2013

Medical Staff Orientation
Mission Statement
South Bay Hospital is committed to being the best community hospital. Our healthcare team strives to provide effective and efficient services tailored to meet the healthcare needs of our community in a skillful, caring and professional manner.

Values
• We recognize and affirm the unique and intrinsic worth of each individual
• We treat all those we serve with compassion and kindness
• We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives
• We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity
# Medical Staff Leadership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen Witt</td>
<td>Chairman Board of Trustees</td>
</tr>
<tr>
<td>Ghassan Ksaibati</td>
<td>Chief of Medical Staff</td>
</tr>
<tr>
<td>Robert Katz</td>
<td>Chief Dept. of Special Services</td>
</tr>
<tr>
<td>John Han</td>
<td>Chief Dept. of Medicine</td>
</tr>
<tr>
<td>Ronald Delgado</td>
<td>Chief Dept. of Surgery</td>
</tr>
</tbody>
</table>

## Administrative Team and Department Directors

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>Sharon Roush</td>
<td>813-634-0101</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Gary Malaer</td>
<td>813-634-0377</td>
</tr>
<tr>
<td>Chief Nursing Officer</td>
<td>Terrie Jefferson</td>
<td>813-634-0103</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>David Cantrell</td>
<td>813-634-0105</td>
</tr>
<tr>
<td>Cardiopulmonary Director</td>
<td>Aaron Gibson</td>
<td>813-634-0116</td>
</tr>
<tr>
<td>Case Management Director</td>
<td>Kathy Bridges</td>
<td>813-634-0253</td>
</tr>
<tr>
<td>Emergency Room Director</td>
<td>Rhonda Burns</td>
<td>813-634-0138</td>
</tr>
<tr>
<td>Environmental Services Director</td>
<td>Laura Burgess</td>
<td>813-634-0518</td>
</tr>
<tr>
<td>Food Services Director</td>
<td>John Deans</td>
<td>813-634-0289</td>
</tr>
<tr>
<td>Human Resources Director</td>
<td>Dana Wheeler</td>
<td>813-634-0372</td>
</tr>
<tr>
<td>Information Services Director</td>
<td>Michael Willms</td>
<td>813-634-0199</td>
</tr>
<tr>
<td>Laboratory Director</td>
<td>Kathy Jones</td>
<td>813-634-0120</td>
</tr>
<tr>
<td>Marketing Director</td>
<td>Natalia Diaz</td>
<td>813-634-0496</td>
</tr>
<tr>
<td>Materials Management Director</td>
<td>Dustin Batista</td>
<td>813-634-0162</td>
</tr>
<tr>
<td>Medical Records Director – Privacy Officer</td>
<td>Marla Jones</td>
<td>813-634-0193</td>
</tr>
<tr>
<td>Medical Staff Coordinator</td>
<td>Argeles White</td>
<td>813-634-0104</td>
</tr>
<tr>
<td>Nursing – ICU/PCU</td>
<td>Marjorie Westerkamp</td>
<td>813-634-0340</td>
</tr>
<tr>
<td>Nursing – 3 East Telemetry</td>
<td>Claudia Ramey</td>
<td>813-634-0393</td>
</tr>
<tr>
<td>Nursing – 2nd Floor – Medical-Surgical</td>
<td>Ronetta Lambert</td>
<td>813-634-0254</td>
</tr>
<tr>
<td>Patient Access Director</td>
<td>Dottie Crist-Marshall</td>
<td>813-634-0177</td>
</tr>
<tr>
<td>Pharmacy Director</td>
<td>Tina Eberstein</td>
<td>813-634-0198</td>
</tr>
<tr>
<td>Plant Operations - Safety Officer</td>
<td>Lauren Labrador</td>
<td>813-634-0165</td>
</tr>
<tr>
<td>Quality/Risk Director</td>
<td>Cheryl Roberts</td>
<td>813-634-0386</td>
</tr>
<tr>
<td>Radiology Director</td>
<td>Christine Helton</td>
<td>813-634-0366</td>
</tr>
<tr>
<td>Rehab Services Director</td>
<td>Paul Melancon</td>
<td>813-634-0221</td>
</tr>
<tr>
<td>Surgery Director</td>
<td>Janiece MacDonald</td>
<td>813-634-0280</td>
</tr>
</tbody>
</table>
2013 National Patient Safety Goals

**Improve the accuracy of patient identification**
- Two patient identifiers are used (name, date of birth)
- Never use a patient room number

**Improve staff communication**
- Telephone orders will be written down and read back to ensure accuracy of orders received
- Telephone orders and orders taken by ARNP or PA must be authenticated by signature of physician within 48 hours
- Hand written orders must have the physician’s signature printed with first and last name so that it is easily readable and legible
- Critical test results will be called within 30 minutes of notification by lab or radiology
- According to the Institute of Medicine an estimated 1.5 million preventable medication errors occur each year. Although abbreviations in health care may be efficient, their use comes at the expense of patient safety. A new Joint Commission study analyzed 30,000 medication errors involving abbreviations and found that the most common error was the use of “qd” in place of “once daily”. *To help us ensure your medication orders are transcribed accurately without error, please do not use the following abbreviations.*

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the #4 (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Mistaken for “IV” or the #10</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., QOD, Q.O.D., q.o.d., qod</td>
<td>Mistaken for each other. Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “daily”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0mg) Lack of leading zero (.X mg)</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS MSO4 and MgSO4</td>
<td>Can mean morphine sulfate or magnesium sulfate Confused for one another</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

**Use medications safely**
- All medications when transferred from the original packaging must be labeled.
- Please be cautious when giving medication orders that “look alike and sound alike”.
- TPN orders must be completed on the pre-printed form by 1500 for the next day.
• Blanket orders like “continue home meds” or “resume all per-op meds” will not be accepted and nursing is required to clarify those medications with you.

**Accurate and complete medication reconciliation across the continuum of care on is required on Admission, Transfer and Discharge**

**Reduce harm associated with the use of anticoagulants**

• When patients are started on Coumadin a baseline INR must be completed.
• Patient education is provided regarding medication use, follow up therapy, dietary restrictions, compliance issues and potential adverse reactions.

**Prevent infections**

• Hand washing is required before entering a patient’s room, after leaving a patient’s room and when visibly soiled.
• Alcohol gel dispensers are available inside and outside of every patient room.
• Patients on contact isolation for Clostridium Dificile require hands to be washed with soap and water.
• MRSA screening is completed on every patient coming from a skilled nursing facility, and or if the patient is immunocompromised
• Pneumonia and Flu (October-March) vaccines are automatically provided to patients unless contraindicated by physician or refused by patient
• Isolation personal protective equipment is to be worn in all isolation rooms

**Use proven Guidelines to Prevent Catheter Associated Blood Stream Infections (CLABSI)**

• Hand hygiene
• Maximal barrier precautions when inserting the line – gown, gloves, mask. A central line cart with required equipment is available in the ICU.
• Chlorhexidine skin antiseptic
• Optimal site selection - subclavian
• Daily assessment of line necessity

**Use Proven Guidelines to Prevent Ventilator Acquired Pneumonia**

• Elevation of the head of the bed to between 30 and 45 degrees
• Daily “sedation vacation” and daily assessment of readiness to extubate
• Medications to prevent peptic ulcer disease (PUD)
• Deep venous thrombosis (DVT) prophylaxis
• Provision of oral care
Reduce the risk of patient harm
- Patients identified as high risk to fall are identified by – yellow bracelet, socks, fall safety slider outside of door
- Bed and chair alarms, low beds and enclosure beds may also be utilized.
- All patients are screened on admission for risk of suicide. Crisis hotline – 234-1234 or call 2-1-1 for Crisis Center Tampa

Improve recognition and response to changes in a patient’s condition

Rapid Assessment Team

What is the Rapid Assessment Team (RAT)?
- The RAT team is comprised of a critical care nurse and Respiratory Therapist who respond to calls whenever additional expert attention is needed to avoid a potential emergency.
- The Rapid Assessment Team saves lives and brings about a positive outcome for our patients here at South Bay Hospital.

Who Can Call?
- Families  Physicians  Staff Members

How to Call?
- Pick up the phone  Dial 1999  Ask the operator to call a RAT

Prevent Mistakes in Surgery

- Take a Time out to verify correct patient, site, procedure, positioning, relevant documentation is complete –H&P, informed consent, correct diagnostic and radiology test results, any required blood products, implants and or special equipment is available. During time out all activity is suspended to the extent without compromising patient safety.
- Mark correct site with Yes and Initials

Pain Management

Definition: Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is whatever the experiencing person says it is, existing whenever he/she says it does. The patient’s self-report is the single most reliable indicator of pain.
1. Acute Pain - Usually brief duration, pain subsides as the healing takes place.
2. Chronic Pain - Non-malignant pain, pain persists longer than what is expected for healing.

Our goal is to make the patient’s stay as comfortable and pain free as possible.
Core Measures – are evidenced based guidelines proven to reduce the patient’s mortality, complication and readmission rates. Hospitals are reimbursed based upon their performance in meeting the following indicators. If the hospital is not above the 90th percentile, we are penalized and reimbursement is reduced. Core measure misses are reported in Peer Review with appropriate corrective actions taken for non-compliance in meeting these national standards of care.

Acute Myocardial Infarction
- ASA within 24 hours of admission and ordered to continue on discharge
- Cholesterol checked within 24 hours of admission and if LDL is greater than 100, statin must be ordered at discharge unless contraindication is documented.
- Beta blocker on admission and discharge unless contraindication is documented.
- STEMI Transfer to the cath lab in less than 90 minutes

Heart Failure
- LVF assessment
- ACE or ARB if EF is less than 40% unless contraindication is documented.
- Specific discharge instructions to include all of the following teaching points (daily weights, diet, activity, signs and symptoms to report to physician, follow up appointments, smoking cessation counseling)
- Accurate and complete medication reconciliation. In discharge summary, please refer to the discharge medication reconciliation form for list of medications rather than trying to list each one individually. If your medication list is not 100% accurate including dosage, route, frequency, we will not meet this indicator.

Pneumonia
- If blood cultures are ordered they must be drawn prior to the administration of the antibiotic
- Antibiotic within 6 hours of admission
- Antibiotic Selection – see guidelines below
- Pneumonia and Influenza vaccines offered prior to discharge
- Smoking cessation counseling
# Pneumonia Antibiotic Recommendations

**Antibiotics to be initiated within 6 hours of arrival – and appropriate antibiotic selection within 24 hours of arrival**

<table>
<thead>
<tr>
<th>Non-ICU</th>
<th>B-lactam (IV or IM) + Macrolide (IV or PO)</th>
<th>OR</th>
<th>Antipneumococcal Quinolone monotherapy (IV or PO)</th>
<th>OR</th>
<th>B-lactam (IV or IM) + Doxycycline</th>
<th>OR</th>
<th>Tigecycline monotherapy (IV)</th>
<th>OR</th>
<th>if &lt; 65 with no risk factors for Drug-resistant Pneumococcus = Macrolide monotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU</td>
<td>Macrolide (IV) + either B-lactam (IV) or Antipneumococcal/Antipseudomonal B-lactam (IV)</td>
<td>OR</td>
<td>Antipneumococcal Quinolone (IV) + either B-lactam or Antipneumococcal/Antipseudomonal B-lactam (IV)</td>
<td>OR</td>
<td>Antipneumococcal Quinolone (IV) + either B-lactam (IV) or Antipneumococcal/Antipseudomonal B-lactam (IV)</td>
<td>OR</td>
<td>Antipneumococcal/Antipseudomonal B-lactam (IV) + Aminoglycoside (IV) + either Antipneumococcal Quinolone or Macrolide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-ICU with Pseudomonal Risk</td>
<td>Antipneumococcal/Antipseudomonal B-lactam (IV) + Antipneumococcal Quinolone (IV or PO)</td>
<td>OR</td>
<td>Antipneumococcal/Antipseudomonal B-lactam (IV) + Aminoglycoside (IV) + either Antipneumococcal Quinolone (IV or PO) or Macrolide (IV or PO)</td>
<td>OR</td>
<td>IF B-lactam allergy = Aztreonam (IV or IM) + Antipneumococcal Quinolone (IV or PO)</td>
<td>OR</td>
<td>Aminoglycoside OR Aztreonam (IV or IM) + Levofloxacin (IV or PO)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B-lactam** = Rocephin, Cefotaxime, Unasyn, Ertapenem  
**Macrolide** = Erythromycin, Clarithromycin, Azithromycin  
**Antipneumococcal Quinolones** = Levofloxacin, Moxifloxacin, Gemifloxacin  
**Antipneumococcal/Antipseudomonal B-lactams** = Maxipime, Zosyn, Primaxin  
**Antipseudomonal Quinolone** = Ciprofloxacin, Levofloxacin  
**Aminoglycoside** = Gentamicin, Tobramycin, Amikacin
Surgical Care Improvement Project

- Hair is clipped not shaved
- Antibiotics are administered within 60 minutes of incision cut time
- Appropriate antibiotics are administered
- Antibiotics are discontinued 24 hours post op
- VTE prophylaxis is started 24 hours post op unless contraindication is documented
- All patients with a urinary catheter placed intraoperatively must have it removed by post-op day 2 - excluding urological, gynecological or perineal procedures – unless documentation is present to continue with reason

<table>
<thead>
<tr>
<th>Appropriate Indications for Indwelling Urethral Catheter Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient has acute urinary retention or obstruction</strong></td>
</tr>
<tr>
<td><strong>Need for accurate measurements of urinary output in critically ill patients</strong></td>
</tr>
<tr>
<td><strong>Perioperative use for selected surgical procedures:</strong></td>
</tr>
<tr>
<td>- Patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract</td>
</tr>
<tr>
<td>- Anticipated prolonged duration of surgery (catheters inserted for this reason should be removed in PACU)</td>
</tr>
<tr>
<td>- Patients anticipated to receive large-volume infusions or diuretics during surgery</td>
</tr>
<tr>
<td>- Operative patients with urinary incontinence</td>
</tr>
<tr>
<td>- Need for intraoperative monitoring of urinary output</td>
</tr>
<tr>
<td><strong>To assist in healing of open sacral or perineal wounds in incontinent patients</strong></td>
</tr>
<tr>
<td><strong>Patient requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine)</strong></td>
</tr>
<tr>
<td><strong>To improve comfort for end of life care if needed</strong></td>
</tr>
<tr>
<td><strong>Indwelling catheters should not</strong> be used:</td>
</tr>
<tr>
<td>- As a substitute for nursing care of the patient or resident with incontinence</td>
</tr>
<tr>
<td>- As a means of obtaining urine for culture or other diagnostic tests when the patient can voluntarily void</td>
</tr>
<tr>
<td>- For prolonged postoperative duration without appropriate indications</td>
</tr>
<tr>
<td>- Routinely for patients receiving epidural anesthesia/analgesia</td>
</tr>
</tbody>
</table>
**Stroke**

- Thrombolytic therapy – for patients who arrive at the hospital within 2 hours of time last known well
- Venous Thromboembolism (VTE) Prophylaxis started within 24 hours
- Antithrombotic Therapy started within 24 hours and patient discharged on medication – ASA or Aggrenox
- Anticoagulation therapy for Atrial Fib/Flutter
- Statin for patients with LDL greater than 100 unless contraindication is documented
- Stroke education
- Patient assessed for rehabilitation

**VTE**

- VTE Prophylaxis is started within 24 hours of admission unless contraindication is documented, non-mechanical treatments are also available to include SCD’s, foot pumps and TED hose.
- Overlap anticoagulation therapy must be administered for:
  - Less than five days and discharged on overlap therapy
  - Five or more days with an INR equal to or greater than 2 prior to discontinuation of parenteral therapy
  - Five or more days with an INR equal to or greater than 2 and discharged on overlap therapy
- Discharge education must include the following 4 elements:
  1) Importance of taking Warfarin as instructed
  2) Importance of monitoring PT/INR – to include name and phone number of clinic or office monitoring and next date for blood draw
  3) Dietary advice – avoid major changes in dietary habits, foods with vitamin K should be monitored and managed consistently
  4) Potential for adverse drug reactions and interactions to include diet, medications, bleeding risks and to check with physician before taking any medications or OTC medications

**Global Immunizations**

**Influenza Vaccine**

- Administered October 1 through March 31
- Vaccine is indicated if patient is 6 months or older and have no contraindications to the vaccine.
- Contraindications include previous immunization this flu season, serious reaction to eggs, previous reaction to influenza vaccine, history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccine, bone marrow transplant within the past 6 months, patient or caregiver refusal
Global Immunizations Continued

Pneumococcal Vaccine

- Offered year round
- Vaccine is indicated if any of the following:
  - 65 years or older
  - Resident of a nursing home or chronic care facility

  **OR**

  - Patient is age 2-64 and has any of the following high risk conditions
    - Cigarette smokers age 19 and over
    - Serious long-term health problems with chronic heart or lung disease (including asthma), diabetes mellitus, or kidney disease including nephrotic syndrome
    - Compromised immunity (HIV infection or aids, organ transplant etc)
    - Alcoholism, cirrhosis of the liver, or chronic liver disease
    - Sickle cell anemia or prior splenectomy
    - Cerebral spinal fluid leaks
    - Candidate or recipient of cochlear implant
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS (pronounced “H-caps”) is the first national standardized, publicly reported survey of our patient’s perspectives regarding their hospital stay while here at South Bay. It is designed to provide data on topics that are objective and important to patients.

Key survey questions include the following topics – communication with nurses and doctors, responsiveness of hospital staff, cleanliness and quietness of environment, pain management, communication about medicines, discharge information, overall rating of hospital and recommendation of hospital.

Public reporting of the survey results began in March 2008. HCAHPS results are published quarterly on the Hospital Compare website found at www.hospitalcompare.hhs.gov. Survey objectives include creating a valid comparison of hospitals and incentives to improve quality care. Again, hospitals are reimbursed based upon their performance in ensuring a positive patient experience.

Core Values

- Quality of care is measured by how well the health care team listens and communicates with the patient and their family
- The meaning and essence of care are experienced in the moment when one human being connects with another
- Feeling connected creates harmony and healing versus feeling isolated
- Everyone has a valuable contribution to make
- Establishing a relationship with the patient is the heart of care delivery
- A therapeutic relationship between a patient and their family is essential to quality patient care

Basic Steps in Establishing Patient Relationships

- First seconds of any interaction must convey clinical confidence, approachability, understanding, compassion and kindness.
- Prepare for an exchange of information, give the patient your full attention, and listen to what the patient is saying before you respond. Engage in friendly conversation.
- Recognize the impact of family, remember to include and listen to them. They (family) know the patient better than we do and can provide valuable insight into their care.
- Provide individualized care involve patients and their family members in clinical decisions.
- Focus on building collaborative relationships. Get to know the patient as a person. Constantly look for ways to engage the patient and family in their care.
- Consider cultural sensitivities. Be aware and accommodate variations.
- Demonstrate empathy. Expressing empathy diffuses tension and fear and helps to build trust. As you listen imagine how you would feel in a strange place, surrounded by people you don’t know, scared and in pain. A way to demonstrate empathy is to say I’m sorry - sorry for the situation, I’m sorry you are in so much pain, I’m sorry you are experiencing this loss.
- Ask for feedback, we want to encourage patients to ask questions, be receptive and respond this helps to build strong relationships.
Emergency Codes
Dial 1999 for the Operator to announce an emergency code

<table>
<thead>
<tr>
<th>Color</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grey</td>
<td>Crisis Team</td>
</tr>
<tr>
<td>Red</td>
<td>Fire</td>
</tr>
<tr>
<td>Blue</td>
<td>Arrest</td>
</tr>
<tr>
<td>Pink</td>
<td>Pedi Arrest</td>
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<tr>
<td>White</td>
<td>Hazmat Spill</td>
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<tr>
<td>Orange</td>
<td>Bioterrorism</td>
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<tr>
<td>Charles Atlas</td>
<td>Abduction</td>
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<tr>
<td>D Internal</td>
<td>Internal disaster</td>
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<tr>
<td>D External</td>
<td>External Disaster</td>
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<tr>
<td>Yellow</td>
<td>Bomb Threat</td>
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<tr>
<td>EVAC/EVAC/Evac</td>
<td>Evacuation</td>
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<tr>
<td>Rapid Assessment Team</td>
<td>Change in patient condition</td>
</tr>
<tr>
<td>Stroke Alert</td>
<td>New stroke symptom</td>
</tr>
</tbody>
</table>

Fire Safety
R – Rescue the patient from danger P – Pull the ring
A – Activate the alarm A – Aim at the base of the fire
C – Contain the fire S – Squeeze the handle
E – Extinguish or evacuate S – Sweep side to side

Evacuation – horizontal past the next set of fire doors
Departmental Phone Directory
<table>
<thead>
<tr>
<th>Hospital Departments</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>(813) 634-0102</td>
</tr>
<tr>
<td>Business Office/Billing Inquiries</td>
<td>(813) 386-1520</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>(813) 634-0116</td>
</tr>
<tr>
<td>Case Management</td>
<td>(813) 634-0371</td>
</tr>
<tr>
<td>Community Relations</td>
<td>(813) 634-0172</td>
</tr>
<tr>
<td>Digital Mammography</td>
<td>(813) 642-8468</td>
</tr>
<tr>
<td>Emergency Department Information</td>
<td>(813) 634-0145</td>
</tr>
<tr>
<td>Food &amp; Nutritional Services</td>
<td>(813) 634-0290</td>
</tr>
<tr>
<td>H2U - Health, Happiness, You</td>
<td>(813) 634-0187</td>
</tr>
<tr>
<td>Human Resources</td>
<td>(813) 634-0349</td>
</tr>
<tr>
<td>Infection Control</td>
<td>(813) 634-0385</td>
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<tr>
<td>Laboratory Services</td>
<td>(813) 634-0120</td>
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<tr>
<td>Marketing/Public Relations</td>
<td>(813) 634-0172</td>
</tr>
<tr>
<td>Materials Management</td>
<td>(813) 634-0161</td>
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<tr>
<td>Medical Imaging (Radiology)</td>
<td>(813) 634-0148</td>
</tr>
<tr>
<td>Medical Records</td>
<td>(813) 634-0190</td>
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<tr>
<td>Medical Staff Office</td>
<td>(813) 634-0104</td>
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<tr>
<td>Nursing Units</td>
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<tr>
<td>2 East</td>
<td>(813) 634-0250</td>
</tr>
<tr>
<td>2South</td>
<td>(813) 634-0240</td>
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<tr>
<td>3 East</td>
<td>(813) 634-0362</td>
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<tr>
<td>PCU</td>
<td>(813) 634-0350</td>
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<td>ICU</td>
<td>(813) 634-0355</td>
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<td>Outpatient Scheduling</td>
<td>(813) 634-0422</td>
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<tr>
<td>Quality/Risk Management</td>
<td>(813) 634-0386</td>
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<tr>
<td>Rehab Services</td>
<td>(813) 634-0156</td>
</tr>
<tr>
<td>Surgery Scheduling</td>
<td>(813) 634-0279</td>
</tr>
</tbody>
</table>
Medical Record Documentation Requirements

