

PROFESSIONAL STAFF BYLAWS AND RULES/ REGULATIONS

Hutcheson Medical Center, Inc.
Ft. Oglethorpe, Georgia

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DEFINITIONS

1. “**ADMINISTRATION**” means the President and the Administrative Staff of Hospital.
2. “**APPLICANT**” means an applicant for Professional Staff membership, clinical privileges or both.
3. “**BOARD OF DIRECTORS**” means the Directors of Hutcheson Medical Center, Inc.
4. “**BYLAWS**” means the Bylaws of the Professional Staff of Hutcheson Medical Center, Inc. d/b/a Hutcheson Medical Center and d/b/a Parkside at Hutcheson Medical Center.
5. “**CHIEF OF STAFF**” means the chief officer of the Professional Staff who is elected by the members of the Professional Staff.
6. “**CLINICAL FUNCTIONS**” means the duty or permission to provide one or more direct patient care services in the Medical Center at the request or direction, or under the supervision of a member of the Professional Staff.
7. “**CLINICAL PRIVILEGES**” means the duty or permission to independently provide direct patient care services within well defined limits, based on the Practitioner’s professional license, experience, demonstrated competence, ability and judgment.
8. “**CREDENTIALS COMMITTEE**” means the Credentials Committee of the Professional Staff.
9. “**DEPARTMENT**” means any clinical department of the Medical Center.
10. “**MEDICAL EXECUTIVE COMMITTEE**” means the Medical Executive Committee of the Professional Staff.
11. “**BOARD OF DIRECTORS**” means the Board of Directors of Hutcheson Medical Center, Inc.
12. “**HOSPITAL**” means Hutcheson Medical Center.
13. “**INITIAL APPOINTMENT**” means the appointment of an applicant who is not a member of the Professional Staff at the time of the appointment to the Professional Staff, whether or not the applicant was formerly a member of the Professional Staff.
14. “**MEDICAL CENTER**” means Hutcheson Medical Center and Parkside at Hutcheson Nursing Home.

15. **“PHYSICIAN”** means any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is fully licensed in the State of Georgia to practice medicine.
16. **“PRACTITIONER”** means an individual who has been licensed by the State of Georgia as a physician, dentist or podiatrist and who is a graduate of an accredited medical, osteopathic, dental, or podiatry program.
17. **“PRESIDENT”** means the chief executive officer of Hutcheson Medical Center, Inc. appointed by the Board of Directors.
18. **“PROFESSIONAL STAFF”** means all graduates of approved schools of medicine, osteopathy, dentistry, and podiatry who are licensed by the State of Georgia and who have been granted clinical privileges to attend patients in the Medical Center.
19. **“REPRESENTATIVE”** means the Board of Directors and any member or committee thereof; the President; the Professional Staff organization and any Professional Staff Member, Officer, Department or Committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

ARTICLE I: NAME

The name of this organization shall be the Professional Staff of Hutcheson Medical Center, Inc. d/b/a Hutcheson Medical Center and d/b/a Parkside at Hutcheson Medical Center.

ARTICLE II: PURPOSES

It is recognized that the organized Professional Staff is responsible for providing oversight for the quality of medical care, treatment and services provided by each practitioner with privileges at the Medical Center and must accept and discharge this responsibility subject to the ultimate authority of the Board of Directors. The cooperative efforts of the Professional Staff, the Administration and the Board of Directors are necessary to fulfill the Medical Center's obligation to its patients.

The purposes of this organization are as follows:

- A. To create a written set of documents that describes the organizational structure of the Professional Staff and the rules for self-governance.
- B. To promote a uniform standard of patient care, treatment and services consistent with resources that are locally available.
- C. Initiating, developing and approving medical staff bylaws and rules and regulations.
- D. Approving or disapproving amendments to the medical staff bylaws and rules and regulations.
- E. Selecting and removing medical staff officers.
- F. Determining the mechanism for establishing and enforcing criteria and standards for medical staff membership.
- G. Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges.
- H. Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges.
- I. Engaging in on-going performance improvement activities.

ARTICLE III: MEMBERSHIP

Section 1. Nature of Professional Staff Membership

Membership on the Professional Staff is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Sex, race, creed and national origin are not considered in the decision regarding an applicant for membership and /or privileges.

Section 2. Qualifications for Membership

- A. Only Practitioners currently licensed to practice in the State of Georgia who can document their relevant training or experience, current competence, ability to perform the privileges requested, adherence to the ethics of their profession, good reputation and ability to work with others with sufficient adequacy to assure the Professional Staff and the Board of Directors that any patient treated by them in the Medical Center will be given a high quality of medical care, shall be qualified for membership on the Professional Staff. No Practitioner shall be entitled to membership on the Professional Staff or to the exercises of particular Clinical Privileges in the Medical Center merely by the virtue of the fact that the Practitioner is duly licensed in this or any other state, or that the Practitioner is a member of any professional organization, or that the Practitioner had in the past, or presently has, such privileges at another hospital. Members agree to provide for the continuous care of his or her patients.
- B. All members of the Professional Staff, with the exception of physicians practicing teleradiology and emergency medicine, are required to reside or maintain their primary practice in a thirty (30) mile radius of the Medical Center.
- C. Teleradiology: The Medical Staff has determined that teleradiology is an acceptable use of electronic communication. Practitioners utilizing teleradiology will be members of the courtesy medical staff with clinical privileges in diagnostic radiology. Licensed Independent Practitioners (LIP's) who provide official readings of images through a telemedicine link will be credentialed and privileged under the same guidelines as listed in Articles IV, V and Vi of these Bylaws.
- D. No Practitioner, including those in medico-administrative positions by virtue of contracts with Medical Center, shall admit or provide medical or health related services to patients in Medical Center until the Practitioner is a member of the Professional Staff in accordance with the procedures set forth in these Bylaws.

Section 3: Condition and Duration of Appointment

- A. All appointments, reappointments and revocation of appointments to the

Professional Staff shall be made by the Board of Directors. The Board of Directors shall act on appointment, reappointments and revocation of appointments only after there has been a recommendation from the Medical Executive Committee as provided by these bylaws. In the event of unwarranted delay on the part of the Medical Executive Committee, the Board of Directors may act without such recommendation on the basis of documented evidence of the Applicant or Professional Staff member's professional and ethical qualifications have been obtained from reliable sources.

- B. Initial appointments shall be made for a period of two years, subject to the other provisions of these Bylaws. Reappointments shall be for a period of not more than two Professional Staff years. For the purposes of these Bylaws, the Professional Staff year commences on the first day of each calendar year and ends on the last day of each calendar year.
- C. Appointment to the Professional Staff shall confer on the Practitioner only such clinical privileges as have been granted by the Board of Directors in accordance with these Bylaws.

Section 4. Termination of Membership

Professional Staff membership may be voluntarily terminated by written notification to the Credentials Committee by the member.

ARTICLE IV: CATEGORIES OF THE PROFESSIONAL STAFF

Section 1. The Professional Staff

The Professional Staff shall be divided into provisional, active, senior, honorary, medical leave of absence, and leave of absence categories.

Section 2. Provisional Professional Staff

- A. All initial Appointments to the Active Professional Staff and the Courtesy Professional Staff shall be provisional for twelve months from the date of the initial Appointment; however, the Board of Directors may approve advancement after six (6) months upon the recommendation of the Medical Executive Committee. During the twelve (12) month period following initial appointment, the preceptee is required to admit or treat at least five (5) patients or perform at least five (5) procedures or consultations at the hospital. Reappointment to the Provisional Professional Staff may be made by the Board of Directors, but may not exceed one additional six (6) month term, at which time the failure to advance from Provisional Professional Staff to the Active Professional Staff or Courtesy Professional Staff shall be deemed a termination of the Practitioner's Professional Staff appointment. A recommendation by the Medical Executive Committee or a decision by the Board of Directors that a Practitioner not be advanced from Provisional Professional Staff which recommendation or decision would result in the termination of the Practitioner's Professional Staff membership, shall be an adverse recommendation or adverse decision; and the Practitioner shall be given notice of such action and shall have the hearing and appellate rights which are provided for in Article VIII hereof; however, reappointment to Provisional Professional Staff status shall not be deemed to be an adverse recommendation or adverse decision.
- B. Each member of the Provisional Professional Staff shall undergo a period of review. The review shall be to evaluate the Practitioner's (1) proficiency in the exercise of clinical privileges initially granted; and (2) overall eligibility for continued Professional Staff membership and advancement within staff categories. The review of Provisional Professional Staff members shall follow whatever frequency and format each Department deems appropriate in order to adequately evaluate the Provisional Professional Staff member, including, but not limited to, concurrent or retrospective chart review, mandatory consultation and/or direct observation. Appropriate records shall be maintained. The result of the review shall be communicated to the Credentials Committee by the Chairman of each Department to which the Practitioner has been assigned.
- C. Action For Conclusion of Provisional Staff Status: If the Provisional Professional Staff member has satisfactorily demonstrated the ability to exercise clinical privileges initially granted and otherwise appears qualified for continued Professional Staff membership, the member shall be eligible for placement in the Active Professional

Staff or Courtesy Professional Staff, as appropriate, upon recommendation of the Medical Executive Committee and upon approval by the Board of Directors.

Section 3. The Active Professional Staff

The Active Professional Staff shall consist of Practitioners who regularly provide services to patients in the Medical Center, admit patients to the Medical Center, and provide continuous care to their patients. Procedures performed at the Ambulatory Surgery Center do not count toward eligibility on the Active Professional Staff. Members of the Active Professional Staff shall assume all the responsibilities of membership on the Active Professional Staff in accordance with these Bylaws and with the Rules and Regulations of the Professional Staff in accordance with such rules and regulations as may be established from time to time by the Board of Directors and by the Medical Center. Members of the Active Professional shall be eligible to vote, to hold office and to serve on Professional Staff Committees. Members of the Active Professional Staff shall be required to attend ten (10) patients within the two (2) year reappointment cycle. Practitioners who do not serve as attending practitioners must have worked a minimum of ten (10) days at Hutcheson within the two (2) year reappointment cycle. Members of the Active Professional Staff will participate in emergency service care and indigent care as provided by the Rules and Regulation of the Professional Staff and by the rules and regulations established from time to time by the Board of Directors. Members of the Active Professional Staff will serve on the "ON-CALL" roster as required by the rules and regulations of the Professional Staff.

Section 4. The Courtesy Professional Staff

The Courtesy Professional Staff shall consist of Practitioners who are eligible and qualified for Professional Staff appointment who do not wish to become members of the Active Professional Staff. Members of the Courtesy Professional Staff may admit patients to the Medical Center. Practitioners on the Courtesy Professional Staff shall be permitted to work in the Medical Center no more than twenty-one (21) working days per calendar year when the Practitioner is not attending a patient who has been admitted to Medical Center by the Practitioner. This does not apply to the Ambulatory Surgery Center. Members of the Professional Staff who primarily practice at Hutcheson Medical Center owned Family Practice Centers will be appointed to the Courtesy Professional Staff.

Members of the Courtesy Professional Staff who admit patients to the Medical Center are permitted to admit no more than twelve (12) patients per calendar year to the Medical Center and are permitted to perform no more than twelve (12) surgical procedures at Medical Center in any calendar year. This does not apply to procedures performed at the Ambulatory Surgery Center. Appointments to the Courtesy Professional Staff shall be in the same manner as provided for appointments to the Active Professional Staff. Members of the Courtesy Professional Staff are not eligible to vote or hold office, but may serve on committees in an advisory status without vote.

Members of the Courtesy Professional Staff shall not be required to attend Professional Staff meetings and shall not be required to serve on the "ON-CALL" roster.

Section 5. The Senior Professional Staff

The Senior Professional Staff shall consist of Practitioners who have reached the age of sixty (60) years and have been members of the Active Professional Staff for seven (7) consecutive years, or who have reached the age of sixty (60) years and have been members of the Active Professional Staff for five (5) years and for reasons of health cannot engage in full-time practice. Members of the Senior Professional Staff may admit patients to the Medical Center. Members of the Senior Professional Staff shall be appointed to a specific department, shall have the same rights provided members of the Active Professional Staff, including the right to serve on Professional Staff committees at the discretion and direction of the Chief of Staff.

Members of the Senior Professional Staff shall not be required to attend Professional Staff meetings and shall not be required to serve on the "ON-CALL" roster. Requests for transfer of membership to the Senior Professional Staff shall be made by written application to the Credentials Committee. Appointment to the Senior Medical Staff shall be made only upon the recommendation of the Medical Executive Committee and the approval of the Board of Directors.

Section 6: The Honorary Professional Staff

The Honorary Professional Staff shall consist of Practitioners who are not active in the Medical Center and who are honored by emeritus positions. They may be (1) Practitioners who have retired from active hospital service, or (2) Practitioners of outstanding reputation, not necessarily residents in the community. Honorary Professional Staff members shall not be eligible to admit patients, perform surgery, hold office or vote, but may serve on staff committees in an advisory status.

Section 7. Medical Leave of Absence (MLOA)

The Medical Leave of Absence Professional Staff, hereinafter referred to as "MLOA Staff" consists of individual Practitioners who are members of the Hutcheson Medical Center Professional Staff who have developed a health related impairment or disability which affects the Practitioner's ability to render quality medical care to patients at Medical Center, or who have developed a condition which significantly compromises the Practitioner's psychological, social or occupational functioning due to substance use disorders (e.g. alcohol dependence, drug dependence) or mental illness (e.g., severe neurosis, depression, bi polar disorder, or organic brain disease); who have requested to be placed on the MLOA Staff; and who have been granted that status by the Board of Directors. Requests for membership on the MLOA Staff shall be in writing and shall state the Practitioner's reasons for requesting membership on the MLOA Staff. The process for consideration of a Practitioner's application to become a member of the MLOA Staff shall be in accordance with Article V, Section 2. If the Medical Executive

Committee makes a recommendation that the Practitioner's application to become a member of the MLOA Staff be denied, or if the Board of Directors denies the Practitioner's application for transfer to the MLOA Staff, such recommendation or denial shall be an "adverse decision" as that term is defined in Article VIII; and in such event, the Practitioner shall have all rights provided to the Practitioner under Article VIII.

