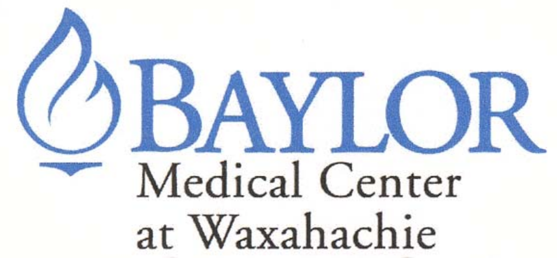

MEDICAL STAFF
RULES & REGULATIONS
2008

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BAYLOR MEDICAL CENTER at WAXAHACHIE
MEDICAL STAFF – RULES AND REGULATIONS

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DEFINITIONS

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

The *Administration* refers to the President, The President's designee, Chief Executive (CEO) or the CEO's designee, who is responsible for managing the day to day operations of the Hospital.

Adverse Action means a professional peer review activity resulting in the denial of Medical Staff membership, restriction, reduction, suspension or revocation of Medical Staff membership or the member's ability to exercise clinical privileges at the Hospital.

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

Board of Trustees means the governing body of Baylor Healthcare Systems.

Bylaws means the Medical Staff Bylaws of Baylor Medical Center at Waxahachie

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

Chief of the Department, Department Chief, Chair of the Department or Department Chair Means the head of a clinical department.

Clinical privileges means the permission granted to a Physician, Dentist or Podiatrist, as recommended by the Medical Staff and approved by the Board of Trustees, to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the hospital.

Day means calendar day.

Dentist means any Medical Staff member who is licensed to practice dentistry in the State of Texas by the state licensing authority.

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

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

He or His as used in these Rules and Regulations refers to both genders. The use of a masculine pronoun is not intended to express an opinion about the gender of the Practitioners governed by these Rules and Regulations.

Hospital means Baylor Medical Center at Waxahachie located in Waxahachie, Texas.

Medical Staff member means, unless otherwise stated, a fully licensed Practitioner who is appointed by the Board of Trustees as a member of the Medical Staff of Hospital.

Physician means any Medical Staff member licensed to practice medicine in the State of Texas by the state licensing authority.

Podiatrist means any Medical Staff member who is licensed to practice podiatry in the State of Texas by the state licensing authority.

Practitioner means any individual who is a graduate of an approved medical, dental or podiatry school and holds a current, valid license to practice medicine, dentistry, or podiatry in the State of Texas.

President means the individual designated by the Board of Trustees to manage the performance of Baylor Medical Center at Waxahachie.

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 Practitioner that affects or may affect the Practitioner's Medical Staff membership or clinical privileges.

Professional review actions means activities undertaken in determining whether a Practitioner 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.

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

Rules and Regulations mean the Medical Staff Rules and Regulations of Baylor Medical Center at Waxahachie

Year means twelve (12) consecutive months

The phrase "work cooperatively with others" as used in Sections 11.3-1(c)(2) and the phrase "working cooperatively with Medical Staff Members, nurses, Medical Center Administration and others" in Section 11.7(3) include, but are not limited to, the following restrictions on behavior:

(1) Medical Staff members must not berate other people who work at the Medical Center.
(2) Gentle and constructive suggestion in a private setting is sometimes appropriate, but scolding, sarcasm, put-downs, profanity, or loud, angry or abusive language, and other similar behavior are not permitted.
(3) Criticism of a person because of difficulty in communication caused by such person's native language is not permitted; such problems should be discussed only with Medical Center Administration or Chiefs of Service.
(4) Remarks of a sexual nature or reference to a person's ethnic background are not permitted.

SECTION 1- Introduction

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

SECTION 2 - Admission and Discharge of Patients

2.1. The hospital shall admit patients suffering from all types of illness requiring general, acute care.

2.2. A patient may be admitted to the hospital only by a member of the Medical Staff and all admissions shall be governed by the official admitting policies of the hospital.

2.3. A physician member with appropriate privileges of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for accurately and promptly completing the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring individual and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, a statement covering the transfer of responsibility shall be entered on the order sheet of the medical record. The admitting physician shall be considered the primary attending physician, unless this responsibility is transferred, as indicated above. A physician must see all patients within 24 hours of admission to the hospital. Each patient admitted to the Intensive Care Unit must be seen by a physician within four hours.

2.4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible. When patient presents for admission, orders shall be written immediately or should already have been received or phoned in to Nursing Staff.

2.5. Staff members admitting emergency cases shall be prepared to justify to the Executive Committee and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

2.6. A patient, who needs admission on an emergency basis that does not have a private physician, dentist, or podiatrist, may select any staff member in the applicable department to attend him/her, with consent of the physician, dentist or podiatrist. When no such selection is made, the patient will be assigned to the physician on-call in the Emergency Department.

2.7. Each staff member shall name a member of the Staff who is to be called to attend his/her patients in an emergency if he/she cannot be reached. If neither the attending physician nor his/her designated associate can be reached and if the chief of the appropriate department cannot be reached, the Chief of Staff or his designee shall have the authority to call any member if the Staff to provide interim treatment, should this be considered necessary.

2.8. Patients will be admitted on the basis of the following order of criteria:

a. Emergency Admissions: those patients who are designated by the attending physician as needing immediate Hospital care and whose condition would suffer if such admission were delayed;

b. Reservation Admissions: those patients already scheduled for surgery , as well as other patients who have previously made reservations in advance for admission on a particular day;

c. Routine Admissions: those patients who are elective admissions in all departments

2.9. The admitting Staff member shall be responsible for providing such information as may be required to assure the protection of patient from self harm and to assure the protection of others whenever the patient(s) might be a source of danger to personnel or property. In the event of the admission of a patient with known or suspected suicidal intent, the admitting Staff member shall advise the patient to seek psychiatric consultation, shall offer assistance in the arrangement of such consultation and shall document this in the patient's medical record

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

2.11 Patients shall be discharged only on the order of the attending practitioner. Should a patient leave this 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 the result of the patient's action. Any refusal to sign this statement shall be documented in the medical record.

