and approved by the Board.

SECTION VIII PATIENT CARE POLICIES

- 8.1 Members of the Medical Staff shall supervise members of the House Staff in carrying out patient responsibilities. Written descriptions of the roles, responsibilities and patient care activities of House Staff shall be developed by the Medical Staff. These descriptions shall include identification of the mechanisms by which the supervising Practitioner and the member of the House Staff make decisions about progressive involvement and independence in specific patient care activities, and delineate when House Staff may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising Practitioner. The Medical Staff shall regularly communicate with the Medical Education Committee about the safety and quality of patient care provided by, and the related educational and supervisory needs of, the House Staff.
- 8.2 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 Executive Committee for adoption. New or revised policies and procedures approved by the Executive Committee and/or the Board of Trustees will be communicated to the Medical Staff members and maintained for convenient reference on nursing units.

SECTION IX HOUSESTAFF

The house staff shall consist of individuals who are graduates of a medical school or are pursuing additional training through accredited or approved medical education programs at this hospital or another allied health facility. Such individuals may include medical students, interns, residents and fellows. Such individuals shall not be considered Medical Staff members nor shall the term house staff be considered a category of Medical Staff membership. Such individuals shall be subject to these Rules and Regulations, Rules and Regulations of the Medical Staff, departmental rules and regulations and any other policies and procedures applicable to the medical education program while providing medical care in the hospital. The house staff will attend meetings of the staff and the department for which he is assigned and participate in Medical Staff committees to which he may be appointed. Because they are not members of the Medical Staff, the house staff shall not be entitled to any procedural rights afforded by these Rules and Regulations including, without limitation, any due process rights. The Medical Staff rules and regulations and/or policies shall define the mechanisms and requirements for the supervision of house staff.

SECTION X ALLIED HEALTH PROFESSIONALS

The Executive Committee may recommend to the Board the granting of Clinical Privileges to allied health professionals, including, but not limited to, psychologists, physicians' assistants, physician employed assistants, clinical registered nurses, including clinical registered nurse anesthetists, and nurse practitioners, based upon investigation and evaluation of the education, training, experience, and demonstrated ability and judgment of individuals requesting privileges as allied health professionals, according to procedures established in the rules and regulations of the staff or other document approved by the Board. A recommendation by or on behalf of the Executive Committee to not grant privileges to an applicant for privileges as an allied health professional, or to suspend, to terminate, or to discontinue such privileges, or such a decision by the Board, shall give rise to only those procedural rights set forth in Texas Health and Safety Code Section 241.105. All allied health professionals will be under the supervision of a Physician who is an active Medical Staff member and who holds clinical privileges in the same department in which the allied health professional is practicing and who will be responsible for the

performance of each of these individuals. All decisions with regard to the granting, suspending, terminating or discontinuing privileges of allied health professionals shall be at the sole direction of the Board and/or the Executive Committee, which decision can be made with or without cause.

SECTION XI PEER REVIEW

11.1 Criteria for Initiation

Whenever a Practitioner with Clinical Privileges shall engage in, make, or exhibit acts, statements, demeanor, or professional conduct, either within or outside the hospital, and the same is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality

patient care, or is reasonably likely to be disruptive to hospital operations, such Practitioner shall be subject to peer review initiated by any Peer listed in Section 7.2.1.

11.2 Peer Review Investigation and Action

All requests for peer review shall be in writing and subject to further review and investigation as described in Sections 7.2.2 and 7.2.3. The time for conducting the peer

review process and reporting the final determination shall comply with the timeliness in Sections 7.2.4 through 7.2.8.

11.3 External Peer Review

A review shall be performed by a qualified Peer who is not a member of the Medical Staff when either (1) conflicts of interest or other circumstances affecting professional impartiality reasonably preclude a member of the Medical Staff, otherwise qualified as a Peer, from conducting the review, or (2) there is no Practitioner member of the Medical Staff qualified as a Peer of the Practitioner whose performance is being reviewed.