In the event the Practitioner is granted membership on the MLOA Staff, if the Practitioner does not request transfer to another Professional Staff category within one year after the Practitioner is granted membership on the MLOA Staff, the Practitioner will be removed from membership as a member of the Professional Staff upon thirty (30) days written notice to Practitioner. If the Practitioner is removed as a member of the Professional Staff under the provisions of this paragraph, that shall be an "adverse decision" as that term is defined in Article VIII; and in such event, the Practitioner shall have all right provided to the Practitioner under Article VIII.

At the time when the Practitioner requests to be transferred from the MLOA Staff to another category, the Practitioner:

- (A) will state in detail why and how the conditions which were in the reasons for the Practitioner's request to be placed on the MLOA Staff are no longer applicable or have been corrected;
- (B) will furnish the Medical Center with documentation that the Practitioner has received treatment and counseling with respect to any health related impairment or disability;
- (C) will provide documentation that the health related impairment or disability will not affect the Practitioner's ability to provide quality medical care to patients at Medical Center;
- (D) if the reason for the physician's request for membership on the MLOA Staff was due to a substance use disorder, the Practitioner will provide documentation which evidences that the Practitioner can, as of the time of the request for transfer from MLOA Staff, provide quality medical care to patients at Medical Center and that the Practitioner is not currently under the influence of any alcohol or drug and that the Practitioner is involved in a continued proposed treatment care/maintenance program.
- (E) Will file an application for reappointment in accordance with the provisions of Article V, Section 2 of these Bylaws, whether or not an application for reappointment is otherwise required under the provisions of Article V.

The process for the filing and the consideration of an application by a Practitioner to be changed from MLOA Staff category to another professional staff category shall be in accordance with the provisions of Article v, Section 2 of these Bylaws.

If a Practitioner's request to be transferred from the MLOA Staff to another category is denied, that shall be an "adverse decision" as that term is defined in Article VIII, and the Practitioner shall be entitled to all rights provided by Article VIII. A member of the MLOA Staff shall not be entitled to attend meetings of the Professional Staff, shall have

no rights to admit patients to Medical Center or provide care to patients at Medical Center, shall not be an officer or serve on any committee of the Professional Staff or to vote on any Professional Staff matter.

Section 8. Leave of Absence Staff (LOA)

Members of the Professional Staff may obtain a voluntary leave of absence upon submitting a written request stating the approximate period of leave desired, which may not exceed thirteen (13) months. During the period of the leave, the member shall not exercise clinical privileges at Medical Center, and membership rights and responsibilities shall be inactive.

At least thirty (30) days prior to the termination of the Leave of Absence, or at any earlier time, the Professional Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Credentials Committee. When the Professional Staff member requests reinstatement, the Professional Staff member shall submit a summary of relevant activities during the leave. If the Professional Staff member's term of appointment expired during the leave, upon request for reinstatement the Practitioner must submit an application for reappointment in accordance with the provisions of Article V of these Bylaws. The process for the filing and consideration of the request for reinstatement and/or reappointment shall be in accordance with the provisions of Article V of these Bylaws. In the event that the Medical Executive Committee recommends that the Practitioner not be reinstated or in the event that the Board of Directors refuses to reinstate the Practitioner, the action shall be an "adverse decision" as that term is defined in Article VIII and the Practitioner shall be entitled to all rights provided by Article VIII.

If the Practitioner does not request reinstatement in the manner provided herein within thirteen (13) full calendar months from the beginning date of the leave of absence, the Practitioner will be removed from membership as a member of the Professional Staff upon thirty (30) days written notice to the Practitioner. If the Practitioner is removed as a member of the Professional Staff under the provisions of this paragraph, that shall be an "adverse decision" as that term is defined in Article VIII and the Practitioner shall have all rights provided by Article VIII.

Practitioners who are qualified for MLOA Staff shall not be qualified for LOA Staff status.

A member of the LOA Staff shall not be entitled to attend meetings of the Professional Staff, shall have no rights to admit patients to Medical Center or provide care to patients at Medical Center, shall not be an officer or serve on any committee of the Professional Staff or to vote on any Professional Staff matter.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment

- A. All applications for appointment to the Professional Staff shall be in writing, shall be signed by the Practitioner in all areas provided for signature and shall be submitted on a form prescribed by the Board of Directors after consultation with the Medical Executive Committee. The application shall require:
- (1) Detailed information concerning the Applicant's relevant training or experience and current competence.
 - (2) Documentation of continuing medical education experience, particularly if related to requested privileges or procedures.
 - (3) The names and complete addresses of at least three (3) Practitioners who are not current practice partners of the Applicant who can provide adequate written reference pertaining to the Applicant's current professional competence and ethical character.
 - (4) A statement concerning the status of previous and present professional and/or medical staff memberships and information as to whether the Applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or institution or whether the Applicant has ever voluntarily resigned from the staff of any hospital or institution.
 - (5) A statement concerning the status of membership in medical and professional societies and associations including information as to whether the Applicant's membership status in any medical or professional society or association has ever been denied, revoked, or suspended.
 - (6) A statement concerning the present status of all licenses to practice medicine which have ever been granted to the Applicant, including information concerning the state(s) where licensed, and all information concerning all proceedings relating to any suspension, termination, revocation, or non-renewal of any such license, the reduction of any rights or privileges, or the imposition of any conditions or probationary terms on any such license, or whether the Applicant has ever voluntarily or involuntarily relinquished any such license or whether there have ever been any restrictions or conditions placed on any such license for any reason. If any restrictions or conditions have ever been placed on the Applicant's license to practice medicine, full details concerning the situation must be provided. A photostatic copy of the current Georgia license shall be filed by the Applicant with the Applicant's application for staff privileges.

- (7) A detailed description of all proceedings which have ever been filed before any medical board or court relating to the licensure of the Applicant. Photostatic copies of all proceedings before the medical board or court must be furnished as part of the application
 - (8) A statement concerning the status of a narcotic permit, including information regarding any suspension or revocation of such a permit. If any restrictions or conditions have ever voluntarily or involuntarily been placed on the Applicant's narcotics permit, full details concerning such action must be stated. The Applicant shall attach a copy of the current narcotics permit to the Applicant's application for Professional Staff membership.
 - (9) A statement regarding malpractice insurance that shall include the name and address of the carrier that provides malpractice insurance to the Applicant, the policy number, and the amount of coverage provided.
 - (10) A statement providing detailed information concerning all malpractice claims or suits ever made against the Applicant, which shall include information concerning all settlements or judgments which resulted in payment by or on behalf of the Applicant. As part of the application for Professional Staff membership, the Applicant shall execute consent for all present and previous malpractice insurance carriers and their representatives to release all information requested by Hutcheson Medical Center relating to the Applicant.
 - (11) A statement from the Applicant indicating whether the Applicant has any illness or physical disability that impairs or could impair his ability to practice medicine within the scope of privileges he is requesting (e.g., alcoholism, convulsive disorders, mental illness, multiple sclerosis, narcotics addiction, etc.). A statement confirming health status is required from the Applicant's personal physician.
 - (12) Specific delineation of privileges requested by the Applicant.
- B. It shall be the Practitioner's responsibility to produce adequate information for proper evaluation of the Practitioner's competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.
- C. By applying for appointment to the Professional Staff, each Practitioner does:
- (1) agree to appear for interviews in regard to the application;
 - (2) authorize members of the Professional Staff and representatives of Medical Center to consult with others concerning the Applicant's qualifications, and to inspect and obtain copies of records and

documents that may be material to an evaluation of the Practitioner's professional qualifications, competence, and character.

- (3) Release from any liability all representatives of the Medical Center and Professional Staff for acts performed in good faith and without malice in connection with the gathering of Information concerning the Practitioner and in evaluating the Practitioner and the Practitioner's credentials and pledge to provide his/her patients continuous care and abide by the Bylaws, rules, regulations and policies of Hutcheson Medical Center;
 - (4) Release from any liability all individuals and organizations who provide information to the Medical Center in good faith and without malice concerning the Practitioner, including otherwise privileged or confidential information;
 - (5) Assume full responsibility for the completion of the application including, but not necessarily limited to, providing all references and documentation of training, experience, and licensure as described in Section 1, Subsection A of this Article V;
 - (6) Acknowledge and agree that the application must be complete before it can be processed. Completion means three things:
 - (a) all blanks on the application form are filled in and necessary additional explanations provided;
 - (b) verification of the information from primary sources whenever feasible is complete; that is, all information necessary to properly evaluate an Applicant's qualifications has been received and is consistent with the information provided in the application form; and
 - (c) responsive letters of reference and information from past hospitals and other affiliations have been received.
- D. If an application is not completed within ninety (90) days from the date of the receipt of the initial application by the Professional Staff Office, then it shall be presumed that the Applicant has voluntarily withdrawn the application upon written notice to that effect by the Medical Center to the Practitioner. Any Practitioner, whose application has been withdrawn in accordance with the provisions of this paragraph, shall have the right to refile a new application for membership on the Professional Staff at any time.

Section 2. Appointment Process

- A. The application shall be submitted to the Professional Staff Office. The Professional Staff Office will notify the Chief of Staff of the pending application so that an interview with the applicant can be scheduled, if desired. After the

application has been completed the Professional Staff Office shall transmit the completed application or photostatic copies of the completed application and supporting materials to the appropriate Department Chairman for evaluation and written comments. The Department Chairman may be asked to consult with other hospital staffs concerning the Practitioner's qualifications and competency.

- B. Promptly after the completed application has been delivered to the Department Chairman and the Department Chairman has been required to make an evaluation and written comment, the Department Chairman shall submit a written report concerning any investigation and the Department Chairman's evaluation and recommendations relating to both membership on the Professional Staff and to privileges requested by the Applicant to the Professional Staff Office. The recommendations of the Department Chairman shall be made a part of the application file. The application shall then be transmitted to the Credentials Committee.
- C. Promptly after receipt of the application and the evaluation and comments of the appropriate Department Chairman, the Credentials Committee shall examine the application and consider the character, professional competence, qualifications and ethical standing of the Practitioner. The Credentials Committee will promptly make a written report of its investigation to the Medical Executive Committee. The report shall include a favorable or adverse recommendation for acceptance or refusal or the Applicant's request for membership on the Professional Staff and a recommendation for the specific privileges to be granted to the Applicant if the Applicant is provisionally appointed to the Professional Staff.
- D. Promptly after receipt of the Credentials Committee's recommendation, the Medical Executive Committee shall examine the application and consider the character, professional competence, qualifications and ethical standing of the Applicant. The Medical Executive Committee will promptly make a written report of its investigation to the Board of Directors. The report shall include a favorable or adverse recommendation or acceptance or refusal of the Applicant's request for membership on the Professional Staff and a recommendation for the specific privileges to be granted to the Applicant if the Applicant is provisionally appointed to the Professional Staff.
- E. After receipt of the recommendation from the Medical Executive Committee, the Board of Directors will promptly consider the application and will make a determination as to whether the Applicant will be appointed to the Professional Staff and, if appointed what clinical privileges will be granted to the Applicant. Applicant will be promptly notified of the Board of Director's action.
- F. If the recommendation of the Medical Executive Committee is to deny the Applicant's application for Professional Staff membership or to deny any of the clinical privileges requested by the Applicant, or if the Board of Directors denies the Applicant's application for membership on the Professional Staff, or denies any of

the clinical privileges requested by the Applicant, such action shall be an “adverse decision” as that term is defined in Article VIII and the Applicant shall be entitled to all of the hearing and appellate review rights provided by Article VIII

- G. Whenever an Applicant shall make an application for Professional Staff membership, the Board of Directors will take final action thereon within ninety (90) days after receipt of the completed application by the Medical Center; provided however, that whenever the Applicant is licensed by any governmental entity outside the continental limits of the United State, the Board of Directors shall have one hundred twenty (120) days to take action following receipt of the completed application. Notwithstanding the above provisions, this section shall be construed to read in conformity with O.C.G.A. 31-7-7 as the same may be amended from time to time and shall stand amended to the extent such statute is change or amended.

Section 3. Reappointment Process

- A. Reappointment shall be conducted every two (2) years for all Professional Staff members, except in the case of Applicants in the Honorary, Medical Leave of Absence, and Leave of Absence Categories. Members on the Honorary, Medical Leave of Absence and Leave of Absence Staffs will not be required to complete a reappointment application except as otherwise provided by these Bylaws. An Applicant for reappointment shall provide such relevant information or documentation as required by the Board of Directors including, but not limited to, voluntary/involuntary limitation, reduction or loss of clinical privileges at another hospital; continuing medical education; changes in hospital staff memberships; changes in the status of narcotics permits; changes in the status of state licenses to practice medicine; changes in medical society or professional organization memberships; the existence of disciplinary proceedings or reprimands by any administrative agency, medical society, hospital or professional organization; changes in the status of malpractice claims, suits or judgments; at least one (1) recommendation pertaining to the current competence of an application from a practitioner who is not in current practice with the applicant; changes as to board certifications; additional continuing medical education; and any changes in physical status which might affect the Practitioner’s ability to practice his or her medical specialty; professional performance, judgement, clinical or technical skills. A statement confirming health status is required from the Applicant’s personal physician. The application shall indicate any changes in Clinical Privileges desired by the Practitioner. The application shall be accompanied by a legible photostatic copy of the Practitioner’s current narcotics permit, if applicable, and a copy of a declarations page from the current malpractice insurance liability policy for the Practitioner which includes information concerning the limits of professional liability coverage and the expiration date for the policy.
- B. The approval for rejection of the application for reappointment of a Professional Staff member and of the Clinical Privileges to be granted upon reappointment shall

be based upon the Practitioner's current professional competence and clinical judgment in the treatment of patients; the Practitioner's ethics and conduct; the Practitioner's participation in staff affairs; the Practitioner's compliance with Professional Staff Bylaws, Rules and Regulations, which includes the maintenance of timely, accurate and complete medical records; the Practitioner's cooperation with Medical Center personnel/ the Practitioner's relations with other Practitioner's; the Practitioner's patterns of care; a review of malpractice claims in three areas: (a) previously reported and still pending, (b) previously reported and resolved since the last application, and (c) new litigation arising since the last application; and a review of the Practitioner's general attitude toward patients, the Medical Center, the public, and other health care providers.