2.12. In the event of a death in the Hospital, the deceased shall be pronounced dead by the attending Staff member or his/her designee within a reasonable 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. Policies with respect to the removal of deceased patients shall conform to local law.

SECTION 3 - Medical Records

3.1 Required Content

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

The record shall include:

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

3.2 Assessment, History and Physical

An assessment, appropriate to the level of care the patient is receiving, must be documented on every patient. A complete history and physical examination report will be written or dictated in all cases by the admitting practitioner or that practitioner's physician assistant no later than twenty-four (24) hours following the admission of each patient. A short stay record may be used in lieu of a complete history and physical for those patients who are discharged within 48 hours after admission. A consultation containing a history and physical will also suffice as a formal history and physical. The history and physical examination must include:

a. The chief complaint;
b. Details of present illness;
c. All relevant past medical, social and family history: the patients emotional, behavior, and social; status when appropriate
d. Review of body systems;
e. Comprehensive physical examination;
f. A statement of the conclusions or impressions drawn from the history and physical;
g. Current medications and allergies
h. The goals of treatment and the treatment plan

All history and physicals performed by an Allied Health Professional must be confirmed by a physician member signing the patient chart.

All podiatric patients must be co-admitted by a Medical Staff Member who will be responsible for completing the admission history and physical examination of the patient. A Podiatrist will be responsible only for that part of the history and physical examination related to podiatry.

3.2.1 A previous H&P may be used if it was documented within 30 days of admission. However, within 24 hours of an admission (or prior to procedures – whichever time frame is shorter) the H&P must be completed or updated. Updates related to changes in patient condition need to be annotated on the H&P or in the progress notes. If there are no changes, there must be documentation of such and the statement must be dated, signed, and timed.
H&Ps must be dated, timed, and authenticated.

In the situation where the patient will undergo a procedure using sedation or anesthesia within the first 24 hours of admission, the update to the patient's condition can be the pre-anesthesia assessment.

3.2.2 When the history and physical examination are not recorded on the patient's medical record before an operation or another potentially hazardous procedure, the procedure will be canceled, unless the practitioner states in writing in the medical record that delay entailed by writing or dictating of a complete history and physical examination statement would be harmful to the patient. The provisional diagnosis and a general statement indicating the imperative risk may be substituted; however, a complete history and record of a physical examination will be completed by the practitioner immediately after the surgical procedure and prior to the patient going to the next level of care. Either the chairman of the surgery department or the chief of staff can carry out cancellation of surgery. All such incidents shall be reported to the surgery department.

3.2.3. Invasive outpatient procedures requiring moderate sedation or anesthesia shall have a clinically pertinent history and physical exam. The content of a complete history and physical examination report and exceptions to the requirement of a complete history and physical examination report for certain procedures or categories of patient will be periodically recommended by the Health Care Improvement Committee and approved by the Executive Committee.

3.3 Progress Notes

Progress notes must be recorded timely, to give pertinent chronological report of the patient's course in order to provide continuity of care and transferability of the patient. The progress note must be dated and signed. Progress notes will be recorded with sufficient frequency to give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment and ensure comprehensiveness of the record in the even of transfer of responsibility of care. Progress notes will be made once a day for those patients in the intensive care unit.

3.4 Operative Report

An operative or other higher risk procedure note is entered in the medical record immediately after the procedure and must include:

1. a detailed account of the findings at surgery
2. the name of the procedure(s) performed
3. specimens removed (if applicable)

4. post-operative diagnosis
5. name of the primary surgeon and any assistants.
6. estimated blood loss
7. complications

Operative reports shall be written or dictated immediately following surgery for all outpatients as will as inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record. A brief post-operative note must be written in the patient's progress notes immediately following surgery.

3.5 Consultation Request and Report (New)

The attending practitioner is primarily responsible for the initiation of a consult and is responsible for contacting the physician directly to relay relevant patient information when indicated. A request for a consultation from an appropriate source and the need for the consultation (i.e. the reason for a consultation service) shall be documented in the patient's medical record on the order sheet; failure to do so, constitutes and invalid order. The consultant shall see the patient within a reasonable time period as agreed upon between the attending and consulting physicians. A brief report of findings and recommendations shall be entered in the medical record at the time of consultation. In the event that the consultant contacted is unable or unwilling to accept the requested consultation alternative arrangements shall be made between the two physicians. When operative procedures are involved, the consultant note, except in an emergency, shall be recorded prior to the operation.

Guidelines for call consultations are as follows:

1. When the rules of any clinical unit, including any intensive or special care units , of the Staff require it;

2. When required by state law;

3. When requested by the patient or family;

4. Problems of critical illness when doubt exists as to the appropriate diagnostic or therapeutic measures to be utilized;

When additional expertise is needed for appropriate patient care.

3.6 Obstetrical Record (new)

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changed in the physical findings. If no prenatal care was provided, the record should so indicate.

3.7 Conclusion of Hospitalization

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

3.8 Discharge Summary

A discharge summary shall be written or dictated for every patient who has been admitted to the hospital by the practitioner who is primarily responsible for the patient at the time of discharge. The discharge summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family specific attention should be given to diet, medication (patient must receive current copy of Medicine reconciliation form), activity, and follow-up.

3.9 Completion of Records

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

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

3.9.1 All entries in the medical record (including progress notes) must be legible, dated, timed, and authenticated in written or electronic form. All entries by AHP must be co-signed, dated, and timed by the covering practitioner on the next visit. Opinions requiring medical judgment should be written, or authenticated, only by individuals who have been granted appropriate clinical privileges and by authorized Housestaff members. Authentication may be by written signatures, initials or computer key. The person utilizing a computer key (electronic signature) must sign a statement that he alone will use the code for the computer key.

3.10 Removal of Records

All medical records are property of the Hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a subpoena, court order or statute, with the exception of x-ray film, which may be transferred from doctor to doctor or Hospital to doctor and then returned to the Hospital. In the event of re-admissions of a patient, all previous records shall be available for the use of the attending physician.

