

THE HEART HOSPITAL Baylor Plano

Rules and Regulations of the Medical Staff

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PREAMBLE

These Rules and Regulations of the Medical Staff of The Heart Hospital Baylor Plano are established under the authority of the Bylaws of the Medical Staff and shall be administered and amended as provided thereby. For convenience, they shall be referred to as the Rules and Regulations. Any capitalized terms not defined in the Rules and Regulations shall have the meaning assigned to them in the Bylaws of the Medical Staff.

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 and his, are used 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 the provisions of these Rules and Regulations. The following definitions shall apply regarding patient care activities and these Rules and Regulations:

- (a) The *Administration* refers to the President of THE HEART HOSPITAL or his designee(s) who are responsible for managing the day-to-day operations of THE HEART HOSPITAL.
- (b) *Adverse Action* means a peer (professional) review activity which results in reducing, restricting, suspending, revoking or denying clinical privileges or Medical Staff membership at THE HEART HOSPITAL.
- (c) *Allied Health Professional* is an individual who is not an employee of THE HEART HOSPITAL, but is an individual who:
 - (1) Is qualified by academic and clinical training, prior and continuing experience, and current competence in a discipline which THE HEART HOSPITAL's Board of Managers allows to practice in THE HEART HOSPITAL; and
 - (2) Functions under the direction and supervision and/or delegation of a Medical Staff Member.
- (d) *Applicant* means any individual possessing the qualifications for Medical Staff membership specified in these Rules and Regulations who seeks membership or reappointment to the Medical Staff.
- (e) *Appointment and Reappointment* refer to the process specified herein by which one acquires and retains Medical Staff membership and delineated clinical privileges.
- (f) *At-Large members* are members of the Medical Staff elected to serve on the Medical Executive Committee (MEC) or other Medical Staff committees who are voting members of the committee.
- (g) *Attending Physician*: Any physician Member of the Medical Staff with admitting privileges who admits patient to inpatient, outpatient, or emergency services and is responsible for the overall care of the patient. Physician actively caring for the patient.
- (h) *Board of Managers or Board* means the governing body of THE HEART HOSPITAL Baylor Plano.
- (i) Cardiac Universal Bed (CUB) ICU level of care is a patient who requires a 2:1 or 1:1 staffing ratio.
- (j) *Category* designates one of five levels of Medical Staff membership that may be granted to a Member: Active-Clinical, Active-Senior, Courtesy, and Administrative and Medico-Administrative.

- (k) *Certified Registered Nurse Anesthetist (CRNA)*: An advanced practice registered nurse who provides anesthesia and anesthesia-related care and has been granted delineation of clinical privileges by the Board of Managers.
- (l) *Chairman of the MEC* is the elected Active-Clinical who presides at meetings of the MEC
- (m) *Active-Clinical* is the elected physician representative of the Medical Staff.
- (n) *Clinical privileges* means the permission granted to an individual Physician, Dentist, Podiatrist, or Licensed Health Practitioner, recommended by the Medical Staff and approved by the Board of Managers, to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at THE HEART HOSPITAL.
- (o) *Co-Attending*: The Medical Staff Member who treats the patient jointly with the Attending Physician but who does not assume the primary responsibility for the patient's care.
- (p) *Consultant*: A Medical Staff Member who, upon request of the Attending Physician or Co-Attending, provides clinical advice in the diagnosis or treatment of the patient.
- (q) *Department* means a Section of the Medical Staff composed of members who practice a similar specialty or related specialties.
- (r) *Department Chair* means the head of a Clinical Department, sometimes referred to as a clinical service, who is appointed by the Board of Managers.
- (s) *Emergency Medical Condition*: As used by the Federal Emergency Medical Treatment and Labor Act: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; result in serious impairment of bodily functions or serious dysfunction to any bodily organ or part; or with respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or her unborn child.
- (t) *Ex Officio* means one who serves as a resource person by virtue of an office or position held, but without voting privileges.
- (u) *Hospital or THE HEART HOSPITAL* means The Heart Hospital Baylor Plano.
- (v) *Licensed Independent Practitioner* is any practitioner permitted by State legislated law and hospital policy as having authority to independently order treatments, procedures and medications.
- (w) *Medical Staff* means all Physicians, Podiatrists, and Dentists appointed by the Board of Managers as Members of the Medical Staff of THE HEART HOSPITAL.

- (x) *Medical Staff Member* means, unless otherwise expressly limited, any fully licensed Physician, Dentist, or Podiatrist, who is appointed by the Board of Managers as a Member of the Medical Staff of THE HEART HOSPITAL.
- (y) *Monitoring committees* are those standing committees of the Medical Staff that are responsible for monitoring activities described by the accrediting organization.
- (z) *Physician* means any Medical Staff Member who holds a Medical Doctor ("M.D.") or Doctor of Osteopathy ("D.O.") degree and is licensed to practice medicine by the Texas State Board of Medical Examiners.
- (aa) *Practitioner* means any individual who is a graduate of an approved medical, dental or podiatry school and holds an unrestricted license to practice medicine, dentistry, or podiatry in the State of Texas.
- (bb) *President of THE HEART HOSPITAL* means the individual designated by the Board of Managers to manage the operations of THE HEART HOSPITAL Baylor Plano.
- (cc) *Professional review action* means an action or recommendation of a professional review body duly authorized by these Rules and Regulations, in the furtherance of quality health care, which is taken based on the competence or professional conduct of an individual Medical Staff Member, which conduct affects or could adversely affect the health or welfare of a patient(s) and which affects or may affect his Medical Staff membership or clinical privileges.
- (dd) *Professional review activity* means activities undertaken in determining whether a Physician, Dentist, or Podiatrist may be appointed or reappointed and/or be granted clinical privileges in THE HEART HOSPITAL, determining the scope or conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.
- (ee) *Professional review body* pertains to THE HEART HOSPITAL and the Board of Managers or any committee of THE HEART HOSPITAL which conducts professional review activities, and includes any committee of the Medical Staff of the hospital when assisting the Board of Managers in a professional review activity.
- (ff) *Restraints*: Any physical or chemical method of restricting a patient's freedom of movement, physical activity, or normal access to the patient's body, determined necessary to help improve the patient's well-being or to help prevent injury to others.
 - (1) *Physical Restraint* – any manual method, or physical or mechanical device, material or equipment, attached or adjacent to the patient's body that the patient cannot easily remove that restricts freedom of movement or normal access to the patient's body.
 - (2) *Chemical Restraint* – the use of any chemical including pharmaceuticals, through topical application, oral administration, injection, or other means, for purposes of restraining a patient and that is not a standard treatment for the patient's medical or psychiatric condition.
 - (3) *Non-emergency Application of Restraint* - use of restraint to promote medical/surgical healing.

- (4) *Emergency Application of Restraint* – use of restraint for behavioral health reasons to manage an unanticipated outburst of aggressive or destructive behavior that poses an imminent danger to the patient or others.
- (gg) *Rules and Regulations* refer to the Rules and Regulations of the Medical Staff of THE HEART HOSPITAL.
- (hh) A Section is a sub-group of a Clinical Department consisting of a specialty or a combined group of specialties.
- (ii) *Year* means twelve consecutive months.
- (jj) The phrase "work cooperatively with others" as used in Sections 3.3-1(c)(2) and the phrase "working cooperatively with Medical Staff members, nurses, THE HEART HOSPITAL Administration and others" in Section 3.7(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 HEART HOSPITAL.
 - (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 THE HEART HOSPITAL Administration or Section Chairs.
 - (4) Remarks of a sexual nature or reference to a person's ethnic background are not permitted.

SECTION 1- ADMISSION OF PATIENTS

Patients may be admitted to the Hospital only upon the orders of an Attending Physician. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Hospital has facilities and personnel. When the Hospital does not provide the services required by a patient or person seeking necessary medical care, or for any reason cannot be admitted to the Hospital, the Attending Physician and/or the Hospital staff shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient

1.1 PRIORITIES FOR ADMISSION

Whenever a patient requires admission, the Attending Physician shall contact Access Services Department to determine if a bed is available. Access Services Department will allocate beds on the following order of priority:

- (a) Emergency Admissions: those patients whose medical condition qualifies as an Emergency Medical Condition as defined in the Hospital's relevant policies.
- (b) Urgent Admissions: are those patients whose medical condition is severe or painful enough to require medical treatment or evaluation to prevent serious deterioration.

(c) Pre-operative Admissions: this category includes patients scheduled for surgery.

(d) Routine Admissions: this category includes all other admissions.

1.2 ATTENDING PHYSICIAN'S RESPONSIBILITIES

At the time the Attending Physician requests admission of a patient, a provisional diagnosis, which may be used for initiating care of the patient, shall be given to the Access Services Department. The Attending Physician shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, and shall be responsible for providing the Hospital with the information that may be necessary to protect the patient or the Hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm.

The Attending Physician may delegate any of Attending Physician's responsibilities and obligations described in these Rules and Regulations to an appropriately credentialed Medical Staff Member, provided, however, the Attending Physician retains responsibility for overseeing the overall care furnished to the patient.

The Attending Physician shall be responsible for the accuracy and completeness of the medical record which shall include patient identification data, consent forms, history of the patient, report of the physical examination, diagnostic and therapeutic orders, observations, reports of actions and findings, and conclusions.

It shall be the responsibility of the Attending Physician to record a complete history and physical examination for a patient within 24 hours after admission and before any interventional or invasive procedure is performed, and within 4 hours for a patient in an intensive care unit.

1.3 ADMISSION OF PODIATRY PATIENTS

A patient admitted for foot surgery by a podiatrist is the dual responsibility of the Co-Attending podiatrist and Attending Physician. Management of these patients' general medical condition is the responsibility of the Attending Physician.

1.4 ADMISSION OF DENTAL AND ORAL AND MAXILLOFACIAL SURGICAL PATIENTS

A patient admitted for dental surgery is the dual responsibility of the Co-Attending Dentist and the Attending Physician.

Responsibilities of a Dentist:

- A detailed dental history justifying admission;
- A detailed description of the examination of the oral cavity and preoperative diagnosis;
- A complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
- Progress notes pertinent to the oral condition;
- Clinical summary or statement; and
- Discharge order.

If a patient has medical problems at admission for oral or maxillofacial surgery, an Attending Physician is required and the oral and maxillofacial surgeon shall be Co-Attending.

Responsibilities of attending oral and maxillofacial surgeons for patients without medical problems:

- Medical history pertinent to the patient's general health;
- A physical examination to determine the patient's condition prior to anesthesia and surgery;
- Supervision of the patient's general health status while hospitalized; and
- Clinical summary or statement.

SECTION 2 - MINIMUM REQUIREMENTS FOR MEDICAL RECORDS

The medical record shall contain sufficient information to identify the patient clearly, to support the diagnosis and treatment, to describe the patient's progress and response to medications and services, and to document the results accurately. Entries shall contain only pertinent, meaningful observations and information and each entry shall be legible, dated, timed and authenticated. All entries by Allied Health Practitioners must be co-signed, dated, and timed by the covering practitioner on the next visit.

The medical record is the property of the Hospital and is maintained for the benefit of the patient and the Medical Staff. The medical record may only be removed with permission of the Director of the Hospital Health Information Management Department or in response to a court-order or by statutory authorization.