SECTION XII STAFF CLINICAL DEPARTMENTS AND SECTIONS

12.1 ORGANIZATION OF DEPARTMENTS

The Medical Staff shall be organized into departments. Each department shall have a medical director who shall be selected and have the qualifications, duties, and responsibilities as set out in Sections 10.2.1 and 10.2.2 of these Rules and Regulations. The departments shall be as follows:

Department of Adult Specialty Care
Department of Pediatrics Specialty Care

12.2 ASSIGNMENT TO DEPARTMENTS

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

12.3 FUNCTIONS OF DEPARTMENTS

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

- (a) Participate in the quality/utilization management program for the purpose of

reviewing and evaluating the quality of care within the department. Each department shall establish a procedure to review all clinical work performed under its jurisdiction whether or not a particular Practitioner whose work is subject to such review is a member of that department;

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

12.4 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

Upon recommendation of the President and the Executive Committee, the Board may create, eliminate, subdivide, or combine departments, or any other clinical organization units at the hospital.

SECTION XIII OFFICERS

13.1 General Officers & Other Officers of the Medical Staff

13.1.1 General Officers of the staff shall be:

- (a) Chief of Staff of Adult Specialty Care
- (b) Chief of Staff of Pediatric Specialty Care

13.1.2 Other Officials of the Staff

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

13.1.3 Qualifications

General Officers must be members of the active staff in good standing at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office

involved. They each shall be qualified by training, experience and demonstrated ability in the clinical services covered by the department. The General Officers may hold other offices in the medical staff including the office of medical director of a department.

13.1.4 Nominations

The Executive Committee will recommend, prior to the expiration of the current term of office, to the Board one or more qualified nominees for Chief of Staff of Adult Specialty Care and Chief of Staff of Pediatric Specialty Care. Nomination of additional candidates for each office may be made by the Board or any member of the Medical Staff.

13.1.5 Appointment

Each of the General Officers shall be appointed by a separate majority vote of the Board for each office.

13.1.6 Term of Appointed Office

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

13.1.7 Removal of Appointed Officers

Except as otherwise provided, removal of an elected officer may be made by the Board acting upon its own initiative or by a majority vote of the active staff members so long as such vote takes place at the general Medical Staff meeting duly convened pursuant to these Rules and Regulations. Removal may be based upon, but not limited to, failure to perform the duties of the position held as described in these Rules and Regulations or mental and/or physical impairment.

13.1.8 Vacancies in Appointed Offices

All vacancies in any General Office shall be filled in the same manner in which such offices are filled as set forth above in Sections 10.1.4 and 10.1.5. Duties of General Officers

The Chiefs of Staff of Adult Specialty Care and Pediatric Specialty Care shall serve as the chief medical officer and chief administrative officer of the Medical Staff for their respective areas of care. As the principal appointed officials of the Medical Staff, the Chiefs of Staff shall, for their respective areas of care:

- (1) Be responsible for the organization and conduct of the Medical Staff;
- (2) Aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the Medical Staff;
- (3) Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the President, and other officials of the staff;
- (4) Be responsible for the enforcement of the Medical Staff Bylaws and rules and regulations, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
- (5) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- (6) Serve, on a rotating basis as set forth in Section 11.4, as chairman of the Executive Committee, and as an ex officio member without vote of all other staff committees;
- (7) Serve as an ex officio member of the Board;
- (8) Be accountable to the Board, in conjunction with the Executive Committee, for the quality and appropriateness of clinical services and performance within the hospital and for the effectiveness of the quality/utilization

- management program;
- (9) Develop and implement, in cooperation with the department medical directors and committee chairmen (if any), methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and quality assessment;
 - (10) Jointly appoint the staff representatives to staff the hospital committees, unless otherwise expressly provided by these Rules and Regulations or hospital Bylaws, policies, or procedures;
 - (11) The Chief of Staff of Adult Specialty Care shall also function as the Medical Director of the Department of Adult Specialty Care and shall appoint the Associate Medical Director of Adult Specialty Care of all other hospital satellites;
 - (12) The Chief of Staff of Pediatric Specialty Care shall also function as the Medical Director of the Department of Pediatric Specialty Care; and
 - (13) Serve as the spokesman for the staff in its external professional and public relations.