3.11 Confidential

Members of the Medical Staff recognize that all patient medical record information is strictly confidential and agree not to access, use, disclose or reproduce any information contained in patients' medical records outside the course and scope of Medical Staff functions. Medical Staff members shall not photocopy any portion of a patient's medical record without specific approval from the Director of Health Information Services.

SECTION 4 General Conduct of Care

4.1 AUTOPSIES

The conduct of a Medical Staff member will be in accordance with the hospital's policies and guidelines of autopsies

4.2 Orders

4.2.1. All orders must be legible, in writing, dated, timed, and authenticated promptly by the ordering physician. Physician Assistants and Advance Practice Nurses may order outpatient diagnostic and therapeutic procedures on behalf of their supervising physician; such orders do not require the supervising physician to co-sign. Verbal orders may be taken by the nursing staff and read back to the ordering physician**.** Verbal Orders must be signed, dated, and timed within 48 hours of order**.** (Original order requires a date, time, and signature of the person writing the verbal order. The practitioner signature should have the date and time that the order was co-signed not the date and time the order was given).

Orders which are not legible or properly written are not to be carried out until corrected or clarified by the nursing staff. Orders for radiology examinations should include a concise reason for the study.

In order to prescribe narcotics for his/her patient in the hospital, a physician must have current, unrestricted Drug Enforcement Administration (DEA) and State Narcotics (DPS) license.

4.2.2 There will be orders that must be approved but can be used by nursing staff without being written. These orders must be approved by submission to the respective departments prior to use in patient care. All Orders must originate from and subsequently be signed by a physician.

1. Pre-printed Order Sets – individual order sets for an individual medical staff member or licensed independent practitioner or a physician practice;

2. Protocol Order Sets – orders for treatment or therapy approved by the appropriate medical staff department(s);

3. Standing Orders – orders for specific patients initiated by specific medical staff members or licensed independent practitioners that may be a part of pre-printed orders, protocol order sets, or care paths;

4. Care Path Order Sets – orders for specific diagnosis outlining care and treatment to correspond with the clinical pathway approved by the appropriate medical staff department(s). All orders must originate from and subsequently be signed by a physician.

4.2.3. Medication orders must include the name of the drug, dose or strength, route of delivery, and frequency or rate. PRN medications should include the indication for usage. Dose information should include a zero preceding a decimal point, and no trailing zeroes should be used.

4.2.4 All orders must be rewritten when the patient is transferred to a different unit because of a change in status or when the patient returns from the OR, Endoscopy lab, or Labor and Delivery Unit, exception may be made where Carepath applies or procedure is not anticipated to impact patients ongoing care.

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

Before the Institutional Review Board for Human Protection approves a project that requires the use of experimental or investigational drugs, the Medical Staff member performing the research will submit to the Pharmacy and Therapeutic Committee printed material released by the manufacturer of the medication, any additional information concerning side effects, dosage, antidotes, along with the name of the drug and explanation as to how it is to be dispensed.

4.2.6 Automatic Stop/Renewal Orders

All automatic Stop and Renewal Orders will be governed by the current hospital policy.

Neuromuscular blocking agents must be reordered every 7 days. All other orders must be reordered every thirty (30) days and/or when a patient changes status.

Hospital pharmacists approved to provide select medications management services may do so at the order of the attending physician and shall be subject to physician direction

4.3 Restraints

The conduct of a Medical Staff member will be in accordance with the Hospital's policies and procedures for use of restraints.

4.4 Continuous Care

All members of the Medical Staff are required to provide for continuous care for all patients in the hospital and daily patient visits with progress notes written daily, and if they are not immediately available, they must designate a physician to provide care for patients on a daily basis, and are required to have an appointed member of the Medical Staff who will be immediately available in case of emergency.

For the handing-off of patients from one physician to another will require physician to physician communication regarding the patient s current condition, treatment, any recent or anticipated changes. This communication shall be noted in the patient's medical record.

4.5 Emergency Services

4.5.1 Definition of Call

All members of the active-clinical Medical Staff are required to provide emergency coverage to the Hospital, unless granted and exemption as provided by the Medical Staff Rules and Regulations. Emergency coverage will be provided through those specialty categories, which have been approved by the Medical Staff. Emergency service call will be optional for active members of the Medical Staff who are age 55 and have been active staff for 20 continuous years, or who are 60 years of age or older. Emergency service call is not required for members granted an exemption based on age, length of service or other appropriate basis by the appropriate department and approved by the Executive Committee and Board of Trustees.

4.5.2 Schedule of Call

If there are three or more physicians in a Specialty, coverage shall be provided on a continuous basis rotating among that specialty. If there is only one practitioner of a specialty, continuous coverage shall not be required, however they shall provide coverage seven days per month. If there are two physicians in a specialty they shall provide coverage at least ten days per month. The time absent from coverage will be reviewed by the Executive Committee, and if the coverage is considered inadequate, the question will be brought before the Medical Staff under due process. All practitioners on specialty call shall keep an accurate schedule of their call posted in the Hospital

Emergency Department.

4.5.3 On-Call Physician Coverage

Physicians on call shall be accessible at all times via standard accepted means of communication and shall be able to respond when Emergency Services requests within 30 minutes. This also applies to inpatients, should emergency situations occur concerning the care of those patients

It is the responsibility of the medical Staff member to find a suitable replacement if he/she cannot be available for duty and for notifying Medical Staff Services. The physician shall take his/her assigned call if a replacement physician cannot be found.

4.6 Calling of Time Outs

A time out must be conducted in the location where the procedure will be preformed and just before the starting of the procedure. This includes any procedures done at the bedside. Time out's must be documented and should contain the following information:

a. Correct patient Identity
b. Correct side and site
c. Agreement on the procedure
d. Correct patient position
e. Availability of correct implants and any special equipment for special requirements
f. Site marking must be done for any procedure that involves laterality, multiple structures or levels
g. Relevant documentation (e.g. consent, H&P)

4.7 Review of Unusual Cases

The Healthcare Improvement Committee may review actual or potential Sentinel Events, unimproved cases, and undiagnosed cases.