2.1 AUTHENTICATION

Authentication may be by written signatures 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. This statement is maintained in the licensed independent Practitioner's credentials file.

Signature stamps are approved for outpatient use only and not for the use in the inpatient medical record. If used in the inpatient medical record, then the signature stamp must be authenticated with an original signature. Acknowledgments for the use of signature stamps will be maintained in the practitioner's credentials file for those Medical Staff Members who choose to use them. The acknowledgement states that the signature stamp must be in the control of the Medical Staff Member and no unauthorized use of the stamp will be allowed by the Medical Staff Member. Signature stamps must include the Medical Staff Member's complete signature for ease of reference.

2.2 ADMISSION NOTE

Within 24 hours of admission, the Attending Physician shall record an admission note which shall contain an admitting diagnosis, a brief description of the patient's condition on admission, and the Attending Physician's admission orders.

2.3 HISTORY AND PHYSICAL

A complete history and physical must be completed by the Attending Physician, or his designee where appropriate, within 24 hours of admission and must be placed in the medical record within 24 hours after admission. When a history and physical has been performed within 30 days prior to admission, a durable, legible copy of the report may be used in the patient's record provided the Attending Physician documents any changes in the patient's condition between the date of the report and the patient's date of admission.

This updated information must be placed in the chart within 24 hours after admission or prior to a procedure, whichever time period is shorter.

The history of the patient may be recorded by a Medical Staff Member designated by the Attending Physician, or by a physician assistant or advanced practice nurse with delineated clinical privileges, but only under the following conditions:

- (1) Stable pre-surgical patients admitted for elective surgery;
- (2) Stable patients admitted for elective therapeutic or diagnostic procedure;
- (3) Non-emergent or non-urgent patients admitted from the Emergency Department to Nursing Units if the Emergency Department physician has previously evaluated them. This does not include patients who are admitted to the critical care units.
- (4) Non-emergent or non-urgent patients admitted directly from the Attending Physician's office where the Attending Physician has previously evaluated them.

History and physicals performed using a physician assistant or advance practice nurse must be authenticated and countersigned.

A history and physical must contain the following elements which are labeled accordingly:

- (a) Present Illness shall include a listing of the patient's current medical problems, stated in a concise manner to include, when appropriate, assessment of the patient's emotional, behavioral and social status, the patient's allergies, and a list of the medications the patient is currently taking.
- (b) Past History shall include any previous illnesses, injuries, or surgery.
- (c) Review of Systems should include an inventory by body systems. If all systems are not covered, the record should explain the reason(s) for each system not covered.
- (d) Family History should include illness in the family of the patient, which might contribute to the cause, or development of the present illness.
- (e) Social History shall include the social history of the patient that might contribute to the cause or development of the present illness.
- (f) Physical Examination which is a comprehensive and current physical assessment appropriate to the patient's medical condition.

When a patient is readmitted to the Hospital within 30 days for the same disease or symptoms, the Attending Physician may write an interval history reflecting any subsequent changes and refer to the history on the previous admission.

2.4 PROGRESS NOTES

Progress notes made by Medical Staff Members should give a pertinent, chronological report of the patient's course and should reflect any change in condition and the results of treatment. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific

orders and the results of tests and treatment. Progress notes should be written at least daily on all patients. Progress notes should be dated, timed and authenticated.

2.5 MENTAL STATUS EXAMINATION

This examination shall be recorded for all patients admitted with a concurrent psychiatric disorder. The mental status exam may be included in the history and physical or progress notes.

2.6 DIAGNOSTIC AND THERAPEUTIC ORDERS

- (a) Orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until they are rewritten and are understood by the nurse.
- (b) All previous orders are canceled when patients go to surgery. The use of the terms 'renew', 'repeat', 'resume', and 'continue' in reference to previous orders is not acceptable.
- (c) Orders shall not contain abbreviations and symbols on the medical staff approved Dangerous Abbreviation List.
- (d) Medical orders must include the name of the drug, dose route, frequency, time/date order written, and prescriber's signature. Acceptable drug names include: the complete generic name or the brand name. All orders for a drug dose less than one shall have a zero preceding the decimal amount. A trailing zero shall not be used after a decimal. (e.g., 0.25 shall not be written as 0.250) All orders for microgram amounts shall be clearly written as " mcg" (Greek letters) to clearly distinguish from milligrams (mg). All orders for units shall be clearly written as "units" (abbreviations and Greek letters are not to be used).
- (e) Except for the limited authority for use of Heart Hospital facilities for diagnostic and treatment procedures for outpatients of physicians, dentists, podiatrists, and other licensed health care professionals not members of the Medical Staff, only Medical Staff Members shall have the authority to give or write orders and only as permitted by their clinical privileges.
- (f) All orders must be entered in the patient's record and timed, dated, and signed by the responsible Medical Staff Member.
- (g) Verbal Orders

Verbal orders for diagnostic and therapeutic procedures shall be accepted under circumstances when it is impractical for such orders to be given in writing by the Medical Staff Member. Verbal orders shall be transcribed in the "Orders" section of the medical record and shall include the date, time and name of the prescribing physician / LIP who placed the order as well as the date, time, and signature of the person taking the verbal order. Verbal orders shall only be accepted by appropriately credentialed personnel who are authorized to do so by the medical Staff policies and procedures consistent with federal and state laws.

Verbal orders must be read back to the prescribing Medical Staff Member /LIP and confirmed as accurate before they will be accepted. All verbal orders shall be dated, timed and countersigned by the prescribing Medical Staff Member / LIP or the Medical Staff Member providing substitute coverage for the prescribing Medical Staff Member within 48 hours. Authentication of verbal orders by a Medical Staff Member shall be by signature or computer key. "On-call" orders should specify the date of the procedure. Verbal orders cannot be given for Parenteral cytotoxic and chemotherapy.

(h) Physicians Treating Family Members

Members of the Medical Staff shall not write any orders or participate in the patient's care involving a member of his/her immediate family (spouse, parents/in-laws, children or significant other) or for any patient for which the physician holds Power of Attorney.

Members of the Medical Staff shall not be allowed to participate in any major surgical procedure involving any member of his/her immediate family (spouse, parents/in-laws, children, or significant other) or for any patient for which the physician holds Power of Attorney.

In the event of an emergency, isolated setting or when no other qualified physician or appropriate healthcare personnel is available, treatment of a family member may be initiated and continued until such time as the patient's care can be assumed by other appropriate qualified healthcare personnel.

2.7 PROTOCOLS

Protocols are approved for use in THE HEART HOSPITAL. All new Protocols will be reviewed and approved by the MEC. The MEC will review annually. Protocols used in the special care areas and Protocols in other clinical areas on an appropriate schedule.

(a) Orders for Restraints

Patients have the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation. Restraints will only be used as a last resort in the least restrictive manner possible and removed at the earliest possible time. Initiation of restraint use requires a physician's order except as noted below:

- (i) A physician must initiate the use of restraints through individual orders. All restraint orders must include the following:
 - (A) time limited duration,
 - (B) type of restraint to be used; and
 - (C) clinical justification,
 - (D) PRN ("per required need") orders are not acceptable.
- (ii) For Application of Restraint an order is required prior to application:
 - (A) telephone or verbal orders for restraint must be signed by the ordering or covering physician within 24 hours.
 - (B) for each episode of restraint use, a new order is required every 24 hours.
- (iii) For Application of Restraints for Behavior Management:

- (A) An RN may initiate use of restraint.
 - (B) An order must be obtained from a physician / LIP either during the emergency application of the restraint or immediately after the restraint has been applied.
 - (C) A face-to-face assessment by a physician /LIP must occur within 1 hour of the initiation of restraints. The purpose of the assessment is to evaluate the patient's condition, clinical justification, type of restraint, and the need for continuation of restraints.
 - (D) An order for physical restraint or seclusion under emergency application is limited to 4 hours for adults; 2 hours for children and adolescents ages 9 to 17; 1 hour for patients under 9.
 - (E) After the original order expires, a physician / LIP must see and assess the patient prior to issuing a new order.
 - (F) A physician must conduct a face to face re-evaluation of the patient in person at least every 8 hours for patients 18 years of age and older and every 4 hours for patients ages 17 and younger. The original order may only be renewed in accordance with these limits for up to a total of 24 hours.
 - (G) A consultation with the patient's Attending Physician must occur as soon as possible (if the restraint is not ordered by the patient's Attending Physician).
 - (H) A written modification to the patient's plan of care must occur.
- (iv) The RN may initiate early release trials if the behavior/reason for the restraint has abated prior to the expiration of the time-limited order. Patient care policies for the use of restraints on general patient care units are reviewed and approved by the MEC.

2.8 CONSULTATION REPORTS

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

2.9 OPERATIVE REPORTS AND NOTES

An operative report shall be dictated or written immediately after surgery and includes name and ID of the patient, date and time of surgery; the name of the primary surgeon and assistants; other practitioners who performed surgical tasks and the description of those tasks; preoperative diagnosis, findings, technical procedures used, specimens removed, tissues altered, appliances implanted, complications, and post-operative diagnosis and condition and estimated blood loss, type of anesthesia administered, tissues, transplants or devices implanted, prosthetic devices or grafts if any.. The operative report must be authenticated by the surgeon.

An operative note must be written in the Physician Progress Record immediately after surgery to include the name of the licensed independent practitioner and assistants, what surgery was performed, findings, post-operative diagnosis, estimated blood loss, and specimens removed.

2.10 DISCHARGE SUMMARIES

All relevant diagnoses established by the time of discharge or death, as well as all operative procedures performed, shall be recorded within twenty-eight (28) days, using acceptable disease and operative terminology, including etiology as appropriate. The final diagnoses or cause of death shall be recorded in the discharge summary.

For patients hospitalized for less than 48 hours with only minor problems, a short-stay form approved by the MEC may substitute for the discharge summary. It shall document the patient's condition at discharge, discharge instructions, and follow-up care required.

The discharge summary shall include the reason for hospitalization, the significant findings, the procedures performed and treatments rendered the condition of the patient on discharge, and any specific instructions given to the patient or family. The condition of the patient on discharge shall be stated in terms that permit a specific comparison with the condition on admission. When pre-printed instructions are given to the patient or family, the record shall so indicate and a copy of the instruction sheet used shall be placed on file. All discharge summaries shall be authenticated by the Attending Physician.

2.11 REPORTS OF ACTIONS AND FINDINGS

Reports of actions and findings include such items as reports of pathology and clinical laboratory examination, radiological/imaging examination, medical and surgical treatment, and any other diagnostic or therapeutic procedures.

2.12 EMERGENCY DEPARTMENT RECORDS

For every patient receiving emergency service, a medical record shall be kept containing:

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

- Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.
- Authorization for treatment.

The record shall be authenticated for its clinical accuracy by the patient's Attending Physician in the Emergency Department.

The Emergency Department shall maintain a control register which shall contain the name, date and time of arrival and record number of each patient as well as diagnosis, disposition of patient, and name of Attending Physician in the Emergency Department. The name of patients dead on arrival shall also be entered in the register. The register shall include the time an on-call physician was called and when the on-call physician responded.