<table>
<thead>
<tr>
<th>Time Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Physical (H&amp;P)</td>
</tr>
<tr>
<td>Must be completed within 24 hours of the patient</td>
</tr>
<tr>
<td>admission time and or prior to surgery</td>
</tr>
<tr>
<td>Brief Operative Note</td>
</tr>
<tr>
<td>Must be completed before the patient transfers to</td>
</tr>
<tr>
<td>the next level of care</td>
</tr>
<tr>
<td>Full Operative Report</td>
</tr>
<tr>
<td>Must be completed within 24 hours of surgery end</td>
</tr>
<tr>
<td>time</td>
</tr>
<tr>
<td>Verbal Orders</td>
</tr>
<tr>
<td>Must be signed, dated and timed within 48 hours.</td>
</tr>
<tr>
<td>Signature must be printed and legible for example</td>
</tr>
<tr>
<td>- Frank Jones MD</td>
</tr>
<tr>
<td>Medication Reconciliation Forms</td>
</tr>
<tr>
<td>Must be completed upon admission, transfer and</td>
</tr>
<tr>
<td>discharge</td>
</tr>
<tr>
<td>Progress Notes</td>
</tr>
<tr>
<td>Must be completed daily at the time of assessment</td>
</tr>
<tr>
<td>of patient to include, treatments to be taken,</td>
</tr>
<tr>
<td>patient response to treatments provided, reasons</td>
</tr>
<tr>
<td>for delays</td>
</tr>
<tr>
<td>Discharge Summary</td>
</tr>
<tr>
<td>Must be completed within 30 days and include</td>
</tr>
<tr>
<td>principal diagnosis, additional diagnoses or</td>
</tr>
<tr>
<td>procedures, reason for admission, hospital</td>
</tr>
<tr>
<td>course – significant findings, condition on</td>
</tr>
<tr>
<td>discharge, specific follow up instructions</td>
</tr>
</tbody>
</table>

Delinquent Medical Records
Incomplete medical records are considered delinquent after 30 days. A medical record is considered finalized after all orders, progress notes, dictated reports, and queries are completed in both the daily Meditech Workload and in the HPF Portal. Any orders not completed in the daily Meditech Workload will automatically flow over to the HPF portal. Physicians with incomplete orders will be notified weekly. Suspension warning letters are sent out two weeks prior to the suspension date.

Confidentiality:
The medical record is a legal document and is confidential. Physicians are not to review a patient’s chart unless they are directly involved in that patient’s current hospital care.

Please remember the medical record is a legal document and all information contained within the record is discoverable so please refrain from unprofessional or disparaging remarks about the patient, family or other staff members.

Please use caution when discussing patient care with colleagues so you’re your conversation cannot be overheard by the public.

Clinical Documentation Reviews
Clinical documentation reviews are completed monthly to ensure required documentation is complete and timely. Results are reported at the Utilization Review Committee.
Dictation Instructions

Step 1
Dial extension 1408 (if inside the hospital)
Dial (813) 634-0408 (if outside the hospital)

Step 2
Enter your physician ID, followed by the # key

Step 3
Enter the work type, followed by the # key

<table>
<thead>
<tr>
<th>01 H&amp;P</th>
<th>02 Consultation</th>
<th>03 Operative/Procedure Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>04 Final Summary</td>
<td>25 EEG</td>
<td>26 Echocardiogram</td>
</tr>
<tr>
<td>30 Pulmonary Function Test</td>
<td>56 Progress Note</td>
<td>76 Stress Test</td>
</tr>
</tbody>
</table>

Step 4
Enter the last 7 digits of the patient’s Account Number, followed by the # key

Step 5
Begin dictating after the tone

Step 6
Press “3” to begin a new report

Step 7
At the end of your dictation, always press #0 for the confirmation number and document it in the medical record

Keypad Functions

<table>
<thead>
<tr>
<th>1 No Function</th>
<th>2 Record</th>
<th>3 Rewind</th>
<th>4 No Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Disconnect</td>
<td>6 Pause</td>
<td>7 Fast Forward</td>
<td>8 Play Back From Beginning</td>
</tr>
<tr>
<td>9 No Function</td>
<td>*STAT</td>
<td>0 Fast Forward to End</td>
<td># No Function</td>
</tr>
<tr>
<td>#0 Play Back Job #</td>
<td>#3 New Report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medical Staff Structure

<table>
<thead>
<tr>
<th>Department</th>
<th>Department Chair</th>
<th>Department Vice Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>John Han, MD</td>
<td>Satya Gullapalli, MD</td>
</tr>
<tr>
<td>Special Services</td>
<td>Robert Katz, MD</td>
<td>Julie Vitko, MD</td>
</tr>
<tr>
<td>Surgery</td>
<td>Ronald Delgado, MD</td>
<td>Mark Alkire, MD</td>
</tr>
</tbody>
</table>

### Medical Staff Committees
- Medical Executive Committee
- Peer Review
- Utilization Review
- Pharmacy & Therapeutics
- Infection Control
- Critical Care
- Cancer Committee
- Quality Council

### Ongoing Professional Practice Evaluations:
Every six months a retrospective reappraisal of professional performance including clinical and medical knowledge, patient care, interpersonal and communication skills, practiced based learning and improvement, professionalism and systems based practice will be prepared for each physician and reviewed by the department chair. Methodologies for collecting information may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques and discussion with other individuals involved in the care of each patient including consulting physicians, surgery assistants, nursing and administrative personnel. These reports will be provided to individual physicians. The timeframe for distribution will be at least annually.

If the practitioner has no volume to be evaluated he/she will be ask to provide a competency assessment from another healthcare facility, hospital or outpatient surgery center. If this assessment cannot be provided within 30 days of notification, the practitioner’s medical staff category and privileges may be reclassified.
Focused Professional Practice Evaluations:
May be requested by the Credentials Committee for all initially requested
privileges and or by the Peer Review Committee or MEC when issues affecting
the provision of safe quality patient care are identified
The organized medical staff has developed the following criteria to be used for
evaluating the performance of practitioners when issues affecting the provision
of safe, high quality patient care are identified.

- High Complication Rates (Actual/Expected)
- Adjusted Mortality (Actual/Expected)
- Medical Record Accuracy/Completion
- Confirmed Quality Complaint
- Core Measure Outliers – 3 or more in a Quarter
- Failure to meet SIMS criteria – 3 or more in a Quarter

On Site Orientation:
An onsite orientation is required and scheduled through Argelis White, Medical
Staff Coordinator to secure a badge, complete computer training, take a facility
tour and receive personal introductions to the senior management team
members, department directors and hospital staff.

Parking:
Parking is available both in front of the hospital as well as in the back.

Cellular Phones:
Cellular phones are permitted to be used within the facility.

Changes in Personal Information:
Please keep the medical staff office apprised of any changes in office phone
numbers, home phone, cell phone, beeper numbers and e-mail address.
Changes should be reported as soon as they occur.
Dr. Doctor,

Thank you for your interest in affiliation with South Bay Hospital.

HCA has a comprehensive, values-based Ethics and Compliance Program. This Code of Conduct, which reflects our tradition of caring, provides guidance to ensure our work is done in an ethical and legal manner. It emphasizes the shared common values and culture which guide our actions. It also contains resources to help resolve any questions about appropriate conduct in the work place. Please review HCA’s Code of Conduct thoroughly at


Welcome to be part of our Medical Staff.

Respectfully,

Argelis White, CPCS
Medical Staff Coordinator
2011

MEDICAL STAFF BYLAWS

AND

RULES AND REGULATIONS

OF

SOUTH BAY HOSPITAL

Foreword

South Bay Hospital located at 4016 Sun City Center Blvd., Sun City Center, Florida is a proprietary acute care, general hospital, owned and operated by Sun City Hospital, Inc., a Florida corporation (the "Corporation").

Preamble

Recognizing that the Medical Staff is responsible for the quality of medical care in the Hospital, and must accept and assume this responsibility subject to the ultimate authority of the Governing Body, and that the best interests of the patient are protected by cooperative effort, the members of the Medical Staff practicing at South Bay Hospital hereby establish themselves in conformity with these Bylaws and Rules and Regulations.
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I. Name and Definitions

A. The name shall be the Medical Staff of South Bay Hospital.

B. Definitions:

1. The term "Allied Health Professional Affiliate" or "Affiliate" means an individual, other than a Practitioner, whose patient care activities require him/her to exercise independent judgment within the areas of professional competence and to perform specified patient care services and who is qualified to render direct or indirect medical or surgical care under the supervision of a medical staff member with appropriate privileges. Allied Health Professional Affiliate shall include, without limitation, clinicians/practitioners, physician assistants, therapists and anesthetists. Affiliates may be independent practitioners, employees of the Hospital or of members of the Medical Staff.

2. The term "Chief Executive Officer" means the individual appointed by the Corporation to provide the overall management of the Hospital.

3. The term "Clinical Privileges" or "Privileges" means the permission granted to an individual to admit patients and to render specific diagnostic, therapeutic, medical, dental or surgical services.

4. The term "Corporation" means the corporation, which owns and/or operates the Hospital.

5. The term "Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

6. The term "Ex-Officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

7. The term "Governing Body" means the Board of Trustees of the Hospital.

8. The term "Hospital" means South Bay Hospital.

9. The term "Limited Health Practitioner" shall mean those practitioners whose scope of practice is anatomically limited by licensure law, except for oral surgeons, and shall include dentists, podiatrists and psychologists.

10. The term "Medical Staff" or "Staff" means the group of physicians duly licensed to practice medicine and surgery, and dentists, podiatrists, and psychologists duly licensed to practice dentistry, podiatry, and psychology in the State of Florida who are privileged to attend patients in the Hospital.

11. "Medical Staff Year" means the period from January 1st through December 31st.

12. The term "Member" means a physician, dentist or podiatrist that has been granted membership and admitting and clinical privileges on the Medical Staff in accordance with these Bylaws.

13. The term "Oral Surgeon" shall mean a duly licensed dentist who has successfully completed an approved oral surgery residency program.

14. The term "Physician" shall mean a medical or osteopathic doctor who is duly licensed in the State of Florida to practice medicine.
15. The term "Practitioner" means a duly licensed dentist, podiatrist, or medical or osteopathic physician.

II. Purposes

The purposes of this organization are:

A. To maintain a qualified Medical Staff whereby all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive quality medical care of the same level as all patients in the Hospital with the same problems.

B. To provide a high level of professional performance of all members of the Medical Staff through the appropriate delineation of clinical privileges for each practitioner and through planned systematic ongoing monitoring and evaluation of each Staff member's or Allied Health Professional's clinical and ethical performance in the Hospital.

C. To provide an appropriate atmosphere in which quality educational standards are maintained to afford continuous progress of the Medical Staff in professional knowledge and skill.

D. To provide a means of continuing accountability to the Governing Body for delivery of quality health care services and appropriate care in the Hospital.

E. To provide a means whereby issues of a medico-administrative nature concerning the Medical Staff may be discussed with the Chief Executive Officer and the Governing Body and resolved.

F. To promote, support and participate in medical programs designed and conducted to improve the general health of the community, which the Hospital serves.

G. To promote and maintain accreditation of the Hospital by the Joint Commission on Accreditation of Health Care Organizations.

III. Medical Staff Membership

A. Nature of Membership and General Qualifications

1. The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints. Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws.

2. Patients may be admitted to the Hospital only on the orders of a Physician. All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.

B. Eligibility and Qualification for Membership

3. Practitioners shall be eligible for membership on the Medical Staff only if they satisfy all of the following:
a. Graduate of an approved and accepted medical, osteopathic, dental or podiatry school or of an accredited program for a terminal degree in psychology;

b. registered and possess an active license to practice his/her profession in the State of Florida;

c. possession of a current, valid Drug Enforcement Agency (DEA) number, if applicable;

d. live and practice closely enough to the Hospital to provide continuous care of his/her patients, (except as otherwise provided in these Bylaws);

e. provide documentation of professional education, training, experience, demonstrated competence, judgment, character, current capability and mental and physical ability to perform the services for which privileges are requested to have been granted, adherence to the highest ethics of his/her profession, professional and moral character and integrity, ability to work and cooperate with the Hospital personnel and staff members, and good reputation with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by him/her in the Hospital will be given proper medical care with professional skill; and

f. in order for an applicant to qualify for memberships and to remain qualified for membership on the Medical staff, he/she shall show evidence of professional liability insurance with current and 24 months prior acts at a minimum of $250,000/$750,000 coverage, or limits as mandated by the current licensure law of the State of Florida, whichever is greater. All applicants for Staff membership will be required to show evidence of such minimum insurance coverage at the time application is made for appointment and reappointment as a pre-requisite to and condition of Staff membership. Such insurance shall be maintained during the time that he/she is a member of the Medical Staff.

g. application for staff membership is open only to persons who meet the following qualifications:

1. Board Certification or meets the qualifications for eligibility for Board Certification;

2. Alternatives to be considered including, but not limited to:

   (a) Fellowship or membership in specialty body or society approved by the American Board of Medical Specialties, Accreditation Council for Graduate Medical Education, American Medical Association, American Association of Medical Colleges and/or other resources and

   (b) Clinical experience/management shall be considered when the applicant or practitioner being appointed or reappointed is not board certified or has not been recertified in that specialty board.

4. No practitioner shall be automatically entitled to Medical Staff membership or to exercise admitting or clinical privileges in the Hospital merely because he/she is licensed to practice in the State of Florida, is a member of any professional organization, or has had or presently has, privileges at this or another hospital.

5. No aspect of Medical Staff membership or privileges shall be denied or affected because of sex, race, creed, color, religion, national origin, disability or any other criterion lacking professional or performance justification.
6. Application for membership on the Medical Staff shall constitute the applicant’s certification that he/she has in the past, and his/her agreement that he/she will in the future, strictly abide by the Principles of Ethics of his/her professional association.

7. Appointments to the Medical Staff will also be guided by the ability of the Hospital, as determined by the Governing Body, to meet the present and future health care needs of the community it serves and specifically with reference to:
   a. provision of continuity of service by the Medical Staff in light of projected resignations, transfers to inactive status and death of members;
   b. provision of new professional skills as they may be developed by the evolution of medical science and specialty areas not adequately represented on the Medical Staff;
   c. special interest in the Hospital and active participation in its programs, committee assignments and supervisory responsibilities; and
   d. availability of Hospital staff and facilities to provide quality health care and to maintain its plan of development including the mix of patient care services to be provided.

8. Each person possessing privileges at the Hospital shall report to the Chief Executive Officer any of the following events within seven (7) days of the occurrence. Any applicant for privileges at the Hospital shall report the following events to the Chief Executive Officer with his or her application or, if occurring subsequent to the submittal of the application and prior to final disposition, to the Chief Executive Officer within seven (7) days of the occurrence. The Chief Executive Officer shall forward such information to the Executive Committee of the Medical Staff in a timely manner. The following events are reportable under this paragraph: (I) any suspension or revocation of the individual’s license to practice medicine in any jurisdiction; (ii) any suspension, revocation or involuntary reduction or non-renewal of an individual’s hospital privileges/membership and any resignation or voluntary relinquishment of privileges under threat of any such action; (iii) any denial of an individual’s application for membership to any hospital staff; (iv) any disciplinary action initiated against the individual by any medical organization; (v) final judgments or settlements involving the individual in any such action; and (vi) any suspension, revocation or involuntary reduction or non-renewal of privileges or rights to participate in Medicare, Medicaid, and Champus; and (ix) any malpractice claims or actions made or filed against practitioner. The individual involved in any such events shall, upon request, appear before the Executive Committee of the Medical Staff and/or the governing Body, or their respective designees, and give an accurate explanation of the circumstances involving the individual in any of the foregoing events. Such appearance shall be informal and shall not be conducted or considered a hearing under Article VIII of these Bylaws.

C. Ethics and Ethical Relationships

9. The Code of Ethics as adopted or amended by the appropriate professional association and as provided in these Bylaws shall govern the professional conduct of the members of the Staff. Specifically, each applicant and member of the Staff pledges and agrees as follows:

   I authorize South Bay Hospital to request, procure and review any information regarding my professional practice at any institution or from any individual or organization. Moreover, I pledge myself to
shun unwarranted publicity and dishonest money seeking; to seek consultation when necessary; to refuse money trades with consultants, practitioners, makers of surgical appliances or optical instruments; to make my fees commensurate with the services rendered; to refrain from "ghost" surgical or medical services; to avoid discrediting my associates by taking unwarranted compensation; to refrain from delegation of diagnosis or care to unqualified or improperly supervised personnel; to provide continuous care to my patients. I fully understand that any significant misstatements in or omissions from my application constitute cause for refusal of my application or for disciplinary action as provided in these Bylaws. Further, I understand that as a member of the Staff I must conduct my professional and personal life according to the highest moral precepts. Failure in this regard may be grounds for disciplinary action as provided in these Bylaws. Specifically, the illegal use of narcotics or addicting drugs or habitual use of alcohol or drunkenness, conviction of a felony, or any action which might adversely reflect on the Hospital or Medical Staff or which tends to degrade the ideals of my profession, shall be considered as grounds for disciplinary action as provided in these Bylaws. I agree to maintain in strictest confidence any information I may obtain as a result of my participation as a member of any medical staff committee. I agree to abide by the Medical Staff Bylaws, Rules and Regulations and policies, as amended and issued from time to time.

D. Conflict Management/Resolution

10. Conflicts Between the Board and the Medical Executive Committee

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:
• Three officers of the Medical Staff
• One other Medical Executive Committee member
• The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
• The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

11. Conflicts Between the Medical Staff and the Medical Executive Committee

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting
recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff’s recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff, the representatives of the Medical Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- Three voting members of the Medical Staff representing the recommendations in the written petition
- The Chairperson of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.
If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

E. Dues

12. The Executive Committee shall establish the annual dues of members of the Medical Staff which are to be used by the Medical Staff to provide education, to support the medical library, to promote good relationships within the Medical Staff of the Hospital and for other purposes as the Executive Committee shall determine. Dues are due and payable on June 1st of each year. Members who have not paid their dues by July 1st are notified by letter that their dues are past due and that if they are not paid by August 1st, he/she shall be deemed to have resigned voluntarily from the Medical Staff. Reappointment may be granted only after application in the manner prescribed for an initial appointment.

F. Status of Members

13. Nothing contained in these Bylaws, nor the fact of Medical Staff membership shall be deemed to create, nor does it create, any type of employment status or relationship between any member of the Medical Staff and the Hospital.

IV. Procedure for Appointment and Reappointment

A. Application for Appointment

14. Applicants for appointment to the Medical Staff shall file with the Chief Executive Officer a written and signed application on a prescribed form furnished by the Hospital, together with his/her professional references.

a. the application shall require detailed information concerning:

1. the applicant’s professional qualifications

2. the names and addresses of at least two (2) qualified persons with recent, extensive experience in observing and working with the applicant who can provide adequate references pertaining to the applicant’s professional competence and ethical character;

3. the applicant’s membership status and/or admitting and clinical privileges at any other hospital or institution;
4. whether his/her privileges or medical staff membership at any hospital or other facilities or organization or membership in local, state, or national medical societies, or his/her license to practice any profession in any jurisdiction, has ever been denied, revoked, reduced, withdrawn or voluntarily/involuntarily relinquished;

5. any professional liability actions involving the applicant including a consent to release of information from his/her present and past malpractice insurance carrier(s);

6. whether the applicant’s narcotic license has ever been suspended, revoked or voluntarily/involuntarily relinquished;

7. any felony or professional practice related misdemeanor; and,

8. any suspension, sanction or other restriction from participating in any private, federal or state health insurance program.

9. health status;

10. such other matters as may be deemed appropriate.

b. the applicant shall completely fill in all parts of the application or adequately explain any failure to do so. Falsification of the application in any material respect shall void the application and it shall be removed from consideration.

15. The applicant has the burden of producing the information required by these Bylaws and application for a proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

16. Upon application for appointment to the Medical Staff, each applicant will receive a copy of the Bylaws and Rules and Regulations and agrees:

a. to be bound by the Hospital and Medical Staff Bylaws and Rules and Regulations and the Hospital policies as amended from time to time;

b. to appear for interviews;

c. to authorize representatives of the Medical Staff and Governing Body to consult with members of other Hospital Medical Staffs with which the applicant has been associated and with others concerning the applicant’s professional and ethical qualifications, current competence, and character for Staff membership and other factors, which may be considered in evaluating his/her application, and authorizes such persons to release such information; and

d. to consent to the inspection and copying of any and all records in the possession of any such hospitals, persons, or other entities which would be material in any evaluation of his/her qualifications and authorize anyone in possession of such records to release them.