4.8 Visitors in Delivery Room

Visitors are permitted in the LDR (labor, delivery, recovery room) and/or delivery room at the discretion of the attending physician.

4.9 Emergency Preparedness

Physicians shall be assigned duties for the care of mass casualties in accordance with the hospital disaster emergency plan.

SECTION 5 - PATHOLOGY

It is the responsibility of the Staff Member in charge of the patient to assure that all tissues or specimens removed at the operation are sent to the Hospital Pathologists for examination and report, which shall be made a part of the medical record. The Pathologist shall make such examination, as he may consider necessary in order to arrive at a diagnosis and prepare his report. The following items are exempt from the requirements as long as the Staff Member verifies that the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used and when there is an authenticated operative or other official report that documents the removal. The Staff Member may also request a gross description only on these items. The list exemptions includes, but is not limited to the following:

a. Teeth;
b. Toenails;
c. Stones;
d. Lens from cataract;
e. Foreign bodies, (piece of glass bullet);
f. Orthopedic hardware such as metal fragment, nail, screw;
g. Portion of rib removed only to enhance operative procedure;
h. Select bone fragments (bunionectomy, trauma, nasal septatl reconstruction);
i. Tissues adherent to foreign materials (wooden splinter with attached fat);
j. Semilunar cartilage removed on account of laceration;
k. Newborn foreskins and placentae

SECTION 6 - Self-Treatment or Treatment of First Degree Family Members

Physicians generally should not treat themselves or members of their first-degree families. Professional objectivity may be compromised when the first-degree family member of a physician is the patient; the physician's personal feelings may unduly influence his or her professional judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medial history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is a first-degree family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or first-degree family members, physicians may be inclined to treat the problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the

family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their first-degree family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care form their patients. Likewise, physicians may feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of first-degree family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as primary or regular care providers for first-degree family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or first-degree family members. They shall not participate in the care of first-degree relative as an admitting physician or consultant.

SECTION 7 - MEMBERSHIP

7.1 COMPOSITION OF THE MEDICAL STAFF

The Medical Staff of Baylor Medical Center at Waxahachie shall be composed of fully licensed, independent practitioners, specifically Physicians, Dentists and Oral Surgeons, and Podiatrists, who are selected on the basis of their professional and personal qualifications and for their ability to further the fulfillment of the Medical Center's objectives in patient care. The Medical Center shall endeavor to maintain a balance among the various specialties required for an outstanding medical and referral center. It shall also endeavor to provide for systematic admission of outstanding members in a manner that will assure a continued development of the Medical Staff in future years.

Pursuant to the policy of the Board of Trustees, the size of the Medical Staff - the number of practitioners in the Active-Clinical, Active Community, Courtesy categories - shall be related to the capacity of the Medical Center's facilities to serve its patients effectively and meet the needs of the community it serves.

7.2 NATURE OF MEMBERSHIP

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

Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

7.3 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

(a) Basic responsibilities that apply to all members include:

1. providing patients with the quality of care meeting the professional standards of the Medical Staff of this Medical Center;
2. abiding by these Bylaws and the Rules and Regulations and policies of the Medical Staff;
3. working cooperatively with Medical Staff members, nurses, Medical Center administration and others;
4. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership;
5. abiding by applicable Medical Center bylaws, rules and policies;
6. providing medical care to patients in emergency situations wherever and whenever needed regardless of the member's category of appointment or the patient's ability to pay;
7. requesting consultation from other specialties as the needs of the patient require, and providing consultation to other Medical Staff members when requested;
8. self-reporting any physician health matter, including impairment or substance abuse matters;
9. self-reporting any investigation, recommendation, limitation, suspension or termination regarding (1) privileges at any other health care facility or (2) license to practice by any state or federal agency as required by these Rules and regulations;
10. actively participating in the Medical Center's quality assurance and utilization review activities;
11. performing other staff obligations as may be established from time to time by the Medical Staff; and
12. promoting and participating in a work environment that is conducive to the well being of patients and Medical Center personnel including an environment that is free of unlawful harassment. Unlawful harassment includes that which is based on race, color, religion, national origin, sex, disability, age, citizenship or harassment which may be considered sexual in nature.

(b) By virtue of appointed category, Medical Staff members may also be expected to discharge in a reasonable manner the following responsibilities:

1. serving on Medical Staff Committees;

2. providing Emergency Department call coverage;

3. regularly attending Medical Staff meetings and departmental meetings as specified in these Rules and regulations;

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

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

6. participating in continuing education programs.

(c) Reporting of incidents and sentinel events:

Each member of the Medical Staff has the duty to report timely any incident or sentinel event to the Director of Healthcare Improvement. The Director of Healthcare Improvement shall report the incident to the Healthcare Improvement Committee, and as required by Medical Center policy. A report is timely if made as soon as is practical after the occurrence, taking into account the patient's immediate need for care, and the need for intervention to prevent further adverse events.

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

1. medication errors; and

2. perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams.

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

1. the event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition; or

2. the event is one of the following:

   i. patient suicide
   ii. infant abduction
   iii. rape or sexual assault

iv. hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
v. surgery or other procedure on wrong patient or wrong body part
vi. retained foreign objects remaining from surgery or other procedure
vii. brain or spinal damage

(d) Disclosure of unanticipated outcomes:
Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event.

7.4 DUES

Dues may be assessed, the use of which, will be determined by the Executive Committee of the Medical Staff. Dues may be assessed regardless of Category.

SECTION 8 - ALLIED HEALTH PROFESSIONALS

8.1 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are not Medical Staff Members, nor shall Allied Health Professionals be considered a category of Medical Staff membership. Allied Health Professionals shall not have any of the prerogatives or responsibilities of Medical Staff membership.

The approved categories of Allied Health Professionals as well as the prerogatives, responsibilities and procedure for requesting to perform patient care services are outlined in the Medical Center's Allied Health Professional Manual.