2.13 SURGICAL RECORDS

Except in emergencies, the following data shall be recorded in the medical record prior to surgery, or the surgery shall be automatically canceled:

- (a) Verification of identity of patient;
- (b) Medical history and supplemental information regarding drug sensitivities and other pertinent facts;
- (c) General physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;
- (d) Pre-operative diagnosis;
- (e) Diagnostic data;
- (f) Consultation reports; and
- (g) Informed consent shall include name of practitioner(s) performing the procedures or important aspects of the procedure, as well as the name(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. and signed by the patient or legal guardian and at least one witness.

The patient shall not leave for the operating room until the chart is complete or the operating room has received a telephone report of the results of the diagnostic tests. In an emergency situation, the surgeon shall write a note before the surgery on the patient's condition, stating that a delay for recording these requirements would constitute a danger to the health or safety of the patient and that the surgeon accepts responsibility for the patient's physical condition

Post-operative documentation records the patient's vital signs; level of consciousness; medications (including intravenous fluids); blood and blood components; and any unusual events or post-operative complications and the management of the events. Post-operative documentation records the patient's discharge from the post-anesthesia care area by the responsible anesthesiologist or CRNA or according to approved discharge criteria. Compliance with the discharge criteria must be fully documented in the medical record.

2.14 PREANESTHESIA AND POSTANESTHESIA NOTES

For anesthetics administered by anesthesiologists or CRNAs, or for anesthesia administered by or under the direction of other physicians, podiatrists, and/or dentists, the preanesthesia evaluation, performed within 48 hours of surgery, of the patient shall be recorded on the Anesthesia Record or Physician Progress Record. Documentation should include pertinent information relative to the choice of anesthesia and the surgical

procedure anticipated, the patient's previous drug and allergy history, other anesthetic experiences and any potential anesthetic problems identified, patient condition prior to induction.

The recording of post anesthetic visits should include a timed report in the recovery room. A post-anesthesia follow up report written by the person administering the anesthesia before transferring the patient from the PACU and shall include evaluation for recovery from anesthesia; level of activity; level of consciousness; and patient color.

For anesthesia administered by a CRNA, an order for provision of anesthesia by the CRNA must be written on the Attending Physician's order sheet.

For inpatient procedures, Post-anesthesia evaluation for proper anesthesia recovery shall be performed after transfer from PACU and written 48 hours after surgery by the anesthesiologist, RN, or physician.

For outpatient procedure, immediately prior to discharge, a post anesthesia evaluation for proper anesthesia recovery will be performed by the area RN or physician.

SECTION 3 - MEDICAL RECORDS DELINQUENCY PROCEDURES

The requirements and suspension process for: 1) failure to complete medical records; 2) extended leave of absence or vacation; 3) repetitive infractions; and 4) reporting to the Texas Medical Board are stated under Section 19 General Provisions and shall be governed by HIM policies and procedures.

SECTION 4 - PHARMACY

4.1 DRUGS AND FORMULARY

Drugs administered to patients shall be obtained through the Hospital pharmacy, except as noted below. All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Services," or "A.M.A. Drug Evaluations." Drugs used for bona fide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals shall be subject to approval by a Human Subjects Research Committee participated in by the Hospital.

4.2 INTRAVENOUS SOLUTIONS

A pharmacist or pharmacy technician may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by a Medical Staff Member, an LVN, RN, APN, or PA. Each drug dose shall be recorded in the medical record of the patient and properly signed by the individual administering the dose.

4.3 SELF-ADMINISTRATION: PATIENTS' OWN DRUGS

If patients bring their own drugs, these drugs shall not be administered unless the Attending Physician has written an order for their administration. If the drugs are not ordered by the Attending Physician, they shall be packaged and sealed and returned to the patient at discharge.

Patients admitted to the Hospital who are participating in a clinical study approved by another facility Institutional Review Board ("IRB") or a non-institutional study may continue to receive the study medication if (i) the patient's Attending Physician approves the continuance of the medication; (ii) the Hospital

Pharmacy and IRB receive a copy of the study protocol and informed consent; and (iii) the Pharmacy stores the study medication and otherwise complies with the Hospital Pharmacy policy for administration of patient's own drugs.

4.4 MEDICATION ERRORS AND ADVERSE REACTIONS

Any medication error or apparent drug reaction that may cause harm to the patient shall be reported immediately to the Medical Staff Member who ordered the drug and/or the Attending Physician. Any entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the medical record of the patient. Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible, in order to notify everyone treating the patient, throughout the duration of the hospitalization, of this drug sensitivity and thereby prevent a recurrence of adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the Attending Physician, prescribing Medical Staff Member, and to the Pharmacy Director.

SECTION 5 - INFORMED CONSENT

5.1 GENERAL

It is the Attending Physician's duty to inform patients about risks, benefits and alternatives to proposed medical and surgical procedures. Although nurses may assist in preparing the disclosure and consent form and obtaining the necessary signatures, the Attending Physician, surgeon, and/or Co-Attending must be available to the patient to answer questions and to discuss the information contained on the form.

It is the attending Physician's duty to inquire about the existence of and act in accordance with a health care power of attorney and/or living will. An individual shall be deemed to be incapacitated if the person lacks the ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, and lacks the ability to make health decisions because of impairment.

5.2 DURATION OF CONSENT

Generally, informed consent shall be obtained by the physician prior to or contemporaneously with the treatment/procedure.

Signatures shall be obtained prior to administration of pre-operative or pre-treatment medication which may cause sedation or confusion unless delay of the procedure would be significantly hazardous to the patient, or in the opinion of the Attending Physician or Co-Attending, the patient has the capacity to exercise judgment.

5.3 INFORMED CONSENT BY SURROGATE DECISION MAKERS

- (a) For a patient who lacks decision-making capacity, the Attending Physician or Co-Attending shall identify the appropriate surrogate decision maker who may be, in order of priority:
 - (i) Court-appointed guardian;
 - (ii) Agent with Durable Power of Attorney for Health Care;
 - (iii) Patient's spouse (includes common law spouse, i.e., a person who resides with the patient and who along with the patient holds himself or herself out to the public as a married couple);

- (iv) An adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision maker;
 - (v) A majority of the patient's reasonably available adult children;
 - (vi) The patient's parents;
 - (vii) The individual clearly identified by the patient to act for the patient before the patient became incapacitated;
 - (viii) The patient's nearest living relative.
- (b) For a patient who possesses decision-making capacity and is able to exercise judgment but is physically unable to sign, a responsible adult may sign for the patient. (This signature confirms that the patient is giving the Attending Physician or Co-Attending consent for the treatment or procedure.) The responsible adult need not be next-of-kin. Medical Staff Members and the Hospital employees may not sign for the patient.
- (c) For patients who are less than 18 years of age, the parent or legal guardian shall sign the consent form unless one of the following exceptions applies, allowing patients under 18 years of age to sign consent forms:
- (i) A patient who is married at any age;
 - (ii) A patient who is divorced (not annulled) or widowed under 18 years of age;
 - (iii) Unmarried pregnant females for any problem related to the pregnancy other than termination of pregnancy;
 - (iv) Patient on active duty with the military; or
 - (v) Patient 16 years of age or older living apart from his/her parents and managing patient's own affairs, regardless of source of income.

5.4 INFORMED CONSENT: EMERGENCY SITUATIONS

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

5.5 TELEPHONE CONSENTS

If the patient lacks decision-making capacity and the responsible surrogate decision maker is not and will not be present in the Hospital to express verbal consent or sign the consent forms, the Attending Physician shall obtain consent over the telephone from the surrogate decision maker. The Attending Physician should explain the proposed treatment or procedure including the risks benefits and alternatives and should obtain the surrogate's consent over the phone. The Attending Physician or a nurse must read the consent form to

the surrogate and ask if the surrogate understands and agrees with the form. Telephone consents must have two witnesses, and the Attending Physician and the Hospital personnel may be witnesses.

SECTION 6- CONSULTATIONS

6.1 WHO MAY GIVE CONSULTATIONS

A Medical Staff Member can be asked for consultation within the Medical Staff Member's area of expertise. In circumstances of grave urgency, or where consultation is required by these Rules and Regulations, the President and the Chairperson of the MEC acting together shall at all times have the right to call in a consultant or consultants.

6.2 REQUIRED CONSULTATIONS

Consultations shall be required in all non-emergency cases whenever requested by the patient, the patient's family, or legal representative. Examples where consults shall be considered are:

- (a) The patient has significant risk factors for medical or surgical treatment;
- (b) When insurance or third party payor requests a second opinion;
- (c) Unusually complicated situations are present that may require specific knowledge and skills of other Practitioners who are not on the Medical Staff.

The Attending Physician shall be responsible for requesting consultation when indicated and for calling in a qualified consultant.

The Attending Physician's request for a consultation shall be entered on the physician's order sheet in the medical record. It shall be the responsibility of the Attending Physician requesting the consultation to provide the consulting physician with the appropriate patient information.

SECTION 7 - OPERATING ROOMS AND SURGERY

7.1 GENERAL

Surgeons and Co-Attending podiatrists and dentists must be in the Hospital and ready to begin operating at the time of induction. No patient shall receive anesthesia unless the surgeon or Co-Attending podiatrist or dentist is physically present in the Operating Room ("OR") or Surgery lounge. In any elective procedure of unusual complexity or which is associated with unusual hazard to life, there must be a surgeon present and scrubbed as first assistant. The Department of Surgery or the applicable surgical section may designate those procedures which require a surgeon as first assistant.

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

- (a) General anesthesia - time of induction
- (b) Epidural anesthesia - time epidural is established
- (c) Spinal anesthesia - time spinal procedure begins

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

7.2 SCHEDULING OF OPERATING ROOMS

The number of OR's to be allocated to the various Sections, if any, shall be determined by the Department of Surgery.

The schedule shall be arranged to permit the fullest utilization of personnel and facilities. OR personnel will inform the surgeon and the anesthesiologist or CRNA of any change and will lend assistance in contacting the Medical Staff Members involved.

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

The OR shall be staffed for elective surgery Monday through Friday from 7 a.m. through 7 p.m. Emergency surgery services will be provided as needed. Patients with Emergency Medical Conditions will have precedence over all other cases. Postponement of elective surgery by patients with urgent conditions is first negotiated between the respective operating surgeons. If resolution cannot be reached between the operating surgeons, the decision will be referred to the Section Chair.

The first surgery in each room will be posted at 7:30 a.m. A surgeon desiring an earlier time should contact the supervisor of the OR and the anesthesiologist. Every effort will be made to schedule as close as possible to the time requested by the surgeon. Rooms will not be held for late starts.

A surgeon, Podiatrist, Dentist or Anesthesiologist who is late for a 7:30 a.m. surgical procedure on three occasions in any one calendar quarter will not be permitted to schedule procedures at 7:30 a.m. for four weeks following the third offense during that particular calendar quarter. "Late" is defined as a period of time greater than fifteen minutes. The Section Chair Surgery, or Section Chief if applicable, will be responsible for maintaining records of late arrivals. If a third offense occurs within the calendar quarter, the four weeks prohibition from early posting will begin on the third Monday following the third offense, thereby permitting the Medical Staff Member concerned to perform surgical procedures already on the schedule.