13.2 Department Officers

13.2.1 Department Medical Director

- (a) **Qualifications:** Each department medical director shall have been a member in good standing of the active staff, and shall have demonstrated ability in at least one of the clinical areas covered by the department, and shall be willing and able to faithfully discharge the functions of his office. No Practitioner may be a medical director of more than one department, but may hold a position as one of the general officers of the medical staff as well as medical director of a department.
- (b) **Selection and Appointment:** The Chief of Staff of Adult Specialty Care shall also function as the Medical Director of the Department of Adult Specialty Care and shall appoint the Associate Medical Director of Adult Specialty Care of all other hospital satellites. The Chief of Staff of Pediatric Specialty Care shall function as the Medical Director of the Department of Pediatric Specialty Care.
- (c) **Term of Office:** A department medical director shall serve a two-year term coinciding with the term of the newly appointed Chiefs of Staff. He shall serve until the end of the succeeding Medical Staff Year and until his successor is chosen, unless he shall resign or be removed from office.
- (d) **Removal:** Removal of a department medical director from office may be made by the Board, acting upon its own initiative, or upon the recommendation of the Executive Committee, or by a two-thirds majority vote of the department members eligible to vote on departmental matters.

13.2.2 Duties: Each department medical director shall:

- (a) Be accountable to the Executive Committee and to the appropriate Chief of Staff for all professional, administrative, and quality review functions within his department;
- (b) Develop and implement departmental programs, in cooperation with the appropriate Chief of Staff and consistent with the provisions of these Rules and Regulations for credentials review and privileges delineation, continuing medical education, and quality/utilization management;
- (c) Be a member of the Executive Committee, give guidance on the overall medical policies of the hospital, and make specific recommendations and suggestions regarding his own department;
- (d) Maintain continuing review of the professional performance of all Practitioners with Clinical Privileges and of all limited health professionals with specified Clinical

- Privileges in his department and report regularly thereon to the appropriate Chief of Staff and to the Executive Committee;
- (e) Transmit, as requested, to the appropriate authorities his department's recommendations concerning appointment and classification, reappointment, delineation of Clinical Privileges, and corrective action with respect to Practitioners in his department;
 - (f) Appoint such committees as are necessary to conduct the functions of the department specified in Section 9.3;
 - (g) Enforce the hospital and Medical Staff Bylaws, rules and regulations, and policies within his department, including initiating corrective action, investigation of clinical performance, and ordering consultations to be provided or to be sought when necessary;
 - (h) Implement within his department, actions taken by the Executive Committee and by the Board;
 - (i) Participate in every phase of administration of his department through cooperation with the nursing service and the hospital administration in matters affecting patient care including personnel, supplies, special regulations, standing orders, and techniques;
 - (j) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Executive Committee, the President, or the Board;
 - (k) Act as presiding officer at all department meetings or appoint a designee to preside in his absence; and
- (l) Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the appropriate Chief of Staff, the Executive Committee, the President, or the Board.

13.3 Additional Officers

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

SECTION XIII COMMITTEE AND FUNCTIONS

14.1 Designation, Structure and Function

14.1.1 The Medical Staff may utilize the resources of the organized medical staff of other hospitals as appropriate in the efficient and orderly operation of the Medical Staff, and may, in lieu of forming the following committees, participate in and access the following medical staff committees of other hospitals in furtherance of the continuous quality improvement of the Baylor Specialty Health Centers: Professional Health, Physician Relations, Institutional Ethics, Medical Education, Infections, Institutional Review Board for Human Protection, Medical Records, Pharmacy & Therapeutics, Transfusions.

14.1.2 Composition and Appointment

Committees will be standing and special as may be from time to time necessary and desirable to perform the functions of the staff required by these Rules and Regulations or

necessarily incidental thereto. All committee chairmen and members, other than the Executive Committee, will be appointed by the Chairman of the Executive Committee. All hospital personnel, other than staff members, to serve on committees will be appointed by the President. The Chairman of the Executive Committee will appoint staff members to hospital-wide committees if requested by the President. Appointment of any Medical Staff members to any hospital committees will be made according to Bylaws, rules and regulations, and established policies and procedures of the hospital and of the staff.