Allied Health Professionals and the employment of such individuals by Medical Staff members are subject to these Bylaws and Rules and Regulations of the Medical Staff, as well as any Medical Center policies and procedures, Medical Center approved position descriptions and any local, state or national requirements applicable to a particular category of Allied Health Professionals.

SECTION 9 - OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and Immediate Past-Chief of Staff.

9.1.2 QUALIFICATIONS

(a) The Chief of Staff, Vice-Chief of Staff and the Immediate Past-Chief of Staff shall be members of the Active Clinical Category for at least two years. The Chief of Staff shall have been a member of the Executive Committee for at least one year at some time during the past 5 years.

(b) Officers of the Medical Staff must be Board Certified in their specialty, not be presently serving as a Medical Staff or corporate officer, Chief of Service or credentials chairman at another Medical Center and shall not so serve during the term of office.

(c) Officers must remain members in good standing during their term of office. They must have no pending adverse recommendations concerning staff appointment or clinical privileges. Failure to maintain such status shall create a vacancy in the office involved.

(d) Officers must have constructively participated in Medical Staff affairs, including quality review and peer review activities, possess and have demonstrated an ability for harmonious interpersonal relationships, and be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected.

9.1.3 NOMINATIONS

(a) Nominating Committee

The Nominating Committee shall consist of Chief of Staff, Vice Chief of Staff and Immediate Past Chief of Staff.

(b) Nomination and Election of Vice Chief of Staff and (1) Member at Large and 2 Department Chiefs

(1) The Nominating Committee shall prepare a slate of nominees for Vice Chief of Staff and the Members at Large seats on the Executive Committee to be filled at that election, each of whom must possess all the qualifications set forth above.

(2) The committee will recommend at the September general medical staff meeting one or more qualified nominees for Vice Chief of Staff, and one (1) Member-At-Large of the Medical Staff Executive Committee. A statement from the chairman of the nominating committee will be included with the recommendations stating that each nominee has agreed to stand for election to office.

9.1.4 ELECTIONS

(a) Election of each of the Vice Chief of Staff and the one Members At Large shall be made by a separate majority vote for each. A nominee shall be elected upon receiving a majority vote on the first ballot In the event of a tie vote; the results will be forwarded to the Board of Trustees

for resolution.

9.1.5 TERM OF ELECTED OFFICE

Each officer of the Medical Staff shall serve a two-year term. The current Vice Chief of Staff shall replace the retiring Chief of Staff, Chief of Staff, and new Members at Large shall be elected every two years.

9.1.6 RECALL OF OFFICERS

The Executive Committee, by a two-thirds vote, may remove any Medical Staff officer or the Member at Large of the Executive Committee who is found to no longer meet any one or more of the qualifications set forth above or, if the individual elected is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office, provided that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten 10 days prior to the date of the meeting. The individual shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when approved by the Board of Trustees.

9.1.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. If the office of Chief of Staff is vacated during the year, the Vice-Chief of Staff is elevated to that office and shall serve as Chief of Staff for the remainder of the unexpired term. If the office of Vice-Chief is vacated, one of the Members at Large is could be elevated to that office and shall serve as Vice-Chief of Staff for the remainder of the unexpired term. If a Member at Large seat on the Executive Committee is vacated, a replacement shall be elected as soon as feasible to serve the remainder of the term. A slate of nominees shall be developed by the previous election's Nominating Committee and voting shall take place by mail ballot. Should the office of the Immediate Past Chief of Staff be vacated, it shall remain unfilled until the next following election.

9.2 DUTIES OF OFFICERS

9.2.1 CHIEF OF STAFF

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

(a) calling, presiding at, and being responsible for the agenda at the Executive Committee and General Staff Meetings;

(b) serving as a Chairman of the Executive Committee, Bylaws Committee, and

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

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

(e) serving as an ex-officio member of all other Medical Staff committees without vote, unless his membership on a particular committee is required by these Rules and regulations;

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

(a) making recommendations for appointment of committee chairpersons and members, in accordance with the provisions of these Rules and regulations, to all standing and special Medical Staff committees except the Executive Committee;

(h) have the right to participate on all Medical Staff committees;

(i) making known the views, needs, and grievances of the Medical Staff and report on the medical activities of the Medical Staff to the Board of Trustees and to the President; and

(j) is responsible for the organization and conduct of the Medical Staff.

9.2.2 VICE-CHIEF OF STAFF

The duties of the Vice-Chief of Staff shall include, but not be limited to:

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

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

(c) serving as chairman to the Healthcare Improvement Committee and Physician Behavior Review and Advisory Committee;

(d) performing such other duties as the Chief of Staff may assign or as may be delegated by these Rules and regulations, or by the Executive Committee.

9.2.3 IMMEDIATE PAST CHIEF OF STAFF

The duties of the Immediate Past-Chief of Staff shall include, but not be limited to:

(a) serving as a voting member of the Executive Committee

SECTION 10 - DEPARTMENTS AND DIVISIONS OF THE MEDICAL STAFF

10.1 CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have clinical services under the direction of a Chief of Service. The Chief of Service shall be selected and entrusted with the authority, duties, and responsibilities specified in Section 14.6.6. A department may be further divided, for the purpose of development or strengthening the subspecialty, into divisions which shall be directly responsible to the department within which it functions.

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

10.2 DEPARTMENTS

Departments are Medicine, Surgery, Pediatrics, OB/GYN. There shall be a Division of Emergency Medicine and a Division of Radiology under the Department of Medicine. There shall be a Division of Pathology and Anesthesiology under the Department of Surgery. Departments include but are not limited to the following specialties:

Department of Family Medicine
Family Medicine

Department of Medicine:
- Allergy & Immunology
- Cardiology
- Critical Care Medicine
- Dermatology
- Endocrinology
- Gastroenterology
- Geriatric Medicine
- Hematology
- Internal Medicine
- Oncology
- Infectious Disease
- Nephrology
- Neurology
- Psychiatry
- Pulmonary Disease
- Rheumatology
- Physical Medicine and Rehabilitation
- Psychology

Department of Surgery:
- General Surgery

Colorectal Surgery
Vascular Surgery
Podiatry
Plastic Surgery
Cardiovascular Surgery
Thoracic Surgery
Urology
Orthopedics
Ophthalmology
Otolaryngology
Neurosurgery
Dentistry
Pain Management

Department of OB/GYN:
Gynecology
Gynecologic Oncology
Obstetrics & Gynecology
Perinatology
Maternal & Fetal Medicine
Reproductive Endocrinology

Department of Pediatrics:
General Pediatrics
Pediatric Cardiology
Pediatric Gastroenterology
Pediatric Ophthalmology
Pediatric Neurology

10.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

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

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

10.4 FUNCTIONS OF DEPARTMENTS

Under the responsibility of its Chief of Service, each department shall perform certain functions.