Surgical procedures scheduled for a time later than 7:30 a.m. by surgeons or anesthesiologists during the time they are in the penalty period may be moved to 7:30 a.m. by the Section Chair or Section Chief. Such a move may occur in the interest of improving operating room efficiency.

Surgical procedures may be scheduled as far in advance as necessary. The time on the OR schedule is reserved for the patient rather than for the surgeon. If a procedure is canceled, the OR reservation is lost and the next patient scheduled will be moved to that time.

The posting of cases shall be made or canceled by the Medical Staff Member or office personnel.

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

Medical Staff Members entering the OR's shall wear OR apparel approved by the Chair of Surgery.

In addition, physicians must adhere to the Rules & Regulations of the Medical Staff, Section 2.3 regarding history and physical requirements and Section 19.1 under Administrative Suspension.

SECTION 8 - EMERGENCY DEPARTMENT COVERAGE

8.1 EMERGENCY DEPARTMENT PHYSICIAN RESPONSIBILITIES

It is the responsibility of Emergency Department physicians to personally arrange for a Medical Screening Examination that is within the capability of the Emergency Department for individuals who present themselves with an Emergency Medical Condition and request examination or treatment, or when a request is made on behalf of the individual for examination or treatment for an Emergency Medical Condition. All individuals who present for care in the Emergency Department shall receive an appropriate medical screening examination for the presence of an emergency medical condition, and if so, shall be stabilized or transferred in accordance with available resources and Hospital and Emergency Department policy. A medical screening may be performed by either:

- A. A licensed physician with clinical privileges granted by the Board; or
- B. A licensed nurse practitioner or physician assistant with appropriate advanced training, certification and clinical privileges granted by the Board

If the individual refuses to consent to examination and treatment by the Emergency Department physician after having been informed of the risks and benefits of such examination and treatment and of the risks of delay of examination and treatment, the Emergency Department physician shall take all reasonable steps to secure the individual's written refusal of such examination and treatment.

If a patient requests transfer to another facility, or the patient requires transfer to another facility for treatment of the patient's Emergency Medical Condition, it is the responsibility of the Emergency Department physicians to personally arrange for the transfer. All transfers from the Emergency Department must comply with the provisions of the Emergency Medical Treatment and Labor Act ("**EMTALA**"), State of Texas patient transfer rules, and the Hospital policies and procedures. It is the responsibility of the Emergency Department physician to ensure compliance with such laws, policies, procedures, and regulations.

With respect to pregnant women who are having contractions, the Emergency Department physician is responsible for evaluating if there is adequate time to effect a safe transfer to another facility before the delivery. If the Emergency Department physician determines that the transfer may pose a threat the health and safety of the woman or her unborn child, the woman must be treated until her condition is stabilized and transfer no longer poses a threat to the woman or her child.

8.2 ROSTER AND SCHEDULE

A specialty roster of appointees to the Active Staff shall be maintained for rotational service coverage of the Emergency Department. Weekly coverage begins on Monday morning at 7:00 a.m. Daily coverage begins at 7:00 a.m. each day.

8.3 ROTATIONAL ON-CALL PHYSICIAN RESPONSIBILITIES

Availability: The physician or his designee on rotational call for the Emergency Department must be available for telephone consultations within 30 minutes of receiving a page from the Emergency Department physician and must be physically present at the Hospital within 30 minutes of receiving a verbal request from the Emergency Department physician for any consultation, decision or treatment.

Aspects of Care: The physician on rotational call for the Emergency Department is responsible for providing care for all aspects of the physician's specialty. If the Emergency Medical Condition is within the specialty but outside the physician's personal expertise, it is the responsibility of such

physician to personally make an appropriate referral to another physician in his specialty on the Medical Staff with such expertise. If the expertise does not exist on the Medical Staff, or such Medical Staff Member is unavailable, the Emergency Department physician shall inform the patient and arrange a transfer to another facility with such expertise.

Ambulatory Follow-up: Patients evaluated and treated by an Emergency Department physician will be provided contacts for ambulatory follow-up after being discharged from the Emergency Department. This information will include address and telephone number of 1) the physician taking rotational call in the applicable specialty for the date the patient is seen and treated and 2) the local Medical Society. If the physician taking rotational call for the Emergency Department physically evaluates and treats a patient in the Emergency Department or elsewhere in The Heart Hospital, a physician-patient relationship has been established.

Alternative Coverage: If a physician does not wish to be on-call during the week or day assigned, it is the physician's responsibility to secure the substitute services of a qualified Active Staff Member within the same specialty, with the exception of sub-specialties the MEC has designated as having too few members to provide continuous on-call coverage, to take the physician's place. The physician shall inform the Emergency Department Director of the substitute coverage. The physician acting as substitute coverage is responsible for the same duties and obligations as the physician who was replaced.

Failure to Accept Responsibility: Failure to provide Emergency Department coverage when on-call shall be grounds for summary suspension from the Medical Staff. If such a failure occurs, the matter will be reported to the Emergency Department Director for evaluation, and then forwarded to the appropriate Department Chair and the Chief Executive Officer of The Heart Hospital.

In the event that there is disagreement between the Emergency Department physician and the physician on call as to responsibility for care of the patient, the Emergency Department physician will immediately contact the appropriate Department Chair or Section Chief for resolution.

In instances where a physician admits an Emergency Department patient as an inpatient to or for another physician, the admitting physician will assume responsibility as the Attending Physician for the patient in the event that the physician for whom the patient was admitted refuses or is unable to be the Attending Physician.

8.4 EMERGENCY DEPARTMENT EXEMPTION

Physicians who meet the criteria set by the physician's Department Exemption policy may voluntarily withdraw from the Emergency Department rotation coverage schedule. If no such policy has been developed by the physician's Department, the physician may voluntarily withdraw from the Emergency Department rotation schedule if the physician is over the age of 60, regardless of time served on the Medical Staff. The request must be submitted to the MEC in writing at least 60 days prior to the request for exemption.

SECTION 9 - INTENSIVE CARE UNIT

9.1 WHO MAY BE ADMITTED

Any patient who, in the opinion of the Attending Physician, requires the intensity of treatment and observation available in the Cardiac Universal Bed (CUB) for treatment of the patient's medical condition may be admitted to the CUB. Questions related to the appropriateness of an Attending Physician's orders for

admission to or discharge from the CUB with a staffing ratio requirement of a 1:1 or 1:2 shall be referred to the Department Chair of Medicine or applicable Section Chief.

9.2 ADMISSIONS

All admissions to the CUB with a staffing ratio requirement of 1:1 or 1:2 will be made at the request of the Attending Physician. In the event of a bed shortage, conflicting requests for admission will be resolved by the Department Chair of Medicine or applicable Section Chief. Family practice physicians must have delineated clinical privileges to admit to CUB. Every CUB Admission with a staffing ratio requirement of 1:1 or 1:2 will be required to call for a Critical Care consult. (See single-organ exemption)

- (a) Direct Admissions: Patients may be admitted directly to CUB at the request of the Attending Physician. The Attending Physician requesting such admission will notify Admissions of the nature of the patient's illness and state that admission to the CUB is desired. Access Services will immediately notify the CUB that the patient is on the way to the Hospital to be admitted to the CUB with a ratio of 1:1 or 1:2
- (b) Emergency Department: Need for admission to the CUB with a ratio of 1:1 or 1:2 from the Emergency Department will be determined by the Attending Physician. Admission to the CUB will be made directly from the emergency room with the proper information being conveyed to the Admissions.
- (c) Other Admissions: In extenuating circumstances when shock, or gross arrhythmias are evident, a patient may be admitted to the CUB with a ratio of 1:1 or 1:2 without first being examined by the Attending Physician, per verbal phone order from the Attending Physician. The patient then will be seen by the Physician/LIP within 1 hour and the Attending Physician assumes total responsibility for the patient's medical care, unless the Attending Physician has transferred responsibility for the patient to another physician.

9.3 PHYSICIAN VISITS

Patients admitted to the CUB requiring a staffing ratio of 1:1 or 1:2 are to be seen by the Physician/LIP within 2 hours of admission unless the Attending Physician evaluated the patient immediately prior to the admission. CUB patients requiring a staffing ratio of 1:1 or 1:20 are to be seen by their Attending Physician at least daily or more frequently if the patient's condition warrants. Visits are to be documented with a progress note.

SECTION 10 - PATHOLOGY

Tissues removed at surgery shall generally be sent to the Hospital pathology laboratory for examination, and consultation. Limited categories of specimens may be exempted from this requirement. Exemptions must be established by the Section Chair of Surgery, and agreed upon by the Section Chair of Pathology. The exempted specimens shall only be those that by their nature do not permit fruitful examination (*e.g.* cataract, orthopaedic appliance, foreign body, incidental rib removal, arthroscopic surgery fragments, and traumatic injured tissue).

Specimens shall be sent for gross examination to establish operative procedure or information for the medical record, except for bullets and other foreign objects used in the commission of a crime, which for legal reasons, are given directly in the chain of custody to law enforcement representatives. A record of all tissues and appliances removed during an operative procedure shall be made in the Operative Record.

A complete surgical pathology requisition form shall be filled out on all specimens by the surgeon or at his direction. This form shall accompany the tissue to the laboratory and must include adequate information for the pathology consultation, such as pre and post-operative diagnosis, the nature of the specimen, and sufficient clinical data to assist the proper pathological examination, and to provide the information for justification of the surgery by the Chair of Surgery. Specimens sent to the laboratory without specific consultation requests will receive a gross examination. Pathologists shall conduct more detailed examinations of specimens where gross examination only is requested if the pathologist believes additional examination is clinically indicated.

10.1 MAJOR OPERATIONS BASED ON BIOPSIES PERFORMED ELSEWHERE

When major surgical procedures are scheduled on the basis of a biopsy performed elsewhere, the pathology material from the previous biopsy must be made available for examination and verification of diagnosis by a pathologist of the Hospital. A HEART HOSPITAL pathology report will be placed on the chart prior to the contemplated surgery.

If compliance with this rule will delay surgery in a manner that is harmful to the patient, the rule may be waived for that particular patient by either the Department Chair of Surgery or Pathology, or Section Chiefs. In such a case, the provisions of this rule shall be carried out as soon as possible following the operation.

10.2 AUTOPSIES

Every Medical Staff Member shall seek to secure autopsy permits on appropriate cases. When required by law, deaths shall be reported to the Medical Examiner's office.

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

SECTION 11 - DISCHARGES

11.1 WHO MAY DISCHARGE PATIENTS

Patients shall be discharged only on a written order of the Attending Physician / LIP or Co-Attending. Should a patient leave against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Leaving Against Medical Advice form.

11.2 DISCHARGE PLANNING

Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge planning shall include the following:

- (a) Appropriate referral and transfer plans;
- (b) Methods to facilitate the provision of follow-up care;
- (c) Information to be given to the patient, the patient's family, or significant others by the Attending Physician or Co-Attending and documented in the progress notes or discharge summary include matters such as:
 - (i) The patient's condition;
 - (ii) Health care needs;

- (iii) The amount of activity the patient should engage in;
- (iv) Any necessary medical regimens including drugs, diet, or other forms of therapy;
- (v) Sources of additional help from other agencies;
- (vi) Procedures to follow in case of complications; and
- (vii) Follow-up care and/or treatment.