17. He/she releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant’s competence, ethics, character and other qualification for Staff appointment and privileges, including otherwise privileges or confidential information.
18. He/she agrees to sign the Attestation Statement as required by Medicare and any other similar statements required by other payers.

B. Appointment Process

19. The applicant shall deliver an application to the Chief Executive Officer who shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Chief Executive Officer or designee shall promptly notify the applicant of any problem in collecting such information and it shall be the applicant’s responsibility to obtain the information. If the application is not completed within six (6) months, it shall automatically be removed from consideration. When the information is collected and verified, the Chief Executive Officer or designee shall transmit the application and all supporting materials to the chairman of each department in which the applicant seeks privileges and to the Credentials Committee.

20. All reports and recommendations during the review process shall be submitted in writing along with the application and all other documentation considered. Each report shall specify whether membership is recommended and note any changes, comments or conditions to be attached to the appointment. The report shall state the reasons for each recommendation and support it with reference to the application and documentation considered.

21. Upon receipt, each Department Chair or his/her designee shall promptly review the application and supporting documentation, and transmit to the Credentials Committee a written report and recommendations according to Section B (18) of this Article. A Department Chair may also recommend that the Credentials Committee defer action on the application. The report shall be transmitted to the Credentials Committee within fifteen (15) days of the Department Chair’s receipt of the application.

22. Upon receipt, the Credentials Committee shall promptly review the application, the supporting documentation, the Department Chair’s report and recommendations, and such other relevant information as may be available to it and it may interview the applicant. The Credentials Committee shall then transmit to the Executive Committee via minutes and recommendations according to Section B (18) of this Article. The Committee may also recommend that the Executive Committee defer action on the application. The Credentials Committee shall submit its report to the Executive Committee not more than sixty (60) days after the receipt of the Department report.

23. At its next regular meeting after receipt of the Credentials Committee minutes and recommendations, the Executive Committee shall consider the minutes and other relevant information available to it and shall forward to the Governing Body via minutes and recommendation according to Section B (18) of this Article. The Committee may defer action on the application for further consideration of the application but for not more than thirty (30) days or until necessary documentation is received, after which time the Executive Committee must make a recommendation to the Governing Body to accept or reject the applicant. Any member of the Medical Staff may offer information about the applicant to the Chairman of the Executive Committee.

24. The Governing Body, at its next regular meeting following receipt of the Executive Committee minutes and recommendations, shall consider the final recommendations of the Executive Committee. The Governing Body shall accept, reject or modify the report and recommendations and return its action to the
Executive Committee stating the reasons, in writing, for such referral and setting a time limit within which an additional report shall be made to the Governing Body. At its next regular meeting after its receipt of the additional report, the Governing Body shall make a final decision. All decisions to recommend appointment shall delineate admitting and clinical privileges to be granted to the practitioner and assign the practitioner to a category, department and section of the Staff.

25. When the Governing Body has taken final action on any application for appointment to the Medical Staff, it shall, acting through the Chief Executive Officer, notify the Chairman of the Executive Committee and the applicant of the action taken. If the decision is adverse to the applicant, the Governing Body shall direct the Chief Executive Officer to notify the affected applicant by certified mail, return receipt requested, and the applicant shall be entitled to a hearing as prescribed in Article VIII, Section I of these Bylaws. The notice to the applicant shall advise the applicant of the reasons for the adverse recommendation, the right to a hearing and shall summarize the applicant’s rights during the hearing.

26. Initial appointment to the Medical Staff shall be on a provisional basis for a period of one (1) year during which the member’s professional and clinical performance and activities shall be observed and evaluated by the chair of the department to which the member has been assigned or his/her designee. Provisional status may be extended for a period not to exceed one (1) additional year.

C. Terms of Appointment

27. Appointments and reappointments shall be made by the Governing Body of the Hospital only after there has been a recommendation from the Executive Committee.

28. The Governing Body shall always have the right to suspend or revoke a member’s membership or privileges whenever it deems it necessary for the good of the patients or Hospital, subject to Articles VII and VIII of these Bylaws.

29. Appointment to the Medical Staff shall confer on the appointee only such admitting and clinical privileges as have been granted by the Governing body. An applicant for Staff membership must be able to render continuous and appropriate care and supervision of his/her patients, abide by the Bylaws and Rules and Regulations of the Medical Staff and Governing Body, agree to accept committee assignments and provide emergency care as applicable.

D. Acceptance to Staff Membership

30. No applicant shall be deemed to have been accepted for Medical Staff membership except upon application made and fully acted upon according to these Bylaws. Temporary privileges granted pursuant to these Bylaws shall not be deemed to confer upon any applicant any form of Staff membership or any rights and privileges of membership associated with the Medical Staff of the Hospital.

E. Reappointment Process

31. No member shall be automatically entitled to or have a vested right of renewal of membership and privileges.

32. Each member of the Medical Staff of all categories shall be subject to reappointment one (1) year from the date of initial appointment and, thereafter, every two (2) years from the date of last reappointment.

33. The Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board shall direct and enforce the
establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include ongoing professional practice evaluation through the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospital’s Performance Improvement Plan.

34. Except as otherwise provided in these Bylaws, no member of the Medical Staff shall be reappointed until his/her competence and qualifications have been demonstrated, and review shall include but shall not be limited to:
   a. clinical privileges requested, with any basis for change;
   b. data issuing from the Medical Staff monitoring and evaluation process and citations, if any, by Medical Staff review committees, including quality care committees;
   c. professional performance, current competence and ability, judgment, and technical skills to perform the services for which privileges and medical staff membership are requested;
   d. professional ethics and conduct;
   e. attendance at required Staff affairs and willingness to serve on Staff committees when requested;
   f. continuing medical education since the previous appointment;
   g. conscientiousness in maintaining timely, accurate and legible medical records;
   h. compliance with the Medical Staff Bylaws and Rules and Regulations and the Hospital policies;
   i. cooperation with Hospital personnel and relations with other Staff members,
   j. utilization of Hospital facilities, as set forth in Categories of the Medical Staff. (Section VI)
   k. general attitude toward his/her patients and the Hospital, and
   l. any suspension, sanction, or other restriction from participating in any private, federal or state health insurance program.
   m. whether the applicant’s narcotic license has ever been suspended, revoked or voluntarily/involuntarily relinquished; and
   n. any felony or professional practice related misdemeanor.
   o. health status; and
   p. query of the National Practitioners Data Bank.

35. All reports and recommendations during the reappointment process shall be submitted in writing. If the recommendation is to (i) deny reappointment; (ii) reduce or increase clinical privileges; (iii) deny a requested increase in privileges or change of staff category, the reasons must be stated and supported with reference to documentation considered.
36. The Chief Executive Officer or designee shall provide each Staff member with a Reappointment application form. Each Staff member who desires reappointment shall, at least ninety (90) days before expiration of his/her appointment, send a Reappointment application to the Chief Executive Officer or his/her designee. Failure, without good cause, to file the application for reappointment shall be considered a voluntary resignation of membership at the expiration of the member’s current term. The Chief Executive Officer shall, in timely fashion, collect and verify the information on the application form and collect any other relevant materials or information, including information regarding the member’s professional activities, performance and conduct in the Hospital. When the information has been collected and verified, the Chief Executive Officer or designee shall transmit the application and supporting materials to the Chair of each department in which the staff member requests clinical privileges no later than 45 days after receiving the application.

37. Upon receiving a member’s application for reappointment, each Department Chair shall review and evaluate the member’s Staff membership activities and clinical privileges for reappointment and data provided by the Medical Staff monitoring and evaluation process. The Department Chair shall provide information concerning the member’s professional performance, judgment, technical skill, ability to work with and cooperate with Hospital staff and personnel, current competence and ability, and his/her opinion of the Staff member’s physical and mental health status as it relates to ability to practice and exercise Hospital and clinical privileges in compliance with these Bylaws. The Chair shall submit a report of the findings to the Credentials Committee within 15 days after receiving the application.

38. The Chair of the Credentials Committee shall submit via minutes a recommendation to the Executive Committee according to Section E (33) of this Article in sufficient time to allow review by the Executive Committee and the governing body before expiration of a member’s term of appointment.

39. The Executive Committee shall submit via minutes a recommendation through the Chief Executive Officer or designee to the governing Body according to Section E (33) of this Article in sufficient time to allow review by the Executive Committee and the governing body before expiration of a member’s term of appointment.

40. If the Executive Committee’s communication to the Governing Body is adverse to the member, he/she shall have the right of hearing and appeal as set forth in these Bylaws. Unless the action taken is a summary suspension, the member’s then current status on the Medical Staff with all rights and privileges shall remain in effect pending the outcome of any hearing and appeal, and final action by the Governing Body.

41. If a member’s review is not completed within the time frame provided in this Section, the Review shall be completed as soon as possible and practical. In the interim, the member shall not be deemed reappointed, but shall retain his/her current membership and privileges until the process is completed, unless the applicant’s membership and/or privileges are otherwise modified or revoked pursuant to these Bylaws. If the review is not completed due to the member’s failure to provide requested information, the failure to provide such information shall be deemed a voluntary withdrawal of the application for reappointment and a voluntary resignation from the Medical Staff.

F. Leave of Absence
42. Staff member may be granted a leave of absence by applying in writing to the Executive Committee, with a copy forwarded to the Department Chair and Chief Executive Officer. A leave of absence may last 1 year with up to one additional year granted upon written request at the discretion of the Executive Committee and Board of Trustees. A leave of absence cannot extend beyond two (2) years.

43. Reasons for a leave would be considered for academic, health, military and missionary services, and other conditions of undue hardship. The leave of absence will be at the discretion of the Medical Executive Committee/Board of Trustees.

44. It is the responsibility of the physician requesting the Leave of Absence to satisfactorily complete all obligations, including medical records, prior to 30 days after receipt of the requested leave of absence letter by the hospital. Failure to comply with all obligations will result in termination of privileges with the right to the fair hearing process as in Section VIII.

45. It is the responsibility of the staff member to initiate reinstatement 90 days prior to the end of a leave of absence and provide a summary of activities conducted during his/her leave of absence. Failure without good cause, to request reinstatement and provide a summary of activities during this time period, shall be deemed as voluntary resignation and result in automatic termination of membership and clinical privileges.

46. Upon reinstatement staff member shall return to the same department or section, in the same Staff category and with the same admitting and clinical privileges. However, the Executive Committee, or the Governing Body may reserve the right to review the member’s admitting and clinical privileges and ability to provide competent and professional patient care services and to adhere to these Medical Staff Bylaws before reinstatement and the right to modify the membership and privileges as appropriate. Any modification that is adverse to the member shall be subject to the right of hearing and appeal.

47. Any request by the member after a leave of absence for a change in department, Staff category and/or clinical privileges shall be processed at the time of reappointment according to Articles IV and V.

48. A leave of absence shall not relieve a member of the obligation to comply with Article IV, Section E concerning reappointment in a timely manner.

G. **Resignation from Medical Staff**

49. Any member who desires to resign from the Medical Staff must submit a letter to the Medical Executive Committee, with a copy to the Department Chairman and Chief Executive Officer. The Executive Committee shall forward its recommendation to the governing Body, which shall take the final action.

50. A request for resignation shall not be considered until all obligations to the Hospital have been satisfactorily met by the member, including completion of all medical records, or arrangements satisfactory to the Board of Trustees have been made.

51. All obligations must be satisfactorily completed (including medical records) 90 days after receipt of requested resignation letter. Any member not complying with this Section shall be considered as having resigned from the Staff not in good standing and shall be reported to the appropriate licensing/regulatory agencies.

H. **Reapplication to Medical Staff**
52. A practitioner who is denied membership or reappointment to the Medical Staff or whose membership is revoked, may not reapply to the Medical Staff for at least two (2) years after such action is considered final.

V. Clinical Privileges

A. Clinical Privileges Restricted

53. Medical Staff members or others practicing at South Bay Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as otherwise provided in these Bylaws. The privileges shall only be within the scope of the licensure, certification or other legal limitations authorizing the practitioner’s practice.

B. Application for Privileges

54. Applications for Staff appointment or reappointment must contain a request for the specific clinical privileges desired by the applicant supported by documentation of the applicant’s relevant recent training and/or experience. Requests for privileges will be processed in the same manner as applications for appointment or reappointment to the Medical Staff.

C. Delineation of Privileges

55. Initial requests for clinical privileges shall be evaluated based upon the applicant’s documented education, training, experience, references, specialty board qualifications, demonstrated current competence, ability, judgment, and licensure; the criteria developed by each department of the Medical Staff; and an appraisal by the service in which privileges are requested.

56. Upon reappointment, requests for clinical privileges shall be based on the member’s training, experience, specialty board qualifications, competence, judgment and current capability which shall be evaluated by reviewing the practitioner’s credentials, the peer review records and reports of the Medical Staff and observing the care rendered.

57. The practitioner applying for appointment or reappointment shall have the burden of establishing his/her qualifications and competence to exercise the clinical privileges requested.

D. Dentist Privileges

58. Privileges granted to dentists shall be based on their training, experience, demonstrated competence, judgment, current capability, and licensure. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical procedures and shall be under the overall supervision of the Chair of the Department of Surgery.

59. Dental members of the Medical Staff may admit dental patients to the Hospital under the jurisdiction of the Department of Surgery or one of its subdivisions and shall designate in the patient’s medical records upon admission a physician Staff member to have primary medical responsibility for the patient. All dental patients must have the same basic medical appraisal as patients admitted to other services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.
Oral Surgeons who admit patients without medical problems may perform an admission history and physical examination and assess the medical risks of the procedure on the patient if they have privileges to do so. Criteria to be used in granting such privileges shall include, but shall not necessarily be limited to, the following: successful completion of a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education, and as determined by the Medical Staff, evidence of current competence to conduct such a history and physical and assessment. Patients with medical problems admitted to the Hospital by qualified Oral Surgeons shall receive the same basic medical appraisal as patients admitted to other services. The responsible dentist shall take into account the recommendations of this consultation in assessing the procedure proposed and its effect on the patient. When there is significant medical abnormality, the final decision must be a joint responsibility of the dentist and the medical consultant. The dentist is responsible for that part of the history and physical examination related to dentistry. The designated physician member shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of dental patients.

60. Dentists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.

E. **Podiatrist Privileges**

61. Privileges granted to podiatrists shall be based on their training, experience, demonstrated competence, judgment, current capability and licensure. The scope and extent of their medical and surgical privileges shall be specifically delineated and granted in the same manner as all other medical and surgical procedures and shall be exercised under the overall supervision of the Chair of the Department of Surgery.

62. A podiatrist member may admit patients to the Hospital under the jurisdiction of the Department of Surgery and shall designate a physician member with appropriate privileges to have primary medical responsibility for the patient in the medical record upon admission. All podiatry patients must have a history and physical appraisal performed by the physician member. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patient’s hospitalization and shall signify willingness to do so in the medical record. The physician and the podiatrist shall assess, with consultation if necessary, the overall risk and effect of surgery on the patient’s health.

63. Podiatrists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.

F. **Psychologist Privileges**

64. Privileges in Psychology are granted under the guidelines of the Allied Health Professional Affiliate Staff.

65. A psychologist member may not admit patients to the Hospital but may attend patients under the jurisdiction of the Department of Medicine. A physician member with appropriate privileges shall have primary medical responsibility for the patient in the medical record. All psychologists’ patients must have a history
and physical appraisal performed by the physician member. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patients' hospitalization and shall signify willingness to do so in the medical record.

66. Psychologists may write orders within the limits of their licensure and privileges granted pursuant to these Bylaws.

G. Health Professional Affiliates’ Privileges

67. The Allied Health Professional Affiliate Staff (Affiliates) shall consist of persons trained and qualified in allied health disciplines who exercise independent judgment and provide special professional advice or specified services to Hospital patients, the medical or the administrative staffs.

68. Affiliates shall be qualified by training, education and licensure appropriate for their special services and shall service within the scope of their recognized professional qualifications and skills.

69. Affiliates shall be appointed or reappointed and granted privileges according to the procedures provided in Articles IV and V of these Bylaws. They shall be subject to the provisions of these Bylaws pertaining to Hospital privileges, duties and the ethical practice of their professions.

70. Affiliates shall not be considered members of the Medical Staff and shall not be entitled to vote. Affiliates will not have the rights of hearing or appeal as afforded to the members of the Medical Staff. However, such individual shall have the right to appeal through the sponsoring physician to the Executive Committee.

71. Affiliates shall be assigned to a department of the Medical Staff by the Executive Committee and shall be responsible to the Chair of that department.

72. Affiliates may not admit or discharge patients. When requested by a patient’s attending physician, they may within the scope of their privileges and these Bylaws and Rules and Regulations, attend that patient in the Hospital. The extent of the service shall be determined by the Staff and the attending physician who has the final responsibility for the welfare of the patient.

73. Notwithstanding anything to the contrary contained in this Section:

a. Affiliates employed by the Hospital shall be assigned to the appropriate department(s) or section(s) to perform such clinical duties as designated by the Hospital. The Chair or chief or his/her physician designee, of the department(s) shall provide professional supervision of the Affiliates' services, as required. The Hospital shall otherwise be solely responsible for the control of and duties performed by the Affiliates employed by the Hospital. Affiliates who are employed or sponsored by members of the Medical Staff shall limit their practice to patients of their employer/sponsor, shall be assigned to the clinical section of their employer/sponsor, and shall be directly responsible to their employer/sponsor.

b. The Hospital or the physician employer/sponsor may solicit from the appropriate Department or Section Chair or Chief, and such Department or Section Chair or Chief shall provide comments on the professional performance of such Affiliates.

H. Temporary Privileges
74. Temporary Privileges shall be granted only in extraordinary situations when necessary to avoid undue hardship to the applicant or the facility and following:
   a. receipt of a completed application, which includes a request for temporary privileges;
   b. query of National Practitioner Data Bank and American Medical Association;
   c. verification of information relevant to licensure, DEA certifications, current clinical competence, character, ethical standing, physical and mental health status; professional liability insurance coverage, and claims history; and
   d. Receipt of written agreement to abide by the bylaws, policies and rules and regulations of the Medical Staff and South Bay Hospital.

75. Upon written concurrence of the appropriate Department Chair or his/her designee, the Chief Executive Officer and Chief of Staff may grant temporary privileges for an initial period of thirty (30) days, with subsequent renewals not to exceed pendency of the application or ninety (90) days, whichever is less. The CEO or COS may not grant membership status to any appropriately licensed practitioner.

76. Such privileges shall be granted based on the information then available in the application or a written request from the physician and which may reasonably be relied upon as to the competence and ethical standing of the applicant requesting such temporary privileges. In the exercise of such privileges, the applicant shall act under the supervision of the Department Chair to which he/she is assigned.

77. The Chief Executive Officer may at any time, upon the recommendation of the appropriate Department Chair or the Chief of Staff, terminate the practitioner's temporary clinical privileges effective as of the discharge from the Hospital of the patient(s) then under his/her care. However, where the life or health of such patient(s) could be endangered by continued treatment by the practitioner, the Chief of Staff, the department chairman or the Chief Executive Officer, may terminate the temporary privileges effective immediately. The appropriate department chairman or the Chief Executive Officer may terminate the temporary privileges effective immediately. The appropriate Department Chair or, in his/her absence, the Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until they are discharged from the Hospital or have chosen another practitioner with appropriate clinical privileges in the Hospital.

78. Special requirements of supervision and admissions may be imposed on the practitioner to whom temporary privileges are granted. The Chief Executive Officer may immediately terminate the temporary privileges if the practitioner fails to comply with such requirements. The Chief Executive Officer or the Chief of Staff may terminate temporary privileges upon an adverse recommendation by the Executive Committee or the Governing Body as to applicant’s application, pending final determination and disposition of the application.

79. A practitioner whose temporary privileges have been terminated pursuant to this Section shall have no right to the hearing and appeal provided by these Bylaws.

80. An applicant to the medical staff is not automatically entitled to Temporary privileges nor does the granting of Temporary Privileges imply any guarantee that membership or permanent privileges will be granted. The applicant will follow the Procedures for Appointment – Section IV (A) for permanent placement on the medical staff.
I. Emergency Privileges

81. Emergency admitting and clinical privileges for care of a specific patient or patients may be granted by the Chief Executive Officer, with written concurrence of the appropriate Department Chair, or his/her designee, to a physician who is not an applicant for appointment, but necessary to fulfill a medical staff vacancy on a case by case basis.

82. A request for emergency privileges will include at a minimum, a query of the National Practitioner Data Bank, Licensure, DEA Certificate, Malpractice Insurance and AMA Profile.

83. Verification of current clinical competence may be requested.

84. Emergency Admitting privileges may not exceed 60 days.

85. The granting of emergency privileges does not imply any guarantee that membership or permanent privileges will be granted.

J. Disaster Privileges

86. The hospital may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

87. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

88. The medical staff will oversee the professional performance of volunteer practitioners who receive disaster privileges via direct observation or clinical record review.

89. All volunteer practitioners will be identified as disaster providers within the physician database, and will be provided with special badges denoting their status.

90. Volunteer practitioners must provide, at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport, and at least one of the following:
   a. A current picture hospital ID card that clearly identifies professional designation;
   b. A current license to practice;
   c. Primary source verification of the license;
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC,ESAR-VHP, or other recognized state or federal organization or group;
   e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
   f. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster.

91. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
92. The medical staff will oversee the professional practice of volunteer licensed independent practitioners.

93. The hospital will decide within 72 hours whether to continue practitioner’s disaster privileges, based on information obtained regarding the professional practice of the volunteer.

K. Locum Tenens

94. Any member of the Active Staff in good standing may have an appointment granted to a Locum Tenens when the member is temporarily absent from his/her practice because of vacation, illness, military service, or attendance at a medical post-graduate educational course. The privileges of the Locum Tenens shall depend on his/her training and experience as presented in the application of appointment endorsed by the member, evaluated by the appropriate Department Chair, and the Credentials Committee, and approved by the Executive Committee and the Governing Body. The privileges of the Locum Tenens shall not exceed those of the member who is temporarily replaced. A Locum Tenens shall have no right to vote or to hearing and appeal.