- C. The completed reappointment application and all the supporting information outlined in paragraph B above shall be forwarded to the Chairman of the assigned Department for evaluation and recommendation. The Department Chairman will review all information and provide a peer recommendation.
- D. The completed reappointment application, along with the recommendation of the Department Chairman, shall be forwarded to the Credentials Committee for investigation, evaluation and recommendation. After receipt of the completed reappointment application, the Credentials Committee will promptly review the application and make a written report to the Medical Executive Committee which shall include a favorable or adverse recommendation for approval or rejection of the Practitioner's application for reappointment and a recommendation delineating the specific Clinical Privileges to be granted to the Applicant.
- E. After receipt of the report and recommendation of the Credentials Committee, the Medical Executive Committee shall promptly investigate and evaluate the application. The Medical Executive Committee will promptly make a written report to the Board of Directors which shall include a favorable or adverse recommendation for approval or rejection of the Practitioner's application for reappointment and a recommendation delineating the specific Clinical Privileges to be granted to the Applicant.
- F. After receipt of the recommendation from the Medical Executive Committee, the Board of Directors shall promptly consider the application. The Board of Directors shall either approve or deny the Practitioner's application for reappointment to the Professional Staff. If the Board of Directors approves the Practitioner's application for reappointment to the Professional Staff, the Board of Directors shall specifically delineate the Clinical Privileges to be granted to the Practitioner. The Practitioner shall be promptly notified of the Board of Director's action.
- G. If the recommendation of the Medical Executive Committee or the action of the Board of Directors is that the Practitioner's application for reappointment be denied or that the Practitioner not be granted all privileges requested by the Practitioner,

then such action shall be an “adverse decision” as that term is defined in Article VIII and the Practitioner shall be entitled to all rights provided by Article VIII.

ARTICLE VI: CLINICAL PRIVILEGES

Section 1: Exercise of Privileges

- A. Except as otherwise provided in these bylaws, a Practitioner providing clinical services at Medical Center shall be entitled to exercise only those Clinical Privileges specifically granted to the Practitioner by the Board of Directors. The Clinical Privileges must be within the scope of any license, certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to those rules and regulations of the Professional Staff and of the Department where those privileges are to be exercised. Clinical privileges specifically granted to the Practitioner by the Board of Directors.
- B. If members of the Professional Staff who occupy Medico-Administrative positions are terminated under the provisions of the Agreement by which the Medico-Administrative position was assumed, such action will not affect the Practitioner's status on the Professional Staff, and will not alter the Clinical Privileges specifically granted to the Practitioner by the Board of Directors.
- C. Each application for appointment and reappointment for the Professional Staff must contain a request for the specific Clinical Privileges desired by the Practitioner. A request by a member of the Professional Staff for a modification of Clinical Privileges may be made at any time, but such request must be supported by documentation of training and experience which support the request.
- D. Requests for Clinical Privileges shall be evaluated on the basis of the Applicant's education, training, experience, demonstrated professional competence and judgment, clinical performance, documented results of patient care, and other quality review and monitoring which the Professional Staff deems appropriate. Clinical Privileges shall be granted uniformly to all applicants and members. Clinical Privileges determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the Applicant has exercised Clinical Privileges.
- E. When a request for Clinical Privileges is made at a time other than when the initial application for appointment to the Professional Staff is filed or when a request for reappointment is filed, the procedure for processing the request shall be the same as set out in Article V, Section 2 of these Bylaws.

Section 2: Preceptorship

- A. Except as otherwise determined by the Board of Directors, all initial Appointees to the Professional Staff shall be subject to a period of preceptorship. Each initial

Appointee shall be assigned to a Department where performance on an appropriate number of cases as established by the Department shall be reviewed by the Chairman of the Department, or the Chairman's designee, during the period of preceptorship specified by the rules and regulations of the Department, to determine suitability to continue to exercise the Clinical Privileges granted in that Department. The Practitioner shall remain subject to preceptorship until the Board of Directors determines that the Practitioner has successfully completed the preceptorship and grants the Practitioner the privileges requested or the Practitioner's right to exercise the Clinical Privilege is otherwise terminated under these Bylaws.

- B. With respect to preceptorship for each Clinical Privilege requested by a Practitioner, the preceptor shall submit a written report in accordance with the rules and regulations of that Department, which report will contain the evaluation of the Practitioner's performance, and a statement concerning whether, in the opinion of the preceptor, the Practitioner meets all of the qualifications for the unsupervised exercises of the Clinical Privileges reviewed by the Department.
- C. After receipt of a report from a preceptor as described in Paragraph B above, the Credentials Committee shall make an investigation and issue a recommendation to the Medical Executive Committee in which the Medical Executive Committee shall state what Clinical Privileges, if any, the Practitioner is qualified to exercise in an unsupervised manner.
- D. After receipt of the recommendation of the Medical Executive Committee, the Board of Directors shall promptly make a determination concerning what Clinical Privileges, if any, the Practitioner is qualified to exercise in an unsupervised manner.
- E. Rules and regulations for preceptorship shall be established by each Department.
- F. The preceptorship activities described in these Bylaws shall be conducted as part of the peer review activities of the Board of Directors of the Medical Center and shall be the purpose of evaluation and improving the quality of health care rendered at Medical Center, for the purpose of reducing morbidity or mortality, and for the purpose of evaluating the quality and efficiency of services performed by the Practitioner being reviewed.

Section 3. Failure to Obtain Approval to Exercise Privileges

- A. If an Initial Appointee within the time of Provisional Professional Staff membership fails to obtain approval by the Board of Directors to exercise a Clinical Privilege in an unsupervised manner, or if the Board of Directors fails to authorize a Practitioner exercising new Clinical Privileges to exercise those Clinical Privileges in an unsupervised manner within the time allowed by the Department rules and regulations, those specific Clinical Privileges shall automatically terminate.

- B. In the event that Clinical Privileges are terminated pursuant to the provisions of Paragraph A, prompt written notice shall be given to the Practitioner whose Clinical Privileges are terminated. In the event that Clinical Privileges are terminated pursuant to the provisions of paragraph A above, that action shall be an “adverse decision” as that term is defined in Article VIII and the Practitioner whose Clinical Privileges have been so terminated shall be entitled to all rights provided by Article VIII.
- C. If a Practitioner who is a member of the Provisional Professional Staff does not obtain appropriate certification for any Clinical Privileges during the time of Provisional Professional Staff membership, that Practitioner shall not be entitled to be advanced to any other category.

Section 4. Conditions for Privileges of Dentists and Podiatrists

- A. Admissions – Dentists (other than oral and maxillofacial surgeons) and podiatrists who are members of the Professional Staff may only admit patients if a physician member of the Professional Staff conducts or directly supervises the admitting history and physical examination (except the portion relating to dentistry or podiatry) and assumes responsibility for the care of the patient’s medical problems present at the time of admission or which may arise during hospitalization which are outside of the lawful scope of practice of the dentist or podiatrist. A physician member of the Professional Staff shall determine the risk and affect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member of the Professional Staff and a dentist or podiatrist based upon medical or surgical factors outside the scope of the licensure of the dentist or podiatrist, the treatment will be suspended insofar as possible while the dispute is resolved by the Chairman of the appropriate Department and/or the Chief of Staff.
- B. Surgery – Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery or the Chairman’s designee.

Section 5. Temporary Privileges

- A. If the President determines that because of patient care needs certain medical services are needed at Medical Center and cannot otherwise be provided at Medical Center, with the written concurrence of the Chief of Staff and the Chairman of each Department in which the Practitioner’s privileges will be exercised, the President may grant temporary admitting and/or Clinical Privileges (hereinafter referred to as Temporary Privileges) to Practitioners. Temporary admitting and/or clinical privileges may also be granted for the care of a specific patient to a practitioner who is not an applicant for membership; however, such privileges shall be restricted to the treatment of not more than four (4) patients in

any one year by any practitioner, after which such practitioner shall be required to apply for membership on the Professional Staff before being allowed to attend additional patients.

- B. Temporary privileges shall be granted upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the Practitioner, and Licensure has been verified with the State of Georgia. Notwithstanding the above, no Temporary Privileges shall be granted until the Chairman of the Department in which the Practitioner will exercise Temporary Privileges, or his designee, has contacted at least one person who has (a) recently worked with the applicant, (b) directly observed the applicant's professional performance over a reasonable period of time and (c) provides reliable information regarding the applicant's current professional competence, ethical character and ability to work well with others so as to adversely affect patient care.
- C. In exercising Temporary Privileges, the Practitioner shall act under the supervision of the Chairman of the Department in which the Practitioner has Temporary Privileges or his designee.
- D. All Practitioners who are granted HMC Temporary Privileges must sign an acknowledgement that the Practitioner has received and read copies of the Professional Staff Bylaws, Rules and Regulations and the Bylaws and agree to be bound by the terms thereof prior to exercising any Temporary Privileges at Medical Center.
- E. In no event shall the duration of the Temporary Privileges for an Applicant for membership on the Professional Staff exceed a ninety (90) day period for which the application for Professional Staff membership is pending.
- F. No Temporary Privileges shall be granted to any Practitioner until that Practitioner has provided satisfactory evidence that the Practitioner has malpractice insurance with such coverage and in such amounts as is required by the Medical Center or the Board of Directors.
- G. Special requirements of supervision and reporting may be imposed by the Chairman of the Department in which any Practitioner is granted Temporary Privileges or by the Chief of Staff. Temporary Privileges shall be immediately terminated by the President upon notice from the Chairman of the Department in which the Practitioner is granted Temporary Privileges or upon notice from the Chief of Staff of the failure by the Practitioner to comply with any such special conditions.
- H. Upon the discovery of any information or the occurrence of any event which raises some question as to the Practitioner's professional qualification or professional ability to exercise any or all the Temporary Privileges granted, the President may terminate any or all of such Practitioner's Temporary Privileges.

Where the life or well-being of a patient under the care of the Practitioner is determined to be endangered by the continued treatment by the Practitioner, termination of the Practitioner's Temporary Privileges may be effectuated by any person entitled to impose summary suspension under these Bylaws. In the event of such termination, the Practitioner's patients then in the hospital shall be assigned to another member of the Professional Staff by the Chief of Staff in consultation with the relevant Department Chairman.

- I. The denial, termination or limitation of Temporary Privileges shall not be deemed to be an "adverse decision" for which any Practitioner shall have the right to a Hearing or Appellate Review provided for in Article VIII of these Bylaws. Furthermore, Practitioner specifically acknowledges that the granting of Temporary Privileges to a Practitioner does not in any way affect the process with respect to an application for Professional Staff membership nor does the granting of Temporary Privileges in any way obligate the Medical Center to grant Professional Staff status to the Practitioner.

Section 6. Locum Tenens Privileges

A practitioner serving as a locum tenens practitioner may be permitted to attend patients without applying for membership on the Professional Staff for a period not to exceed ninety (90) days, providing all of the practitioner's credentials have first been reviewed and approved by the Chairman of the Department, the Chief of Staff and the Medical Center President. Verification of current licensure by the state of Georgia and verification of current competence by a person who has recently worked the applicant will be obtained prior to being granted Locum Tenens Privileges

Section 7. Emergency Privileges

In the case of emergency, any member of the Professional Staff, to the degree permitted by the Practitioner's license and regardless of Department, staff status, or Clinical Privileges, or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Professional Staff member must request the Clinical Privileges necessary to continue to treat the patient. Notwithstanding the above, emergency Clinical Privileges are limited to Practitioners whose Clinical Privileges at Medical Center have not been previously or otherwise terminated or suspended at the time the emergency Clinical Privileges are exercised. For purposes of this section an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in imminent danger and any delay in administering treatment would add to that danger.

ARTICLE VII: CORRECTIVE ACTIONS

Section 1. Corrective Actions

- A. Whenever a Practitioner shall engage in, make or exhibit acts, statements, demeanor, or professional conduct, either within or outside the Medical Center, which is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, which will or will likely result in the imposition of sanctions by any governmental authority, which does not meet accepted standards or aims of the Professional Staff, or which is disruptive to the operations of the Medical Center, or which is in violation or contrary to these Bylaws, an investigation or corrective action with respect to such Practitioner may be requested by any member of the Professional Staff, or by the President, or by the Board of Directors, or may be initiated by the Medical Executive Committee on its own initiative. All requests for corrective action shall be supported by references to the specific activities or conduct which constitute grounds for the request.
- B. Upon receipt of a request for an investigation or corrective action, the Medical Executive Committee shall forward such request to the Chairman of the Department where the Practitioner has privileges. Upon receipt of such request, the Chairman of the Department shall appoint an Ad Hoc Committee composed of not less than three (3) members who shall be members of the Active or Senior Professional Staff who are not members of either the Medical Executive Committee or the Board of Directors to investigate the matter. The investigation under this provision shall not be deemed to be a "hearing" as described in Article VIII
- C. During the investigation, the affected Practitioner shall have an opportunity for an interview with the Ad Hoc Committee. At such interview, the Practitioner shall be informed of the general nature of the charges against the Practitioner, and shall be invited to discuss, explain or refute the charges. This interview shall not constitute a hearing, but shall be preliminary, and none of the procedural rights provided by these bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Ad Hoc Committee and included in its report to the Medical Executive Committee. The Ad Hoc Committee shall complete its investigation as soon as practicable after the assignment to investigate has been made. When the investigation has been completed, the Ad Hoc Committee shall forward a written report of the investigation to the Medical Executive Committee.
- D. At the next regular meeting of the Medical Executive Committee, after receipt of the written report from the Ad Hoc Committee, unless deferred pursuant to Section 1(E), the Medical Executive Committee shall act thereon. Such action may include, without limitation, recommending:
- (1) No corrective action.
 - (2) Rejection or modifications of any proposed corrective action.
 - (3) Letter of admonition, letter of reprimand, or warning.
 - (4) Terms of probation or individual requirements of consultation.