11.3 TRANSFER OF INPATIENTS

An inpatient shall not be transferred to another health care facility unless prior arrangements for admission to that facility have been made and the receiving physician and facility have agreed to accept the patient. Clinical records of sufficient content to insure continuity of care must accompany the patient.

11.4 DISCHARGE OF MINOR AND INCOMPETENT PATIENTS

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents or legal guardian unless otherwise directed by the parent, legal guardian or a court-order. If the parent, legal guardian, or court-order directs that discharge be made otherwise, the parent or legal guardian shall so state in writing, and the statement, or court order if applicable, shall become a part of the permanent medical record of the patient.

11.5 DISPOSITION OF BODY

The remains of any deceased patient shall not be disposed of until:

- (a) Officially pronounced dead by a physician/ LIP /RN;
- (b) The event is adequately documented by the treating physician,
- (c) Consent of the parent, legal guardian, or legally responsible person is obtained.

SECTION 12- CONTROL OF INFECTIONS AND COMMUNICABLE DISEASES

12.1 REPORTING OF INFECTIONS AND COMMUNICABLE DISEASES

It is the duty of the Attending Physician to notify the charge nurse if a particular patient has an infection or communicable disease.

The Attending Physician shall specify the diagnosis in case measures beyond Standard Precautions may be implemented if required.

If the Attending Physician is not available to order the isolation and if the nurses become aware of a diagnosis which requires special isolation, the charge nurse shall isolate the patient until the Attending Physician can be consulted.

If any unusual type or incidents of infection or healthcare acquired infections are suspected, the Attending Physician shall report the infections to the infection control nurse.

Medical Staff Members shall also report healthcare acquired infections which are discovered after the discharge of the patient.

12.2 ISOLATION PROCEDURES

The MEC or its designee shall monitor policies and procedures regarding the isolation of patients admitted with infectious diseases and for those patients who develop infectious diseases subsequent to admission.

12.3 MODIFICATION OF PRACTICE

A Medical Staff Member who is infected with Human Immunodeficiency Virus or is infected with Hepatitis B or Hepatitis C virus and is HBeAg positive may not perform an exposure-prone procedure as defined by law until the Medical Staff Member has sought counsel from an expert review panel and been advised under what circumstances, if any, the Medical Staff Member may continue to perform exposure-prone procedures.

SECTION 13 - REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

13.1 GENERAL

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

13.2 PROXIMITY TO HEART HOSPITAL

Each Member of the Medical Staff in the Active-Clinical, Active-Senior, and Courtesy categories must be able to travel to the Hospital from the Medical Staff Member's or delegate's place of residence or medical office within 30 minutes during normal driving conditions.

Individual Medical Staff Sections may recommend modifications to these proximity requirements to shorten the distance and driving time if required to meet patient care needs of the Section. Any modification to the proximity requirements for individual Sections must be approved by the MEC.

13.3 COMPOSITION OF THE MEDICAL STAFF

The Medical Staff of the Hospital 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 Hospital's objectives in the highest quality of patient care. The Hospital 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 Managers, the size of the Medical Staff - the number of practitioners in the Active-Clinical, Active-Senior, Courtesy, Consulting, Administrative and Medico-Administrative Practitioners shall be related to the capacity of the Hospital's facilities to serve its patients effectively and meet the needs of the community it serves.

13.4 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 Hospital unless he is a Member of the Medical Staff and has been granted clinical privileges in accordance with the Bylaws and these Rules and Regulations and applicable policies or unless he has been granted temporary privileges in accordance with the procedures set forth in the Medical Staff Bylaws and these Rules and Regulations and applicable policies. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with the Medical Staff Bylaws, these Rules & Regulations and applicable policies.

13.5 EFFECT OF OTHER AFFILIATIONS

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

13.6 NONDISCRIMINATION

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

13.7 ETHICS AND ETHICAL RELATIONS

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

13.8 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

Basic responsibilities that apply to all Members include:

- (a) providing patients with safe quality care that meets the professional standards of the Medical Staff of the Hospital;
- (b) abiding by the Bylaws, these Rules and Regulations, the Credentialing and Professional Review Policy, and the policies of the Hospital;
- (c) working cooperatively with Medical Staff Members, nurses, other health care providers, the Hospital administration and others;
- (d) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership;

- (e) 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;
- (f) requesting consultation from other specialties as the needs of the patient require, and providing consultation to other Medical Staff members when requested;
- (g) self-reporting any Medical Staff health matter, including a temporary or permanent impairment or substance abuse matters, to the Credentials Committee;
- (h) self-reporting to the Credentials Committee any investigation of, or recommendation, limitation, suspension or termination regarding (1) appointments or privileges at any other hospital or health care facility; (2) license to practice by any state or federal agency as required by these Rules and Regulations; or (3) loss of professional liability insurance, (4) loss of a Federal Drug Enforcement Administration ("DEA") or Texas Department of Public Safety ("DPS") certificates or registrations, (5) any investigation, sanctions or exclusion from any state or federal health insurance program, including Medicare and Medicaid;
- (i) actively cooperating with and participating in The Heart Hospital's quality improvement and utilization review activities, and all corporate compliance efforts, activities and programs of the Heart Hospital;
- (j) performing other staff obligations as may be established from time to time by the Medical Staff; and
- (k) promoting and participating in a work environment that is conducive to the well being of patients and the Hospital 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.

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

- (a) serving on Medical Staff committees;
- (b) providing Emergency Department call coverage;
- (c) regularly attending Medical Staff meetings and Departmental meetings as specified in Rules and Regulations;
- (d) timely response to patients upon admission and ordering appropriate tests and basic treatments when given basic admitting privileges;
- (e) preparing and completing in a timely fashion the medical records for all patients to whom the Member provides care in The Heart Hospital; and
- (f) participating in continuing education and quality improvement programs.

Reporting of incidents: Each Member of the Medical Staff has the duty to timely report any incident or Sentinel Event (as defined below) to the nursing supervisor or to the Director of Healthcare Improvement, and to the appropriate Department Chair or the MEC, and as required by the Hospital 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 or significant risk of injury if left uncorrected, including medication errors and perinatal deaths unrelated to congenital conditions in infants with birth weights greater than 2500 grams. A "Sentinel Event" is an event that meets one of the following criteria:

- (a) any event that 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 the event is a sentinel events as identified in the Sentinel Event Policy;

13.9 DUES

Dues may be assessed, the use of which, will be determined by the MEC. Dues may be assessed regardless of Category. Medical Staff Funds will be kept separate from Hospital funds.

SECTION 14 - ADDITIONAL QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP AT THE HEART HOSPITAL

Section 2.8 of the Medical Staff Bylaws sets forth the categories of the Medical Staff and the qualifications, prerogatives, and responsibilities for the respective categories. Notwithstanding Sections 2.9 and 7.6 of the Medical Staff Bylaws, this Section 14 provides qualifications in addition to those provided for in the Medical Staff Bylaws and such qualifications are considered to be required in addition to those specified in Section 2.8 of the Medical Staff Bylaws. Further, this Section 14 supplements the Medical Staff Bylaws by the addition of an Active-Senior Staff category as outlined below and the omission of the Active-Community Staff category.

14.1 ACTIVE-CLINICAL STAFF

As part of the Hospital's ongoing effort to sustain medical excellence, in addition to those qualification requirements required under Section 2.8-1 of the Medical Staff Bylaws regarding Active-Clinical Staff status, a Member of the Medical Staff is eligible for the category of Active-Clinical Staff by maintaining a minimum number of twenty-four (24) patients per year during each appointment period. A "patient contact" means a face-to-face encounter (defined as a Practitioner-to-patient) from which it is possible to make a meaningful evaluation of the Member's clinical experience, competence, and care of the patient. As applied to Active-Clinical Staff, a "patient contact" shall include those activities commensurate with the scope of privileges held by the Member, to include: admissions, surgeries, inpatient and outpatient procedures, and consultations that occur at the Hospital. Interpretations for the following will not constitute a patient contact except for those Members of the Radiology Section: electrocardiograms, echocardiograms, nuclear medical studies, and computed tomography (CT) or magnetic resonance imaging (MRI) angiographies. All patient contacts for the purpose of fulfilling this patient contacts requirement must occur at the Hospital. To ensure this patient contacts requirement represents an adequate measure of a given Member's clinical competency, no patient admission will result in more than one (1) patient contact. Upon Member request and presentation of sufficient information, the MEC reserves the right to establish certain patient care activities not listed above as meeting the patient contact requirement.

In addition to that information considered for reappointment as set forth in Section 1.9-2 of the Medical Staff Bylaws, satisfaction of the preceding patient contacts requirement will be a consideration for reappointment.

14.2 ACTIVE-SENIOR STAFF

As part of the Hospital's ongoing effort to sustain medical excellence, if a Member meets the qualifications for Active-Clinical Staff as outlined in Section 2.8-1 of the Medical Staff Bylaws regarding Active-Clinical Staff status, and who focuses primarily on an office-based medical practice, but who desires to occasionally treat Hospital patients within the scope of their training and experience, he or she may apply for the category of Active-Senior Staff. Members of the Active-Senior Staff must:

- 1) Have at least six (6) and up to a maximum number of twenty three (23) patient contacts per year during each appointment period. A "patient contact" means a face-to-face encounter (defined as a practitioner-to-patient) from which it is possible to make a meaningful evaluation of the Member's clinical experience, competence, and care of the patient. As applied to Active-Senior Staff, a "patient contact" shall include those activities commensurate with the scope of privileges held by the Member, to include: admissions, surgeries, inpatient and outpatient procedures, and consultations that occur at the Hospital. The interpretation of imaging or vascular testing for the interpretation of imaging physiologies without face to face contact will not constitute a patient contact except for Members of the Radiology Section. All patient contacts for the purpose of fulfilling this patient contacts requirement must occur at the Hospital. To ensure this patient contacts requirement represents an adequate measure of a given Member's clinical competency, no patient admission will result in more than one (1) patient contact. Upon Member request and presentation of sufficient information, the MEC reserves the right to establish certain patient care activities not listed above as meeting the patient contact requirement;
- 2) Be aged fifty-five (55) or older;
- 3) Operate a full-time, office-based medical practice. The term "full-time, office-based practice," as used herein, shall mean a combined average of thirty-two (32) hours of practice per week, forty (40) weeks per year at the Member's primary medical office;
- 4) Participate in at least six (6) quality evaluation, performance improvement and monitoring, or peer review activities per year at the Hospital as required of Active-Clinical Staff or as may be assigned by Division or Committee chairpersons; and
- 5) Maintain current cardiology clinical competence through continuing education and a sufficient level of patient treatment activity to maintain adequate quality standards.

In addition to that information as set forth in Section 1.9-2 of the Medical Staff Bylaws, satisfaction of the preceding patient contacts requirement will be consideration for reappointment

Members of the Active-Senior Staff are exempt from the emergency services call program.