95. The privileges of a Locum Tenens may, at any time upon the recommendation of the appropriate Department Chair or the Chief of Staff, be terminated immediately by the Chief Executive Officer where there is reason to believe that it would be in the best interest of the Hospital or patient care. The department chairman or the Chief of Staff shall assign a member of the Active Staff to assume responsibility for the care of such patient and the desire of the patient shall control if possible. If privileges are terminated under this provision, the Locum Tenens shall have no right to a hearing and appeal under these Bylaws.

L. Telemedicine Privileges

96. Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions. In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

a. When a telemedicine provider is providing services from a different State, licensure will be verified for both the State where the hospital is located and the State where the practitioner is located

b. Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries will be limited to the top five high volume affiliations and any healthcare organization from which the practitioner was reassigned during the last five years.

M. Medical students, residents, and/or fellows

97. Medical students, residents, and/or fellows are Practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will participate in health care services at the Hospital. Medical students,
residents, and/or fellows shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. Medical students, residents, and/or fellows shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school, program or medical group; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments. The school or program shall provide a written description of the role, responsibilities, and patient care activities of participants in the training program. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting medical students, residents, and/or fellows to participate in educational experiences at this Hospital. Medical students, residents, and/or fellows may participate in educational patient care experiences at the Hospital only pursuant to and limited by the following:

98. Medical students, residents, and/or fellows who have completed the basic level of training for licensure shall be licensed in this State and shall be limited by applicable provisions of the professional licensure requirements of this State;

99. A written affiliation agreement between the Hospital and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a medical student, resident or fellow, in the amount of $250,000 for each claim and $750,000 in aggregate or other demonstration of insurance as approved by the Facility; and,

100. The protocols or policies established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a medical student’s, resident’s, and/or fellow’s authority (e.g., authority and circumstances in specific patient care activities), and other conditions imposed upon a medical student, resident, and/or fellow by this Hospital or the Medical Staff.

101. While functioning in the Hospital, medical students, residents, and/or fellows shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Chief Executive Officer or the Chief of Staff. Medical students, residents, and/or fellows may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. Medical students, residents, and/or fellows shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. Medical students, residents and/or fellows may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, or committees, but shall have no voting rights.

102. The Credentials Committee shall have oversight for Medical students, residents and/or fellows approving their participation in educational experiences with sponsoring practitioners and shall communicates to the Medical Executive Committee and the Board regarding related educational and supervisory needs including demonstrated compliance with any review committee citations as applicable to the program.
VI. **Categories of the Medical Staff**

**A. Medical Staff**

103. The Medical Staff shall be divided into the following categories: Provisional, Active, Courtesy, and Honorary Staff.

**B. Provisional Staff**

104. All initial appointments to or reassignments to any category of the Medical Staff shall be provisional for at least 12 months, and may be extended for up to one year. During the provisional period, the member's professional and clinical performance and activities shall be evaluated by the Chair (or his/her designee) of the department to which the member is assigned to determine eligibility for active status and exercising the admitting and clinical privileges granted to them. The evaluation period must include a minimum of 12 patient contacts over the 12-month period.

105. If at the end of the provisional period, the member does not qualify for active status, the member may be reassigned to the previous category or his/her membership and privileges may be terminated subject to the right of hearing and appeal.

106. Provisional members shall not be eligible to vote at Departmental, General Staff or Annual Staff meetings or hold office but shall pay dues and serve on Medical Staff committees, except Executive, Credentials and Nominating. They shall attend general Medical Staff meetings, as well as department and section meetings.

107. The Provisional members shall serve on the Emergency Room On Call Service at the discretion of the Medical Executive Committee for their respective specialty.

**C. Active Staff**

108. Physicians who have satisfactorily completed their Provisional/Active year shall serve a year on the Active Staff prior to consideration for a change in their staff category.

109. The Active Staff shall consist of practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital, who live and practice within a reasonable distance from the Hospital in order to provide continuous care and supervision of their patients, and who assume active participation in the prescribed duties and functions of the Medical Staff, and otherwise meet the qualifications as prescribed in these Bylaws, including the application.

110. Those staff members seeking reappointment with less than 12 patient contacts for the previous reappointment period will be automatically placed on courtesy staff and must provide supporting documents attesting to their competency for those privileges requested in the application. Those reapplications lacking this supporting documentation will not be accepted.

111. Members of the Active Staff shall be eligible to vote, hold office, and serve on Medical Staff committees. They shall be responsible to perform Staff assignments, pay dues and attend Medical Staff and department or section meetings. Limited Health Practitioners may not hold office or Chair standing committees.

112. Members of the Active Staff shall retain full responsibility within their area of professional competence for the continuous care and supervision of their patients.
in the Hospital, or arrange a suitable alternative (as approved by the appropriate Department Chair) for such care and supervision. Active Staff members shall actively participate in quality assurance activities required of the Staff, and they shall faithfully discharge all Staff functions as may be required from time to time.

113. Active Staff members shall serve on the Emergency Room On-Call Service and may act as consultants if granted appropriate privileges.

D. **Courtesy Staff**

114. The Courtesy Staff shall consist of members who only occasionally admit patients to or perform procedures in this Hospital, are located closely enough to the Hospital to provide continuous care and supervision to their patients, and are on the Active Staff in good standing at another Hospital which is located closely enough to allow the member to service patients at both Hospitals.

115. Members of the Courtesy Staff shall be privileged to have a total of 50 inpatient and outpatient "admissions", procedures, and consults per two year period which include surgical suite procedures and endoscopy room procedures. Physicians having more than 50 contacts will be automatically advanced to Active Staff. Such limitation would exclude Radiologists, Pathologists, and Emergency Medicine physicians. The Board of Trustees approval, upon recommendation of the Executive Committee, may waive the fifty contact limit when necessary to fill a clinical specialty need within the hospital.

116. Those Courtesy Staff members with less than 12 hospital admissions, consults or surgical procedures for the previous application period, must provide supporting documents attesting their competency for those privileges requested in the application. Those reapplicants lacking this supporting documentation will not be accepted.

117. Members of the Courtesy Staff shall not be eligible to vote or hold office, but may be required to take Emergency Room On-Call, shall pay dues and may be assigned to serve as members of Medical Staff Committees as determined by the Chief of Staff.

118. Members of the Courtesy Staff who signify a willingness to advance to Active Staff membership shall be considered as provided in Articles IV and V of these Bylaws.

E. **Honorary Staff**

119. Honorary Status shall consist of members who are no longer active medical staff members and are deemed worthy of honorary status positions by the Executive Committee and Board of Trustees. This staff status represents those individuals who have retired from active practice in good standing and supported the hospital and medical staff during their active tenure.

120. Honorary Status members shall not be eligible to admit patients, be granted clinical privileges, vote, hold office, or serve on standing medical staff committees.

121. Honorary Status members shall not be required to pay dues, maintain current medical licensure, liability insurance coverage, or DEA certification.

F. **Associate Staff**

122. The Associate Staff shall consist of Community based primary care physicians who utilize the Hospital’s services, maintain a practice which is office based, do
not admit patients to this or any other hospital and refer all inpatient and/or outpatient admissions to active staff members for admission.

123. Members of the Associate Staff may not do any of the following: admit patients, perform procedures, maintain clinical privileges or hold office. They may not take Emergency Room call. They shall pay dues.

124. To be eligible for Associate Staff, physicians must have satisfactorily completed their provisional year to be eligible for consideration for change to Associate Staff Status. Associate members must attend the Annual Medical Staff meeting.

VII. Disciplinary Action

A. Disciplinary Action

125. Disciplinary action against any member of the Medical staff may be requested by the Chief of Staff, Department Chair, the Chief Executive Officer or the Governing Body. All requests for disciplinary action shall be addressed in writing to the Chair of the Executive Committee and shall refer to the specific activities or conduct which constitutes the grounds for the request. The Chair of the Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for disciplinary action, and shall continue to keep him/her fully informed of any action taken. Initiation of disciplinary action shall not preclude imposition of a summary suspension under Section B.

126. Grounds for requesting disciplinary action of Medical Staff membership or privileges shall include, but not be limited to the following:

a. A member’s professional performance or professional, ethical or moral activities or conduct which are reasonably believed to be inconsistent with the generally recognized professional standards or aims of the Medical Staff, or be disruptive of Hospital operations or to reflect negatively upon the reputation of the Medical Staff, or detrimental to patient safety or quality of patient care in the Hospital.

b. Engaging in unethical practice.

c. Conviction of a felony.

d. Failure to maintain adequate medical records, as determined by any state or federal law, rule or regulation.

e. Any violation of the Bylaws and/or Rules and Regulations of the Medical Staff or current Hospital policies.

127. A requirement for monitoring or supervision of a practitioner may be imposed at any time, shall not be considered a disciplinary action and shall not entitle a member to a hearing or appellate review.

128. When the disciplinary action is requested, the Executive Committee shall either conduct an investigation through an Ad Hoc Committee appointed by the Chairperson or promptly submit such request to the Chairperson of the Department in which the member has privileges. Upon receiving such a request, the appropriate Chairperson or Ad Hoc Committee shall immediately conduct a detailed investigation of the matter. If an investigation is initiated, the affected member shall be notified and advised of the general nature of the complaint. A report of the findings and recommendations of the Chair or Ad Hoc Committee shall be made to the Chair of the Executive Committee within fourteen (14) days after the Department Chair’s or Ad Hoc Committee’s receipt of the request.
Before the Department Chair or Ad Hoc Committee makes his/her report, if the affected member requests, he/she shall be permitted to appear before the Chair or his/her designee(s) or Ad Hoc Committee, be informed of the general nature of the complaint against him/her, and be permitted to make a statement on his/her behalf. This appearance shall constitute an interview and shall not be a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such appearance shall be made by the Chair or Ad Hoc Committee and included with his/her report to the Chair of the Executive Committee. A copy of such report will be made available to the member.

129. The Executive Committee shall consider the report from the Department Chair or Ad Hoc Committee within fourteen (14) days after receiving it. If the report recommends suspension, reduction or revocation of membership or privileges on the Medical Staff, the member may be requested to appear before the Executive Committee before it acts on such report. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearing shall apply. The Executive Committee shall make a record of such appearance.

130. The member upon receiving the notice of a recommended disciplinary action may waive all further proceedings as outlined herein and request a final hearing before the Governing Body. Such a request shall be deemed a waiver of any further rights to hearing procedures and appeals according to these Bylaws. Such waiver shall be in writing to the Chief Executive Officer within fourteen (14) days after receipt of such notice.

131. The action of the Executive Committee may take the form of recommending: a letter of warning, admonition, or reprimand; reduction, suspension, or revocation of clinical privileges; terms of probation, or suspension or revocation of membership on the Medical Staff. Only those actions described in Article VIII, Section B shall entitle the member to the rights of hearing and appeal. Any other action(s) adverse shall entitle the member to an interview with the Executive Committee before it sends its recommendation to the Governing Body. Notice of the recommended disciplinary action shall be given to the affected member within three (3) days after the Executive Committee action. All recommendations of the Executive Committee shall be subject to approval or modification by the Governing Body.

B. Summary Suspension

132. Upon a determination that immediate action is required, the Chief of Staff, any Department Chair, the Chief Executive Officer, and the Executive Committee of either the Medical Staff or the Governing Body shall each individually have the authority to summarily suspend all or part of a member’s admitting and/or clinical privileges and membership. Such summary suspension shall be based on the need to protect or reduce the substantial and imminent likelihood of significant danger to the life, health or safety of any patient, employee or other person and shall become effective immediately upon imposition. Written notice of the summary suspension shall be given promptly to the affected member, the Governing Body, the Executive Committee and the Chief Executive Officer.

The notice of the summary suspension shall constitute a request for disciplinary action and the procedures in Section A, Paragraphs 4-7 of this Article shall then be followed. The notice to the affected members
shall also conform to Article VIII, Section C.

133. As soon as practicable but not later than seven (7) business days after imposition of the summary suspension, the Executive Committee shall convene to review the summary suspension. The affected member may, upon request, appear at the meeting of the Executive Committee to make a statement concerning the summary suspension, on such terms and conditions as the Executive Committee may impose. This meeting shall constitute only an interview and not a "hearing" within the meaning of Article VIII. The Executive Committee may recommend continuation or termination of the summary suspension or modification of its terms.

134. Unless the Executive Committee recommends termination of the summary suspension, the terms of the summary suspension as continued or modified by the Executive Committee shall remain in effect pending the disciplinary process and any hearing and appellate review afforded under Article VIII. If the Executive Committee recommends termination of the summary suspension, the Governing Body shall lift the suspension pending a final determination of the disciplinary action. The final result of the disciplinary process shall substitute for the summary suspension.

135. Immediately upon the imposition of a summary suspension, the Chief of Staff in consultation with the appropriate Department Chair, shall have authority to provide for alternative medical coverage for the patients of the suspended member in the Hospital at the time of such suspension. The wishes of the patient shall determine, if possible, the selection of such alternative member.

C. Automatic Suspension

136. Medical Records: When a member fails to complete medical records within the time prescribed by the Medical Staff Rules and Regulations, he/she, after being provided with warning, shall have all admitting, consulting and surgical privileges suspended by the Chief Executive Officer, the only exception being to existing patients that are already admitted. Any such suspension shall remain in effect until all delinquent records are complete. Any practitioner suspended three (3) times within any twelve (12) month period for delinquent records shall be subject to further disciplinary action, and may be reported to the appropriate regulatory bodies. Failure to complete the records within three (3) months of initial suspension shall result in termination of the member’s Medical Staff membership.

137. Licensure: Action by the State Board of Medical Examiners revoking a member’s license shall result in the automatic termination of his/her staff membership and privileges. If the State Board of Medicine suspends or restricts a member’s license, the Chief of Staff or the Chief Executive Officer may revoke or suspend automatically all or some of the member’s admitting and clinical privileges, or membership at the discretion of the Chief of Staff or Chief Executive Officer. If the member has been suspended and his/her license is not reinstated in good standing within one (1) year, it shall be deemed a voluntary resignation of the member’s Medical Staff membership and privileges.

138. Controlled Substances: Upon revocation or suspension of a member’s DEA Certificate, the member’s right to prescribe medications covered by the certificate shall be automatically suspended immediately for the duration of such suspension or revocation.

139. Financial Responsibility: If a member fails to maintain the minimum professional liability insurance required as a qualification for membership, he/she shall:
a. have his/her admitting and clinical privileges suspended until such time as he/she provides evidence of such minimum insurance coverage. Failure to provide evidence of coverage within six (6) months after the suspension shall be deemed a voluntary resignation of Medical Staff membership and privileges.

b. be placed on a Special Leave of Absence for a period not to exceed one (1) year. During the leave of absence, he/she shall not be permitted to exercise his/her clinical or admitting privileges. The member may return from the leave of absence at such time as he/she demonstrates compliance with the Medical Staff requirements for professional liability insurance. The Special Leave of Absence is not renewable.

140. Conviction of a Felony: A member who has been convicted of a felony shall be automatically suspended from membership pending an investigation under this Article. If the conviction is upheld, the member shall be deemed to have voluntarily resigned from the Medical Staff.

141. The Chief of Staff, with the cooperation of the Chief Executive Officer, shall enforce all automatic suspensions.

142. A member whose membership or privileges are automatically suspended or revoked under this Section shall have no right to a hearing and appellate review as provided in these Bylaws.

VIII. Hearing and Appellate Review Procedure

A. Definitions and Preamble

143. Except as provided in Section I of this Article, only members of the Medical Staff shall be entitled to the hearing and appellate review procedure provided in this Article. However, Allied Health Professionals and Locum Tenens shall be entitled to the right to appeal through the sponsoring physician to the Executive Committee.

144. A member shall be entitled to only one hearing and one appellate review before receiving a final determination.

145. The Executive Committee and the Governing Body shall act on all recommendation(s) and report(s) described in this Article not later than at the first regular meeting following their receipt of such recommendation(s) or report(s).

146. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct.

147. In event of an adverse action or recommendation, the member shall exhaust all hearing and appeal procedures afforded by these Bylaws before resorting to any legal action on either procedural or substantive grounds. If the member takes legal action and does not prevail, he/she shall bear the legal costs (including reasonable attorneys' fees) incurred by the Hospital in defending such legal action.

148. All hearings and appellate reviews shall be conducted according to the procedural safeguards set forth in this Article to assure that the affected member is accorded all rights to which he/she is entitled.

149. Definitions:

a. Notice: All notices and requests provided for during the hearing and appellate review process shall be made in writing through the Chief Executive Officer by certified mail, return receipt requested, or by personal delivery.
b. Date of Notice: Shall mean the date on evidence of mailing the notice or delivery of any other written communication.

c. Computation of Time: For the purposes of this Article, the day of mailing of notice or delivery of any other communication shall not be included in the computation of time. The last day of the time computed shall be included. If the time period is seven (7) days or less, the computation shall be business days; if the period is more than seven (7) days, the computation shall be calendar days. If the last day is a Saturday, Sunday or legal holiday, the period shall run to the next business day.

B. Right of Medical Staff Member to Hearing

150. Except otherwise specified in these Bylaws, any one or more of the following or recommended actions of the Executive Committee or proposed action of the Governing Body shall constitute grounds for a hearing:

a. denial of requested advancement in Staff membership status, or category.

b. denial of Medical Staff appointment or reappointment.

c. demotion to lower Medical Staff category or membership status.

d. suspension or revocation of some or all clinical privileges or of medical Staff membership.

e. denial of requested clinical privileges except when the denial is based on the hospital's inability to provide clinical support necessary.

f. imposition of a monitoring or consultation requirement when agreement must first be reached with the monitor or consultant as to the course of treatment before treatment may be rendered; or,

g. reduction, restriction, revocation or suspension of current clinical privileges.

C. Request for Hearing

151. In all cases described in Section B of this Article, the affected member shall be promptly notified as provided in this Article of the adverse recommendation, the reasons for the recommended action, the right to request a hearing pursuant to this Section and the time within which to request a hearing, and given a summary of the member’s rights during the hearing.

152. The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Executive Committee or the Board of Trustees, as appropriate. If the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and appellate review to which he/she is entitled, and to have accepted the recommendation or action involved. Such action or recommendation shall then become effective against the member pending final action by the Governing Body. The Chief Executive Officer shall promptly notify the member of his/her status.

D. Notice of Hearing

153. Within fourteen (14) days after receiving a request for a hearing from a member, the Executive Committee or the Governing Body, whichever is appropriate, shall, through the Chief Executive Officer, notify the member of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than forty-five (45) days from the date of the notice to the member.
154. The notice of hearing shall state the acts or omissions with which form the basis of the proposed action, a list of specific or representation charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation, and shall contain a list of the witnesses who are expected to testify at the hearing on behalf of the recommendation.

155. The hearing may be postponed or extended by the member beyond the times provided in these Bylaws only with approval, and at the sole discretion, of the Hearing Committee upon a showing of good cause. The Hearing Committee may postpone the hearing beyond the time provided in these Bylaws for good cause shown with the concurrence of the member.

E. Hearing Committee

156. Upon receipt of a request for a hearing, the Chief of Staff, in consultation with the Chief Executive Officer, shall appoint a Hearing Committee. The Hearing Committee shall be composed of at least five (5) members, and alternates as appropriate, of the Active Medical Staff in good standing who are not on either the Executive Committee or the Board of Trustees. The Chief of Staff shall appoint one of the members as Chair. No committee member shall be in direct economic competition with the affected member, or have actively participated in considering the matter that is the subject of the hearing, unless the size of the active Medical Staff is too small, in which case, members of other categories may be selected. The Chief of Staff may at his/her discretion appoint additional members to the Hearing Committee as deemed necessary to attain a Peer Committee as to the specialty or privileges of the affected member.

F. Conduct of Hearing

157. The purpose of the Hearing is to determine the facts involved in the charge, to determine if the evidence supports the charge and to determine if the requested action is appropriate to the charge and based on the evidence.

158. There shall be at least three (3) members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.

159. An accurate record of the hearing must be kept. The Committee shall establish the mechanism, which may be a court reporter, electronic recording unit or detailed transcription.

160. A member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights to the hearing and to have accepted the adverse recommendation or proposed action involved. The recommendation or proposed action shall then become and remain effective against the member pending a final decision by the Governing Body.

161. The affected member shall be entitled to be accompanied and/or represented at the hearing by an attorney or another person of the member’s choice. The Executive Committee or Governing Body may appoint one of its members, some other Medical Staff member, or an attorney to represent it at the hearing.

162. The Chair of the Hearing Committee, or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Chief Executive Officer may, in the alternative, appoint a hearing officer from within or outside the Facility, who is not in direct economic competition with the affected member, to serve as the presiding officer. The presiding officer may take such action as may
be deemed necessary if he/she determines that either side is not proceeding efficiently and expeditiously. If a hearing officer is appointed by the Chief Executive Officer, such person shall not participate in the deliberations of the committee or vote.

163. The rules of law relating to the examination of witnesses or presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may at its discretion, order that oral evidence shall be taken only on oath or affirmation.

164. Within reasonable limits, both parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. Both parties shall also be entitled to submit a written statement on any issue of fact or procedure before, during or within ten (10) days after the hearing and such statement shall become part of the record. If the member does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

165. Except as provided in Section I of this Article, the Executive Committee or Governing Body, as appropriate, shall have the burden of presenting substantive evidence to support its recommendation or action. The affected member shall then have the burden of persuading the Hearing Committee to support his/her position.

166. The Hearing Committee may, without special notice, recess the hearing and reconvene it for the convenience of the participants or to obtain new or additional evidence. After presentation of all oral and written evidence, the hearing shall be closed. The Hearing Committee may then at a convenient time deliberate outside the presence of the affected member.