- (5) Reduction or revocation of clinical privileges.
 - (6) Suspension of clinical privileges until completion of specific conditions or requirements.
 - (7) Reduction of membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care.
 - (8) Suspension of Professional Staff membership until completion of specific conditions or requirements.
 - (9) Revocation of Professional Staff membership.
 - (10) Other actions appropriate to the facts, which prompted the investigation.
Nothing set forth herein shall inhibit the implementation of the summary suspension procedures at any time pursuant to Article VII, Section 2.
- E. If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and shall so notify the affected Practitioner. A subsequent recommendation for any one or more of the actions referred to in Section 1(D) must be made within the time specified by the Medical Executive Committee, but in no event more than sixty (60) calendar days after the Medical Executive Committee has received the report from the Ad Hoc Committee.
- F. The Medical Executive Committee shall, within five (5) calendar days after rendering its decision, forward the President the record of all proceedings of the Ad Hoc Committee and the Medical Executive Committee with respect to the matter under consideration together with a written report which shall state the recommendation of the Medical Executive Committee and the reasons for the recommendation.
- G. The President shall transmit the recommendation of the Medical Executive Committee together with the report of the Medical Executive Committee and record of the Ad Hoc Committee and Medical Executive Committee proceedings to the Board of Directors. At the next regular meeting of the Board of Directors after receipt of the recommendation of the Medical Executive Committee, the Board of Directors shall consider the matter and shall recommend confirmation, modification or rejection of any previous recommendation or decision concerning the matter. That recommendation shall be made in a written report to the President which shall be forwarded to the President within five (5) calendar days after the meeting of the Board of Directors at which action was taken with respect to the matter under consideration. In addition to the written report and recommendation, the Medical Executive Committee shall also forward a copy of the record of the proceedings in the Medical Executive Committee relating to the matter under consideration.
- H. Notwithstanding the provisions of Paragraph G, if additional time is needed by the Board of Directors to complete its consideration of the matter, it shall notify the affected Practitioner. However, in no event shall the Board of Directors take more than sixty (60) calendar days for consideration of the matter after it receives the

recommendation of the Medical Executive Committee together with the respect of the Medical Executive Committee and the record of the Ad Hoc Committee and Medical Executive Committee proceedings.

- I. If the recommendation of the Board of Directors is an adverse recommendation, as that term is defined in Article VIII, Section 1(A) , the Practitioner shall be entitled to notice of the recommendation made by the Medical Executive Committee in accordance with the provisions of Article VIII and shall otherwise be entitled to all of the rights provided by Article VIII of these Bylaws.
- J. If any action of the Board of Directors with respect to the Practitioner is an adverse decision as that term is defined in Article VIII, Section 1(A), and if the Practitioner has not otherwise been given an opportunity for a Hearing in accordance with the provisions of Article VIII with respect to the matter under consideration, the Practitioner shall be entitled to notice of the adverse decision by the Board of Directors in accordance with the provisions of Article VIII, and shall otherwise be entitled to all of the rights provided by Article VIII.

Section 2. Summary Suspension

- A. Whenever a Practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Medical Center, either the Chief of Staff, Vice Chief of Staff, a Department Chairman, the President, Immediate Past Chief of Staff, the Medical Executive Committee or the Board of Directors, shall have authority to summarily suspend all or any portion of the clinical privileges of a Practitioner, and each such summary suspension shall become effective immediately upon imposition.
- B. The person or body responsible for imposing the summary suspension shall promptly give oral notice of the suspension to the Practitioner, and as soon as possible thereafter shall give written notice of the suspension to the Practitioner, the Board of Directors, the Medical Executive Committee, and the President. The notice of the investigation under Section 1 of this Article VIII; and the procedures set forth under Section 1 of this Article shall be followed thereafter.
- C. Notwithstanding the provisions of this Section 2 with respect to the initiation of an investigation under Section 1 of this Article VII, and without in any way affecting the investigation, within seventy-two (72) hours after the imposition of any summary suspension, the Chairman of the Department in which the Practitioner has Clinical Privileges, the Chief of Staff and the President shall review the summary suspension and if at any time after the summary suspension, until the Medical Executive Committee makes its recommendation with respect to the investigation under Section 1 of this Article VIII in said matter, the Chairman of the Department in which the Practitioner has Clinical Privileges, the Chief of Staff and the President shall, on unanimous approval by all three, have the right to remove the summary

suspension if they deem it to be appropriate under all the circumstance. However, if the recommendation of the Medical Executive Committee with respect to the matter does not include the immediate termination of the summary suspension, then the terms of the summary suspension as determined by the Medical Executive Committee shall be effective immediately and shall remain in effect pending the final decision thereon by the Board of Directors. If the recommendation of the Medical Executive Committee is an adverse recommendation, as that term is defined in Article VIII, Section 1(A), the Practitioner shall be entitled to notice of the recommendation by the Medical Executive Committee in accordance with the provisions of Article VIII, Section 3 and shall thereafter be entitled to all rights as provided by Article VIII.

- D. In the event of a summary suspension, the Practitioner's patients whose treatment by such Practitioner is terminated by the summary suspension shall be assigned to another Practitioner by the Chief of Staff or a responsible Department Chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

Section 3. Automatic Suspension

- A. Whenever a Practitioner is placed on probation by the applicable licensing authority, the Practitioner's Professional Staff membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.
- B. Whenever a Practitioner's Drug Enforcement Administration Certificate is revoked or has expired, the Practitioner shall immediately and automatically be divested of the right to prescribe medications covered by the Certificate.
- C. Whenever a Practitioner's Drug Enforcement Administration Certificate is suspended, the Practitioner shall be divested of his right to prescribe medications covered by the Certificate effective upon, and for the term of the suspension.
- D. Whenever a Practitioner's Drug Enforcement Administration Certificate is subject to an order of probation, the Practitioner's right to prescribe medications covered by this Certificate shall automatically become subject to the terms of the probation.
- E. Action by the Composite State Board of Medical Examiners, the Georgia Board of Dentistry, or the Georgia Board of Podiatry revoking or suspending a Practitioner's license shall automatically suspend all of Practitioner's privileges and rights at Medical Center.
- F. As soon as practicable after action is taken pursuant to Paragraphs A, B, C, D, or E above, the Medical Executive Committee shall convene and review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action or investigation

pursuant to Section 1 of this Article VII as may be appropriate based upon information disclosed or otherwise made available to it.

- G. At all times each Practitioner shall be responsible for furnishing satisfactory evidence to the President that the Practitioner then has in effect Professional Liability Insurance in such amount as shall be required by the Board of Directors from time to time. Practitioner's membership on the Professional Staff and Clinical Privileges shall be automatically suspended ten (10) calendar days after the mailing of a written notice to the Practitioner that the Practitioner has failed to provide adequate evidence to the Medical Center that the Practitioner has the required Professional Liability Insurance. This automatic suspension may be rescinded by the President when the Practitioner provides evidence to the Medical Center that the Practitioner has secured Professional Liability Insurance in the amount required by the Board of Directors or by the Medical Center.
- H. If a Practitioner does not complete medical records within thirty (30) calendar days from the date of a patient's discharge, the Practitioner's admitting and Clinical Privileges may be temporarily suspended. The suspension provided for in this paragraph shall become effective fifteen (15) calendar days after written notice of such suspension is mailed by the Medical Center to the Practitioner. The suspension shall be automatically removed when the Practitioner has completed all medical records for patients who have been discharged for more than thirty (30) calendar days from the Medical Center.
- I. Practitioners whose Clinical Privileges are automatically suspended because of their failure to complete medical records, because of actions by applicable licensing authorities, because of revocations, suspensions or probations with respect to Drug Enforcement Administration Certificates, or because of failure to maintain malpractice Insurance, shall not be entitled to the procedural rights set forth in Article VIII of these Bylaws.
- J. Whenever a Practitioner's privileges are automatically suspended in whole or in part under paragraphs A, B, C, D, or E above, within fifteen (15) calendar days after the suspension becomes effective, notice of such suspension shall be given to the Practitioner, the Medical Executive Committee, the President and the Board of Directors. Giving such notice shall not, however, be required in order for the automatic suspension to become effective.
- K. In the event of any suspension, the Practitioner's patients, whose treatment by such Practitioner is terminated by the automatic suspension, shall be assigned to another Practitioner by the Chief of Staff or the responsible Department Chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.
- L. The Chief of Staff and the President shall have the responsibility and duty of cooperatively enforcing all automatic suspensions.

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Definitions

- A. As referred to in this Article VIII, the phrases “adverse recommendation” and “adverse decision” and “final decision that will adversely affect” are defined as a recommendation or decision to restrict or deny a Practitioner’s request for appointment or reappointment to the Professional Staff, or to reduce or limit the Practitioner’s Clinical Privileges as a member of the Professional Staff or to admonish, reprimand or warn the Practitioner or to otherwise adversely affect the Practitioner’s Clinical Privileges as a member of the Professional Staff.
- B. As referred to in this Article VIII, the phrase “favorable recommendation” and “favorable decision” are defined as a recommendation or decision to neither restrict nor deny a Practitioner’s (1) request for reappointment, with all the Clinical Privileges requested by Practitioner; (2) request for reappointment with all of the Clinical Privileges requested by the Practitioner; (3)

Section 2. Right to Hearing and Appellate Review

- A. When any Practitioner receives notice of an adverse recommendation of the Medical Executive Committee, the Practitioner shall be entitled to a Hearing. After the Hearing, if the Hearing Committee makes an adverse recommendation, the Practitioner shall be entitled to an Appellate Review prior to the Board of Directors rendering its final decision regarding the Practitioner.
- B. When any Practitioner receives notice of an adverse decision or adverse recommendation by the Board of Directors, and the Practitioner has not previously had an opportunity for both a Hearing and an Appellate Review, then the Practitioner shall be entitled to a Hearing and an Appellate Review or only an Appellate Review if the Practitioner has had a Hearing, but has not previously had an opportunity for an Appellate Review.
- C. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one Hearing and one Appellate Review regarding any matter which is the basis of an adverse recommendation or an adverse decision or a final decision that will adversely affect the Practitioner.

Section 3. Notice of Adverse Recommendation or Adverse Decision

- A. Within five (5) calendar days of an adverse recommendation by the Medical Executive Committee or an adverse decision by the Board of Directors, the body which made the adverse recommendation or adverse decision shall submit a written report to the President which shall state in concise language the adverse recommendation or adverse decision and the reasons for the adverse

recommendation or adverse decision and shall include a list of specific or representative charts being questioned and/or the other reasons or subject matter that was considered in making the adverse recommendation or adverse decision.

- B. Within three (3) calendar days of the receipt of the written report required by Section 3 (A) regarding the adverse recommendation or adverse decision, the President or an appropriate designee, shall forward to the Practitioner, by certified mail, return receipt requested, notice of the adverse recommendation or adverse decision; the reasons for the adverse recommendation or adverse decision; shall advise the Practitioner of the Practitioner's right to request a Hearing if the Practitioner has not previously had an opportunity for a Hearing regarding the occurrence which is the subject of the adverse recommendation or adverse decision; shall advise the Practitioner that the request for a hearing must be made in writing and must be delivered to the President as provided in the manner and within the time as provided in Section 4 of this Article; and shall provide the Practitioner a summary of the Practitioner's rights to be granted in the Hearing if the Practitioner requests a Hearing.

Section 4. Request for Hearing

If the affected Practitioner has not previously had an opportunity for a Hearing regarding the matter which is the basis of an adverse recommendation or an adverse decision, then within forty (40) calendar days from the date of the mailing of the notice required by Section 3(B), the Practitioner shall be entitled to request a Hearing. The request must be in writing and must be delivered personally to the President or mailed to the President by certified mail, return receipt requested. The request for a Hearing will be deemed to be given on the date that the request is received by the President. If the affected Practitioner does not request a Hearing within the time provided in this Paragraph, then the Practitioner shall be deemed to have waived the right to both a Hearing and an Appellate Review.

Section 5. Hearing Committee

- A. If the affected Practitioner requests a Hearing within the time and in the manner required by this Article VIII, then the Chairman of the Medical Executive Committee shall appoint a Hearing Committee which shall be composed of not less than five (5) members of the Active or Senior Professional Staff. The members of the Hearing Committee shall not be members of the Medical Executive Committee. No member of the Hearing Committee shall be direct economic competition with the Practitioner.
- B. The Chairman of the Medical Executive Committee shall designate one of the members of the Hearing Committee to be the Chairman of the Hearing Committee.

Section 6. Hearing

- A. The Chairman of the Hearing Committee shall set the date, time and place for the Hearing. The Hearing shall begin not less than thirty (30) calendar days after receipt by the President of the Practitioner's request for the Hearing. The place for the Hearing shall be on the premises of Hutcheson Medical Center in Fort Oglethorpe, Georgia. Notice of the date, time and place of the Hearing shall be mailed by certified mail to the Practitioner not less than thirty (30) calendar days before the Hearing and shall contain a list of witnesses (if any) expected to testify at the Hearing on behalf of the body (Medical Executive Committee or Board of Directors, whichever is appropriate) whose adverse recommendation or adverse decision is the basis for the Hearing.
- B. There shall be at least a majority of the members of the Hearing Committee present at the Hearing and no member may vote by proxy.
- C. Postponement of the Hearing shall be granted only for good cause shown in the sole discretion of the Hearing Committee.
- D. Prior to the Hearing, upon written requests, the affected Practitioner shall be given a copy of the records of the Medical Executive Committee and, if the Board of Directors has considered the matter, the records of the Board of Directors, which relate to the consideration of the Practitioner's matter.
- E. The affected Practitioner and the body which made the adverse recommendation or adverse decision shall be entitled to submit written memoranda concerning any issue relating to the adverse recommendation or adverse decision, and such memoranda shall become a part of the Hearing record. Written memorandum must be submitted within five (5) calendar days of the close of a Hearing or at such other reasonable time after the close of the Hearing as shall be set by the Hearing Committee. The written memorandum shall be delivered to the President who shall mail copies to each member of the Committee and to the adverse party. Notwithstanding the provisions of this paragraph, the affected Practitioner and the body which made the adverse recommendation or adverse decision may waive their right to file written memorandum and permit the Hearing Committee to make a decision after the close of the Hearing without waiting for the time to lapse within which the parties could file written memoranda.
- F. The affected Practitioner shall be entitled to be accompanied by and/or represented at the Hearing by a member of the Professional Staff in good standing or by a member of his local professional society and/or by any attorney.
- G. The body (Medical Executive Committee or Board of Directors, whichever is appropriate) whose adverse recommendation or adverse decision is the basis for the Hearing shall appoint one of its members or some other representative (including an attorney if it so elects) to attend the Hearing and present the facts in

support of its adverse recommendation or adverse decision and to examine witnesses including the affected Practitioner. It shall be the obligation of such member or representative to present appropriate evidence in support of the adverse recommendation or adverse decision, but the affected Practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or adverse decision by an appropriate showing that the charges or grounds involved lack factual basis or are either arbitrary, unreasonable or capricious.