14.3 ~~ACTIVE~~—COMMUNITY STAFF

Notwithstanding Section 2.8-3 of the Bylaws, the Hospital has no Active-Community Staff category.

SECTION 15 - OFFICERS

15.1 OFFICERS OF THE MEDICAL STAFF

15.1.1 IDENTIFICATION

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

15.1.2 QUALIFICATIONS

- (a) The President, Vice-President and the Immediate Past-President shall be members of the Active-Clinical Category.
- (b) Officers of the Medical Staff must be specialty Board Certified in their specialty, not be presently serving as a Medical Staff or corporate officer, Department Chair or Credentials Chairman at another hospital and shall not serve as such 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 member is elected.

15.1.3 NOMINATIONS

- (a) Nominating Committee

At least three months before the scheduled date of the next Medical Staff election, the MEC shall appoint a five person Nominating Committee. The President shall serve as a member of the Nominating Committee for the initial year. Thereafter, the Immediate Past President shall serve as a member of the Nominating Committee.

- (b) Nomination and Election of President and Vice-President

- (i) The Nominating Committee shall prepare a slate of nominees for the office of President and Vice-President to be filled at that election, each of whom must possess all the qualifications set forth above.
- (ii) Nominations for officers of the Medical Staff and the at-large members of the MEC shall be presented to Medical Staff Services no later than October 15 of each year.
- (iii) Any nomination made by members other than the Nominating Committee must be submitted, in writing, to the Nominating Committee no later than October 10, and must be endorsed by ten (10) Active Staff appointees who would be eligible to vote for the proposed nominee. The proposed nominee must possess all qualifications set forth above.

15.1.4 ELECTIONS

- (a) No later than October 31 of each year, a ballot for President of the Medical Staff and Vice-President shall be mailed, emailed or delivered to each eligible Member of the Active-Clinical and Active-Senior Staff. Votes shall be cast by the Active-Clinical and

Active-Senior Staff Members completing, signing and returning their ballots by mail, by email, by fax or in person to Medical Staff Services, or by appearing in Medical Staff Services to complete and sign a ballot. Voting shall close at 5:00 p.m. on the second Monday in November. The candidates who receive a majority vote from those Active-Clinical and Active-Senior Staff Members eligible to vote shall be elected. The election of each officer shall become effective as soon as approved by the Board.

- (b) In any election, if there are three or more candidates for an office and no candidate receives a majority vote on the first ballot, there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

15.1.5 TERM OF ELECTED OFFICE

For purposes of continuity, the initial officers shall serve for a period of three years. After this initial three year period, each officer shall serve for a period of two years, beginning on January 1 and ending on December 31, or until their successors are chosen, unless that officer shall sooner resign or be removed from office. The President and a new Vice-President shall be elected every 2 years. An officer may serve for a second term with the agreement of the Board of Managers upon recommendation by the MEC.

15.1.6 RECALL OF OFFICERS

The MEC, by a two-thirds vote, may remove any Medical Staff officer or At-Large member of the MEC who is found to no longer meet any one or more of the qualifications set forth above, or if the member elected is suffering from a physical or mental infirmity that renders the member incapable of fulfilling the duties of the office. Notice of the meeting at which such action shall be decided must be given in writing to such officer at least ten 10 days prior to the date of the meeting. The member 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 Managers.

15.1.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. If the office of President is vacated during the year, the Vice-President is elevated to that office and shall serve as President for the remainder of the unexpired term. If the office of Vice-President is vacated, a replacement shall be appointed as soon as feasible to serve the remainder of the term.

15.2 DUTIES OF OFFICERS

15.2.1 PRESIDENT

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

- (a) serving as Chair of the MEC, and calling, presiding at, and being responsible for the agenda at the MEC;

- (b) serving as a liaison between the Medical Staff and the Board of Managers. The President shall attend meetings of, and communicate Medical Staff matters to, the Board of Managers;
- (c) reporting to the Medical Staff on actions taken by the MEC;
- (d) serving as an ex-officio member of all other Medical Staff committees without vote, unless his membership in a particular committee is required by the Bylaws or these Rules and Regulations;
- (e) interacting with the Administration and Board of Managers on matters of mutual concern within the Heart Hospital;
- (f) 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 MEC;
- (g) having the right to participate on all Medical Staff committees;
- (h) making known the views, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Board of Managers and to the President of the Heart Hospital; and
- (i) being responsible for the organization and conduct of the Medical Staff.

15.2.2 VICE-PRESIDENT

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

- (a) assuming all duties and authority of the Active-Clinical in the absence of the President;
- (b) serving as a Member of the MEC; and
- (c) serve as an ex-officio Member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is required by the Bylaws or these Rules and Regulations;
- (d) performing such other duties as the President may assign or as may be delegated by the Bylaws or these Rules and Regulations, or by the MEC.

15.2.3 IMMEDIATE PAST PRESIDENT

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

- (a) serving as a Member of the MEC; and
- (b) performing such other duties as the President of the Medical Staff may assign or as may be delegated by the Bylaws or these Rules and Regulations, or by the MEC

SECTION 16- DEPARTMENT AND SECTIONS OF THE MEDICAL STAFF

16.1 CLINICAL SECTIONS

The Medical Staff shall be one clinical Department, Cardiovascular Disease. The Department shall have Sections under the direction of a Section Chief. The Department Chair shall be entrusted with the authority, duties, and responsibilities specified in Section 16.5 herein. Proposals to realign, rename, create, eliminate, or modify the Department must first be presented and approved by a majority vote of the Members of the Department present at a regular or specially called meeting for that purpose. Proposals shall then be presented to the MEC and the procedures outlined in Article 15 shall apply.

For the purpose of development or strengthening the specialties, the Department shall be divided into Sections which shall be directly responsible to the Department, and shall have a Section Chief selected and entrusted with the authority, duties and responsibilities specified in Section 16.75. Sections may be established upon written request to the MEC by Department Chair or the membership of the Active-Clinical Staff in the particular specialty requesting a section, and upon approval by the MEC and the Board of Managers. No Section may be established with less than 3 Active-Clinical or Active Senior Members.

Two or more clinical Sections may combine and function as a combined Section for the purposes of convenience, function or education. The combined Section may elect a single Section Chief, or maintain individual Section Chiefs, upon approval of the MEC.

The MEC may act as a Department of the Whole during the first 6 months of the Hospital's existence.

16.2 SECTIONS

Departments include, but are not limited to, the following specialties:

Medicine Section:

- Allergy and Immunology
- Critical Care Medicine
- Dermatology
- Emergency Medicine
- Endocrinology
- Family Practice
- Gastroenterology
- Geriatric Medicine
- Hematology
- Infectious Disease
- Internal Medicine
- Nephrology
- Neurology
- Oncology
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry
- Pulmonary Disease
- Radiology
- Rheumatology

Surgery Section:

Anesthesiology
Cardiovascular/Vascular Surgery
Colon and Rectal Surgery
General Surgery
Gynecology
Neurosurgery
Oncologic Surgery
Ophthalmology
Oral Surgery/Dentistry
Orthopaedic Surgery
Otolaryngology

Pathology
Plastic Surgery
Podiatry
Thoracic Surgery
Urology
Cardiology Section:
Invasive Cardiology
Non-invasive cardiology
Electro-Physiology

16.3 ASSIGNMENT TO THE DEPARTMENT

Members shall participate in only one Department known as the Cardiovascular Disease Department. The Department Chair of that Department shall recommend to the Credentials Committee the clinical privileges to be granted to the Member. All Members in the Department are subject to these Rules and Regulations of the Department and to the authority of the Department Chair.

Practitioners may apply for clinical privileges in Sections other than their primary Section. 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 Section Chief in the other Section) in which clinical privileges are requested. Such recommendation(s) will be sent to the Department Chair who will forward them along with his own recommendation to the Credentials Committee.

16.4 FUNCTIONS OF THE DEPARTMENT

Under the responsibility of the Department Chair, each Section shall perform certain functions.

The Section Chief may assign the responsibility for the accomplishment of specific functions to a section, sub-committee or to a Department Member(s). Such Sections, committees or Member(s) shall perform delineated functions pursuant to Medical Staff Bylaws or these Rules and Regulations.

The general functions of the Department shall include:

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

- (iii) evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that Department;
- (iv) conducting, participating and making recommendations regarding continuing education programs pertinent to Departmental clinical practice;
- (v) coordinating patient care provided by the Department's Members with nursing and ancillary patient care services;
- (vi) meeting at least quarterly, or more often at the discretion of the Department Chair, for the purpose of considering patient care review findings and the results of the Department's other review and evaluation activities, as well as reports on other Department and staff functions;
- (vii) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it;
- (viii) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- (ix) accounting to the MEC for professional and Medical Staff administrative activities within the Department;
- (x) establishing Departmental Best Care Committees as needed to develop and implement evidence based best care practices to improve patient safety and quality of care for the Department;
- (xi) formulating recommendations for Departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the MEC; and
- (xii) 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.

16.5 DEPARTMENT CHAIR

16.5.1 QUALIFICATIONS

The Department Chair shall have a Chair-Elect, who shall be a Member of the Active-Clinical Staff and shall be qualified by training, experience and demonstrated ability in the clinical services covered by the Department. In addition, a Section chief must have demonstrated leadership qualities and be a strong supporter of The Heart Hospital. Under special circumstances, in order to serve the best interests of The Heart Hospital, one or more of the above requirements may be waived. The Department Chair Elect must meet the same qualifications as a Department Chair.

The Department Chair must be specialty board certified in their specialty, not be presently serving as a Medical Staff or corporate officer, Department Chair or Credentials Committee Chairman at another hospital or health care facility and shall not serve as such during the term of office.

The Department Chair 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.

The Department Chair 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 Member is elected.

16.5.2 APPOINTMENT; TERMS OF OFFICE

The Department Chair and the Department Chair Elect shall be appointed by the Medical MEC and ratified by the Board of Managers for a one year term. The current Department Chair Elect shall replace the retiring Department Chair, and a new Department Chair Elect shall be appointed every year. A Department Chair may serve a second term.

16.5.3 REMOVAL

A Department Chair may be removed by the Medical Staff and Board of Managers 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 or failure to comply with the provisions of Section 13 of these Rules and Regulations.

16.5.4 VACANCIES

Vacancies in Department Chair or Department Chair Elect positions occur upon the death or disability, resignation, or removal of the Member, or the loss of membership on the Medical Staff. If the position of Department Chair is vacated during the year, the Department Chair Elect is elevated to that position and shall serve as Department Chair for the remainder of the unexpired term.

In the event that the position is not filled by the Department Chair Elect, for any reason, an interim appointment shall be made by the Board of Managers until such time as the Board can appoint a Department Chair under 15.52.