167. Within ten (10) days after closing the hearing, the Hearing Committee shall submit a written report and recommendation, including a statement of the basis for the recommendation, together with the hearing record and all other documentation, to the Executive Committee and to the Governing Body. A copy of the report and recommendation shall simultaneously be sent to the affected member. The report may recommend confirmation, modification, or rejection of the original adverse recommendation or proposed action. The Governing Body shall consider the Hearing Committee’s report and recommendation, but shall not be bound by it.

168. The Governing Body shall take action on the Hearing Committee’s report and issue a final decision and report with a statement of the basis for its decision within fifteen (15) days after receipt. Notice of this final decision, with a copy of the report, shall promptly be provided to the affected member by the Chief Executive Officer.

G. Appellate Review

169. Within thirty (30) days after notice of the final action of the Governing Body, the affected member may, by written notice to the Governing Body, request an appellate review. The notice must state clearly and concisely the grounds for the appeal and the facts supporting it. If oral argument is desired, the notice must specifically request that it be permitted as part of the appellate review; otherwise, the appellate review shall be conducted only on the written record.
170. If the member does not request appellate review in the time and manner provided, he/she shall be deemed to have waived his/her right to appellate review, and to have accepted such final action which shall then become effective immediately.

171. The only grounds for appeal shall be:
   a. failure to comply substantively with these Bylaws;
   b. the recommendation or decision was arbitrary or capricious; or
   c. the recommendation or decision was not supported by substantial evidence.

172. Within fourteen (14) days after receipt of a request for appellate review, the governing Body shall make a determination that the request is not in compliance with paragraph 3 or schedule a date for such review, including a time and place for oral argument if such has been requested, and shall notify the affected member in writing. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the request. The Governing Body upon a showing of good cause may postpone the date of the appellate review.

173. The appellate review shall be conducted by the Governing Body or by a duly appointed Appellate Review Committee of the Governing Body of not less than three (3) members. If the appellate review is of an initial proposed action of the Governing Body, the Appellate Review Committee will be an Ad Hoc Committee of three (3) Medical Staff members appointed by the Chief of Staff. The Ad Hoc Committee members shall be members in good standing of the Active Staff who are not in direct economic competition with the affected member and who have not participated in consideration of the matter during the process unless the size of the Medical Staff is too small, in which case, members of other categories may be selected. For the purposes of this Section, “Appellate Review Committee” shall mean the Governing Body or Appellate Review Committee or Appellate Ad Hoc Committee, as appropriate.

174. The affected member shall have access to the record (and transcript, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she may be charged reasonable charges for copies of such material. This shall not include, however, minutes or proceedings of Peer Review committees or other records or information, which are confidential or privileged by law. Both parties to the appeal shall be permitted to submit a written statement in support of their position specifying the facts and procedures in dispute and the reasons therefore. A copy of the statement shall be provided to the other party when it is received by the Chief Executive Officer. This statement shall be submitted to the Appellate Review Committee at least ten (10) days before the date scheduled for the appellate review.

New or additional evidence may be accepted by the Appellate Review Committee in its sole discretion and only if it can be shown that such information could not reasonably have been made available at the hearing. Both parties shall have the right to cross-examine concerning such additional or new information.

If oral argument has been permitted, both parties shall be present at the Appellate Review to make oral arguments and answer questions addressed to them by the Appellate Review Committee. The Appellate Review Committee may limit the time for oral argument and length of written statements.
175. The Appellate Review Committee shall review the record created in the proceedings, and shall consider the written statements to determine whether:
   a. there was a substantial failure to comply substantively with the Medical Staff Bylaws; or
   b. the recommendation or decision was arbitrary or capricious; or
   c. the recommendation or decision was not supported by substantial evidence.

176. If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse the prior decision, or in its discretion, refer the matter back to the Executive Committee for further review and recommendation within ten (10) days after the conclusion of the appellate review. If the matter is referred back to the Executive Committee, it may request that the Executive Committee arrange for a further hearing to resolve specific disputed issues. The Executive Committee shall submit its report within thirty (30) days of such request.

177. If the review is conducted by the Appellate Review Committee of the Governing Body, it shall, within thirty (30) days of receipt of the request, either make a written report to the Governing Body recommending that the Governing Body affirm, modify or reverse the prior decision, or refer the matter back to the Executive Committee within ten (10) days for further review and recommendation. Such referral may include a request that the Executive Committee arranges for another hearing to resolve specific disputed issues. The Executive Committee’s report shall be due within ten (10) days after receiving the Executive Committee’s recommendation to the Governing Body.

178. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section have been completed or waived. Where permitted by the Board of Trustee Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

H. Final Decision by Governing Body

179. Within thirty-five (35) days after receiving the Appellate Review Committee’s recommendation, the Governing Body shall make its final decision in the matter and will send notice to the Executive Committee and to the affected member, as provided herein.

I. Right of Practitioner Applicants to Hearing

180. An applicant (non-member) to the Medical Staff, upon receiving notice of an adverse decision of the Governing Body on his/her application for membership or privileges, shall be entitled to a hearing in accordance with Article VIII, Paragraphs E and F of these Bylaws. The applicant shall request the hearing in writing within thirty (30) days of receipt of notice of the adverse decision. Failure of the applicant to request a hearing in the time and manner prescribed in this Article shall be deemed a waiver of the applicant’s rights to such proceedings and an acceptance of the Governing Body’s decision as final.

181. Within fourteen (14) days following receipt of a request for a hearing, the Governing Body shall, through the Chief Executive Officer, notify the applicant of the time, place and date of the hearing.

182. The Hearing Committee shall be constituted as described in Section E of this Article.
183. The Hearing Committee shall convene the hearing within not less than thirty (30) and not more than forty-five (45) days after giving notice to the applicant of the hearing. The hearing shall be conducted in the manner described in Section F of this Article. The Hearing Committee shall make a recommendation to the Governing Body within ten (10) days after closing the hearing. A copy of the recommendation shall be sent to the applicant. The applicant may also obtain a copy of the transcript of the hearing and may be charged reasonable charges for such copy.

184. If the Hearing Committee’s recommendation is still adverse to the applicant, the applicant may submit to the Governing Body a written statement containing the objections to the recommendation, including any allegations of procedural errors. The applicant may make an oral statement to the Governing Body as well.

185. The Governing Body shall consider the record of the hearing as well as the applicant’s written and/or oral statements in addition to all the other material presented with the application. The Governing Body shall determine whether:
   a. there was substantial failure to comply substantively with the Medical Staff Bylaws;
   b. the initial decision was arbitrary or capricious;
   c. the initial decision was supported by substantial evidence.

The Governing Body shall consider the recommendation of the Hearing Committee and shall render its final decision within thirty (30) days after receiving the recommendation.

186. The practitioner may waive his/her right to a hearing before the Hearing Committee and request a hearing before the Governing Body. The Governing Body’s decision will be final.

J. Hearing and Appeal Procedures for Allied Health Practitioners

187. Individuals with clinical privileges who are not eligible for Medical Staff Membership and who are not Medical Staff members (i.e. Allied Health Professionals – AHP’s) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical staff membership. Hospital based contracts (i.e. Radiology, ER, Anesthesia, Pathology) are not covered under this auspice. The hospital reserves the right to suspend any AHP to protect or reduce the substantial and imminent likelihood of significant danger to the life, health or safety of any patient, employee or other person and shall become effective immediately upon imposition.

188. The following procedures shall be used for AHP’s:
   a. Notice of Hearing: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the AHP who is the subject to the adverse recommendation or action. The notice shall state the AHP has 30 days in which to request a hearing. If the AHP does not request a hearing within 30 days, the AHP shall have waived right to a hearing.
   b. Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, Chief of Staff and Board of Trustees member.
   c. Rights: The AHP subject to the adverse recommendation or action shall not have the right to legal representation or call witnesses.

Hearing Panel Determination
1) Following presentation of information and panel deliberations, the panel shall make a determination:

2) determination favorable to the AHP shall be reported in writing to the body making the adverse recommendation or action and the hearing panel’s determination is final.

3) determination adverse to the AHP shall result in notice to the Board of Trustees for action.

4) Final Decision

5) The Board of Trustees has the final authority on all cases.

K. **EXTERNAL REPORTING REQUIREMENTS**

189. The Hospital shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual’s license to practice) and all other agencies as required by all applicable Federal and/or State law(s).

IX. **Elected Officers**

A. **Officers of the Medical Staff**

190. The officers of the Medical Staff shall be the:

   a. Chief of Staff (President of Staff);
   b. Chief of Staff-Elect (Vice Chief);
   c. Secretary-Treasurer;
   d. Representative-at-Large;
   e. Immediate Past Chief of Staff.

B. **Qualifications of Officers**

191. Officers must be members of the Active Staff in good standing at the time of nomination and election and must remain in good standing during their term of office. Failure to maintain such status shall immediately terminate the officer’s term.

C. **Nomination of Officers**

192. The Nominating Committee which shall consist of the Chief of Staff, Vice Chief of Staff and three (3) members of the Active Staff representing departments of Medicine, Surgery and Special Services appointed by the Chief of Staff, shall prepare a list of one or more nominees for the offices of Chief of Staff - Elect and Secretary-Treasurer.

193. The list of nominees shall be submitted to the Executive Committee for approval. If the Executive Committee disapproves of a nominee, the Nominating Committee shall be notified and a new nominee recommended. The Chair of the Executive Committee shall publish the approved list of nominees to the Medical Staff at least fourteen (14) days before the annual meeting.

194. Nominations may also be made by petition signed by at least ten (10) per cent of the Active Staff with the written consent of the proposed nominee and filed with the Secretary-Treasurer of the Medical Staff at least seven (7) days before the annual meeting. No nominations shall be made from the floor at the annual meeting.
D. Election of Officers

195. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Staff present at the meeting shall be eligible to vote.

196. The official ballot shall specify which nominees are offered by petition. Voting shall be by secret ballot and officers shall be elected by majority vote. When there are three (3) or more nominees for an office and no candidate receives a majority on the ballot, the name of the nominee receiving the fewest votes will be omitted from each successive ballot until a majority vote is obtained for one nominee.

197. The Chief of Staff - Elect and three (3) other members of the Medical Staff named by the Chief shall serve as Tellers. The Tellers shall determine the procedure to be followed in counting the ballots.

198. All elected officers are subject to, and shall take office only after, confirmation by the Governing Body. All elected officers may be removed from office by the Governing Body.

199. If there is no quorum at the annual meeting, the offices shall be considered vacant and shall be filled according to Section F of this Article.

200. The Chief of Staff - Elect shall become Chief of Staff upon the expiration or termination of the term of the preceding Chief of Staff.

E. Term of Office

201. Except as otherwise provided in these Bylaws, officers shall serve a two (2) year term beginning the first day of the new Medical Staff Year, or upon taking office, and ending on the last day of the Medical Staff Year immediately following assumption of office or until their successors take office (whichever occurs last), subject to the confirmation by the Governing Body. An officer must be out of office for one (1) year before being eligible to be nominated for another term in the same office. This does not preclude nomination of such officer to another office.

202. Officers of the Medical Staff may be recalled for grounds specified under Article VII, Section A (2), upon presentation to the Chief of Staff of a petition signed by thirty percent (30%) of the Active Staff members. Within twenty (20) days of receipt of a petition, the Chief of Staff shall verify the signatures and call a special meeting of the Medical Staff to vote on the recall. An officer shall be recalled and removed from office upon a vote of not less than two thirds of the Active Staff membership. The vote shall be by secret written ballot.

F. Vacancies in Office

203. Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled immediately by the Executive Committee, subject to confirmation by the Governing Body. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff - Elect shall serve out the remaining term after which the Chief of Staff - Elect shall be eligible to fulfill his/her full term as Chief of Staff. If there is no Chief of Staff - Elect, the Executive Committee shall fill the vacancy, subject to the approval of the Governing Body.

G. Duties

204. Chief of Staff - The Chief of Staff shall serve as chief administrative officer of the Medical Staff to:

a. be responsible for enforcing the Medical Staff Bylaws and Rules and Regulations, for implementing sanctions where they are indicated, and for
the Medical Staff complying with the procedural safeguards in all disciplinary proceedings;
b. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
c. Chair the Executive Committee and serve as a member of the Joint Conference Committee;
d. serve as an Ex-Officio member of all other Medical Staff committees;
e. coordinate and cooperate with the Chief Executive Officer in enforcing Hospital policies and Medical Staff Bylaws and in all matters of mutual concern within the Hospital;
f. appoint committee Chair and members to all standing and special committees of the Medical Staff except as provided in these Bylaws;
g. represent the views, policies, needs and grievances of the Medical Staff to the Governing Body, the Chief Executive Officer and the corporation;
h. receive and implement the policies of the Governing Body and report to the Governing Body on the effectiveness of the Quality Assurance program, the clinical performance and quality patient care of the Medical Staff related to its delegated responsibility to provide quality patient care;
i. be responsible for the continuing education activities of the Medical Staff; and
j. represent the Medical Staff in its external professional and public relations.

205. Chief of Staff - Elect - In the absence of the Chief of Staff, he/she shall assume the duties and the authority of the Chief. He/she shall be a member of the Executive Committee and the Joint Conference Committee. He/she shall automatically succeed the Chief when the latter fails to serve for any reason.

206. Secretary-Treasurer - He/she shall be a member of the Executive Committee. The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings pursuant to these Bylaws, attend to all the correspondence and perform such other duties as ordinarily pertain to his/her office. He/she shall also act as the Treasurer and as such he/she shall collect, disburse and be accountable for all Medical Staff funds, dues, etc. He/she shall render a monthly financial report to the Executive Committee and provide a financial statement at the Staff meetings.

207. Immediate Past Chief of Staff - The Immediate Past Chief of Staff shall be a member of the Executive Committee and the Nominating Committee and shall perform such other advisory duties as are assigned to him/her by the Chief of Staff, Executive Committee or the Governing Body.

208. Representative-at-Large - The Representative-at-Large shall be a member of the Executive Committee and shall also perform such duties as are assigned by the Chief of Staff.

H. Resignation and Removal from Office

209. resignation

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and upon acceptance by the Medical Executive Committee.

210. Removal
Any Medical Staff officer may be removed from office for cause. Removal shall occur with the majority vote of all the members of the Medical Executive Committee and upon approval by a majority of the BOT. Grounds for removal may include any one or more of the following causes:

a. Failure to perform the duties of office;

b. Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

c. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

d. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

e. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of the hospital, or inconsistent with the best interests of the Medical Staff.

X. Meetings

A. The Annual Meeting

211. An annual meeting of the Medical Staff shall be held before the end of each year. During the year elections are held, at this meeting, the Nominating Committee shall present the slate of nominees for officers. Officers for the ensuing term shall be elected and installed. This meeting shall include a business session in which all departments (and sections thereof) and committees shall be required to present an annual report. If Staff funds exist, a report of the treasurer shall be presented.

B. General Meetings

212. Additional regular meetings of the Medical Staff may be held at the discretion and at a time and place designated by the Executive Committee.

C. Special Meetings

213. Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Governing body, the Executive Committee, or by the joint written request of at least twenty-five percent (25%) of the Active Staff. At any special meeting no business shall be transacted except that stated in the notice of the meeting.

D. Attendance at Meetings

214. Each appointee to the Active or Provisional Active Medical Staff is required to attend the Annual Meeting and must comply with Article XII, Section F.

E. Quorum

215. Twenty-five percent (25%) of the voting membership of the staff shall constitute a quorum for the transaction of all Staff business excluding General Staff and Medical Executive Committee which shall require Fifty percent (50%).

F. Manner of Action

216. The action of a majority of members present and voting at a meeting at which a quorum is present shall be the action of the Medical Staff.

G. Clinical Presentations
217. If a case is to be discussed at a meeting because of problems found either during routine case review, or otherwise, the affected member shall be notified and invited to attend. The case shall be presented in the member’s absence unless the absence is excused and/or the member has requested that discussion be postponed. Discussion shall not be postponed later than the next regular meeting.

H. Order of Business and Agenda

218. The meeting shall be conducted according to Roberts' Rules of Order as last amended. The agenda shall include at least:

a. reading and acceptance of the minutes of the last regular meeting and of all special meetings held since the last regular meeting;

b. administrative reports from the Chief Executive Officer, the Chief of Staff, department chairmen, and committee chairmen;

c. The election of officers, when required by these Bylaws;

d. reports by responsible officers, committees, and departments on the overall results of patient care monitors and other quality assurance activities of the Staff and on the fulfillment of any required Staff functions;

e. recommendations for improving patient care within the Hospital.

219. The agenda at special meetings shall be:

a. reading of the notice calling the meeting; and

b. transaction of the business for which the meeting was called.

I. Minutes

220. Minutes of each regular and special meeting of a department or committee shall be prepared and shall include a record of attendance and the vote taken on each matter. The minutes shall be signed by the Presiding Officer and copies shall be available to the Staff. The Chief Executive Officer or designee shall maintain a permanent file of the minutes of each meeting.

J. Meeting as a Committee-of-the-Whole

221. Notwithstanding any other provision of these Bylaws, whenever the medical staff or a department or service meets, it shall be considered to be meeting as a committee of the whole medical staff, department, or service, respectively. Unless otherwise specified in these Bylaws, the action of a majority of the members present and eligible to vote at a meeting at which a quorum is present shall be the action of a committee. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereon.

K. Confidentiality

222. All meetings shall be open to any member of the Medical Staff. Meeting Chair may close a portion of any meeting if in their judgment the best interest of the medical staff is served by this closure.

XI. Departments and Sections of the Medical Staff

A. Departments and Services

223. There shall be a Department of Medicine, Surgery, and Special Services. Each department shall be organized as a separate part of the Medical Staff and have a Department Chair and a Vice-Chair. The Chair shall be responsible for the overall
supervision of the clinical work within the department. The anesthesiology service shall be part of the Department of Surgery and the radiology service, emergency service and pathology service shall be part of the Department of Special Services.

224. Other departments may be established from time to time upon the written request to the Executive Committee by the membership of the Active staff or a department and upon approval of the Executive Committee and Governing Body. No department may be established or maintained with less than three (3) Active staff members.

225. An approved and authorized department may be eliminated if the Executive Committee and Governing Body determine that the patient activity of the department has decreased so that it is not substantial enough to warrant such status or the number of Active staff members decreases to less than three (3), except Hospital-based services.

B. Organization of Departments and Services

226. Each department and service shall be organized as a separate part of the Medical Staff and shall have a Chair who is elected and has the authority, duties and responsibilities as specified in this Article.

227. In order to promote and maintain quality care, lower costs and administrative efficiency, Hospital-based services may be provided through physician contracts with the Hospital. Such agreement(s) may provide for the extent of such services. The Medical Director shall be approved, as any other member, for membership and privileges except as otherwise provided in these Bylaws.

C. Assignment to Departments

228. Each member of the Staff shall be assigned to not more than one (1) department but may be granted clinical privileges in one (1) or more departments. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of the Department Chair.

229. Allied Health Professionals, regardless of source of employment and degree of practice independence, shall be assigned to a department where their clinical performance shall be monitored. They shall be subject to all applicable rules and regulations of the department and authority of the Department Chair.

D. Functions of Departments and Services

230. The primary responsibility of each department and service is to implement and conduct specific monitoring review and evaluation activities that contribute to preserve and improve the quality and efficiency of patient care provided in the Hospital.

231. To carry out this responsibility, each department and service shall:

a. conduct ongoing monitoring to analyze, review and evaluate the quality and efficiency of care within the department based on objective criteria reflecting current knowledge and clinical experience. This function shall be designed to strive to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served: (i) the ability to obtain information and interpret information in terms of the patients' needs; (ii) a knowledge of growth and development; and (iii) an understanding of the range of treatment needed by these patients. Each department shall review all clinical work performed under its jurisdiction whether or not the practitioner
is a member of the Department. The Department shall also identify actions to be taken to resolve identified problems.

b. establish criteria, consistent with the policies of the medical Staff and of the Governing Body, for granting clinical privileges in the department and submit the recommendations required under these Bylaws regarding the specific privileges to be granted to each Staff member or applicant and each health professional affiliate.

c. conduct or participate in, and recommend continuing education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.

d. monitor on a continuing and concurrent basis, adherence to:
1. staff Bylaws, Rules and Regulations, and Hospital policies and procedures;
2. requirements for alternate coverage and consultations;
3. sound principles of clinical practice; and
4. fire and other regulations designed to promote patient safety.

e. coordinate the patient care provided by the department’s members with nursing and ancillary services and administrative support services.

f. foster an atmosphere of professional decorum within the department appropriate to the healing arts.

g. submit reports to the Executive Committee on a regularly scheduled basis concerning:
1. findings of the department’s review and evaluation activities, action taken thereon and the results of such action;
2. care provided in the department and the Hospital; and
3. such other matters as may be requested from time to time by the Executive Committee.

h. meet at least four times per year to receive, review and consider patient care review findings and the results of the department’s other monitoring, evaluation and education activities and to perform or receive reports on other department and staff functions.

i. establish such committee or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

j. establish written rules and regulations for the organization, operation and function of the department that do not conflict with the Medical Staff Bylaws and Rules and Regulations. The Rules and Regulations must be reviewed annually and any additions, deletions, revisions or changes must be approved by the Executive Committee and ratified by the Governing Body.

E. Qualifications, Appointment and Tenure of Department Chair

232. Each Department Chair and vice-chairman shall be an appointee to the Active Staff certified by an appropriate specialty board or affirmatively established, through the privilege delineation process, as possessing comparable competence.
233. Each clinical Department Chair, except as otherwise provided in these Bylaws, shall be elected subject to approval of the Executive Committee and the Governing Body. The election shall be held concurrently with the Elections for officers of the medical staff. Any member of a department on Active staff may stand for election, upon nomination by another member of the same department. Each active staff member within the department may cast a vote, and may only vote within the department for which they are assigned. Each Department Chair, except as otherwise provided in these Bylaws, shall serve a two (2) year term commencing on the first day of the new Medical Staff Year. He/she shall serve until the end of the succeeding Medical Staff Year or until his/her successor takes office, whichever is later. A Department Chair shall be eligible to succeed himself/herself.