- H. At the request of the Practitioner, the Hearing Committee, the Chairman of the Hearing Committee, or the Board of Directors, the President or his designee may appoint a Hearing Officer to preside at the Hearing. The Hearing Officer shall be qualified to preside over a quasi-judicial Hearing. The Hearing Officer must not act as a prosecuting officer or as an advocate for the Medical Center, the Board of Directors, the Professional Staff, the body whose action prompted the Hearing, or the Practitioner. If requested by the Hearing Committee, the Hearing Officer may participate in deliberations of such body and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.
- I. Either a Hearing Officer, if one is appointed, or the Chairman of the Hearing Committee shall preside over the Hearing and determine the order of procedure during the Hearing to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Hearing Officer can advise the Hearing Committee on procedural matters, and the Hearing Officer can elicit information from any of the participants in order to aid the Hearing Committee in making a recommendation. If a Hearing Officer is appointed, the Hearing Officer shall not be in direct economic competition with the Practitioner.
- J. An accurate record of the Hearing shall be kept. The mechanism shall be established by the Hearing Committee and may be accomplished by the use of a Court Reporter, electronic recording unit, detailed transcription, the taking of adequate minutes, or any combination thereof. No record, except of the decision and the reasons for the decision of the Hearing Committee shall be kept during the deliberation phase of the Hearing, which deliberations may be conducted in private session if the Hearing Committee so elects. The Practitioner shall be entitled to copies of the record upon payment of a reasonable charge associated with the preparation thereof.
- K. The Hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which reasonable persons customarily rely upon in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule, which might make the evidence inadmissible over objection in a civil or criminal court action.

- L. The Practitioner and the body which made the adverse recommendations or adverse decision which is the subject of the Hearing shall have the following rights: To call and examine witnesses, to cross examine witnesses, to introduce documents and other written matter, and to rebut any evidence. If the Practitioner does not testify in the Practitioner's own behalf, the Practitioner by be called and examined by the Hearing Committee or any participants at the Hearing.
- M. The Hearing Committee may, without special notice, recess the Hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining additional evidence or consultation. Such recess shall be in the sole discretion of the Hearing Committee. Upon the conclusion of the presentation of oral and written evidence, the Hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the affected Practitioner.
- N. Within five (5) calendar days after the Hearing is closed and the time for filing written memoranda has expired, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the Hearing record and all other relevant documentation to the President. The report may recommend confirmation, modification or rejection of any previous recommendation or decision. If the recommendation is an adverse recommendation, in its report the Hearing Committee shall state in concise language the reasons for the adverse recommendation.
- O. (1) If the recommendation of the Hearing Committee is a favorable recommendation, then the President shall forward a notice of the favorable recommendation and a copy of the Hearing record to the Board of Directors for its consideration.
- (2) If the recommendation of the Hearing Committee is an adverse recommendation, within three (3) calendar days of the receipt of the adverse recommendation, the President or an appropriate designee shall forward to the affected Practitioner, by certified mail, return receipt requested, notice of the adverse recommendation; shall advise the Practitioner of the reasons for the adverse recommendation or adverse decision; shall advise the Practitioner of the Practitioner's right to request an Appellate Review if the Practitioner has not previously had an opportunity for an Appellate Review regarding the occurrence or matters which are the subject of the adverse recommendation or adverse decision; shall advise the Practitioner that the request for Appellate Review must be made in writing and delivered to the President as provided in Section 7 of this Article; and shall contain a summary of the Practitioner's rights to be granted at the Appellate Review if the Practitioner requests an Appellate Review.

Section 7. Request for Appellate Review

If the affected Practitioner has not previously had an Appellate Review, then within forty (40) calendar days from the date of the mailing of the notice required by Section 6(O), the Practitioner shall be entitled to request an Appellate Review. The request must be in writing and must be either delivered personally to the President or mailed to the President by certified mail, return receipt requested. The request for an Appellate Review will be deemed to be given on the date the request is received by the President. If the affected Practitioner does not request an Appellate Review by the time provided in this paragraph, then the Practitioner shall be deemed to have waived his right to an Appellate Review.

Section 8. Appellate Review Committee

- A. If the affected Practitioner requests an Appellate Review pursuant to the provisions of Section 7, the Chairman of the Board of Directors shall appoint a committee which shall be composed of not less than three (3) members of the Board of Directors, and may be the entire membership of the Board of Directors, who shall comprise the Appellate Review Committee. No member of the Appellate Review Committee shall be in direct economic competition with the Practitioner.
- B. If the Chairman of the Board of Directors is a member of the Appellate Review Committee, he shall serve as Chairman of the Appellate Review Committee; otherwise, the Chairman of the Board of Directors shall appoint a member of the Appellate Review Committee to serve as Chairman of the Appellate Review Committee.

Section 9. Appellate Review

- A. The Appellate Review shall be held not less than thirty (30) calendar days after the receipt by the President of the Practitioner's request for the Appellate Review. The place for the Appellate Review shall be on the premises of Hutcheson Medical Center in Fort Oglethorpe, Georgia. Notice of the date, time and place of the Appellate Review shall be mailed to the Practitioner not less than thirty (30) calendar days before the Appellate Review hearing.
- B. There shall be at least three (3) or majority (whichever is larger) of the members of the Appellate Review Committee present at the Appellate Review. No member may vote a proxy.
- C. Postponement of the Appellate Review shall be granted only for good cause shown and in the sole discretion of the Appellate Review Committee.
- D. Prior to the Appellate Review, upon written request, the affected Practitioner shall be given a copy of the Medical Executive Committee's record, Hearing Committee

record and, if applicable, Board of Director's record to the extent that those records relate to the consideration of Practitioner's matter.

- E. The affected Practitioner and the Hearing Committee or the Board of Directors (whichever is appropriate) shall be entitled to submit written memoranda concerning any matters raised during the Hearing provided they are submitted at least three (3) calendar days prior to the Appellate Review (unless a later date is approved by the Appellate Review Committee). The memoranda shall become a part of the Appellate Review record. The party who prepared the memoranda shall submit it to the President, who will then forward the memoranda to the Appellate Review Committee and the other party participating in the Appellate Review.
- F. The Appellate Review shall be in the nature of an Appellate Hearing based upon the record of the Hearing before the Hearing Committee, provided that the Appellate Review Committee may accept additional oral or written evidence, subject to a foundation showing that such evidence could not have been made available to the Hearing Committee in the exercised of reasonable diligence and subject to rights of cross examination. If there is new material introduced at the Appellate Review which was not considered during the Hearing before the Hearing Committee, then the party against whom the new material was entered shall be given a reasonable time to investigate the material presented and respond thereto. At the Appellate Review, each party shall have the right to present oral argument, whether or not the parties submitted written memoranda pursuant to Paragraph E of this Section. If there is new evidence to be introduced against the Practitioner, the Practitioner shall be furnished with the name of any witness expected to testify concerning the new evidence not less than thirty (30) calendar days before the Appellate Review Hearing. Furthermore, if new evidence is introduced at the Appellate Review Hearing, then each party shall have five (5) calendar days after the hearing is closed or such other additional time as shall be set by the Hearing Committee within which to file a written memorandum concerning the new evidence.
- G. The Appellate Review Committee shall act as an Appellate Body. It shall review the record of the Hearing, the memoranda, if any, submitted to it pursuant to Paragraph E of this Section 9, and any new matters presented to it pursuant to Paragraph F of this Section 9 and shall consider all oral arguments for the purpose of determining whether it should recommend that the Board of Directors affirm, modify or reverse the recommendation which is being appealed.
- H. The affected Practitioner shall be entitled to be accompanied by and/or represented at the Appellate Review by a member of the Professional Staff in good standing and/or by a member of his local professional society and/or by an attorney.

- I. The body whose decision or recommendation prompted the Hearing shall appoint one of its members or some other representative (including an attorney if it so elects) to attend the Appellate Review and present written memoranda and/or oral argument in support of its position and otherwise represent that body's interest at the Appellate Review proceedings.
- J. At the request of the Practitioner, the Appellate Review Committee, the Chairman of the Appellate Review Committee or the Board of Directors, the President or his designee may appoint a Hearing Officer to preside at the Appellate Review. The Hearing Officer shall be an attorney at law qualified to preside over quasi-judicial Hearings. The Hearing Officer must not act as a prosecuting officer or as an advocate for the Medical Center, the Board of Directors, the Professional Staff, the body whose action prompted the Appellate Review, or the Practitioner. If requested by the Appellate Review Committee, the Hearing Officer may participate in deliberations of such body and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. A person shall not be disqualified to serve as Hearing Officer for an Appellate Review Committee because the person acted as a Hearing Officer for the Hearing Committee on the same manner.
- K. Either a Hearing Officer, if one is appointed, or the Chairman of the Appellate Review Committee shall preside over the Appellate Review to determine the order of procedure during the Appellate Review to assure that all participants have a reasonable opportunity to present relevant oral argument, written memoranda, to maintain decorum and to otherwise sit and preside over procedural matters relating to the Appellate Review. The Hearing Officer can advise the Appellate Review Committee on procedural matters, and the Hearing Officer can elicit information from any of the participants in order to aid the Appellate Review Committee in making a recommendation. However, the Hearing Officer shall not be entitled to vote.
- L. An accurate record of the Appellate Review shall be kept. The mechanism shall be established by the Appellate Review Committee and may be accomplished by the use of a Court Reporter, electronic recording unit, detailed transcription, the taking of adequate minutes, or any combination thereof. No record, except of the decision and the reasons for the decision of the Appellate Review Committee shall be kept during the deliberation phase of the Appellate Review, which deliberations may be conducted in private session if the Hearing Committee so elects. The practitioner shall be entitled to copies of the record upon payment of a reasonable charge associated with the preparation thereof.
- M. If new matter is introduced at the Appellate Review which was not considered at the Hearing, the Appellate Review need to be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which reasonable persons customarily rely upon in the conduct of serious affairs shall be considered, regardless of the

existence of any common law or statutory rule that might make evidence inadmissible over objection in a civil or criminal action.

- N. If new matter is introduced at the Appellate Review, the Practitioner and the body which made the adverse recommendation or decision which is the subject of the hearing shall have the following rights: to call and examine witnesses, to cross examine witnesses, to introduce documents and other written matter, and to rebut any evidence.

If the Practitioner does not testify in the Practitioner's own behalf, then the Practitioner may be called and examined by the Appellate Review Committee or any participants at the Appellate Review.

- O. The Appellate Review Committee may, without special note, recess the Appellate Review and reconvene the same for the convenience of the participants or for the purpose of obtaining additional evidence of consultation. Such recess shall be in the sole discretion of the Appellate Review Committee. Upon the conclusion of the presentation of oral and written evidence, the Appellate Review shall be closed. The Appellate Review Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the affected Practitioner.
- P. If the Appellate Review Committee is composed of less than the entire Board of Directors, then within five (5) calendar days after the close of the Appellate Review Hearing and the time for filing written memoranda has expired, the Appellate Review Committee shall make a written report and recommendation and shall forward the same together with the Appellate Review record and all other relevant documentation confirmation, modification, or rejection of the previous recommendation or decision. A copy of the Appellate Review Committee report shall be delivered to the affected Practitioner.
- Q. (1) If the entire Board of Directors comprises the Appellate Review Committee, then within thirty (30) calendar days after the close of the Appellate Review, the Board of Directors shall meet and make a final decision regarding the affected Practitioner. The Board of Directors shall forward its final decision in writing to the President. The President shall forward a copy of the Board of Directors final decision to the affected Practitioner. If the Board of Directors final decision is adverse to the Practitioner, the written final decision shall include in concise language the reason(s) for the adverse final decision.
- (2) If the Appellate Review Committee is composed of less than the entire Board of Directors, then within thirty (30) calendar days after receiving the Appellate Review Committee report and recommendation and the Appellate Review record, the Board of Directors shall meet and make a final decision regarding the affected Practitioner. The Board of Directors shall forward its final decision in writing to the President. The President shall forward a copy of the Board of Directors final decision to the affected Practitioner. If the Board of Directors final decision is

adverse to the Practitioner, the written final decision shall include in concise language the reason(s) for the adverse final decision.

- R. Notwithstanding any provision to the contrary herein, the Board of Directors, and any members of the Board of Directors, whether sitting as Appellate Review Committee or otherwise, shall have the right to the advice of any attorney at all times whether or not a Hearing Officer has been appointed.

ARTICLE IX: OFFICERS

Section 1. Officers of the Professional Staff

- A. In order to most efficiently carry out the purposes of this organization outlined in Article II of these Bylaws, the Professional Staff shall select officers and delegate to these officers' specific responsibilities and functions.
- B. The officers of the Professional Staff shall be:
 - (1) Chief of Staff
 - (2) Vice Chief of Staff (Chief of Staff Elect)
 - (3) Immediate Past Chief of Staff

Section 2. Qualifications of Officers

Officers must be members of the active Professional Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status or notice of sanction from a government agency shall immediately create a vacancy in the office involved.

Section 3. Election of Officers

- A. A Nominating Committee shall offer one or more nominees for each office, with the exception of the Immediate Past Chief of Staff and Chief of Staff. Nominations may also be made by Professional Staff members. These nominations must be received in the Professional Staff Office no later than October 1.

All nominations shall be made in accordance with Article IX, Section 2 of these Bylaws.

- B. The proposed slate of officers will be mailed with the notice of the November Professional Staff meeting.
- C. Officers shall be elected at the November meeting of the Professional Staff. Only members of the active and senior Professional Staff shall be eligible to vote. Officers shall be elected by simple majority vote of the active and senior members presents at the election meeting, subject to the approval of the Board of Directors. When there are three or more candidates for one office and no candidate receives a majority vote, successive balloting shall be held in such a manner that the name of the candidate receiving the fewest vote is omitted from each slate until a majority vote is obtained by one candidate.