16.5.5 DUTIES

Each Department Chair shall have the following authority, duties and responsibilities, and the Department Chair Elect, in the absence of the Department Chair, shall assume all of them, and shall otherwise perform such duties as may be assigned:

- (a) act as presiding officer at Departmental meetings and provide appropriate minutes of such meetings;
- (b) assure that the Departmental functions in Section 15.4 are carried out;

- (c) be responsible to the MEC for all professional, clinical and administrative activities within the Department;
- (d) 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, and oversee the effective conduct of patient care evaluation and monitoring functions delegated to the Department by the MEC;
- (e) 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, best care practices and quality improvement;
- (f) be a Member of the MEC, and give guidance on the overall medical policies of the Medical Staff and the Hospital and make specific recommendations and suggestions regarding the Department;
- (g) recommend Department membership appointments and reappointments, as well as clinical privilege delineations to the Credentials Committee;
- (h) recommend criteria for membership and clinical privilege delineation;
- (i) recommend and cooperate in corrective action with respect to persons with clinical privileges in the Department when necessary;
- (j) endeavor to enforce the Medical Staff Bylaws, Rules and Regulations and Credentialing policy for all practitioners within the Department;
- (k) implement within the Department appropriate actions taken by the MEC or its designee;
- (l) participate in every phase of administration of the Department, including cooperation with other Departments, nursing and other allied health service and the Administration in matters such as personnel, supplies, space, special regulations, standing orders, techniques and off-site sources for patient care services not provided by the Department or the Hospital;
- (m) direct and participate in continuing medical education programs in the Department and provide support to such programs throughout the Hospital;
- (n) perform such other duties commensurate with the office as may from time to time be reasonably requested;
- (o) delegate to the Department Chair Elect such duties as appropriate, but notably review of applications for appointment, reappointment or clinical privileges or questions that may arise if the Department Chair has a conflict of interest with the individual under review or could be reasonably perceived to be biased;
- (p) be responsible for the integration of the Department into the primary functions of the organization;

- (q) be responsible for the coordination and integration of interdepartmental and intradepartmental services;
- (r) recommend criteria for and the scope of practice allowed for Allied Health Professionals assigned to their respective Departments; and
- (s) recommend to the Credentials Committee the approval for appointment and reappointment of the Allied Health Professionals Staff.

16.6 FUNCTIONS OF SECTIONS

Each approved Section organized as a specialty Section within a Department shall be directly responsible to the Department within which it functions, and shall have a Section Chief who is elected and has the duties and responsibilities as assigned by the Department Chair. Each Section shall perform the functions assigned to it by the Department Chair of the respective Department. Such functions may include, without limitation, patient care reviews, evaluation of patient care practices, credentials review and clinical privileges delineation, development of evidence based best care practices appropriate to the specialty and continuing education programs. The Section shall transmit reports to the Department Chair on the conduct of its assigned functions. Section shall meet as often as necessary to perform the assigned functions.

16.7 SECTION CHIEFS

16.7.1 QUALIFICATIONS

Each shall have a Chief who shall be a Member of the Active-Clinical and Active-Senior Staff and a Member of the Section, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Section.

16.7.2 SELECTION

The Department Chair over the respective Section shall recommend to the MEC Members for appointment. The MEC shall review the recommendation and make its own recommendation to the Board of Managers, which shall make the appointment.

16.7.3 TERM OF OFFICE

Each Section Chief shall serve for a term of one year. A Section Chief may serve for a second term.

16.7.4 REMOVAL

A Section Chief may be removed by the Board of Managers after consultation with the MEC. A Section Chief 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 Section 13 of these Rules and Regulations. This removal shall be effective when it has been approved by the Board of Managers.

16.7.5 DUTIES

The duties of a Section Chief shall include the following:

- (i) act as presiding officer at Section meetings;
- (ii) assist in the development and implementation of programs to carry out the patient care quality review, and evaluation and monitoring functions assigned to the Section;
- (iii) monitor the clinical work performed in the Section and report any patient care quality issue to the Department Chair;
- (iv) conduct reviews and submit recommendations to the Department Chair regarding the clinical privileges to be exercised within the Section by Members of or applicants to the Medical Staff; and
- (v) perform such other duties as assigned by the Department Chair or MEC.

16.8 CONTRACTED MEDICAL DIRECTORS

Contracted Medical Directors for the Hospital based services such as Anesthesiology, Radiology, Pathology and Emergency Services shall be appointed by the Board of Managers, with advice from the appropriate Department of the Medical Staff. The Board of Managers 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 Managers, subject to the terms of the contract between the Medical Director and the Hospital.

SECTION 17 - COMMITTEES

17.1 DESIGNATION

17.1.1 CHAIRPERSONS

All committee chairpersons, unless otherwise provided for in these Rules and Regulations, will be appointed by the Board of Managers after receiving and considering recommendations from the President of the Medical Staff in consultation with the MEC.

All chairpersons shall be selected based on the criteria set forth in these Rules and Regulations for Department Chair and the Department Chair Elect positions. Such appointments will be made by the Board at its first meeting after the end of the Medical Staff year, for an initial term of 2 years.

After serving an initial term, a chairperson may be reappointed by the Board upon the Board's receiving and considering a recommendation from the President of the Medical Staff Active-Clinical and the MEC.

17.1.2 MEMBERS

Except as otherwise provided for in the Medical Staff Bylaws or these Rules and Regulations, members of each committee shall be appointed every two years by the MEC not more than 10 days after the end of the Medical Staff year, and there shall be no limitation in the number of terms they may serve.

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

The President of the Hospital or the President of the Medical Staff or their respective designees shall be ex-officio members on all committees.

17.1.3 TYPES OF COMMITTEES

Medical Staff committees shall include but not be limited to, the general meetings of the Medical Staff as a committee of the whole, meetings of Departments, meetings of Sections, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the MEC pursuant to this Article or by Departments pursuant to Section 15.4. The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the MEC or Departments to perform specified tasks. Each committee shall have the authority to appoint subcommittees to perform studies on subjects within its jurisdiction.

17.2 CREATION OF STANDING COMMITTEES

The MEC may, by resolution and upon approval of the Board of Managers, without amendment of the Medical Staff Bylaws or these Rules and Regulations, establish additional committees to perform one or more staff functions. In the same manner, the MEC may, by resolution and upon approval of the Board of Managers, 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 MEC. 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.

17.3 CONFIDENTIALITY OF INFORMATION

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

17.4 BAYLOR HEALTH CARE SYSTEM BEST CARE COMMITTEE

The Medical Staff shall participate in the Baylor Health Care System Best Care Committee to facilitate the coordination of quality improvement activities in the Baylor Health Care System and to utilize, when appropriate, the resources and recommendations of Best Care Committee as part of the quality assurance and quality improvement of the Medical Staff and the Hospital. The Baylor Health Care System Best Care Committee is a special committee of this Medical Staff and its activities, proceedings, documents, reports, information, records and all communications are privileged and confidential pursuant to Article XII of these Rules and Regulations.

17.5 MEDICAL EXECUTIVE COMMITTEE (MEC)

17.5.1 COMPOSITION

The MEC shall be composed of:

- (i) The President of the Medical Staff, who shall serve as Chair
- (ii) The Vice President of the Medical Staff
- (iii) The Immediate Past-President of the Medical Staff
- (iv) The Chair of the Department of Cardiovascular Medicine
- (v) The Chair of the Credentials Committee
- (vi) Three Section Chiefs.
- (vii) The Medical Director of the Cath Laboratory
- (viii) The Director of Anesthesia
- (ix) Director of Vascular Services
- (x) Director of Electrophysiology
- (xi) Peripheral Vascular Medicine Director.
- (xii) The President of the Hospital and/or designee(s) and the Nurse Executive, who shall attend each meeting as non-voting Members, and shall serve as liaison officers between the Board of Managers and the MEC
- (xiii) The manager or director of Medical Staff Services, who shall attend each MEC meeting as a non-voting Member to record the minutes

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

17.5.2 DUTIES

The duties of the MEC shall be to:

- (i) 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 these Rules and Regulations;
- (ii) coordinate the activities and general policies of the various Departments;
- (iii) receive and to act upon those committee reports as specified in these Rules and Regulations and to make recommendations concerning them to the President of the Hospital and the Board;
- (iv) implement policies of the Hospital that affect the Medical Staff;
- (v) provide liaison among the Medical Staff, the President of the Hospital and the Board;
- (vi) keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital;
- (vii) enforce the Hospital and Medical Staff rules in the best interest of patient care and of the Hospital with regard to all Members of the Medical Staff;
- (viii) refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff

- Member to the Credentials Committee or the Departmental Policy and Quality Review Committee for appropriate action;
- (ix) 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;
 - (x) review the Bylaws, Rules and Regulations, and Credentialing and Professional Review Policy of the Medical Staff at least once a year and recommend such changes as may be necessary or desirable;
 - (xi) determine minimum continuing education requirements for appointees to the Medical Staff;
 - (xii) review all information available regarding the performance and clinical competence of Members of the Medical Staff and, as a result of such review, make recommendations to the Board of Managers for reappointments or changes in clinical privileges;
 - (xiii) review the credentials of all applicants and to make recommendations to the Board of Managers for appointment to the Medical Staff, assignment to Departments, and delineation of clinical privileges;
 - (xiv) be responsible for the mechanism used to review credentials and to delineate individual clinical privileges;
 - (xv) be responsible for the mechanism by which Medical Staff membership may be terminated;
 - (xvi) be responsible for the mechanism for fair-hearing procedures;
 - (xvii) act on behalf of the organized Medical Staff between medical staff meetings;
 - (xviii) designate and appoint special or ad hoc committees to assist in carrying out the duties and responsibilities of the MEC; and
 - (xix) review and implement recommendations of the Baylor Health Care System Best Care Committee for quality improvement, as appropriate to the Medical Staff and the Hospital, and report the activities, findings and recommendations of the Baylor Health Care System Best Care Committee to the Medical Staff.
 - (xx) The MEC will additionally fulfill the credentialing function of the Credentials Committee during the first 6 months of the Hospital's life.

17.5.3 MEETINGS

The MEC shall meet at least 6 times each year or more often if necessary to transact pending business. Medical Staff Services office 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 MEC shall be transmitted to the President of the Hospital routinely as prepared. Recommendations of the MEC shall be transmitted to the Board with a copy to the

President of the Hospital. The Chairman of the MEC shall meet with the Board or its applicable committee on all recommendations that the MEC may make.

Each Member of the MEC shall attend at least 50% of the meetings held each calendar year. A quorum shall consist of 50% of the Members of the MEC.

17.6 CREDENTIALS COMMITTEE

17.6.1 COMPOSITION

The Credentials Committee shall be composed of at least 7 Members of the Medical Staff and at least 1 non-voting Member of the Board of Managers. The Members shall serve a term of 2 years. Service on this Committee shall be considered as the primary Medical Staff obligation of each Member of the Committee and other Medical Staff duties shall not interfere. A Member may serve a second term with the approval of the Board of Managers with recommendation from the Medical Staff

17.6.2 DUTIES

The duties of the Credentials Committee shall be to:

- (i) review the credentials and qualifications 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 MEC;
- (ii) review the credentials and qualifications of all applicants who request to perform services at the Hospital 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
- (iii) review, as questions arise, all information available regarding the clinical competence and behavior of Members currently appointed to the Medical Staff and Allied Health Professionals and as a result of such review, to make a written report of its findings and recommendations to the MEC.

17.6.3 MEETINGS

After the initial 6 month period, during which the MEC will fulfill the credentialing function. the Credentials Committee shall meet at least 6 times each year or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the MEC, the President of the Hospital and the Board. The Chairman of the Credentials Committee shall meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make.