14.1.3 Duties

All committees will:

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

Any standing committees will be organized to assume delegated authority for the oversight of Medical Staff functions.

14.1.4 Term of Appointment

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

14.1.5 Vacancies

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

14.1.6 Meetings

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

14.2 Executive Committee

14.2.1 Composition

The Executive Committee shall be a standing committee and shall consist, at a minimum, of the general officers of the Medical Staff (Chief of Staff of Adult Specialty Care and Chief of Staff of Pediatric Specialty Care), the associate medical director of each hospital satellite not otherwise represented on the Executive Committee by a Chief of Staff, and two members at large (one appointed by the Chief of Staff of Adult Specialty Care and the other appointed by the Chief of Staff of Pediatric Specialty Care) to serve two (2) year terms. Other members of the Medical Staff may be appointed to the Executive Committee as deemed necessary by the Executive Committee. Upon adoption of these Rules and Regulations by the Board, the Chief of Staff of Adult Specialty Care shall serve as the Chairman of the Executive Committee. Thereafter, the Chief of Staff of Adult Specialty Care OF Baylor Specialty Health Centers shall continue as Chairman of the Medical Executive Committee until voluntary resignation or the appointment of a new Chairman by the members of the Medical Executive Committee. The hospital's president shall be invited to attend all meetings of the Executive Committee.

14.2.2 Duties

The duties of the Executive Committee shall be to:

- (1) Receive and act upon reports and recommendations from the departments, committees,

- and officers of the staff concerning quality/utilization management and other quality maintenance activities;
- (2) Coordinate the activities of and policies adopted by the staff, departments, and committees;
 - (3) Recommend to the Board all matters relating to appointments, reappointments, staff category, department assignments Clinical Privileges and corrective action;
 - (4) Account to the Board and to the staff for the overall quality and appropriateness of patient care in the hospital;
 - (5) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating and pursuing corrective action, when warranted in accordance with these Rules and Regulations;
 - (6) Make recommendations on medico-administrative and hospital management matters to the Board through the chief of staff;
 - (7) Inform the Medical Staff of the accreditation program and the accreditation status of the hospital;
 - (8) Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
 - (9) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Rules and Regulations;
 - (10) Conduct an ongoing review of the Bylaws and the rules, regulations, and procedures promulgated in connection therewith to monitor the appropriateness of those documents;
 - (11) Submit recommended bylaw changes to the Medical Staff pursuant to Article XV;
 - (12) Act upon all matters pertaining to the Bylaws, rules and regulations, and other pertinent Medical Staff and hospital policies and procedures as may be referred to them;
 - (13) Resolve conflict of interest matters that arise with or pertain to Medical Staff members;
 - (14) Assist hospital with improvement efforts on processes that affect a large percentage of patients and/or place patients at serious risk if not performed appropriately and/or have been or are likely to be problem prone;
 - (15) Assist hospital with measuring key activities, including, but not limited to, medication management, the use of blood and blood components and the appropriateness of admissions and length of stay;
 - (16) Assist hospital in carrying out an assessment process when performance varies significantly from the norm;
 - (17) Assist hospital in reviewing and evaluating medical records to determine that they: (a) properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; and (b) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital;
 - (18) Assist hospital in reviewing all forms, which are utilized in the medical record;
 - (19) Perform other related duties as directed by the Board;
 - (20) Review and evaluate the qualifications of and make recommendations concerning each applicant for initial appointment, reappointment, or modification of appointment and for Clinical Privileges, and, in connection therewith to obtain and consider the recommendations of the appropriate departments within 60 days of receipt of the report;
 - (21) Design and manage a process that provides education about professional health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of professionals who suffer from a potentially impairing condition, and receive reports related to the health, well-being, or impairment of Medical Staff members and investigate such reports;
 - (22) Establish a subcommittee or appoint an individual to assist with interventions and to monitor the recovery of impaired physicians;
 - (23) Provide consultation on ethical issues as requested by the Medical Staff, limited health professional staff, hospital staff, patients, and their families;
 - (24) Evaluate and make recommendations regarding Medical Staff policies which relate to ethical issues; and

(25) Develop and establish criteria that determine which clinical procedures or treatments of medical, surgical, or psychiatric conditions require consultation with, or management by, a physician, and mechanisms to ensure a patient's condition is managed accordingly.