The Chief of Staff and the Immediate Past Chief of Staff shall not require election to office, but must meet the qualifications outlined in Section 2 of this Article.

Section 4. Term of Office

The officers shall serve for two (2) years or until a successor is elected. Officers shall take office from the first day of the calendar year following the election.

Section 5. Vacancies in Office

A vacancy in the office shall occur whenever there is a loss of Professional Staff membership, a change from active or senior staff, or by reason of death or resignation. Vacancies in office during the Professional Staff year, except for the Chief of Staff, shall be appointed by the Medical Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall automatically serve out the remaining term; thereby creating a vacancy in the office of Vice Chief of Staff.

Section 6. Removal of Officers

The Medical Executive Committee has the duty and responsibility to monitor performance of officers and committee chairman. The conditions for removal of an elected officer shall include failure to abide by the Bylaws of the Professional, failure to discharge the duties of the office, misconduct or conviction of a felony. Removal of an elected officer during his term may be initiated by a two-thirds majority vote from the Medical Executive Committee. Removal of an elected officer during his term may also be initiated by a two-thirds majority vote from the active and senior Professional Staff members present at the Professional Staff meeting. All such removals shall be effective only after it has been ratified by the Board of Directors.

Section 7. Duties of Officers

- A. **Chief of Staff:** The Chief of Staff shall serve as the chief administrative officer of the Professional Staff to:
- (1) call, preside at, and be responsible for the agenda of all general meetings of the Professional Staff;
 - (2) serve as Chairman of the Medical Executive Committee;
 - (3) act in coordination and cooperating with the Administration and the Board of Directors in all matters of mutual concern within the Medical Center.
 - (4) Serve as ex officio member of all other Professional Staff committees without vote;
 - (5) Be responsible for the enforcement of Professional Staff Bylaws, Rules and Regulations; for implementation of sanctions where these are indicated; and for the Professional Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner; and

- (6) Appoint medical directors of those areas of specialized care which are not filled by contractual arrangements between the Medical Center and Professional Staff members, and the appointments shall be in accordance with the requirements of the Joint Commission on the Accreditation of Healthcare Organizations.

The Chief of Staff or his designee from among members of the Medical Executive Committee shall:

- (1) appoint committee chairman to standing and special Professional Staff committees.
- (2) Represent the views, policies, needs and grievances of the Professional Staff to the President or to the Medical Executive Committee or to the Board of Directors and participate in deliberations affecting the discharge of Professional Staff responsibilities;
- (3) Be the spokesman for the Professional Staff in its external professional and public relations;
- (4) Serve on the following committees of the Board of Directors: (a) Medical Executive Committee, (b) Finance Committee, (c) Planning Committee, and (d) Personnel Committee.

B. Vice Chief of Staff:

In the absence of the Chief of Staff, he shall assume all the duties and have the authority of the Chief of Staff. He shall be a member of the Medical Executive Committee, the Nominating Committee, and the Bylaws Committee and shall serve as Chairman of the Credentials Committee.

The Vice Chief of Staff shall automatically succeed to the office of the Chief of Staff in the event of a vacancy in that office; thereby, creating a vacancy in the office of the Vice Chief of Staff.

- C. Immediate Past Chief of Staff:** The duties of the Immediate Past Chief of Staff are advisory in nature. He shall be a member of the Medical Executive Committee, and shall serve as Chairman of the Nominating/Bylaws Committee.

ARTICLE X: CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments

There shall be four (4) Departments of the Professional Staff. Each Department shall be organized as a division of the Professional Staff and shall have as its head a Chairman elected by the Professional Staff and endorsed by the Board of Directors. The Chairman of each Department shall be responsible to the Chief of the Professional Staff for the functioning of his Department and shall have general supervision over the clinical work falling within his Department. The members of each Department shall be responsible to the Chairman of the Department and through them the Chief of the Professional Staff.

- A. Medicine: to include Family Practice, Internal Medicine, and its various subspecialties and Radiology.
- B. Surgery: to include divisions of General Surgery, Anesthesia, Dentistry and Oral/Maxillofacial Surgery, Podiatry, surgical subspecialties and Pathology.
- C. Maternal/Child Health: to include Gynecology, Obstetrics, Neonatology, Perinatology, GYN Oncology and Pediatrics.
- D. Emergency Medicine: to include Emergency Medicine and Lafayette Urgent Care Center.

Section 2. Assignment to Departments

Each Professional Staff member shall be assigned to one Department by the Medical Executive Committee upon recommendation of the Credentials Committee, and may be granted clinical privileges in one or more other Departments in the same manner.

Section 3. Future Departments

When deemed appropriate, the Medical Executive Committee may create a new Department, eliminate, subdivide or combine Departments subject to the approval of the Board of Directors.

Section 4. Function of Departments

Each Department shall function under the Medical Executive Committee.

- A. Each Department shall be responsible for the continual surveillance of the Professional performance of all individuals who have delineated clinical privileges and shall engage in quality of care peer review activities that include review of medical records of patients and other pertinent sources of medical data relating to patient care. This review shall include a multidisciplinary approach to quality

assessment and risk management review activities, but not limited to, the use of blood products and surgical case review. This function shall be carried out as directed by the Department Chairman through the appointment of Department members to an initial peer review body. The Medical Executive Committee will be informed of all matters relating to actions, activities, or problems regarding medical and patient care and recommendations will be presented on items needing further investigation or corrective action. Consideration of findings and actions taken from the ongoing monitoring and evaluation of the quality and appropriateness of the resultant conclusions and recommendations will be kept in the form of departmental minutes. Results of the quality review activities will be forwarded to the Credentials Committee as part of the reappointment process.

- B. Each Department will establish forms and guidelines for the granting of clinical privileges within the Department, as needed.
- C. Each Department will conduct or participate in, and make recommendations regarding the need for continuing educational programs. These Programs will relate to the type and nature of care offered by the Medical Center, the findings of performance improvement activities, and the expressed educational needs of individuals with clinical privileges.
- D. Each Department will submit written reports or minutes of committee meetings to the Medical Executive Committee on a regularly scheduled basis concerning: (1) findings of the Professional Staff's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Medical Center; and (3) such other matters as may be requested by the Medical Executive Committee.

Section 5. Qualifications, Election and Tenure of Department Chairman

- A. Each Department Chairman shall be a member of the Active staff qualified by training, experience and demonstrated ability of the position. Chairman shall be Board Certified or determined to be comparably competent.
- B. Each Department Chairman shall be elected by a majority vote of all Active and Senior Professional Staff members present at the November meeting for a two-year term, subject to the approval by the Board of Directors.

Section 6. Removal of Department Chairman

- A. Removal of a Department Chairman during his term of office may be initiated by a majority vote of all active and senior members of the Department, but no such removal shall be effective unless it has been ratified by the Medical Executive Committee and by the Board of Directors.

Section 7. Functions of Department Chairman

Each Department Chairman shall:

- A. Be responsible to the Chief of Staff for the functioning of the Department and shall have general supervision over the clinically related work falling within the Department.
- B. Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the Medical Center and making specific recommendations and suggestions regarding the Department in order to assure quality patient care;
- C. Appoint department members to represent the department in initial peer review activities.
- D. Be responsible for enforcement of the Hutcheson Medical Center, Inc. Bylaws and of the Professional Staff Bylaws, Rules and Regulations within the Department.
- E. Be responsible for implementation within the Department of actions taken by the Medical Executive Committee.
- F. Transmit to the Credentials Committee the Department's recommendations concerning the staff classification, the reappointment, the provisional advancement, and the delineation of clinical privileges for all practitioners in the Department.
- G. Assist in the preparation of such annual reports pertaining to the Department, including budgetary planning, as may be required by the Medical Executive Committee, the Medical Center President or the Board of Directors. Recommends space and other resources needed by the department or service.
- H. Be responsible for the establishment of the Department's privilege delineations, criteria, consistent with the policies of the Professional Staff and of the Board of Directors, for the granting of privileges in the Department.
- I. Oversee continuing surveillance of the professional performance of all individuals who have delineated clinical privileges within the Department and to provide a recommendation at the time of provisional advancement or reappointment for individuals within the Department.
- J. Be responsible for coordinating orientation and continuing medical education programs at the departmental staff meetings which relate to the type and nature of care offered by the Medical Center, the findings of performance improvement activities, and the expressed educational needs of individuals with clinical privileges.
- K. Assessing and recommending to the Board of Directors off-site services needed patient care, treatment and services not provided by the Department or the Organization.
- L. Be responsible for the integration of the department or service into the primary functions of the organization and the coordination and integration of interdepartmental and intradepartmental services.
- M. Be responsible for the development and implementation of policies and procedures that guide and support the provision of care, treatment and service.
- N. Provide recommendations for a sufficient number of qualified and competent persons to provide care, treatment and service.

- O. Determine the qualifications and competence of department or service personnel who are not LIP's and who provide patient care, treatment and services.
- P. Maintains quality control programs, as appropriate.

ARTICLE XI: COMMITTEES

Section 1. Designation

The Committees described in this Article shall be the standing committees of the Professional Staff. Special or ad hoc committees may be created by the Medical Executive Committee or by a Professional Staff Department to perform specified tasks. Unless otherwise specified, the Chairman of all committees shall be appointed by the Chief of Staff and committee members shall be appointed by the Committee Chairman. All active members of the Professional Staff are eligible for membership on each committee, regarding his/her specialty. Unless otherwise specified, hospital employee members of all Professional Staff committees shall be appointed by the President in consultation with the Chief of Staff.

Section 2. Term of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of two (2) Professional Staff years and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns.

Section 3. Medical Executive Committee

- A. Authority: The organized Professional Staff delegates authority to the Medical Executive Committee to carry out medical staff responsibilities. The Medical Staff Executive Committee carries out its work within the context of the hospital functions of governance, leadership and performance improvement. The Medical Staff Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement for the professional services provided by LIP's and other practitioners privileges through the medical staff process.
- B. Composition: The Medical Executive Committee shall be a standing committee and shall consist of all elected members of the Professional Staff, the Chief of Staff and the Immediate Past Chief of Staff. The Chief of Staff shall serve as Chairman of the Medical Executive Committee. The President, or his designee, shall be an ex officio member without vote and shall meet with the committee at all times.
- C. Duties: The duties of the Medical Executive Committee shall be:
- (1) To represent and to act on behalf of the Professional Staff, subject to such limitations as may be imposed by these Bylaws.
 - (2) To coordinate the activities and general policies of the various Departments;
 - (3) To receive and act upon Departmental, ad hoc and committee recommendations;
 - (4) To implement policies of the Professional Staff not otherwise the responsibility of the Departments;

- (5) To provide liaison between the Professional Staff and the President and the Board of Directors;
 - (6) To recommend action to the President on matters of a medical-administrative nature;
 - (7) To make recommendations on Medical Center management matters and Professional Staff recommendations to the Board of Directors through the Chief of Staff, as Chairman of the Medical Executive Committee or his designee;
 - (8) To fulfill the Professional Staff's accountability to the Board of Directors for the quality of medical care rendered to patients in the Medical Center;
 - (9) To provide input and participation in the Performance Improvement process of the Medical Center;
 - (10) To ensure that the Professional Staff is kept abreast of the accreditation programs and informed of the accreditation status of the Medical Center;
 - (11) To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or to a suitable agent;
 - (12) To review the credentials of all applicants and to make recommendations for Professional Staff structure, membership, assignments to Departments and delineation of clinical privileges.
 - (13) To review periodically all information available regarding the performance and clinical competence of Professional Staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for Reappointments and renewal of changes in clinical privileges;
 - (14) To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Professional Staff, including the initiation of and/or participation in Professional Staff corrective or review measures when warranted;
 - (15) To report at each general staff meeting;
 - (16) To report back to the Departments in a timely manner all actions taken;
- D. Medical Center Professional Staff members shall have the express privilege of presenting complaints, criticism or suggestions to the Medical Executive Committee. This must be presented in writing, but the member shall appear in person. The Medical Executive Committee shall take negative or affirmative action on such requests within 40 days of the presentation to the Committee.
- E. Meetings: The Medical Executive Committee shall meet at least once a month, maintain a permanent record of its proceedings and actions, and shall make a written report thereof to the Board of Directors. Attendance is expected, but not required. In addition, the Medical Executive Committee has the authority to act on behalf of the Professional Staff between scheduled meetings.

Section 4. Standing Committees of the Medical Executive Committee

A. Credentials Committee:

- (1) Composition: The Credentials Committee shall be a standing committee of the Medical Executive Committee and shall consist of a membership of not less than three (3) practitioners and the Vice Chief of Staff, who shall serve as the Chairman. The members of the Credentials Committee shall be appointed by the Chief of Staff.
- (2) Duties: The duties of the Credentials Committee shall be:
 - (a) to review the credentials of all applicants for Professional Staff membership and to make recommendations to the Medical Executive Committee concerning staff appointments, assignments to Departments and delineation of clinical privileges;
 - (b) to review periodically all information available regarding the performance and clinical competence of Professional Staff members and other practitioners with clinical privileges, and, as a result of such reviews to make recommendations to the Medical Executive Committee concerning Reappointments and renewal of, or changes in, clinical privileges.
 - (c) To make recommendations to the Medical Executive Committee concerning measures to ensure professional, ethical conduct and competent clinical performance on the part of all members of the Professional Staff in accordance with the Professional Staff Bylaws.
- (3) Meetings: The Credentials Committee shall meet monthly or as needed and shall make a permanent record of its proceedings and recommendations, and shall make a written report thereof to the Medical Executive Committee. The Medical Executive Committee may act in lieu of the Credentials Committee at the request of the Credentials Committee Chair.