The Chief of Service may assign the responsibility for the accomplishment of specific functions to a sub-committee or to a department member(s). Such committees or member(s) shall perform delineated functions pursuant to these Rules and regulations.

The general functions of each department shall include:

(a) recommending to the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

(b) conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

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

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

(e) meet as needed to discuss patient care;

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

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

(h) formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Executive Committee; and

(i) determining major and high risk diagnostic or therapeutic conditions, procedures and treatments, and establishing criteria for clinical procedures, treatments or medical, surgical or psychiatric conditions which require management by or consultation with a physician or other licensed independent practitioner.

10.5 FUNCTIONS OF DIVISIONS

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

regular reports to the Chief of Service on the conduct of its assigned functions.

10.6 CHIEFS OF SERVICE

10.6.1 QUALIFICATIONS

Each department shall have a Chief of Service who shall be a member of the Active-Clinical Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical services covered by the department. In addition, a Chief of Service should be Board Certified by the appropriate specialty board, (or demonstrate competence comparable to individuals with board certification), have demonstrated leadership qualities and be a strong supporter of Baylor Medical Center at Waxahachie. Under special circumstances, in order to serve the best interests of the Medical Center, one or more of the above requirements may be waived.

Chiefs of Service should not be presently serving as a Medical Staff or corporate officer, Chief of Service or Credentials Committee chairman at another Medical Center and shall not so serve during the term of office.

Chiefs of Service must remain members in good standing during their term of office. They must have no pending adverse recommendations concerning staff appointment or clinical privileges. Failure to maintain such status shall create a vacancy in the office involved.

Chiefs of Service must have constructively participated in Medical Staff affairs, including quality review and peer review activities, possess and have demonstrated an ability for harmonious interpersonal relationships, and be knowledgeable concerning the duties of the office and be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected.

10.6.2 TERMS OF OFFICE

Chiefs of Service shall serve a two year term.

10.6.3 ELECTION

The Chief of Service shall be elected by majority vote of those physicians who are members of the Medical Staff and who have their primary membership in that department.

The nominee(s) for Chief of Service shall be selected by the Nominating Committee as set forth in section 13.3.1 of these Rules and regulations.

10.6.4 REMOVAL

A Chief of Service may be removed by the Board of Trustees after consultation with the Executive Committee. A Chief of Service may also be removed during a term of office by a two-thirds vote of all Active Staff appointees in the department. Chiefs of Service may be removed from office based upon a failure to maintain status as a member in good standing of the Medical Staff, failure to perform the duties of the office to which elected or failure to comply with the provisions of Sections 11.3 – 1 and 11.7 of these Rules and regulations. This removal shall be effective when it has been approved by the Board of Trustees.

10.6.5 VACANCIES

Vacancies in Chiefs of Service occur upon the death or disability, resignation, or removal of the Chief of Service, or the loss of their membership in the Medical Staff. If the position is vacated during the year, an interim appointment shall be made by the Board of Trustees until such time that the department can select a Chief of Service.

10.6.6 DUTIES

(a) Each Chief of Service shall have the following authority, duties and responsibilities:

(1) act as presiding officer at departmental meetings;

(2) assure that the departmental functions in Section 11.4 are carried out;

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

(4) monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process;

(5) oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Executive Committee;

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

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

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

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

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

(11) enforce the Medical Staff bylaws, rules and regulations and policies within the department and Medical Center;

(12) implement within the department appropriate actions taken by the Executive Committee or its designee;

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

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

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

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

(17) be responsible for the integration of the department/service into the primary functions of the organization;

(18) be responsible for the coordination and integration of interdepartmental and intradepartmental services;

(19) recommend criteria for and the scope of practice allowed for Allied Health Professionals assigned to their respective departments;

(20) recommend to the Credentials Committee the approval for appointment and reappointment of Allied Health Professionals to the Allied Health Staff; and

(21) accounting to the Executive Committee for professional and Medical Staff administrative activates within the department.

10.7 MEDICAL DIRECTORS

Medical Directors may be appointed by the Board of Trustees, for ancillary services with advice from the appropriate departments of the Medical Staff and recommendation of the Executive Committee. The Board of Trustees shall establish procedures for securing the advice and shall

also establish formal means of having the incumbent's professional and administrative qualifications evaluated periodically by his peers which may include evaluation by the department.

Contracted full-time or part-time Medical Directors shall be appointed on a continuing basis by the Board of Trustees, subject to the terms of the contract between the individual and the Medical Center.

SECTION 11 COMMITTEES

11.1 DESIGNATION

11.1.1 CHAIRPERSONS

All committee chairpersons, unless otherwise provided for in these rules and regulations, will be appointed by the Chief of Staff and approved by the Executive Committee. Chief of Staff, The President will appoint hospital personnel, other than staff members to serve on committees. The Chief of Staff will appoint staff members to hospital –wide committees if requested by the President. Appointment of any Medical Staff Member to any hospital committee will be made according to the rules and regulations, and established policies and procedures of the hospital and staff.

11.1.2 MEMBERS

All appointed members may be removed and vacancies filled at the discretion of the Chief of Staff.

The President and the Chief of Staff or their respective designees shall be members, ex-officio, without vote, on all committees.