14.2.3 Meetings

The Executive Committee shall meet at least annually and as necessary to perform its function and duties, and will maintain a permanent record of its proceedings and actions.

14.3 Authority to Delegate

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

14.4 Credentials Committee

14.4.1 COMPOSITION

The Credentials Committee shall be composed of at least four members to include members from the Active Medical Staff and one representative. Members shall serve three-year terms and may serve multiple terms. 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 Executive Committee of the Medical Board. Representatives from the Administration shall also attend as non-voting members.

14.4.2 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 departments,
- (b) Submit required reports and information to the Board of Trustees on the qualifications of each practitioner applying for reappointment or particular clinical privileges including recommendations with respect to reappointment, membership category, department affiliation, clinical privileges, and special conditions,
- (c) Investigate, review, and make recommendations on matters referred by the Medical Board or the Executive Committee of the Medical Board regarding the qualifications, conduct, professional character, or competence of any applicant or medical staff member,
- (d) Submit monthly reports to the Medical Board concerning the Committee's recommendations to the Board of Trustees regarding membership reappointments, clinical privilege delineations and status of pending applications and other activities of the Committee.

14.4.3 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 Board of Trustees and the Medical Staff.

SECTION XV MEETINGS

15.1 General Staff Meetings

15.1.1 Regular Meeting

The medical staff shall have an annual meeting. The day and time of the annual meeting will be set and may be changed by the Executive Committee, provided that the Medical Staff is given thirty (30) days notice of the day, time and place or any change thereto.

The order of business at the regular meeting will be determined by the Chairman of the Executive Committee and will include at least:

- (1) Presentation and acceptance of minutes of last regular meeting and all special meetings held since the last regular meeting;
- (2) Administrative reports from the President, the Chiefs of Staff/the Department Medical Directors and any committees which have such reports for the general staff;
- (3) Recommendations for improving patient care within the hospital; and
- (4) New Business

15.1.2 Special Meetings

Special meetings of the Medical Staff may be called at any time by a Medical Director and shall be called at the request of the Board of Trustees, the Executive Committee, the President or within thirty (30) days after receipt of a written request of a least twenty percent (20%) of the active members of the Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be given to Medical Staff members at least seven (7) days before the time set for the meeting.

15.2 Quorum and Attendance Requirement

15.2.1 General Staff Meetings

Fifty (50) percent of the active Medical Staff at any regular or special meeting (in person or represented by proxy) shall constitute a quorum for the purposes of amendment of these Rules and Regulations. The presence (in person or represented by proxy) of those members of the active Medical Staff shall constitute a quorum for the transaction of all other business.

15.2.2 Attendance Requirement

Practitioners on the Medical Staff are not required to attend any meeting of the General Medical Staff, special called or regular.

15.3 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a committee, department or section by a writing setting forth the action so taken signed by each member entitled to vote thereon.

15.4 Minutes

Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Executive Committee, and, to the extent not privileged or confidential, made available to the staff. A permanent file of the minutes of each meeting will be maintained by the Medical Staff office.

SECTION XVI

16.1 OCH General Provisions

Surgeons/Physicians performing procedures must be in the immediate operating room vicinity and ready to begin operating and/or the procedure at the time of induction or administration of sedation. No patient shall receive general anesthesia unless the surgeon/physician performing the procedure is physically present in the Operating Room. In any elective procedure of unusual complexity or which is associated with unusual hazard of life, there must be a physician present and scrubbed.

The Scheduled time as it appears on the Operating Room 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
4. Moderate sedation – time of initial administration of sedation medication.

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.

16.2 Scheduling of Operating Room

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

The Operating Room shall be staffed for elective surgery and procedures Monday through Friday from 0700 till 1700. Saturday elective surgery/procedure is based on the availability of staffing.