B. Pharmacy and Therapeutics Committee:

- (1) Composition: The Pharmacy and Therapeutics Committee shall consist of two members of the Professional Staff, one of who shall serve as Chairman. Other members include the Director of Pharmacy, one representative from Nursing Service, Management and Administrative Services. Other advisory members as needed may be appointed by the Committee Chairman.
- (2) Duties: The Pharmacy and Therapeutics Committee shall:
 - (a) be responsible for the development and surveillance of all drug utilization policies and practices within the Medical Center in order to assure optimum clinical results and minimum potential for hazard;
 - (b) assist in the formulation of broad professional policies regarding the evaluation, use, safety procedures and all other matters relating to drugs in the Medical Center;

- (c) serve as an advisory group to the Medical Center Professional Staff and the pharmacist on matters pertaining to the choice of available drugs;
 - (d) make recommendations concerning drugs to be stocked on the nursing units and by other services;
 - (e) develop, maintain and periodically review a formulary or drug list for use in the Medical Center;
 - (f) receive and deliver information concerning the use and control of investigational drugs or procedures from the Investigational Review Board;
 - (g) define and review all significant untoward drug reactions; and
 - (h) provide for quarterly drug usage evaluation based upon a systematic process including the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use.
- (3) Meetings: The Pharmacy and Therapeutics Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings in the form of written minutes. The minutes shall reflect the conclusions, recommendations, actions and evaluations of the actions taken. Written reports shall be submitted quarterly to the respective Professional Staff Departments and the Medical Executive Committee. The results of drug usage evaluation will be utilized in the reappointment and reappraisal process.

C. **Infection Control Committee:**

- (1) Composition: The Committee shall be a multidisciplinary committee chaired by a member of the Professional Staff with interest and expertise in infectious disease. Other Professional Staff members include a representative from each Department and a Pathologist. Membership shall also consist of the Infection Control Nurse, a representative from Management and Administrative Services, a representative from Nursing Service, departmental representatives from Environmental/Linen Services, Plant Engineering, Operating Room Services, Employee Health, Performance Improvement/Risk Management, Central Services, Pharmacy and Dietetics. Other advisory members as needed may be appointed by the Committee Chairman.
- (2) Duties: The Infection Control Committee shall:
- (a) over the Medical Center's infection control program for surveillance, prevention, and control of infection;
 - (b) the Infection Control Committee shall approve actions to prevent or control infection, based on evaluation and surveillance reports of infections and of infection potential among patients and hospital personnel;
 - (c) develop and implement a preventative and corrective program designed to minimize infection hazards and improvement of the

- quality care rendered in the Medical Center, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
- (d) Assist in the development and approval of written policies and procedures defining special indications for isolation requirements and written policies and procedures describing the role and scope of participation of each Medical Center Department, including employee health, in infection prevention and control activities;
 - (e) Review designated microbiological reports;
 - (f) Provide consultation regarding the purchase of all equipment and supplies used for sterilization, disinfection, and decontamination purposes, including cleaning procedures, agents, and schedules of use throughout the Medical Center;
 - (g) Provide recommendations, feedback and act upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, Departments and other committees; and
 - (h) Provide for the overall supervision of all phases of the infection control practices within the Medical Center and possess the authority to institute any surveillance, prevention, control measures or studies when there is reason to believe that any patient or personnel may be in danger.
- (3) Meetings: the Infection Control Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings in the form of written minutes. The minutes shall reflect the conclusions, recommendations, actions and evaluation of the actions taken. Written reports shall be submitted quarterly to the Medical Executive Committee and to the respective Professional Staff Departments.

Section 5. Standing Committees of the Department of Medicine

A. Parkside Committee:

- (1) Composition: The Committee shall be chaired by the Medical Director of the multidisciplinary committee consisting of the Medical Director and other members of the Professional Staff that utilize the facility, as well as the Administrator, the Director of Nursing, a representative from Management and Administrative Services, Dietary Services, Pharmacy, Physical Therapy, and Social Services. Other advisory members, as needed, may be appointed by the Committee Chairman.
- (2) Duties: The Parkside Committee shall:
 - (a) Be responsible for the monitoring of the patient care provided within its confines and to provide for the improvement of the care when opportunities for this improvement are identified.

- (b) Be available for consultation in evaluating the staffing needs of the facility as well as consultation in meeting the psychosocial, medical and physical needs of its patients.
- (3) Meetings: The Committee shall meet at least semi-annually, more often if required, and shall provide a written report to the Department of Medicine and the Medical Executive Committee on a semi-annual basis. The committee shall maintain a written record of its proceedings in the form of minutes which shall reflect the conclusions, recommendations, actions and evaluation of the actions taken. The results of the performance improvement monitoring of this committee shall be utilized in the reappointment and reappraisal process.

ARTICLE XII: GENERAL PROFESSIONAL STAFF MEETINGS

Section 1. Regular Meetings

- A. Staff meetings shall be held to receive and review reports, evaluate the work done in the Departments and the performance of the required Professional Staff functions.
- B. The staff meeting occurring in the month of November shall be the annual staff meetings at which any election of officers for the ensuing period shall be conducted.
- C. The Medical Executive Committee shall, by standing resolution, designate the time and place for all general staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the staff in the same manner as provided in Section 2 of this Article XII for notice of a special meeting.

Section 2. Special Meetings

- A. The Chief of Staff, the Medical Executive Committee, or not less than one-fourth (1/4) of the members of the Active Professional Staff, may at any time file a written request with the Chief of Staff that within 14 days of the filing of such request, a special meeting of the Professional Staff be called. The Chief of Staff shall designate the time and place of any such special meeting.
- B. Written or printed notice stating the place, day and hour of any special meeting of the Professional Staff shall be delivered, either personally or by mail, to each member of the Active Staff not less than five (5) calendar days before the date of such meeting, by or at the direction of the Chief of Staff (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States mail addressed to each staff member at his address as it appears on the records of the Medical Center. Notice may also be sent to members of other Professional Staff groups who have so requested. The attendance of a member of the Professional Staff shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice of the called meeting.

Section 3. Quorum

Passage of an amendment or addition to the Bylaws, Rules and Regulations shall require a simple majority vote of those present and voting.

Section 4. Attendance Requirements

- A. Attendance at Professional Staff Department and General Staff meetings is encouraged, however, not required. Consequently, attendance will not be tracked and utilized at the time of reappraisal to determine a physician's reappointment or staff category.
- B. Special appearance requirements: At the sole discretion of the Medical Executive Committee or Board of Directors, any person involved in the treatment of a case under review or involved in a special investigation may be required to attend a meeting to discuss this issue, provided that the individual was given reasonable advance notice. Failure on the part of a Professional Staff member to comply with this special appearance requirement, will, after two (2) notices, is deemed a resignation from the Professional Staff.

Section 5. Agenda

- A. The agenda at any regularly Professional Staff meeting shall include:
 - (1) Call to Order
 - (2) Review of Minutes of the Previous Meeting
 - (3) Old Business
 - (4) Professional Staff Announcements
 - (5) Administrative/Board of Directors Report and Announcement
 - (6) Medical Executive Committee Report
 - (7) Miscellaneous
 - (8) Program, if applicable
 - (9) Adjournment
- B. The agenda at special meetings shall be:
 - (1) Reading of the Notice Calling the Meeting
 - (2) Transaction of only the business for which the meeting was called
 - (3) Adjournment

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Meetings

Departmental meetings shall be held as needed. The Department shall, by standing resolution, designate the time and place for all general departmental meetings. Notice of the original resolution and any changes thereto, shall be given to each member of the Department in the same manner as provided in Section 2 of Article XII for notice of a special meeting.

Section 2. Special Meetings

A special meeting of any committee or Department may be called by or at the request of the Chairman thereof, by the Chief of Staff, or by one-third of the group's then members, but not less than two (2).

Section 3. Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting, or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee or Department not less than five (5) calendar days before the time of such meeting, but the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States mail addressed to the member at his address as it appears in the records of the Medical Center. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum at Department and Committee Meetings

Unless otherwise specified in these Bylaws, Rules and Regulation, the definition of a quorum shall be established by each Department and Committee.

Section 5. Manner of Action

The action of a majority of the members present at a meeting shall be the action of a committee or Department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken), signed by each member entitled to vote thereat.

Section 6. Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and they shall not have voting privileges.

Section 7. Minutes

Minutes of each regular and special meeting of a committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer. Each committee and Department shall maintain a permanent file of the minutes of each meeting.

Section 8. Attendance Requirements

Attendance at Professional Staff Department meetings is encouraged but not required.

ARTICLE XIV: CONFIDENTIALITY AND IMMUNITY FROM LIABILITY

Section 1. Confidentiality of Information

Information with respect to any Practitioner submitted, collected or prepared by any Representative of his or her or any other healthcare facility or organization or Professional Staff for the purpose of credentialing or recredentialing, achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of the like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Medical Center records.

Section 2. Immunity From Liability

- A. No representative of the Medical Center or Professional Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a Representative, if such Representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.
- B. No Representative of the Medical Center or Professional Staff and no third party shall be liable to a Practitioner for damages or other relief by reason for providing information, including otherwise privileged or confidential information, to a Representative of the Medical Center or Professional Staff or to any other healthcare facility or organization of health professionals concerning a Practitioner or affiliate who is or has been an Applicant to or Professional Staff Member or who did or does exercise Clinical Privileges or provide specified services at Medical Center provided that such Representative or third party acts in good faith and without malice.
- C. No Representative of the Medical Center or Professional Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a member of a medical review committee or professional peer review body.

Section 3. Activities and Information Covered

- A. **Application of Confidentiality and Immunity:**
Confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in

connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- (1) Applications for appointment, clinical privileges, or specified services;
- (2) Periodic reappraisals for reappointment, clinical privileges, or specified services;
- (3) Corrective Action;
- (4) Hearings and appellate reviews;
- (5) Patient care audits;
- (6) Utilization reviews; and
- (7) Other Medical Center, Department, service or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

B. Relation of Information to Practitioner:

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgement, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

Section 4. Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, indemnification, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

Section 5. Initial Appointment

In addition to all of the consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws with respect to applications for initial appointments to the Professional Staff of Medical Center, appointments to the Professional Staff of Medical Center, all privileges and immunities provided by this Article XIV shall be applicable to all proceedings which relate to applications for initial appointment.

ARTICLE XV: ONGOING PROFESSIONAL PRACTICE EVALUATION

Ongoing evaluation information is factored into the decision to maintain an existing privilege, to revise an existing privilege, or to revoke an existing privilege prior to or at the time of renewal. Information resulting from this evaluation is used to determine whether to continue, limit, or revoke an existing privilege.

Practitioner-specific evaluation reports shall be completed by the Department Chair or his/her designee every six months for Active staff members.

ARTICLE XVI: PHYSICIAN HEALTH PROGRAM

Hutcheson Medical Center, Inc. (“HMC”) in participation with its medical staff provides a Physician Health Program (the “Program”) to its Professional Staff members. The purpose of the Program is to educate management and the medical staff about licensed independent practitioner health, address prevention of physical, psychiatric, or emotional illness, and to facilitate confidential diagnosis, treatment and rehabilitation of medical staff members who suffer from a potential impairment. The goal of this program is assistance and rehabilitation, and to aid licensed independent practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients.

Section 1. Education: HMC will sponsor an annual educational program regarding illness and impairment issues. Physicians will be educated concerning the signs and symptoms generally consistent with impairment (as that term is defined below).

All practitioners will be issued written information regarding illness and impairment issues at the time of their initial appointment and reappointment to the medical staff. The information will include descriptions and symptoms of the impaired healthcare provider and methods to facilitate management of the affected healthcare provider.

Section 2. Prevention of Physical, Psychiatric or Emotional Illness: HMC offers to licensed independent practitioners on an annual basis training and assistance in recognizing health issues, such as smoking hazards, preventing domestic violence and utilizing stress management techniques. HMC will also offer other training and educational programs to attempt to prevent physical, psychiatric or emotional illnesses.

Section 3. Facilitating Confidential Diagnosis, Treatment and Rehabilitation:

Referral to the Physician Health Committee:

Licensed independent practitioners may voluntarily participate in the Program. To do so, they should contact the Physician Health Committee or the Chief of Staff. HMC employees who have a reasonable belief that a practitioner is impaired (as that term is defined below) should report that belief to the Chief Executive Officer, Chief of Staff or respective Department Chairman who will refer the matter to the Physician Health Committee. Methods to facilitate communications by family members, friends or others regarding potentially impaired physician will also be established and reduced to a report which is then submitted to the Physician Health Committee.

The report referred to the Physician Health Committee will be kept confidential and the identity of the practitioner not disclosed except when communication and/or disclosure is required by state and/or federal law or applicable ethical obligation or when maintaining confidentiality would threaten the safety of a patient or patients.

All reports regarding the potential impairment of a licensed independent practitioner will be thoroughly investigated and evaluated by the Committee for validity.

Physician Health Committee Structure:

The Physician Health Committee (“Committee”) will consist of an appropriate active medical staff member, an addictionist and/or a psychiatrist, a high-risk representative (anesthesiology, surgery, ER), and when possible, a physician with personal recovery experience. Members of this committee (except the physician with personal recovery experience who shall volunteer for and be approved by the Medical Executive Committee) will be nominated and approved by a majority vote of the Medical Executive Committee and shall serve a two (2) year term. If a report involves an allegedly impaired physician that is related to, or in practice with, a committee member, that committee member will remove himself from any discussion, recommendation or action concerning the affected practitioner. The Medical Executive Committee will select an alternate member until a resolution has been determined in regard to that practitioner.

The following shall not serve on the Physician Health Committee: any hospital board member, the chief of staff, any Medical Executive Committee member, any department chair, the chair of the credentials committee, any senior management member, any nurse or legal counsel.

Section 4. Definition: Impairment shall refer to a practitioner’s inability to practice his or her profession with reasonable skill by reason of physical or mental illness or disability, including alcohol and/or drug abuse or dependence.

Section 5. Report and Investigation: If an individual with a reasonable suspicion that a practitioner is impaired reports that suspicion to any employee of HMC, the following steps should be taken:

An oral or, preferably, a written report shall be given immediately to the Chief Executive Officer, Chief of Staff or respective Department Chairman. The report shall include a description of the incident(s) that led to the belief that the practitioner may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment, but must state the facts leading to the suspicions. This report

should then be forwarded to the Physician Health Committee for investigation.

If, after the investigation, the Physician Health Committee finds sufficient evidence exists that the practitioner may be impaired, the Committee shall make certain written recommendations and forward them to the Medical Executive Committee for corrective actions.

The recommendations from the committee should include whether the practitioner should be referred for alcohol and drug evaluation and/or undergo physical and/or mental examination or evaluation.