234. Each Department Chair of the Medical Staff may be recalled upon presentation to the Chief of Staff of a petition signed by thirty percent (30%) of the Active Staff members within their department. Within twenty (20) days of receipt of a petition, the Chief of Staff shall verify the signatures and call a special meeting of the Medical Staff to vote on the recall. An officer shall be recalled and removed from office upon a vote of not less than two thirds of the Active Staff membership within their department. The vote shall be by secret written ballot.

235. Each department chairman may at his/her discretion appoint a Vice Chair who must be approved by the Executive Committee and the Governing Body. The Vice Chair shall assume the duties and authority of the Chair in his/her absence and be responsible for such duties as may be assigned by the chairman. The Vice Chair shall serve the same term as the Chair and may be removed in the same manner as the Chair or by the Chair.

236. Upon a vacancy in a Department Chairmanship, the Chief of Staff will immediately appoint a member of the active staff within that department to serve as an interim Chair until such time as the next scheduled department meeting. At the next scheduled department meeting, a new Chair shall be elected in accordance with Section E.209 of this article.

237. The Directors of Pathology, Radiology, Anesthesiology and Emergency Medicine will be appointed in accordance with Governing Contractual Agreement with the hospital. The Chair of these services shall serve in their respective capacities for two-year terms, except as otherwise provided by contractual arrangements.

F. Duties of Department Chair

238. The duties of the Department Chair shall be to account to the Executive Committee for all professional and administrative activities within his/her department and particularly for the quality of patient care rendered by members of the department and the effective conduct of the performance evaluation, other quality improvement functions and the maintenance of Quality Control programs delegated in his department;

239. Develop and implement departmental programs to review credentials and delineate privileges, continuing medical education, utilization review, provide for planned, systematic ongoing monitoring of appropriateness of care and other quality improvement functions as required by these Bylaws;

240. Serve on the Executive Committee, give guidance on the overall development and implementation of policies and procedures that guide and support the provisions of services policies of the Hospital, and make specific recommendations and suggestions regarding his/her own department;
241. Continuously review the professional performance of all practitioners and health professional affiliates with clinical privileges in the department and report to the Executive Committee;

242. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

243. Recommend clinical privileges for each member of the department;

244. Assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;

245. Integrate their department’s activities with the rest of the hospital’s primary functions, particularly the hospital’s overall plan for care delivery including personnel, supplies, special regulations, preprinted orders and techniques;

246. Coordinate and integrate services within their department and with other departments;

247. Assist in developing and implementing policies and procedures that guide and support the provision of services;

248. Recommend a sufficient number of qualified and competent persons to provide care;

249. Determine the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners;

250. The Directors continuously assess and improve their department’s performance and maintain appropriate quality control programs;

251. Orientation and continuing education in all persons in the department or service;

252. Recommendations for space and other resources needed by the department or service.

253. Assist in the preparation of annual reports, including budget planning, pertaining to the department as may be required by the Executive Committee, the Chief Executive Officer, or the Governing Body; and

254. Perform such other duties as may from time to time be reasonably requested by the Chief of Staff, the Executive Committee, the Chief Executive Officer, or the Governing Body.

**XII. Department Meetings**

**A. Regular Meetings**

255. A regular meeting of each department (and section if prescribed by the Department Chair) shall be held at least quarterly to review and evaluate the clinical work of practitioners and affiliates with privileges in the department.

**B. Special Meetings**

256. The Department Chair may call special meetings or convene special department committees, as he/she deems necessary to accomplish the purposes of the department.

**C. Quorum**

257. Twenty-five percent (25%) of the active Staff members of a department (or section thereof), but not less than two (2) members, shall constitute a quorum at any meeting.
D. Minutes

258. Minutes of each department or section meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be reviewed, approved, and signed by the presiding officer. The permanent file for all department (and section) meetings shall be maintained in the Chief Executive Officer’s office.

E. Manner of Action

259. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of that department (or section).

F. Attendance Requirements

260. Each member of the Active and Provisional Staff is required to attend the Annual Staff Meeting for each Medical Staff Year unless excused by the Chair for good cause shown. The Department Chair shall be notified in writing of the reason for a member’s absence. The failure to meet the annual attendance requirements shall be grounds for disciplinary action as provided in these Bylaws. Chair shall report all such failures to the Executive Committee for appropriate action, to include, but not limited to a probationary period of one year with suspension if annual meeting is not attended in the next year.

261. A member of the Medical Staff whose patient's clinical case is scheduled for discussion at a department (or section) meeting shall be so notified and shall be expected to attend such meeting. If the member is not otherwise required to attend the department (or section) meetings, the Chief of Staff shall, through the Chief Executive Officer, give the member advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the member shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that attendance at the meeting is mandatory.

262. Failure of a member to attend any meeting of which he/she was given notice of mandatory attendance or who fails to comply promptly with appropriate requests of duly constituted committees for cooperation and assistance, including but not limited to letters from duly constituted committees or departments, unless excused by the Chief of Staff or department (or section) head upon a showing of good cause, may be cause for disciplinary action. In all cases, if the member shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the chairman until not later than the next regular meeting. Otherwise the pertinent clinical information shall be presented and discussed as scheduled.

XIII. Committees

The committees of the Medical staff shall consist of Standing Committees and Special Committees, the latter appointed on an ad hoc basis. The Standing Committees of the Medical Staff shall be as follows: Executive; Credentials; Peer Review, Nominating; Quality Council; Medical Records/Utilization Review; Pharmacy and Therapeutics/Infection Control; Critical Care; Radiation Safety; and Ethics.

The Chief of Staff and/or the Vice Chief and the Chief Executive Officer or his/her designee shall be ex-officio members of all committees unless otherwise designated.
The Chief of Staff shall, after consultation with the Executive Committee and approval by the Governing Body, appoint members to all standing committees except the Executive Committee unless otherwise provided in these Bylaws.

Minutes of all committee meetings shall be transcribed and maintained in the Office of the Chief Executive Officer.

A. Executive Committee

263. Composition - The Executive Committee shall consist of a minimum of the officers of the Medical Staff, and the Chair of the Departments of Surgery, Medicine, and Special Services. The CEO, Administrator and CNO shall be ex-officio members. The Chief of Staff shall serve as Chair.

264. Duties - The duties of the Executive Committee shall include, but are not limited to:

a. represent, respond to and act on behalf of the Medical Staff subject to any limitations imposed by these Bylaws;

b. make recommendations to the Governing Body regarding Medical Staff structure;

c. manage the affairs and organization of the Medical Staff, and to enforce rules, regulations, and policies;

d. coordinate the activities and general policies of the services, committees and/or departments as required;

e. implement policies of the Medical Staff;

f. receive, review, evaluate and act upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;

g. review the recommendations of the Credentials Committee regarding applicants for appointment, reappointment, advancement or changes in Staff category, delineation of clinical privileges and/or assignments to services for each eligible individual and make recommendations to the Governing Body and Corporation;

h. recommend a mechanism by which Medical Staff membership may be terminated to the Governing Body;

i. recommend the mechanism for fair hearing procedures to the Governing Body;

j. assure participation of the Medical Staff in organizational performance improvement activities;

k. take all reasonable steps to ensure professional and ethical conduct by all members of the Medical Staff and to initiate and/or participate in Medical Staff disciplinary action or reviews as indicated;

l. provide liaison among the Medical Staff, the Chief Executive Officer, the Governing Body, and the Corporation;

m. recommend action to the Chief Executive Officer on medico-administrative matters;

n. make recommendations on hospital management matters, such as long-range planning to the Governing Body through the Chief Executive Officer;
o. fulfill the Medical Staff’s accountability to the Governing Body for the quality of the medical care rendered to the patients in the Hospital;

p. ensure that the Medical Staff is kept informed of the accreditation program and status of the Hospital;

q. prepare the programs of all meetings, either directly or through a program committee or other suitable agent;

r. report at each regular and annual Medical Staff meeting; and

s. bylaws responsibilities to include:

(1) Annual review of the Bylaws, Rules and Regulations, and procedures.

(2) To review recommendations for changes in the Bylaws, Rules and Regulations, and procedures made by the Medical Staff committees, departments, or the Board of Trustees.

265. Meetings - The Executive Committee shall meet monthly with a minimum of ten (10) meetings and maintain a permanent record of its proceedings and actions.

B. Credentials Committee

266. Composition - The Credentials Committee shall consist of one (1) Active Staff member from each of the clinical departments, one (1) Active Staff member who will represent all of the Hospital-based service departments and the Representatives-at-Large elected from the Active Staff.

267. Duties - The duties of the Credentials Committee shall be:

a. to review the report and recommendations of the Department Chair regarding each applicant for membership to the medical staff to ensure that all investigations were pursued with total objectivity, fairness, and impartiality and that the recommendations are soundly based and compatible with the established criteria, needs and objectives of the Medical Staff and Hospital;

b. to make a report and recommendations to the Executive Committee of the Medical Staff regarding each applicant for Staff membership in conformity with Article IV of these Bylaws; and

c. to review the report and recommendations of the Department Chairmen regarding the competence of Staff members and, as a result of such review, to make a report and recommendations to the Executive Committee of the Medical Staff regarding clinical privileges to be granted, reappointments, the assignment of members to the various sections and departments, and changes or advancements in Staff category as provided for in these Bylaws.

268. Meetings - The Credentials Committee shall meet monthly with a minimum of ten (10) meetings and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee of the Medical Staff.

C. Nominating Committee

269. Composition - The Committee shall consist of the Chief of the Medical Staff, the Vice-Chief and three (3) members of the Active Staff appointed by the Chief of Staff. The Departments of Surgery, Medicine, and Special Services shall each have at least one representative in the membership.
270. Duties - The Committee shall prepare and recommend a slate of nominees for the offices of the Chief of Staff-Elect, Secretary-Treasurer and a Representative-at-Large.

271. Meetings - The Nominating Committee shall meet Bi-annually, at least sixty (60) days before the annual meeting, maintain a permanent record of its proceedings and actions, and report its recommendations to the Chief Executive Officer and the Executive Committee.

D. Peer Review

272. Composition: The Peer Review Committee shall consist at a minimum the Chairpersons of Special Services, Medicine and Surgery or Vice Chair; an Active Staff member from each Hospital-based service departments.

273. Duties: A thorough review of work completed in each department with emphasis on:
   a. utilization review,
   b. performance improvement,
   c. risk management
   d. morbidity and mortality analysis with detailed consideration of selected deaths,
   e. unimproved cases,
   f. infections,
   g. complications or errors in diagnosis and results of treatment.
   h. Unplanned outcomes,
   i. Any cases referred through the Quality and Risk programs.

This review shall include medical record number and date of admission of the cases discussed with written resume and/or synopsis of each including recommendations, conclusions and actions of the committee.

274. Meetings: The Peer Review Committee shall meet monthly or as determined by the Chair and maintain a permanent record of its proceedings and actions.

E. Quality Council

275. Composition - Chief of Staff Elect, Administrator, Chief Nursing Officer, Quality/Utilization Management Director, Risk Manager, Human Resources Director or designee, the Managers of Laboratory, Diagnostic Imaging, Pharmacy, Health Information Management, and the Emergency Department. Medical staff membership shall be appointed by the Chief of Staff-Elect and include equal membership from the Departments of Medicine and Surgery, and one member each from the Department of Anesthesia, Pathology and Diagnostic Imaging. The Chief of Staff-Elect serves as chairperson

276. Duties - The duties of the Quality Council shall be:
   a. oversight of the hospital-wide quality improvement program to assure that the program is process oriented, multi disciplinary, coordinated, integrated, and effective;
   b. evaluation and prioritization of program activity and focus;
c. to maintain a written Continuous Quality Improvement Plan for adoption by the Executive Committee and the Governing body and to evaluate the continuous quality improvement program annually; and  
d. to continually assess and provide for the educational needs of the hospital and medical staff with regards to the implementation and growth of the continuous quality improvement program.

277. Meetings - The Committee shall meet no less than quarterly and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

F. Medical Records/Utilization Review

278. Composition - Shall include but is not limited to representation from Physicians, Radiology department, Emergency department, Pathology, Director of Health Information, Nursing, Administrator, Chief Nursing Officer, Director of Quality and Resource Management and Physician Advisor. No member will have a direct or indirect financial interest in the Hospital.

279. Duties - The duties of the Utilization Review Committee shall be:

a. to develop, maintain and execute an effective Utilization Review Plan that provides for equal level of care for all patients and meets regulatory and accrediting body requirements;

b. to effect efficient utilization of inpatient and outpatient beds and services through concurrent and retrospective monitoring of admission necessity, level of care, length of stay and the timely and appropriate use of diagnostic and therapeutic services;

c. to provide that all medical records meet the standards of patient care usefulness, historical validity and realistic documentation of medical events. To conduct a quarterly examination, review and evaluation of currently maintained medical records to ensure that they properly describe and accurately reflect the condition and progress of the patient and therapy provided, the results thereof, and the responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of physician responsibility for patient care. To conduct on a continuous basis a review of records of discharged patients to measure their adequacy as a source document and compare their content with established standards of promptness, completeness, adequacy and clinical pertinence to meet regulatory and accrediting body requirements;

d. to recommend any changes in the format of the medical records and to advise the Director of Information Management concerning filing, indexing, storage and availability of medical records; and

e. to assist the Director of Information Management in maintaining complete medical records and to monitor the delinquency of medical records and timeliness of completion and to recommend to the Chief Executive Officer and Chief of Staff that practitioners considered delinquent be suspended from admitting privileges in the Hospital until such charts are brought up to date.
280. Meetings - The Committee shall meet no less than quarterly, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

G. Pharmacy and Therapeutics/Infection Control Committee

281. Composition - shall include but is not limited to representation from Physicians, Pharmacy, Infection Control, Administrator, Chief Nursing Officer, Risk Management, Director of Quality & Resource Management and Physician Advisor.

282. Duties - The Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital to achieve optimum clinical results and a minimum potential for hazard and shall be responsible for the surveillance of inadvertent infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards and the supervision of infection and environmental sanitation control in all phases of the Hospital's activities. Specifically, the Committee's duties shall be:

a. to assist in formulating broad professional policies regarding the drug evaluation, selection, procurement, distribution, use, safety procedures, evaluation of reported drug reactions, determine who may administer drugs, and other matters relating to drugs in the Hospital;

b. to advise the Medical Staff and Administration on matters pertaining to the choice of drugs;

c. to prevent unnecessary duplication in the stock of the same basic drug and its preparation;

d. to evaluate clinical data concerning new drugs or preparations requested for Hospital;

e. to develop a Hospital formulary or drug list of accepted drugs for use in the Hospital and to evaluate the appropriate use of high risk drugs, including antibiotics;

f. to review untoward drug reactions and medication errors;

g. to perform drug use reviews and antibiotic reviews;

h. to review the use of any investigational drugs;

i. to develop written standards for Hospital sanitation and medical asepsis to include a definition of infection for the purpose of surveillance, as well as specific indications of the need for and the procedures to be used in isolation;

j. to develop, evaluate and revise on a continuing basis the procedures and techniques for meeting established sanitation and aseptic standards to include the routine evaluation of materials used in the Hospital’s sanitation program, namely: dietary and food handling, disposal of biological wastes, traffic control and visiting hours in all areas, sources of pollution and routine periodic culturing of autoclaves and gas sterilizers. The review of existing practices should also include procedures for the education and orientation of personnel in the practice of aseptic techniques. The evaluation may be based upon data supplied from reputable sources or upon in-use tests performed within the Hospital;
k. to develop a practical system for reporting, evaluating and recording infections among patients and personnel in order to provide an indication of endemic situations;

l. to assist in developing the Hospital’s employee health program; and

m. the Chair of this committee shall have authority temporarily to institute appropriate control measures or studies when there is reasonably consideration to be an immediate danger to any patient or personnel.

283. Meetings - The Committee shall meet quarterly or determined by the Chair. An accurate record and minutes shall be kept of the committee’s proceedings and actions and a report of its findings and recommendations shall be made to the Executive Committee and the Chief Executive Officer.

H. Critical Care Committee

284. Composition - shall include but is not limited to representation from Physicians, Nursing, Anesthesia department, Radiology department, Emergency department, Laboratory department, Cardiopulmonary department, Director of Critical Care, Chief Nursing Officer, Risk Management, Director of Quality & Resource Management and Physician Advisor.

285. Duties - The duties of the committee shall be:

a. to evaluate and maintain quality patient care in the unit; to see that safety standards are maintained; and to see that training and education of nursing staff and practitioners is maintained on a continuing basis;

b. to seek ways and means for improving the professional standards and functions of these services for better patient care and proficiency in the execution of the detailed responsibilities;

c. to be responsible for formulating and assuring compliance with the established rules and regulations of the Special Care Unit and for the maintenance of the highest professional conduct of the Medical Staff using these facilities; and

d. to receive and consider all recommendations made by members of the Medical Staff for improving the efficiency of these units.

286. Meetings - The Committee shall meet no less than quarterly and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

I. Radiation Safety Committee

287. Composition - The Committee shall consist of these four (4) individuals: 1) an authorized user of each type (of radioisotope) permitted by the license (the Radiation Safety Officer can also serve as an authorized user); 2) a representative of Nursing; 3) a representative of management; and 4) an individual who is experienced in the assay of radioactive materials. The committee may also include one (1) representative of the Medical Department and the Surgery Department.

288. Duties - The duties of the Committee shall be:

a. to review all proposals for diagnostic and therapeutic use of radio nuclides;

b. to recommend to the Medical Staff practitioners who have suitable training and experience to perform nuclear medicine procedures;
c. to develop policy and procedures for the use, removal, handling and storage of radioactive materials used in nuclear medicine procedures and to recommend remedial action when there is failure to observe such regulations; and

d. to oversee the radiation safety program, maintain occupational doses as low as reasonably can be expected, and review the program annually.

289. Meetings - The Committee shall meet at least two (2) times a year and more often if deemed necessary by the Chair, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee.

J. Ethics Committee

290. Composition - The committee membership shall consist of multi-disciplinary representation with a minimum of 4 members from the Active Medical Staff and the remaining membership to include the Physician Advisor, Nursing, Clergy, Case Managers, Administration, Ethics & Compliance Officer, Community Representatives and others. The Co-Chair shall be appointed as follows: The Physician Co-Chair by the Chief of Staff and the Administrative Co-Chair by Hospital Administration. Initial appointments shall be approved by the Executive Committee and the Hospital Board of Trustees. The initial term shall be for a minimum of two (2) years on same rotation as medical staff committees. To ensure continuity, some members should be retained. Following the initial composition approval by the Executive Committee and Board of Trustees, future appointments/replacements to the committee will be as follows: Physicians by the Chief of Staff and others by recommendation of the Administrative Co-Chair with committee consensus. Ad-hoc consultants and members may be requested to attend or be consulted as deemed appropriate by the committee chair based on the issue at hand.

291. Duties - The duties of the Ethics Committee shall be:

a. to serve as an advisory body to members of the Hospital’s medical, nursing and administrative staff on matters relating to moral and ethical decisions presented while rendering care and treatment;

b. to educate the professional staff in current medical ethical concepts;

c. to develop ethical guidelines that enhances the quality of patient care;

d. to provide advice to other staff committees;

e. to facilitate communication in sharing information so that mutual understanding between the health care providers and affected parties is maintained; and

f. to give advice upon request of providers faced with difficult, ethical issues in individual patient care. Such advice shall not replace the ultimate responsibility of the attending physician in such matters.

292. Meetings - The committee shall meet as needed, but not less than two (2) times a year.

K. Special Committees

293. Special Committees shall be appointed from time to time as may be required to carry out the duties and functions of the Medical Staff properly. These
committees shall report to the Executive Committee, and they shall have no power to act unless specifically granted by the Executive Committee.

294. The Chief of Staff shall biennially appoint a Bylaws Committee to review these Bylaws and to present recommendations to the Executive Committee.

**XIV. Immunity from Liability**

The following shall be express conditions to any practitioner’s membership in the Medical Staff, application for, or exercise of, clinical privileges at this Hospital

295. First, that the applicant/member shall release from liability the Hospital and all other persons participating in any act, communication, report, committee recommendation, or disclosure with respect to any such physician, dentist, podiatrist, licensed psychologist or Health Professional Affiliate, performed or made in good faith and without malice for the purpose of achieving and maintaining quality patient care in this Hospital or any other health care facility.

296. Second, that such release shall extend to members of the Hospital’s Medical Staff and Governing Body, its other practitioners, its Chief Executive Officer and staff or representatives, and to third parties, who supply information to any Hospital or Medical Staff Committee or department of the foregoing. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested or to whom it has been released by an authorized representative of the Hospital, Governing Body, the Medical Staff or any committee thereof.

297. Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure.

298. Fourth, that such immunity shall apply to all acts, communications, committees, reports, recommendations or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:
   a. applications for appointment, clinical privileges or specified services;
   b. periodic reappraisals for reappointment, clinical privileges or specified services;
   c. disciplinary action, including any statutory reporting requirement;
   d. hearings and appellate reviews;
   e. utilization reviews; and
   f. other Hospital department, section, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

299. Fifth, that the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to an applicant’s, member’s, or practitioner’s professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly affect patient care.

300. Sixth, that each applicant, member or practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations set forth.
301. Seventh, that all information received by any practitioner or Allied Health Professional in connection with any investigation, committee, disciplinary action or any other service to the Medical Staff or Hospital is privileged and confidential and shall be held in confidence by the practitioner or Allied Health Professional to the fullest extent required by law.

302. Eighth, that the consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of this Hospital, Hospital’s practitioners, other appropriate Hospital officials and personnel and third parties, shall be applicable also to applications for initial appointment.