11.2 CREATION OF STANDING COMMITTEES

The Executive Committee may, by resolution and upon approval of the Board, without amendment of these Rules and regulations, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Rules and regulations, which is not assigned to a standing or special committee, shall be performed by the Executive Committee. These Rules and regulations shall be amended as soon as practicable to reflect any Medical Staff committee structure, duties or composition changes approved by resolution.

11.3 CONFIDENTIALITY OF INFORMATION

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

11.4 EXECUTIVE COMMITTEE

11.4.1 COMPOSITION

The Executive Committee shall be composed of:

(a) The Chief of Staff
(b) Vice Chief of Staff
(c) Immediate Past Chief of Staff
(d) 1 Member at Large
(e) Chief of Family Medicine
(f) Credentials Chair
(g) Chief Medical Officer shall attend as non-voting member
(h) The President and/or designee(s),the Vice President of Patient Care Services shall attend each meeting as non-voting members and shall serve as a liaison officers between the Board of Trustees and the Executive Committee
(i) Director of Medical Staff Services shall attend meeting as non-voting member.

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

11.4.2 DUTIES

The duties of the Executive Committee shall be to:

(a) represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the Medical Staff, subject only to any limitations imposed by the Bylaws, Rules and Regulations;

(b) coordinate the activities and general policies of the various departments;

(c) receive and to act upon those committee reports as specified in these rules and regulations and to make recommendations concerning them to the President and the Board;

(d) implement policies of the Medical Center that affect the Medical Staff;

(e) provide liaison among the Medical Staff, the President of the Medical Center and the Board;

(f) keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Medical Center;

(g) enforce Medical Center and Medical Staff rules in the best interest of patient care and of the Medical Center with regard to all persons who hold appointment to the Medical Staff;

(h) Refer situations involving questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any Medical Staff member to the Healthcare Improvement Committee for appropriate action

(i) be responsible to the Board for the implementation and participation of the Medical Staff in organizational performance-improvement activities as well as the mechanism used to conduct, evaluate, and revise such activities;

(j) review the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff at least once a year and recommend such changes as may be necessary or desirable;

(k) take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and Allied Health Professionals, including the initiation of and/or participation on in Medical Staff correction or review measures when warranted ;

(l) review all information available regarding the performance and clinical competence of individuals who hold appointments to the Medical Staff and as a result of such review to make recommendations for reappointments or changes in clinical privileges; and

(m) review the credentials of all applicants and to make recommendations for appointment to the Medical Staff, assignment to departments, and delineation of clinical privileges;

(n) be responsible for the mechanism used to review credentials and to delineate individual clinical privileges;

(o) be responsible for the mechanism by which Medical Staff membership may be terminated; and

(p) be responsible for the mechanism for fair-hearing procedures.

(q) designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the Executive Committee.

(r) Establish a subcommittee or appoint an individual to assist with interventions and to monitor the recovery of impaired practitioners. No member of the committee will vote on matters concerning an impaired physician from such committee members same department.

11.4.3 MEETINGS

The Executive Committee shall meet at least (6) times a year or more often if necessary to transact pending business. Medical Staff Services will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the Medical Staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the President routinely as prepared. Recommendations of the Executive Committee shall be transmitted to the Board with a copy to the President.

Each member of the Executive Committee shall attend at least 50% of the meetings held each

calendar year. A quorum shall consist of 50% of the members of the Committee.

11.5 CREDENTIALS COMMITTEE

11.5.1 COMPOSITION

The Credentials Committee shall be composed of:

(a) (2) two previous Chiefs of Staff
(b) (3) three Members at large
(c) The President and/or designee(s), Vice President of Patient Care and Director of Medical Staff Services serving as non-voting members. The Executive Committee shall fill any vacancies in the Credentials Committee.

11.5.2 DUTIES

The duties of the Credentials Committee shall be to:

a) review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations to the Executive Committee;

b) review the credentials of all applicants who request to practice at the Medical Center as Allied Health Professionals, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations; and

c) review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Allied Health Practitioners and as a result of such review, to make a written report of its findings and recommendations to the Executive Committee.

11.5.3 MEETINGS

The Credentials Committee shall meet at least quarterly or more often as needed to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee.

Each member of the Credentials Committee shall attend at least 50% of the meetings held each calendar year. A quorum shall consist of 50% of the members of the Committee.

11.6 HEALTHCARE IMPROVEMENT COMMITTEE (CHIEFS)

11.6.1 COMPOSITION

The Healthcare Improvement Committee shall be composed of:

(a) Vice Chief of Staff
(b) Chief Medical Officer
(c) Chiefs of Service for Departments of Medicine, Surgery, Pediatrics and OB/GYN
(d) Director of Emergency Services
(e) Director of Perioperative Services
(f) The President and/or designee(s), Vice President of Patient Care Services, Director of Healthcare Improvement, Care Coordination and Director of Medical Staff Services shall attend meetings as non-voting members

11.6.2 DUTIES

The Committee functions to implement maintain and promote the continuing quality assessment/improvement functions of the Medical Staff by conducting peer review and evaluation of medical and health care services provided by the members of the Medical Staff and Associate Staff for the purpose of improving the quality of patient care. The Committee may appoint special /ad hoc committees as needed to assist with performance of duties and responsibilities. The Committee's duties include but are not limited to the following:

(a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients in the Medical Center. The Committee shall routinely collect information about important aspects of patient care provided in the Medical Center, 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, and/or risk-management data. Patient care reviews shall include the clinical work performed by all members of the Medical Staff;

(b) investigation of all requests for corrective action as assigned by the Executive Committee;

(c) reviewing, analyzing and making recommendations regarding incidents and sentinel events that involve Medical Staff members;

(d) submitting written reports to the Executive Committee concerning: (1) the Committee'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 Medical Center.

(e) monitoring the affected Medical Staff member or Allied Health Professional, and aiding the individual to retain or regain optimal performance; and

(f) reporting to the Executive Committee instances where there may be a lack of quality care.

(g) investigation and evaluation of all complaints or disruptive or inappropriate conduct or behavior by members of the Medical Staff or Allied Health Professionals;

(h) initiating collegial intervention that does not adversely affect the clinical privileges of the Medical Staff Member or Allied Health Professional under review.