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 Credentials Committee.

17.7 HEALTH & REHABILITATION COMMITTEE

17.7.1 COMPOSITION

The Health & Rehabilitation Committee shall be a shared committee with Baylor Regional Medical Center at Plano, and will be composed of at least 3 Members of the Active-Clinical and Active-Staff Staff and 1 Member of the Allied Health Professional Staff (when discussion of an Allied Health Professional is taking place) of either Hospital, supported by Medical Staff Director or designee.

17.7.2 DUTIES

The purpose of the Health & Rehabilitation Committee shall be to provide education about health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment and rehabilitation of Medical Staff Members and Allied Health Professionals who suffer from a potentially impairing condition for the purpose of assisting recovery and rehabilitation, rather than disciplinary action.

The Committee's duties include, but are not limited to, the following:

- (i) assisting Medical Staff Members and Allied Health Professionals with self-referral to other organizations;
- (ii) referral of the affected Medical Staff Member or Allied Health Professional to the appropriate resource for diagnosis and treatment of the condition or concern;
- (iii) evaluation of the credibility of complaints, concerns, or allegations of impairment;
- (iv) monitoring the affected Medical Staff Member or Allied Health Professional;
- (v) reporting, if necessary, to the MEC instances where there may be a lack of quality care; and
- (vi) aiding Medical Staff Members and Allied Health Professionals in retaining or regaining optimal performance.

17.7.3 MEETINGS

The Health & Rehabilitation Committee shall meet as needed.

17.8 BYLAWS COMMITTEE

17.8.1 COMPOSITION

The Bylaws Committee shall be composed of at least 5 members of the Active-Clinical and Active-Senior Staff, and as ex-officio members, the President of Hospital, the Past President of the Medical Staff, and the Director of Medical Staff Services. The membership may serve for more than one term.

17.8.2 DUTIES

The Bylaws Committee shall review the Medical Staff Bylaws at least annually, and provide recommendations for revisions and updates as may be needed from time to time.

17.8.3 MEETINGS

The Bylaws Committee shall meet as needed.

17.9 ETHICS COMMITTEE

17.9.1 COMPOSITION

Membership on the Ethics Committee consists of the Chaplain, Directors of Care Coordination, Education, and Health Information Management, Medical Director, Representatives from Nursing, Social Worker, Legal Counsel, Representative from the Section of Medicine, Cardiology, and Surgery, and any others with an interest.

17.9.2 DUTIES

The duties of the Ethics Committee shall be to:

- (i) develop policies that enable or assist the clinical staff to perform their functions in an ethical and fair manner;
- (ii) offer consultation to staff or patients regarding ethical questions and dilemmas;
- (iii) provide a conduit of ethics education to the institution.

17.9.3 MEETINGS

The Ethics Committee will meet quarterly, or when necessary at the call of the committee chairperson.

17.9.4 REPORTS

Complete and accurate minutes of the Ethics Committee will be recorded. Report of Committee actions and recommendations will be presented to the Medical MEC.

17.10 POLICY AND QUALITY REVIEW COMMITTEE

17.10.1 COMPOSITION

The Policy and Quality Review Committee of the Medical Staff shall consist of at least 3 Active-Clinical or Active-Senior Staff Members of the Medical Staff appointed by the Chief of Staff, with the Vice Chief of Staff acting as Chair. The Chief of Staff and the President of the Hospital shall serve as ex-officio Members of this committee. Other Administrative staff shall be appointed as Members without vote to assist the medical Staff in fulfilling the following duties:

17.10.2 DUTIES

The duties of the Policy and Quality Review Committee include, but are not limited to the following:

- (i) routinely collect information about important aspects of patient care provided in the Hospital, periodically assess this information, and develop objective criteria for use

in evaluating patient care. These criteria may include, but are not limited to, operative and invasive procedures performed, outcomes, medication management, blood usage, medical record review, mortality rates, autopsy reviews, utilization management, infection control, restraint use, resuscitation and outcomes, peer review, best practices, research, coordination of care, meeting attendance and/or risk-management data.

- (ii) submitting written reports to the MEC 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 Heart Hospital.

17.10.3 MEETINGS

The Policy and Quality Review Committee shall meet at least 6 times per year, and as needed to perform duties and function. The quorum will be 5 including at least 2 physicians.

17.11 PEER REVIEW COMMITTEE

17.11.1 COMPOSITION

The Peer Review Committee shall have at least three (3) Members of the Medical Staff with at least one member from each section and shall be chaired by the Co-Chairs of the Cardiovascular Department.

17.11.2 DUTIES

Peer Review Committee may be appointed to:

- 1) Fulfill the departmental requirement to conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include the clinical work performed by all sections
- 2) Review and evaluate departmental adherence to Medical Staff policies and procedures, as well as sound principles of clinical practice.
- 3) Report their findings regularly to the MEC.

17.11.3 MEETINGS

These committees shall meet as often as required to perform their duties.

SECTION 18 - MEETINGS

18.1 MEETINGS

18.1.1 GENERAL MEETINGS

There may be one or more general meetings of the Medical Staff, which shall be called by the President of the Medical Staff when it shall be determined necessary or beneficial by the MEC. The agenda and program shall be determined by the President of the Medical Staff. Notice of this meeting shall be given to the Members at least 30 days prior to the meeting.

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

- (i) administrative reports from the President of the Medical Staff and the Administration;
- (ii) election of officers when required by the Medical Staff Bylaws or these Rules and Regulations;
- (iii) voting on proposed changes to the Medical Staff Bylaws or these Rules and Regulations when required by the Bylaws or these Rules and Regulations;
- (iv) 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 Medical Staff functions;
- (v) old business; and
- (vi) new business.

18.1.2 SPECIAL MEETINGS

Special meetings may be called at any time by the President of the Medical Staff or upon the written request of 25% of the Members of the Active-Clinical and Active-Senior Staff. Such Members requesting a meeting shall first consult with the President of the Medical Staff as to the purpose and need to call a special meeting. Called special meetings shall be scheduled by the President within 30 days after receipt of such request. No later than 30 days prior to the meeting, notice shall be mailed or delivered to the Members of the Medical Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

18.2 COMMITTEE, DEPARTMENT AND SECTION MEETINGS

18.2.1 REGULAR MEETINGS

Except as otherwise specified in these Rules and Regulations, the chairs of committees, Department Chairs, and Section Chiefs may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to provide adequate notice of the meeting dates.

18.2.2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee, Department or Section may be called by the chairman thereof, MEC, President of the Medical Staff, or by written request of one-third of the current Members, eligible to vote, but not less than five Members.

18.3 VOTING

18.3.1 GENERAL MEDICAL STAFF MEETINGS

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

18.3.2 QUORUMS: DEPARTMENT, SECTION AND COMMITTEE MEETINGS

The presence of at least two voting Members shall be required for all Departmental, Section and committee meetings to constitute a quorum with the exception of the MEC, the Credentials Committee and the Departmental Policy and Quality Review Committees.

18.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at all Department, Section 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 or email communication, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference or email communication. 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.

18.5 MINUTES

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

18.6 ATTENDANCE REQUIREMENTS

18.6.1 REGULAR ATTENDANCE

It is expected that each Member of the Active Staff shall be required to attend:

- (i) The Annual General Medical Staff meetings, and at least one of each Department, Section, or committee meeting of each Department, Section, and committee of which he is a Member in a calendar year with the exception of the MEC, the Credentials Committee and the Departmental Policy and Quality Review Committees. Members of the MEC, the Credentials Committee, and the Departmental Policy and Quality Review Committees shall be required to attend 75% of the meetings in a calendar year.

18.6.2 ABSENCE FROM MEETINGS

Unless excused for good cause by the presiding officer of the Department, Section, 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.

18.6.3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, individuals other than Members and non-voting Members may be asked to attend meetings of the Medical Staff, Departments, Sections, or committees. When a Member's practice or conduct is scheduled for discussion at a Department, Section, 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 MEC upon a showing of good cause, shall be a basis for corrective action.

18.6.4 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.

18.6.5 CONFLICT OF INTEREST

In any instance where an officer, Department Chair, Section Chief, committee chairman, 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 an applicant, another Medical Staff Member, or Allied Health Professional that comes before such Member, or in any instance where such Member brought the complaint, such Member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that Member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairman of that Department, Section Chief, or committee chair 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 chairman by any committee Member with knowledge of the matter.

A Department Chair shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to Department Chair Elect or other Member of the Department, if the Department Chair has a conflict of interest with the applicant, Member, or Allied Health Professional under review, or could be reasonably perceived to be biased.

SECTION 19 - GENERAL PROVISIONS

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

19.1 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.

19.1-1 The Administrative Suspension as provided in the Medical Staff Bylaws is as follows:

A. Expiration of Licensure, DEA, DPS 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 19.1-1A 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. 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.

19.1-2 Notification of Practitioner Suspension or Reinstatement

A. Notification to Suspend

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

B. Notification to Reinstatement

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

19.1-3 Reporting to Texas Medical Board for Failure to Complete Medical Records

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

SECTION 20 - RULES AND REGULATIONS REVIEW POLICY

20.1 MEDICAL STAFF RULES AND REGULATIONS REVIEW POLICY

The Medical Staff shall adopt Rules and Regulations as it may deem necessary governing the proper use of the Hospital for the care and treatment of patients, as well as the conduct of professional standards, education and research programs among the Medical Staff. The Rules and Regulations of the Medical Staff shall be reviewed annually. Proposed amendments shall be brought through or formulated by the MEC.

The Rules and Regulations shall be amended in the following manner:

- (i) Proposed amendments shall be presented to the MEC and must be approved by a two-thirds vote of all Members of the Medical MEC.
- (ii) Adoption is subject to the review and approval of the Board of Managers, which approval shall not be unreasonably withheld.

20.2 NOTIFICATION OF CHANGES

New or amended Bylaws, Rules and Regulations shall be published and made available to Members of the Medical Staff or Members of a specific Department involved, and shall be compiled and maintained in a convenient form in the Hospital, readily available for reference.

SECTION 21 - ALLIED HEALTH PROFESSIONAL

21.1 ALLIED HEALTH PROFESSIONAL

Allied Health Professional is not a Medical Staff Member, and Allied Health Professional is not considered a category of the Medical Staff. Allied Health Professional shall not have any of the prerogatives or responsibilities of Medical Staff membership.

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

Allied Health Professional and the employment of such individuals by Medical Staff Members are subject to these Rules and Regulations and Rules and Regulations of the Medical Staff, as well as any HEART HOSPITAL policies and procedures, Heart Hospital approved position descriptions and any local, state or national requirements applicable to a particular category of Allied Health Professional.

SECTION 22 - PATIENT CARE POLICIES

In addition to these Rules and Regulations of the Medical Staff, other policies and procedures relating to the provision of patient care may be presented to the MEC for adoption. New or revised policies and procedures approved by the MEC and Board of Managers will be communicated to Medical Staff Members. Medical Staff Members shall comply with Hospital policies and procedures relating to patient care and treatment, health care operations, payment, and privacy of individually identifiable health information.

APPROVED BY:

Medical Executive Committee: _____ **Date:** _____

Board of Managers: _____ **Date:** _____