The first procedure/surgery in each room will be posted at 0700. A surgeon/physician performing a procedure desiring an earlier time, should contact the nursing supervisor of the surgical department and the Anesthesiologist. Every effort will be made to schedule as close to the time requested by the surgeon/physician performing a procedure; however, rooms will not be held for late starts.

A surgeon/physician performing a procedure or anesthesiologist who is late for a 0700 surgery/procedure on three occasions in any one calendar quarter will not be permitted to schedule procedures at 0700 for four weeks following the third offense during that particular calendar quarter. Late is defined as a period of time greater than fifteen minutes for either the surgeon or anesthesiologist. The Director of Surgical Services will be responsible for maintaining record of surgeon/physician performing a procedure or anesthesiologist late arrivals. If the third offense occurs within the calendar quarter, the four weeks prohibition from early posting will begin on the third Monday following the third offense, thereby permitting the individual concerned to perform surgery/procedures already on the schedule.

Surgery/procedures scheduled for a time later the 0715 by surgeons/physicians performing a procedure or anesthesiologists during the time they are in the penalty period may be moved to 0715. Such a move may occur in the interest of improving operating room efficiency.

Surgery/procedures may be scheduled as far in advance as necessary. If a block time is allocated to a surgeon/physician, the surgeon/physician will lose a block slot or block day if a reservation is not made 36 hours prior to the date.

The posting of cases shall be made or canceled by the surgeon/physician performing the procedure or

the doctor's office personnel.

In addition, physicians must adhere to the Rules and Regulations of the Medical Records, Section IV on Physical Examination requirements and **Section 16.4-1 Administrative Suspension**

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

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

16.3 Visitors to the Operating Room

Visitors will be permitted in the Operating Room under on of the following categories:

Observation: may be in the Operating Room 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.

Student/Orientees: personnel for whom Operating Room procedure is a part of a BUMC/OCH approved educational program.

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

Observation: written requests by OCH physicians or employees are to be sent to the Director of Surgical Services. State the purpose, visitor's name, affiliation and duration of visit; i.e. one procedure (indicate patient's name), one week, etc. There will be no "standing approval".

Tours: Approval given by the Medical or Nursing Director of Surgical Services. Written request should be made and submitted, when possible.

Clinical Participation: written requests are sent to the Medical Director of Surgical Services from the physician making the request. If the Medical Director Approves, the request should be made 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/Orientees: approval granted by the Medical or Nursing Surgical Director during the orientation process.

The following individuals may be approved:

Physicians, Dentists and Podiatrists,

The following have had clearance from the Medical Director of Surgery and/or the Nursing Surgical Director.

- 1) Interns and residents from this and other hospitals
- 2) Nurses
- 3) Operating Room technicians
- 4) Medical, dental, nursing and pastoral students
- 5) Technicians from BUMC's department of Radiology
- 6) Photographers and medical illustrators employed by BUMC/OCH and Baylor College of Dentistry.
- 7) Invited professional cinematographic teams

- 8) Laboratory technicians
- 9) BUMC research assistants and Baylor College of Dentistry research assistants.
- 10) Technical representatives (allowed in the Operating Room only during that portion of the procedure that their product is being used. They must leave upon completion of that portion of the procedure).
- 11) Interpreters

The following individuals will not be approved without specific consent from the Medical or Nursing Director of Surgical Services.

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

The admission of administratively approved visitors to the OR is subject to the further approval of the operating surgeons and anesthesiologist.

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

16.4 ADMINISTRATIVE SUSPENSION OR REVOCATION

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

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

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

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

B. *Failure to Respond to Requests for Information*

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

C. *Failure to Complete Medical Records*

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

C.1. *Extended Leave or Vacation*

It is the practitioner's responsibility to notify the Health Information Management Department at the respective facility if a leave or vacation is planned that exceeds three (3) weeks. In the event the leave extends unexpectedly past three (3) weeks, the Health Information Management Department will initiate the process to file the charts as permanently incomplete.

D. *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.

16.1-2 *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.

16.3-3 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.

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