303. Ninth, that each applicant to the Medical Staff, each Medical Staff member, each practitioner and each person subject to approval and review under these Bylaws consents to such privileges, release, and immunities under the terms and conditions described in this Article and these Bylaws and the Bylaws and policies of the hospital.

XV. Rules and Regulations

A. The Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws subject to the approval of the Governing Body. These shall relate to the proper conduct and guidelines of Medical Staff activities, as well as, embody the level of practice that is to be required of each practitioner in the Hospital.

B. Rules and Regulations may be promulgated and enforced by the Executive Committee of the Medical Staff. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular or special meeting of the Medical Staff at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those active staff members present. Such changes shall become effective when approved by the Governing Body.

C. Each Department (and Section) may adopt such Rules and Regulations as may be necessary for the proper conduct of its intra-departmental (and intra-section) functions provided that they are not at variance with the Bylaws and Rules and Regulations of the Medical Staff or the Hospital. The Department (and Section) Rules and Regulations shall be appended to the general Rules and Regulations. The method of adoption or amending Department (and Section) Rules and Regulations shall be at the discretion of the individual department (or section thereof), but the Rules and Regulations shall be subject to approval by the Executive Committee and the Governing Body.

XVI. Amendments

A. These Bylaws may be amended, subject to the approval of the Executive Committee and Governing Body, except as otherwise provided, at any regular or special meeting of the Medical Staff provided that all Active members of the Medical Staff are notified by mail of the proposed amendments at least seven (7) days before the meeting at which the amendments are considered.

B. Amendments may be proposed by the Executive Committee or the Governing Body or in writing to the Executive Committee by at least fifteen (15) members of the Active Staff. Except as otherwise provided, the amendments to be adopted shall require a majority vote of the Active Staff who vote either by ballot or in person at the meeting at which amendments are to be considered. Ballots will be mailed certified mail no later than fifteen (15) days prior to the General Staff meeting. Amendments shall become effective only when approved by the Governing Body.

XVII. Hospital-Based Practitioners
The Governing Body has determined that the following services must be provided by contractual arrangements which require membership on the medical staff:

1. Pathology
2. Radiology
3. Anesthesia
4. Emergency Medicine

B. Only members of the medical staff approved through the contracting process are eligible to exercise the exclusive or closed staff privileges in the services of Pathology, Radiology, Anesthesia or Emergency Medicine. Notwithstanding any other provision of these bylaws, including the review, hearing and appeal procedures, to qualify for medical staff membership, either at initial appointment or upon reappointment, members or applicants must request and maintain privileges to provide services at the hospital for which there are no exclusive or closed staff arrangements.

C. A member or applicant who subcontracts to provide services under an exclusive or closed staff arrangement at the hospital may be prohibited from exercising the privileges described in the arrangement without the right to the review, hearing or appeal procedures of these bylaws if the subcontractor is terminated from the general contractor or if the general contractor's contract is terminated.

XVIII. Patient Admission

A. Every patient must be admitted by a member of the Medical Staff in good standing and remain under the primary care of a physician member in good standing of the Medical Staff with the appropriate privileges.

XIX. Adoption

A. These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff and upon becoming effective, shall constitute a repeal of all prior Bylaws and Rules and Regulations. Medical Staff Bylaws and Rules and Regulations shall become effective when approved in accordance with the Bylaws of the Governing Body. Each member of the Medical Staff shall abide by the Medical Staff Bylaws and Rules and Regulations and policies as amended by adoption. These Bylaws and Rules and Regulations shall be reviewed by a committee at least once every two years and revised when timely and appropriate. Nothing contained in these Bylaws and Rules and Regulations shall preclude the Governing Body from exercising its authority notwithstanding these Bylaws or otherwise, when required to meet the Governing Body's responsibility for the conduct of the Hospital. These Bylaws shall be subject to the Bylaws of the Governing Body.

XX. Substantial Compliance

Minor deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the action taken.
SOUTH BAY HOSPITAL

Medical Staff Bylaws / Rules and Regulations

Bylaws Amended By the Medical Staff on: ___November 7, 2011_
Chief of Staff: _________________________________________

Bylaws Adopted by the Governing Body on: ___December 14, 2011_
Chair of the Board: ________________________________

Rules & Regulations Amended by the Medical Staff on: ___November 5, 2012
Chief of Staff: _________________________________________

Rules & Regulations Amended by the Governing Body on: ___November 14, 2012
Chair of the Board: ________________________________
SOUTH BAY HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

I. Admission and Discharge

1. Patients may be admitted to South Bay Hospital only by a member of the Medical Staff, who shall follow the Hospital’s official admitting policies. Every patient admitted to South Bay Hospital shall be admitted by and remain under the care of a physician.

2. The Hospital shall accept patients for care and treatment as follows: Pediatrics (out patient only), adults and Geriatrics.

3. The attending practitioner shall be responsible for the overall medical care of each patient in the Hospital. He/she shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, and for communicating reports of the condition of the patient, if appropriate, to the referring practitioner.

4. Whenever physician responsibilities are transferred to another physician, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient’s condition and treatment shall be made and the physician transferring his/her responsibility shall personally notify the other physician to ensure that acceptance of that responsibility is clearly understood.

5. In the case of a patient requiring admission who has no physician, he or she shall be assigned to the physician on call for the service to which the illness of the patient indicates assignment.

6. Practitioners shall make necessary arrangements in order for all elective admissions to be admitted to the Hospital during normal business hours.

7. Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

8. In any emergency case in which it appears that patient will have to be admitted to the Hospital, the practitioner shall, record a provisional diagnosis or valid reason for admission as soon as possible; and when possible, first contact the admitting office or, if closed, the nursing service supervisor to ascertain if there is a bed available.

9. Each appointee of the staff shall name another appointee of the staff with comparable privileges as an alternate to be called to attend his or her patients in an emergency when the attending physician is not available or until the attending physician can be present. If the covering physician is not available, the CEO or designee shall contact the Chair of the appropriate Medical Staff Department.

10. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

   a. Emergency
   b. Urgent
   c. Preoperative
   d. Routine

11. The patient shall not be transferred within the Hospital without the approval of the attending physician or consultant. If transfer is ordered by the consultant the attending must be promptly notified. The order of priority for patient transfers shall be as follows:

   - Emergency service to appropriate nursing unit.
   - From general care unit to intensive care unit.
   - From intensive care to general care unit.
- From temporary placement in an inappropriate nursing unit or
  a. clinical service to the appropriate service or nursing unit for the
  b. patient being transferred.

12. Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the chairman of the appropriate Medical Staff Department or chairman of the Special Care Committee.

13. Practitioners shall abide by the Hospital’s utilization management plan to include:
   - The appropriateness and medical necessity of admissions.
   - Continued stay
   - Supportive services
   - Discharge planning

14. Patients shall be discharged from the Hospital only on the order of the patient’s attending physician. If a patient leaves the Hospital against the advice of the attending physician, or without proper discharge, a notation shall be made in the patient’s medical record.

15. In the event of a Hospital patient death, the deceased shall be:
   a. Pronounced dead by the attending physician, ER physician, any staff physician present, or two RN’s. In all cases all physicians on the case will be promptly notified of a patient death.
   b. Every member of the Medical Staff shall be actively interested in securing autopsy permission whenever possible for deaths meeting criteria established by the medical staff. No autopsy shall be performed without the written consent of the responsible relative or legally authorized agent as determined by Florida law.
   c. All autopsies shall be performed by the Hospital Pathologist or by a practitioner delegated this responsibility unless required by law to be performed by the County Medical Examiner. The attending physician will be notified that an autopsy is being performed and notified of the results of the autopsy.
   d. For all autopsies, provisional anatomic diagnosis shall be recorded on the medical record within 72 hours and the complete protocol a part of the record within 30 days.

16. Diagnostic work performed outside the Hospital will be handled in the following manner:
   - Laboratory reports on studies performed by a certified or recognized laboratory will be acceptable at the discretion of the attending or consulting physician.
   - Reports of X-rays shall be accepted at the discretion of the attending or consulting physician.
   - Outside EKG reports will be accepted at the discretion of the attending or consulting physician.

II. Emergency Services

17. Medical Staff members shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.  

_The Medical Director of emergency services shall have the overall responsibility for emergency care._

18. Clinical privileges shall be delineated for all practitioners rendering emergency care, in accordance with Staff and Hospital procedures.

19. An emergency physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven days per week.
20. Emergency service policies and procedures shall be approved by the Medical Director of Emergency Services, the Executive Committee and the Board of Trustees.

21. If, in the judgment of the emergency physician, a patient needs to be admitted to the Hospital as an inpatient (either for observation or for further treatment), the patient shall be admitted in the name of the patient’s physician or the physician on call. If, in the judgment of the emergency physician, the patient’s condition requires continuing physician attendance, the emergency physician shall call the attending physician but continue to accept responsibility for the patient until the assigned physician arrives or assumes responsibility for the patient.

*If a patient does not have a private practitioner, he shall be assigned to the member of the Active or Provisional Staff On-Call in the service to which the illness or condition of the patient indicates treatment. Emergency Department (ED) referrals for a patient without a private physician who needs follow up care in a non-hospital setting shall be made to the physician on call for that specialty on the date the patient presents to the ED. A practitioner on-call cannot refuse to see an Emergency Room patient or refuse at least one (1) follow-up visit regardless of the patient’s insurance status and regardless of whether the on call physician actually responds to the ED with respect to the particular patient. Any violations of this policy will be referred to the Executive Committee for possible disciplinary action.*

22. Except in cases where transfer to surgery is contraindicated, in the judgment of the emergency physician, surgery shall not be performed in the emergency treatment area.

23. An appropriate emergency service medical record shall be kept for every patient receiving emergency service and shall be incorporated into the patient’s previous inpatient medical record, if such exists.

24. Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility when, in the judgment of the attending physician, the patient’s condition permits such a transfer. The Hospital’s procedures and State statutes for patient transfers to other facilities shall be followed.

25. The role of the emergency department will be integrated into the Hospital’s disaster plan.

26. Medical and surgical unassigned patients who are readmitted or re-treated in the emergency department within 30 days will be referred back to the original admitting physician, for continuity of care.
III.  MEDICAL RECORDS

27.  The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; medical history; physical examination; diagnostic and therapeutic orders; appropriate informed consent(s); clinical observations, including results of therapy, progress notes, consultations, and nursing notes; reports of procedures, test and results, including operative reports; conclusions at termination of hospitalization, to include relevant diagnoses, clinical resume; and autopsy report when performed.

28.  A medical history and physical exam is required to be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but, in call cases prior to surgery or procedure requiring moderate sedation or an anesthesia services. The H&P may be handwritten or transcribed, but always must be placed within the patient’s medical record within 24 hours of admission or registration, or prior to surgery or a procedure requiring moderate sedation and or an anesthesia services.

When the H&P is conducted within 30 days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital’s medical staff to perform an H&P noting any or no changes in the patient’s dated and timed by the practitioner performing the update.

The History and Physical report should include at a minimum:

   a.  Chief Complaint
   b.  History of present illness
   c.  Past Medical History
   d.  Medications and allergies
   e.  Social/ Family History
   f.  Review of systems
   g.  A physical exam
   h.  Impression
   i.  Plan of care

If a patient is readmitted within 7 days for the same or related condition an interval admission note is acceptable – this must include all additions to the history and any subsequent changes in the physical findings, but prior to surgery or a procedure requiring anesthesia, an updated examination of the patient and any changes in the patient’s condition must be documented.

29.  A recorded progress note will be written daily by the Attending Physician or his/her designee. The progress notes will identify pertinent findings, test results and a plan of treatment during the patient’s admission.

30.  Practitioners shall be responsible for obtaining the patient’s informed consent. When consent is not obtainable, the reason shall be entered in the patient’s medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital policy. Informed consent will be documented by the physician in the physician progress notes, H&P, and/or on procedure consent form.

31.  All orders for treatment shall be electronically entered into the computer. An order electronically entered into the computer that is dictated verbally or by the telephone by a physician to a registered or licensed practical nurse of the Hospital, an ARNP or PA, or other persons authorized by the Hospital, and verified by the attending physician. Orders dictated over the telephone shall be verified by the person to whom dictated with a notation per (name of physician), and such action should be limited to urgent circumstances. All diagnostic and therapeutic verbal orders must be authenticated by the responsible physician within 48 hours from the time the order is taken. All high risk orders, which include DNR, Restraints and Investigational Drugs must be authenticated within 24 hours.

   In additional to RN’s, LPN’s, ARNP’s and PA’s, persons authorized by the Hospital to receive verbal/telephone orders and electronically enter them into the computer are:
- Respiratory Therapy staff;
- Pharmacists;
- Physical Therapist;
- Speech Therapist
- Medical Imaging Technologists
- Occupational Therapist
- Dietitian
- Lab personnel for Outpatient lab orders only

The above-named individuals are authorized to receive only those orders, which pertain to their particular service.

32. Outpatient tests of any type requires the following information to meet medical necessity:
   a. Test Ordered;
   b. Diagnosis(es) or symptom(s) to support medical necessity of test ordered;
   c. Date, authentication of ordering physician.

Probable, suspected, questionable and rule out are not acceptable diagnoses.

33. The attending or covering physician shall see the patient and countersign all orders and verify all orders, and electronically sign the history and physical examination and preoperative notes within 24 hours when they have been recorded by a physician’s assistant or nurse practitioner.

34. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated directly following surgery when possible, but always within 24 hours after surgery (whether outpatients or inpatients). The report shall be promptly signed by the surgeon and made a part of the patient’s current medical record. An immediate postop progress note must be documented at time procedure is complete and before the patient is transferred to the next level of care or discharge (if an outpatient). This note should contain the following minimum elements:
   - Name of primary surgeon and assistants
   - Procedure performed
   - Findings
   - Estimate Blood loss
   - Specimens removed
   - Prosthetic devices, graft, tissues, transplants or devices implanted
   - Unusual events or complications
   - Postop diagnosis

35. All clinical entries in the patient’s medical record shall be accurately dated, time and authenticated.

   Members of a Professional Association are authorized to sign all necessary signatures on the medical record in the absence of another member of the same association or for a covering physician.

36. A complete discharge summary (clinical resume) shall be electronically dictated on all medical records of patients hospitalized over 48 hours. A final summation progress note for minor medical problems and/or surgical is acceptable for an admission less than 48 hours. In all instances, the content of the medical record shall be sufficient to support the diagnosis and treatment. Final diagnosis shall be recorded within the discharge summary. All summaries shall be authenticated by the responsible physician.

37. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Health Information Management Committee. Resignations will not be accepted from physicians who have medical record deficiencies until these deficiencies have been satisfied and approval given by the Executive Committee.

38. A medical record is considered delinquent as of the thirtieth (30) day following discharge. At that time, the Hospital will send a warning to the physician notifying him/her of the number of delinquent records, and
informing the physician the date that his/her admitting, consulting and surgical privileges will be suspended if such records are not completed. If such records are not completed within the prescribed timeframe, the physician shall be sent a notice of suspension, and his/her admitting, consulting and surgical privileges will be suspended. The suspension shall remain in effect until all delinquent records are completed.

The physician will be responsible for arranging any call coverage for the Emergency Department for which he/she is scheduled during the period of the suspension. The appropriate hospital departments will be notified of this action.

Reinstatement of privileges shall be automatic upon the satisfactory completion of all delinquent records and the payment of all levied fines. The appropriate hospital departments will be notified of this action. The Health Information Management Department shall be responsible for analyzing medical records for the purpose of administering this rule.

39. In case of readmission of a patient, all previous records shall be available for use by the attending physician.

40. Only those symbols and abbreviations, which have been approved by the Medical Staff, shall be used in medical records. No symbols or abbreviations may be used in the final diagnosis.

41. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute for the purpose of appearance in court, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away without permission of the CEO. In any case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Staff Executive Committee.

42. Free access to all medical records of all patients shall be offered to appointees of the Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Executive Committee shall approve all such projects before records can be studied. Subject to the discretion of the CEO, former appointees of the Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

43. Access of Information - Each member of the Medical Staff with access to the hospital medical records agrees to comply with the information security policies of the Hospital set forth in the Information Security Agreement, System Access Authorization and Connectivity Agreement. Such policies include maintaining passwords and Personal Identification Numbers (PIN), which allow access to computer systems and equipment, in strictest confidence and not disclosing passwords and/or PIN with anyone, at any time, for any reason. Each member of the medical staff and privileges practitioner understands that the records of the patients maintained are confidential and that access to such records should be limited to those who have a need-to-know in order to provide for care of the patient. Failure to comply with the information security policies of the Hospital may result in termination of access to computer systems, paper or other health information records, resulting in the initiation of corrective action as specified in these Bylaws, Rules and Regulations. Loss of medical staff membership or limitation, reduction, or loss of clinical privileges for any reason may be grounds to terminate access to the system immediately and without notice to the practitioner.

44. Personal Identification Number (PIN) shall be used to authenticate entries only after the PIN owner, who is the author of the entry, has reviewed the entry. The other form of authentication after review of entry is hand-written signature.

45. Each member of the Medical Staff shall have access to previous hospital records of patients he/she is attending on an outpatient basis, when affiliation with the patient is evidenced by documentation of previous hospital care. Patient consent must be obtained by a requesting physician, when affiliation is not evidenced
in previous healthcare records. At the time of readmission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible at the time of and for the duration of the readmission.

46. Unauthorized release of information from hospital records is grounds for summary suspension of the Staff member per Medical Staff Bylaws, Article VII, Section B - Summary Suspension. Unauthorized release includes printing of documents and re-release of these documents to others who do not have appropriate access.

47. All Radiology films, pathology specimens, microscopic slides, photographs, videotapes and photographic slides are the property of the Hospital. Under no circumstances may any of these items be removed for legal purposes without prior approval of the Chief Executive Officer. Removal of original documents will occur only under court order, state statute or subpoena duces tecum. Unauthorized removal from the Hospital is grounds for automatic suspension of the Staff member as per procedure outlined in Article VII, Section C - Automatic Suspension of the Bylaws.

48. Patient records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or state statute, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing.

49. Access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. The Executive Committee of the Medical Staff, with the agreement of the Chief Executive Officer, and Board of Trustees approval, shall approve all such projects before records can be studied. Subject to the discretion of the Chief of Staff, with the agreement of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

IV. CONDUCT OF CARE

50. All orders for treatment shall be in writing, signed and dated. An order shall be considered to be in writing if dictated by as physician to a registered or licensed practical nurse of the Hospital, an ARNP or PA, or other persons authorized by the Hospital, and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with a notation per (name of physician), and such action should be limited to urgent circumstances. All high-risk orders, which include, chemotherapy, DNR, Restraints and Investigational Drugs must be authenticated within 24 hours.

In addition to RN’s, LPN’s, ARNP’s and PA’s, person authorized by the Hospital to receive verbal/telephone orders and write on the physician’s order sheet are:

- Respiratory Therapy;
- Pharmacists;
- Physical Therapists;
- Speech Therapists;
- Medical Imaging Technologists
- Occupational Therapists
- Dietitian; and
- Lab personnel for Outpatient lab orders only

The above individuals are authorized to receive only those orders, which pertain to their particular service.

51. A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission. The admitting staff shall notify the attending physician whenever such consent has not been obtained and shall make an entry in the medical record explaining the reason the consent was not obtainable.
52. All previous orders are canceled and new orders obtained when patients go to surgery or the ICU.

53. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. All drugs shall be provided through, or approved by, the Hospital pharmacy.

54. The Medical Staff, through its Pharmacy and Therapeutics Committee, will assure that medications deemed to be toxic or dangerous will have a reasonable time limit and/or stop order for each such medication as per Hospital policy.

55. The use of antibiotics should be based on cultures and sensitivity tests, except that prophylactic utilization of antibiotics may be made in those specific medical and surgical cases when it has been medically determined that such action is an accepted and appropriate medical practice.

56. Medications brought into the Hospital by patients are administered only in response to written orders. Self-administration of medications by patients is permitted by a specific written order from the prescriber/orderer and in accordance with established Hospital policy.

57. Preprinted orders and/or instruction sheets shall be instituted only after approval of the appropriate medical staff committee(s). Such preprinted orders and/or instruction sheets shall be reviewed and revised as necessary. All preprinted orders and/or instruction sheets must be signed and dated by the responsible physician when utilized, as required for all orders for treatment.

58. Consultation request forms for radiology, pathology and nuclear medicine service shall be filled out completely. The attending practitioner is responsible for providing necessary clinical data and, for radiology and nuclear medicine, sufficient information to conduct the examination. The necessary data may be taken from the order sheet or progress notes by a nurse.

59. It is expected that all physicians on the Medical Staff will obtain and document appropriate consultations whenever the medical or surgical condition of the patient warrants such consultation.

60. Consultations shall be held, except in extreme emergencies, under the following conditions:

- When medical clearance is necessary for a patient who is not a good risk for operation or treatment.
- Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
- Where there is doubt as to the choice of therapeutic measures to be utilized.
- In unusually complicated situations where specific skills of other practitioners may be needed.
- In any instances in which the patient exhibits severe psychiatric symptoms.
- All curettage or other procedures by which a known or suspected normal pregnancy may be interrupted.
- Major surgical cases in which the patient is not a good risk or in which the diagnosis or indications for surgery are in doubt should have a second surgical opinion.
- Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose. That such services were at least recommended must be documented in the patient's medical record.
- When requested by the patient or his family.
- When required by the policy of a special care unit.
Consultations shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion and recommendations. This report shall be made a part of the patient’s record.

When operative procedures are involved, the consultations note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise. All STAT consultations are to be obtained physician to physician. Routine consultations, unless specified otherwise by the referring physician, must be seen or refused within a 24-hour period after proper notification.

61. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior, who in turn may refer the matter to the nursing supervisor. The supervisor will contact the attending physician for clarification. If no resolution is achieved, the CEO or his/her designee and the appropriate Medical Staff Department Chairman will be contacted.