11.6.3 MEETINGS

The Healthcare Improvement Committee shall meet at least quarterly or more often if necessary to transact pending business and shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee.

Each member of the Healthcare Improvement Committee shall attend at least 50% of the meetings held each calendar year. A quorum shall consist of 50% of the members of the Committee.

11.7 PATIENT CARE /PHARMACY MONITORING COMMITTEE

11.7.1 COMPOSITION

The Patient Care/Pharmacy Monitoring Committee shall be composed of the Director of Pharmacy, and three (3) Active Clinical Medical Staff Members appointed by the Chief of Staff. Other members serving without a vote are a representative from the Division of Anesthesia, a Clinical Pharmacist, Vice President of Patient Care, a Clinical Dietician, Director of Healthcare Improvement.

11.7.2 DUTIES

The committee shall participate in formulating Medical Staff policies regarding the evaluation, selection, distribution, handling, use and administration of drugs and devices in the Medical Center, and shall be responsible for reviewing all other Medical Staff matters relating to the use of drugs and devices in the Medical Center. The committee shall make recommendations to the Executive Committee regarding quality issues identified in the review process.

11.7.3 MEETINGS

The Patient Care/Pharmacy Monitoring Committee shall meet at least quarterly or more frequently as needed to perform its duties.

11.8 PHYSICIAN HEALTH & REHABILIATION SUBCOMMITTEE

11.8.1 Pursuant to Section 11.4.2 (r) of the Rules and Regulations, the Executive Committee has created a subcommittee named Physician Health & Rehabilitation Committee

11.8.2 This committee shall provide education about physician health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment and rehabilitation of medical staff members who suffer from a potentially impairing condition for the purpose of assisting and rehabilitation, rather than disciplinary action.

(a) Self-referral to other organizations
(b) Referral of the affected medical staff member to the appropriate resource for diagnosis and treatment for the condition or concern
(c) Evaluation of the credibility of the complaint, concern, or allegation
(d) Monitoring the affected staff member
(e) Reporting, if necessary, to the Executive Committee instances where there may be lack of quality care
(f) Aid medical staff members I retaining or regaining optimal performance.

11.8.3 Meetings

The Physician Health & Rehabilitation Committee shall meet as needed

SECTION 12 - MEETINGS

12.1 MEETINGS

12.1-1 GENERAL MEETINGS

General Medical Staff meetings shall be held Semi-Annually in March and September. Regular semiannual meetings may be changed by the Executive Committee, provided that the Medical Staff is given thirty (30) days notice of the change.

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff. The agenda shall include the following, if feasible:

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

(b) voting on proposed changes to the Bylaws when required;

(c) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the

Medical Staff and on the fulfillment of other required staff functions and;

(d) new business.

12.1-2 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the Chief of Staff, the Board of Trustees, the Executive Committee, or within thirty (30) days after receipt of a written request of at least ten percent (10%) of the active-clinical 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 by registered letter, return receipt requested.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

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

12.2-2 SPECIAL MEETINGS

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

12.3 QUORUM

12.3-1 GENERAL 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.

12.3-2 DEPARTMENT AND COMMITTEE MEETINGS

The presence of at least two voting members shall be required for all departmental and committee meetings to constitute a quorum, with the exception of the Executive Committee, the Credentials Committee and the Healthcare Improvement Committee. The presence of fifty percent (50%) of the members of the Executive Committee, the Credentials Committee, and the Healthcare Improvement Committee shall constitute a quorum for any regular or special meeting of those committees.

12.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at all department and committee meetings at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these 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 at least two thirds of the members entitled to vote.

12.5 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. Summaries of the minutes of standing Medical Staff committees shall be forwarded to the Executive Committee for review and whatever action warranted.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 REGULAR ATTENDANCE

It is expected that each member of the Active-Clinical Staff shall be required to attend:

(a) At least one General Medical Staff Meeting, and 50% department and committee meetings of which he is a member in a calendar year. Members of the Executive Committee, Credentials Committee and the Health Care Improvement Committee shall be required to attend fifty percent (50%) of scheduled meetings in a calendar year.

(b) Members of the Courtesy Category shall be required to attend such other meetings as

may be determined by the Executive Committee.

12.6-2 ABSENCE FROM MEETINGS

Unless excused for good cause by the presiding officer of the department, division, or committee for Medical Staff regular meetings, failure to meet the attendance requirements may be grounds for removal from such committee or corrective action, including termination of Medical Staff membership.

12.6-3 SPECIAL ATTENDANCE

At the discretion of the chairman or presiding officer, individuals other than members and non-voting members may be asked to attend meetings of the Medical Staff, departments, divisions, or committees. When a member's practice or conduct is scheduled for discussion at a department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least [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 Executive Committee of the Executive Committee upon a showing of good cause, shall be a basis for corrective action.

12.6-4 CONDUCT OF MEETINGS

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

12.6-5 CONFLICT OF INTEREST

(a) In any instance where an officer, or Chief of Service or committee chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff appointee that comes before such individual or committee, or in any instance where any such individual or committee member brought the complaint against that appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chairperson by any committee member with knowledge of the matter.

(b) A Chief of Service shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to another member of the department, if the chief has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

Section XIII GENERAL PROVISIONS

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

13.1 ADMINISTRATIVE SUSPENSION OR REVOCATION

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

13.1-1 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 and/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 and/or professional liability insurance may be prohibited from providing patient care (as defined in section 13.1-1A above). Failure to respond to other requests for information will be addressed as defined in Section 3.3-5 of the Medical Staff Bylaws.

C. Failure to Complete Medical Records

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

C.1. Extended Leave or Vacation

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

D. <u>Repetitious Infractions</u>

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

13.1-2 <u>Notification of Practitioner Suspension or Reinstatement</u>

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

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

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

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

13.3-3 <u>Reporting to Texas Medical Board for Failure to Complete Medical Records</u>

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

SECTION 14: REVISIONS, MODIFICATIONS AND AMENDMENTS

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