62. All responses to letters generated as a result of peer review activity must be received within three weeks of receipt. Failure to respond will result in Committee action without the benefit of physician’s input.

1.1.1. V. General Conduct

63. Medical Staff dues will be assessed June 1st and are payable by June 30th. A certified letter will be sent to all physicians who have not responded by June 30th, informing them of automatic suspension from the Medical Staff 15 days after receipt of the notification. Privileges will be automatically reinstated upon receipt of the dues.

64. An original certificate of insurance must be provided by the Medical Staff member’s insurance carrier, naming South Bay Hospital as the certificate holder, and must remain current. Failure of the practitioner to provide this proof of current insurance coverage may lead to temporary suspension of privileges.

65. Physician staff members of the Hospital who have designated privileges may employ non-physicians to assist them in the care of hospitalized patients. They may be designated as physician employees and/or assistants to the physician. The use of such assistants is a privilege of Staff membership and is subject to periodic review. Renewal or revocation, expansion or deletion of privileges, as appropriate, shall occur in accordance with the process established for the Medical Staff.

For each such assistant, the physician employer will submit to the CEO a standard application form and copies of all valid and current State and Federal professional licenses held by the employee. A complete summary of the employee’s training and background that would qualify the employee to perform the functions requested by the physician employer is required. Proof of both professional liability insurance coverage on each such employee will be documented. The application will go through the standard review by the appropriate Medical Staff department, the Credentials and Executive Committees and the Board of Trustees for final approval.

Each department will determine the scope and duties to which all assistants to physicians will be limited and will be specific to each assistant to a physician. Such rules shall include, but not be limited to, the following:

- All such assistants to physicians shall be clearly identified by appropriate identification, such as assistant to physician tags or nametags, to ensure that they are not mistaken for a licensed physician.
- Such assistant to a physician will perform no functions beyond that specifically designated by the department in which he/she is functioning.
- An assistant to a physician may write in the official clinical record; however, no such writing shall be valid unless it is countersigned by the physician employer or his/her clinical
associate. Only assistants to physicians who are RN's, LPN's, Florida-licensed PA's or ARNP's may write orders, in accordance with current Hospital policy.

- The physician employer will be expressly accountable to the Medical Staff and to the Hospital for all actions or lack of actions of his/her assistant. Misconduct by such a physician employee shall be deemed to be misconduct by the physician employer.
- The physician shall indemnify and hold harmless the Hospital for any acts of his/her assistant or employee.

These regulations shall apply equally to inpatients, outpatients and emergency room patients.

66. Any person employed by the Hospital or by a member of the Medical Staff whose duties involve independent judgment regarding the diagnosis and treatment of patients shall work under the direct supervision of a physician or physicians. Such individuals shall be subject to the same review of credentials and assignment of privileges as that prescribed for members of the Medical Staff in the Bylaws.

VI. SURGICAL CARE

67. Except in emergencies, a history and physical examination, the preoperative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure.

   In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient, and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery.

   In all other cases, the responsible nurse shall notify the operating surgeon, preferably no later than the night before surgery is scheduled, and preparation for surgery, including premedication, shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

68. Except in cases of emergency, inpatients admitted for surgery shall not be admitted later than two hours prior to surgery.

69. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, the procedure will be rescheduled to the end of the day, pursuant to the rules and regulations of the surgical services department. In addition, the matter may be referred to the Executive Committee by the Director of OR to the Chairman of the Department of Surgery for action.

70. The anesthesiologist is responsible for maintaining a complete anesthesia record, to include evidence of pre-anesthetic evaluation, and for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before preoperative medication has been administered. The note shall indicate a choice of anesthesia and the surgical procedure anticipated.

71. The anesthesiologist is responsible for post-anesthetic follow-up, and for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care.

72. If, in the opinion of the operating surgeon and/or the Chairman of the Department of Surgery, there is in any surgical procedure an unusual hazard to life, there shall be present and scrubbed, a qualified first assistant. The operating surgeon shall have the responsibility for having such qualified assistants as required for the operative procedure that is planned.

73. A patient admitted for dental care is a dual responsibility of the dentist and attending Medical Staff member.

   a. Dentists responsibilities:
1. Dentist’s are responsible for the part of their patient’s history and physical examination that relates to dentistry.
2. A complete operative report, describing the findings and techniques. In cases of extraction of teeth and fragments removed, all tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination.
3. The dentist is totally responsible for the oral or dental care.
4. Progress notes pertinent to the oral condition.
5. Discharge summary.
6. Surgical procedures performed by dentists shall be under the overall supervision of the Chairman of the Department of Surgery.

b. Physician’s responsibilities:

*1. Medical history pertinent to the patient’s general health.
*2. A physical examination, to determine the patient’s condition prior to anesthesia and surgery.
*3. Supervision of the patient’s general health status while hospitalized.
*4. Physician is not responsible for any dental care of consequences thereof.

* Can be performed by a qualified oral surgeon.

A patient admitted for podiatric care is a dual responsibility involving the podiatrist and attending Medical Staff member.

a. Podiatrist’s responsibilities:

1. Podiatrists are responsible for the part of their patient’s history and physical examination that relates to podiatry.
2. A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.
3. Progress notes.
4. The podiatrist is solely responsible for the care of the feet.
5. Discharge summary (or summary statement).
6. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department Surgery.

b. Physician’s responsibilities:

1. Medical history pertinent to the patient’s general health.
2. A physical examination, to determine the patient’s conditions prior to anesthesia and surgery.
4. Physician’s are not responsible for any podiatric care or treatment of feet or consequences thereof.

A patient admitted for podiatric care is a dual responsibility involving the podiatrist and attending Medical Staff member.

a. Podiatrist’s responsibilities:

1. Podiatrists are responsible for the part of their patient’s history and physical examination that relates to podiatry.
2. A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.
3. Progress notes.
4. The podiatrist is solely responsible for the care of the feet.
5. Discharge summary (or summary statement).
6. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department Surgery.

b. Physician’s responsibilities:

1. Medical history pertinent to the patient’s general health.
2. A physical examination, to determine the patient’s conditions prior to anesthesia and surgery.
4. Physician’s are not responsible for any podiatric care or treatment of feet or consequences thereof.

Written, signed, informed, surgical consent shall be obtained prior to the operative procedure, except in those situations wherein the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the patient’s medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

Specimens removed at the operations shall be sent to the hospital pathologist, who shall make such examination, as he/she may consider necessary to arrive at a tissue diagnosis. Refer to Care of Specimens policy for specifics. His/her authenticated report shall be made a part of the patient’s medical record.
77. Rules for the scheduling of elective or non-emergency surgery will be as follows:
   a. The schedule is available for posting of cases at all times and booked on an as-scheduled basis.
   b. The following information is required in order to post a case:
      1. The patient’s full name
      2. Age
      3. Sex
      4. Surgery procedure
      5. Type of Anesthesia
      6. Operating Surgeon
      7. Time and name of person posting the case.
   c. If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule.
   d. The time of a procedure may be changed if it does not interrupt the normal schedule, as determined by the Chairman of the Department of Surgery.

78. All patients scheduled for surgery shall have appropriate lab or X-ray and diagnostic studies ordered by the attending or consulting physician. Tests should be ordered as needed rather than routine basis. (See attached recommended testing)

VII. DISASTER PLAN

79. As part of the Hospital’s Disaster Plan members of the Medical Staff shall be assigned to positions, either in the hospital or some other designated location for specific medical action.

80. The Hospital Disaster Plan will be rehearsed at least twice a year and it is the responsibility of practitioners to participate in and report to their assigned stations.

81. All policies concerning patient care as it relates to disasters will be the responsibility of the Chairman of the Departments, the Chief of Staff and the Hospital Safety Committee.

VIII. MISCELLANEOUS

82. The Infection Control Committee, through its Chairperson or practitioner members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors or personnel exists.

83. Hospital Policies and Procedures pertaining to the Medical Staff shall be adhered to by all members of the Medical Staff, who are responsible for remaining abreast of all published current directives.

84. Policies and Procedures referred to above and elsewhere in these Rules and Regulations are to be found in the Policy and Procedure Manuals of the Hospital.

85. A preceptorship program may be required for any and all Medical Staff members at the discretion of the Executive Committee, upon the recommendation of the Credentials Committee.

86. South Bay Hospital is committed to providing quality care to its patients and to maintaining a staff of health care professional dedicated to providing quality care. The Medical Staff recognizes that physicians who provide professional services at South Bay Hospital may develop or manifest a physical illness or other conditions that may have the potential to compromise the quality of care provided to patients, either directly or by the effect of the behavior on co-workers. To fulfill its responsibility to identify and manage matters of the individual physician health, the facility has developed a Physician Health Care Policy. Refer to policy.
87. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Radiological procedures are currently the only Telemedicine performed at this facility. Final interpretations must be completed within 24 hours. Final interpretations may be by telemedicine, provided that a system of Quality Assurance is in place and followed, where a reasonable and appropriate percentage of telemedicine over-reads are completed by the house-based radiology group on a consistent basis.

88. The QMP (Qualified Medical Personnel) Process is a medical screening process used to identify those patients who present to a dedicated emergency department (DED) but do not have an emergency medical condition (EMC). (Note: This process is applicable only to the emergency department. It is not applicable to other DEDs such as L&D units, psych intake units, etc.) Those patients identified as not having an EMC will be offered three options for receiving further treatment. 1. Stay to see the Emergency Department doctor for care and treatment after being registered and paying the hospital fees for such medical care and treatment. 2. Follow up with their family physician. 3. Alternative community resources will be offered as the last option. Based on clearly defined protocols, patients who meet established criteria will be medically screened by a qualified medical person (i.e. Physician or mid-level practitioner), each of whom have demonstrated current competencies in the performance of medical screening examinations and who are functioning within the scope of his/her license. (QMPs who are not physicians are employees of the contracted ED physician group, not the hospital.)
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Purpose:
Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

Policy:
The policy of South Bay Hospital is that all persons within the facility will be treated with respect and courtesy. All medical staff members are required to conduct themselves in a professional and cooperative manner. Any medical staff member or employee who witnesses any medical staff member engaging in behavior that disrupts the efficient and professional delivery of health care services must report that behavior.

Definitions:
Sometimes a physician’s conduct is so disruptive to the operation of the hospital or the medical staff review process, that the value of the physician’s clinical work is outweighed by the negative impact of his/her behavior. Such unacceptable behavior can take many forms – tirades in the operating room, abusive treatment of patients or employees, sexual harassment, or disruption of meetings. Physicians that express concerns through the appropriate administrative or medical staff channels are not considered as being disruptive.

A hospital is an especially stressful working environment, so outbursts or other misconduct that probably would not be tolerated elsewhere are often excused. If an isolated outburst is followed by an apology, there is most likely not a longer-term problem. There are clear limits to tolerance, however. When a physician’s conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a “hostile work environment” for the hospital employees or other physicians on the medical staff, or begins to interfere with the physician’s own ability to practice competently, action must be taken.
Disruptive conduct is more than unusual or unorthodox behavior. Examples of disruptive conduct include:

1. Attacks leveled at other medical staff members which are personal, irrelevant, or go beyond the bounds of fair professional comment.

2. Impertinent and inappropriate comments written (or illustrations drawn) in patient medical records, or other official documents that impugn the quality of care in the hospital or attack particular physicians, nurses, or hospital policy.

3. Non-constructive criticism addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence. Profanity or similarly offensive language while in the hospital and/or while speaking with nurses or other hospital personnel.

4. Refusal to accept medical staff assignments or participate in committee or departmental affairs on anything but his/her own terms, or to do so in a disruptive manner.

5. Imposing idiosyncratic requirements on the nursing or hospital staff which have nothing to do with improving patient care, but serve only to burden hospital staff with “special” techniques and procedures.

6. Public criticism of patients, family members, physicians or employees, or of the hospital, outside appropriate hospital or medical staff channels.

7. Throwing equipment or medical records.

**Procedure:**

1. All episodes of disruptive physician behavior shall be reported on an occurrence report or quality referral form.

   The following information will be collected regarding any incidents of disruptive behavior:

   1. Date and time of incident
   2. Name of individual committing disruptive behavior
   3. Name of patients/staff affected
   4. Description of the circumstances in which the incident occurred
   5. Description of disruptive behavior in detail
   6. Description of effects of the behavior that occurred or could potentially occur on patients care or facility operations
   7. Names of witnesses
   8. Description of any remedial action that was undertaken to immediately address the behavior during or after the incident
Individuals providing information concerning disruptive behavior will remain anonymous. The organization will not impose any penalties or take adverse action against the reporting individual and will not tolerate any form of retaliation against reporting individuals by the subject of the report or any other individual.

2. Disruptive behavior exhibited by the medical staff will be investigated and addressed by the Physician Advisor. Disruptive behavior can be a manifestation of impairment and if this is found to be the case, impairment policies for medical staff will be implemented.

3. Inform the practitioner of the concern and receive their input regarding the situation.

4. The results of the Physician Advisor investigation and follow-up will be documented and retained in the physician’s quality file.

5. If a pattern of disruptive behavior or a single incident of substantially disruptive behavior is identified by the Physician Advisor and may warrant further action it may be forwarded to the Chairman of the appropriate department and to the peer review committee.

6. A recommendation of adverse action may be issued pursuant to the procedure outlined in the medical staff bylaws.

7. A single incident of inappropriate conduct, or a continuation of conduct that is so unacceptable, may require immediate disciplinary action and should be referred to the Chief of Staff and Chief Executive Office.
**Purpose:** In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), to provide a mechanism for establishment, creation and maintenance of physician ER Call schedules, to include both primary care physicians and specialists, whose responsibility it is, pursuant to Medical Staff Bylaws and Rules & Regulations, to provide care for patients presenting to the Emergency Department.

**Scope:** Medical Staff; Medical Staff Services; Emergency Department

**Procedure:** In keeping with its function of coordinating departmental activities, South Bay Hospital’s Medical Executive Committee (MEC) is responsible for seeing that call lists are established and for ensuring call coverage, subject to the approval of the Board of Trustees.

The MEC has determined the following subspecialties will maintain call lists:

- General Surgery
- Medicine
- Neurology
- Orthopedic Surgery
- Thoracic Surgery
- Urology
- Vascular Surgery

The Medical Staff Coordinator is responsible for the overall call list for each of the above areas.

**Eligibility for Call:**
A. Minimum standards for call eligibility are:
   1. Medical Staff membership, and
2. Privileges appropriate to the call list.

B. The MEC has determined that participation in call is mandatory for all specialties for active and provisional staff members.

C. Practitioners whose Privileges are suspended or restricted may not serve on call.

D. No Professional Staff Member has a right to serve on any call list. A decision to remove a physician from the call list shall not constitute a denial or restriction of Privileges and gives rise to only the hearing rights set forth in this Rule.

CALL LIST SCHEDULES:

A. Each day of a call schedule begins at 7 a.m. and ends at 7 a.m. the following morning unless otherwise noted.

B. The Department will recommend the on-call period (generally one day or week).

C. Physicians on the call list must be listed **by name**, not by group.

D. Based upon initial appointments, resignations, changes in staff status, and the qualifications as determined by each Department for whom a call schedule is required, a list of physicians eligible, required and/or desiring to participate on each schedule will be determined.

E. The distribution and maintenance of Emergency Department Call Schedules (ER Call Schedules) will be coordinated by staff of the Medical Staff Services Department.

F. ER call schedules will be distributed to those physicians assigned call. In addition, they will receive:

   1. information and instructions for reporting changes in the schedule;
   2. forms on which to submit instructions for changes to the schedule.

G. Completed schedules, indicating the date and time printed, will be provided to the Director of the Emergency Department whose responsibility it is to ensure that the schedules are made available to ED nursing and physician staff. Subsequent changes which require re-printing of a schedule will also include the date and time of printing.

H. Once a schedule is distributed, any changes in coverage **MUST** be arranged by the physician whose name appears on the call schedule for that day or week.

I. It is the responsibility of the physician whose name appears on the published schedule to notify the Medical Staff Office and/or the ER, **in writing**, of any
change in coverage. Any changes submitted may, at the discretion of a physician’s assigned Department, require that the physician accepting the call confirm his/her acceptance in writing on the notice of schedule change submitted to the Medical Staff Office.

1. Changes submitted Monday – Friday, 8:00 am – 5:00 pm should be faxed to the Medical Staff Office. 813-634-0420.

2. Changes submitted Monday – Friday after 5:00 pm or on weekends or holidays should be faxed directly to the Emergency Department. 813- 634-0348

J. The staff of the Medical Staff Services Office will maintain the currency of ER call schedules by receiving changes, as indicated above.

Changes received directly in the ER, as indicated above, should be handwritten on the schedule for the date of the change. All such changes noted by the ER should be maintained and forwarded to the Medical Staff Office for retention as required by federal statutes.

K. The Emergency Department will maintain a phone log for the purpose of tracking calls made to on-call physicians.

L. No later than the 3rd working day following the end of the month, all copies of the previous month’s schedules should be forwarded to the Medical Staff office. Pursuant to EMTALA requirements, physician on-call rosters will be maintained (for purposes of archiving) in the Medical Staff Services Office.

M. Physicians who have contracts for reimbursement for provision of ER coverage should submit the time sheets indicating those shifts actually worked during that month. Time sheets should be submitted to Administration no later than the fifth (5th) working day of the month for coverage provided for the previous month.
ON-CALL RESPONSIBILITIES:

A. The physician on call will be available for all patients in the ED (or where an inpatient consultation is needed).

B. The physician on call will be available for:

1. admission to the hospital (when appropriate), and/or
2. consultation (in person, if requested), and/or
3. performance of emergency surgical procedures, and/or
4. at least one outpatient follow-up visit during regular office hours.

C. The physician on call will be available without regard for the patient's insurance status or ability to pay. The physician may bill the patient, but is prohibited from requesting or requiring payment in advance or conditioning the patient visit on financial status.

D. The physician on call will be available to respond:

1. In person within 180 minutes or, sooner as warranted by the patient’s condition and if requested by the Emergency Physician to appear sooner.

2. Upon being contacted by the Emergency Department for a Trauma Consultation, the on-call General Surgeon will have 15 minutes to respond. Once the General Surgeon has made contact with the Emergency Department Physician, both will agree to a time at which the Surgeon must be physically present within the department. All physicians involved will be responsible for documenting in their dictation the mutually agreed upon time. On call General Surgeon is responsible for evaluating the patient for transfer to an appropriate Trauma Center.

E. If an on-call physician engages in elective surgery while on call, the physician on call will arrange for backup by a qualified physician if the on-call physician is unavailable to respond to call by arranging for a member of his coverage group to be available through the on-call physician’s answering service.

F. The practitioner assigned to the on-call roster is responsible for covering call on the days assigned, subject to non-routine assignment of days to another medical staff member to cover, e.g. while on vacation. It is the assigned practitioner’s responsibility to ensure that the covering physician is a member of the hospital’s medical staff and has privileges adequate to discharge responsibilities to cover call. Physicians who have assigned call must notify the medical staff office using the attached Emergency Room On-Call Transfer Form with the signature of the covering physician. Routine assignment of call obligations to another medical staff member may result in removal from the schedule by the MEC or the CEO. Such a removal does not give rise to any hearing rights, and does not obviate
the mandatory call obligations. If there is an insufficient number of physicians available and willing to cover call, the medical staff member will be returned to the call schedule.

G. Simultaneous call allows a practitioner assigned call to take call at multiple facilities during the same time frame. An on-call physician may schedule elective surgery or simultaneously take call at more than one facility in the geographic area as long as the On-call physician has arranged for back-up pursuant to “E” above.

H. Any disagreement between the emergency physician and the on-call physician as to the need for the on-call physician to examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other qualified medical person who has personally examined and is currently treating the individual.

I. In the event the on-call physician is unable to respond because of circumstances beyond the physician’s control, e.g., is in surgery on another ED patient, the ED physician will attempt to arrange for another physician preferably in the same specialty to see the patient. If no one with the expertise to care for the patient is available, the patient will need to be transferred to a facility able to provide the needed care.

J. Unavailability or refusal to respond to call assignments, or arrange appropriate coverage for responsibilities if unable to fulfill the duties, shall be considered conduct reasonably likely to be detrimental to patient safety or delivery of quality patient care within the Hospital, and shall be considered for corrective action. If a physician on call fails or refuses to respond the following course of action shall be undertaken:

1. ED Staff will report the incident to Quality Management Department. The incident will then be documented and reviewed with the appropriate Department Chair.
2. The first occurrence of a practitioner failing to accept assigned call within a twelve-month (12) period, will have 24 hours from receipt of notification to respond with a satisfactory explanation. If the Department Chairman determines the explanation is unsatisfactory, he may refer the incident to the MEC.
3. Refusal or failure to respond to call a second time in a twelve-month (12) period shall result in automatic suspension and/or corrective action as the Hospital and its Medical Staff deems appropriate and may trigger regulatory reporting requirements.
K. Any dispute between a panelist and the patient or the patient’s family or authorized decision-maker shall be referred to the Emergency Physician. No on-call physician shall presume that his or her services have been refused unless the patient or his or her authorized decision-maker has been fully informed of the benefits of the treatment offered and the risks of refusing such treatment and has given an informed refusal of treatment in writing. The Emergency Physician shall be informed of any such refusal of treatment.

L. Allied Health Practitioners (AHPs) may not be assigned to take ER Call, however, the care of a patient seeking emergency medical treatment may be delegated to an appropriately credentialed / privileged Allied Health Practitioner by the on-call physician. It is assumed that any such delegation to an AHP is under the supervision of the on-call physician with the agreement of the Emergency Physician.

REFERENCES: COBRA Statute 42 USC 1395 dd; HealthONE EMTALA Policy

1 Definition of Trauma:

Any person who has incurred a single or multisystem injury due to blunt or penetrating means or burns and who require immediate medical intervention and treatment.