The practitioner, though, shall have the option, once a recommendation is made by the Committee for referral to the appropriate Medical Staff Committee, to apply for a leave of absence for not more than thirteen (13) months as permitted under the Medical Staff Bylaws.

At any time, if based on the allegations in the report and other information available to the Chief Executive Officer or Chief of Staff, he/she reasonably believes that patient or staff health or safety is jeopardized, immediate and summary suspension regarding the practitioner's privileges may be initiated consistent with the medical staff bylaws.

Section 5. Rehabilitation: If the Medical Staff Committee responsible for corrective action finds that practitioner requires alcohol, drug or other counseling or treatment, the Physician Health Committee will assist the practitioner in locating a suitable substance abuse or other program.

If physician fails to complete required action plan, including but not limited to a rehabilitation program, summary suspension may be initiated.

ARTICLE XVII – Temporary Disaster Privileges

The CEO, or his designee(s), may grant disaster privileges to any Licensed Independent Practitioner's (LIP) not currently appointed to the Medical Staff once the emergency management plan has been activated and it has been determined that Hutcheson Medical Center is unable to meet immediate patient needs.

Such privileges shall be granted on a case by case basis for a period of time to be determined by the disaster situation and shall automatically terminate once the disaster situation has ended, or immediately upon authority of the CEO, or his/her designee(s).

Volunteers considered eligible to act as LIP's at Hutcheson Medical Center must present a valid government-issued photo identification (ID) issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current hospital picture ID card that clearly identifies professional designation.
- A current license to practice.
- Picture ID indicating that the individual is a member of a (DMAT) Disaster Medical Assistance Team, MRC (Medical Reserve Corps), or ESAR-BHP (Emergency System for Advance Registration of Volunteer Health Professionals), or other recognized state or federal organizations or groups.
- Picture ID 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 state, federal, or municipal entity).
- Identification by current hospital or medical staff member(s) who possess knowledge regarding the Volunteer's ability to act as a licensed independent practitioner during a disaster.

1. Each LIP granted disaster privileges shall be required to have a valid picture ID on their person at all times when working in Hutcheson Medical Center.
2. Primary source verification of licensure shall begin as soon as the immediate situation is under control and shall be completed within 72 hours from the time the volunteer practitioner presents to Hutcheson Medical Center. In extraordinary circumstances, i.e. no means of communication or lack of resources, the Medical Staff Coordinator will provide documentation as to why the primary source verification could not be performed and shall complete said verification as soon as the barrier(s) to doing so no longer exist. This process shall be the same as described in these Bylaws.
3. Members of the Medical Staff shall oversee the professional practice of volunteer licensed LIP's through direct observation, mentoring, and medical record review.

4. The CEO and/or his/her designee shall decide within 72 hours (based on information obtained regarding the professional practice of the volunteer LIP) whether or not to continue the disaster responsibilities initially assigned.

ARTICLE XVIII: RULES AND REGULATIONS

The Professional Staff 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 Board of Directors. These shall relate to the proper conduct of Professional Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Medical Center. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting without previous notice or at any special meeting on notice, as provided in these Bylaws. Such action will require a simple majority vote of those present of the Active Professional Staff.

ARTICLE XIX: AMENDMENTS

These Bylaws shall be reviewed as needed. They may be amended at any meeting of the Professional Staff provided that all Active Professional Staff members shall be notified in writing at least two (2) weeks prior to any regular meeting. The proposed changes shall be stated in writing and sent along with the notice.

Adoption shall follow the voting requirements provided in Article XII, Section 3, of these Bylaws. Amendments so made shall be effective when approved by the Board of Directors.

ARTICLE XX: ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Professional Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Board of Directors.

ADOPTED by the Professional Staff:

Radian Florea, M.D.
Chief of Staff

Steve Perlaky, M.D.
Vice Chief of Staff

Daniel Heithold, M.D.
Chairman, Bylaws Committee

APPROVED BY THE BOARD OF DIRECTORS:

Vince Viscomi, M.D.
Secretary, Board of Directors

PROFESSIONAL STAFF RULES AND REGULATIONS

ADMISSION AND DISCHARGE OF PATIENTS

1. The hospital shall accept patients for care and treatment suffering from all types of diseases for which it has facilities to treat.
2. A patient may be admitted to the Medical Center only by a member of the Medical Staff. All Practitioners shall be governed by the official admitting policy of the Medical Center.
3. *Timeliness of Seeing Patients:* All patients admitted to the general floor will be seen by the attending physician, or his designee, not later than 24 hours following admission and at least once every calendar day thereafter during the remainder of the patient's hospitalization.
4. Admission to the ICU/CCU Units: All patients admitted to a critical care unit (ICU/CCU) must be seen within twelve (12) hours by the attending physician, or his designee.
5. Each patient's general medical condition is the responsibility of a qualified physician member of the Professional Staff. Each member of the Professional Staff shall be responsible for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
6. Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
7. In any emergency in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.
8. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Medical Center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
9. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend to him. Where no such selection is made, a member of the Active Staff on duty in the service will be assigned to the patient, on a rotation basis, where possible. The chairman of each service shall provide a schedule for such assignments.
10. Areas of restricted bed utilization shall be as follows:
 - Coronary Care Unit; Intensive Care Unit; Obstetrical Unit; Progressive Care Unit; and Skilled Care Unit.
 - Bed utilization in the above units will be in accordance with the policies and procedures of the individual units.

11. Patients presenting for psychiatric care will receive a Medical Screening Exam (MSE) to establish whether the patient meets criteria for further evaluation by a trained counselor or transfer for inpatient care to an appropriate psychiatric facility outside of Hutcheson Medical Center.
 - a. All patients presenting with acute psychiatric symptoms, suicidal attempts or suicidal risk will be evaluated prior to any discharge or transfer from the Emergency Department.
 - b. All patients identified as having an acute psychiatric condition or suicidal risk that are awaiting transfer for an appropriate psychiatric facility will be re-evaluated by a provider of Emergency care every shift. This encounter should be documented on a designated document.
 - c. When a patient's care is transferred to another provider, a Transfer of Care notation must be made on the designated document.
12. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the Medical Center against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's record.
13. It shall be the responsibility of the attending practitioner to discharge his patients as early as possible on the morning of the discharge.
14. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff.
15. All members of the Medical Staff are encouraged to secure meaningful autopsies. An autopsy may be performed only with a written, signed consent or in accordance with state law. All autopsies shall be performed by the Medical Center pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the record within 90 days.
16. Verbal/telephone orders should be used only in situations where immediate written or electronic communication is not feasible and the patient's condition is determined to warrant immediate action for the benefit of the patient. The following personnel will be authorized to accept verbal orders; registered nurses, licensed practical nurses, certified or registered respiratory therapists, registered physical therapists, licensed or registered physical therapist's assistants, licensed social workers, Radiology Technologists, Licensed Registered Technologists and licensed or registered pharmacists. Verbal physician orders must be authenticated by the physician or other authorized practitioner, or by a physician or other authorized practitioner taking responsibility for the order, within 48 hours. If the individual receiving the order immediately repeats the order to the prescribing physician or other authorized practitioner and verifies the order is correct, the order must be authenticated within 30 days. The individual receiving the order shall document with stamp or otherwise, that the order was "repeated and verified".

EMERGENCY DEPARTMENT RULES AND REGULATIONS

1. **SCOPE OF SERVICE:**

The Emergency Department functions as the continually accessible point of entry into the Emergency Medical Services system in the Dade, Walker and Catoosa County areas.

The Emergency Department serves patients in all major age and disability groups, representing all specific populations and all disease entities whom come to, or are brought to the Emergency Department. There are no observation beds within the Emergency Department. The Emergency Department offers emergency care twenty-four hours a day with a minimum of one physician experienced in emergency care on duty in the emergency care areas and with two physicians on duty during the peak hours in the Department. Specialty consultation is available within thirty minutes according to established schedules, which designate the specialty professional staff member's on-call through a call roster. The Emergency Department functions as the continually accessible point of entry into the Trauma Emergency care system for the most critically injured patients who, after initial resuscitation and definitive treatment are, as indicated, transferred to an appropriate facility.

The Medical Center contracts with a career oriented emergency physician's organization to provide emergency medical care treatment. The practitioners within the organization are members of Hutcheson Medical Center's Professional Staff.

The Emergency Department physician/physician's assistant on duty is responsible for the degree of evaluation and treatment provided to any patient who presents himself or is brought to the emergency care area. In addition, the physician provides on-line medical direction for pre-hospital care in Region I.

An Emergency Department physician will respond to acute, life-threatening emergencies ("code blue/code gray") and provide initial stabilization until the admitting physician (or physician on-call) can arrive and assume care of the patient. As with other emergency consultations, a 30 minute response time is expected.

It is important to note that Emergency Department patients are the ED Physician's primary responsibility and in the event of simultaneous emergencies in the hospital and in the ED, this rule will govern the ED Physician's response. All will be done by the ED Physician in the interim to provide both patients with stabilizing treatment but the patient already admitted to the hospital is the primary responsibility of the admitting physician.

The ED Physician may, at his discretion, provide non-emergency consultations for admitted patients so long as the Emergency Department patients are appropriately managed. This is not a required function of the ED Physician and should not

interfere with the appropriate care and appropriate flow of treatment for the emergency patients. Non-emergency consultations should not delay appropriate medical screening examinations for actual emergency patients. During times where only one emergency physician is available in the ED, non-emergency consultations are strongly discouraged.

There may be times when, based on reports from nursing to admitting medical staff, a patient appears to be deteriorating. Should the medical staff want a brief consultation to determine if an emergency medical condition exists on his admitted patient, it is reasonable that the ED Physician provide an additional opinion and begin emergency treatment if an emergency is identified. At that time, a report to the admitting physician (of the physician on call) should be made requesting that he take over care of that patient. This may or may not involve coming to the hospital, depending on the needs of that patient at that time. Prolonged evaluation and treatment of an inpatient by the ED Physician is not appropriate but a consultation to screen for a medical emergency is very reasonable.

A. DEPARTMENT SPECIFIC:

1. Major Treatment Area:

- a. Purpose: The major treatment area consists of dedicated stretchers which are staffed and supplied to receive and provide care to patients on a twenty-four hour a day basis.
- b. Admission criteria: During single physician coverage hours, all patients are placed in this area. During double physician coverage hours, patients are triaged according to the severity of their illness or injury into this area of the minor treatment area.

2. Minor Treatment Area:

- a. Purpose: The minor treatment area is a unit with a well-equipped ENT room. This area is equipped and supplied to care for patients with less severe acuity, twelve hours a day.
- b. Admission criteria: Patients are admitted to this area by the triaged nurse under written triage guidelines approved by the Emergency Department Committee.

B. PRACTITIONER RESPONSIBILITY:

1. It shall be the responsibility of the Emergency Department physicians to continually provide twenty-four hour daily medical coverage in the Emergency Department. All Emergency Department physicians shall be members of the Professional Staff with privileges in Emergency Medicine.

2. Any private practitioner with privileges at the Medical Center may treat his own patients in the Emergency Department. If the private practitioner chooses to treat his patients in the Emergency Department, he assumes the complete responsibility for the patient and for properly executing the physician's portion of the Emergency Department Record form.
3. Patients with life threatening situations will be treated by the Emergency Department physician in the manner, which he feels most appropriate and beneficial to the patients. The classification listed below is of secondary importance:
 - a. ATTACHED: Patients with a private practitioner will be treated by the Emergency Department physician under the guidelines established by the Private Preference Sheet. Should the patient's private practitioner not have privileges at Hutcheson Medical Center and the patient needs to be admitted, the patient will be offered the opportunity of selecting a practitioner with privileges at this Medical Center. If the patient has no preference, then the practitioner on the Call Roster for that day will be assigned to the patient. If the patient prefers to be managed by his own physician who is not a member of this Medical Center's professional staff, he will be transferred to a facility where his practitioner has medical staff privileges. The transfer of this patient will conform to the rules governing transfer of patients from one facility to another.
 - b. Admission criteria: If the patient has no private practitioner and no preference for a particular practitioner, the Emergency Department physician will manage as indicated and use the appropriate Call Roster for referral or admission.
4. Follow-up care to Emergency Department treatment will be designated to give quality continuous medical care as determined by the treating practitioner. The Emergency Department physician will comply with the patient's wishes regarding follow-up medical treatment. The Emergency Department physician will return the patient to his private practitioner as soon as practical for follow-up care.
5. The emergency medical record shall contain the following:
 - a. Patient identification. When not obtainable, the reason shall be entered in the medical record.
 - b. Time and means of arrival.
 - c. Pertinent history of illness or injury and physical findings, including the patient's vital signs.
 - d. Diagnostic and therapeutic orders.
 - e. Clinical observations, including results of treatment.
 - f. Reports of procedures, test and results.
 - g. Diagnostic impression.

- h. Conclusion at the termination of the evaluation/treatment including final disposition, patient's condition of discharge or transfer, and any instructions given to the patient and/or family for follow-up care.
- i. If applicable, emergency care given to the patient prior to arrival.
- j. If applicable, the patient's leaving against medical advice.

The Medical Record shall be authenticated by the practitioner who is responsible for its clinical accuracy.

- 6. Surgical procedures performed in the Emergency Department shall be limited to those requiring only IV conscious sedation, local or regional anesthesia.
- 7. When a patient presents to the Emergency Department due to a drug overdose because he/she has attempted suicide, a psychiatric consult will be obtained. In addition, psychiatric consultation will be obtained on all other patients presenting as attempted suicides. Appropriate documentation will be entered on the patient's medical record.
 - a. The Emergency Department will provide a medical screening examination (MSE) within the capability of the Emergency Department to determine if an emergency medical condition exists. (See the Emergency Department policy and procedure pertaining to the medical screening examination (MSE).

The Medical Center will provide within the staff and facilities available for such further medical examination and treatment as may be required to stabilize the patient.

Transfer of a patient from the Emergency Department will be implemented when the receiving facility and the accepting physician have agreed to accept the patient, and the patient is deemed sufficiently stabilized for transport, or in the unstable patient, it is determined that the patient can no longer benefit from services at Hutcheson Medical Center and that it is medically necessary in the patient's best interest to be transported to a higher level of care as an integral part of stabilization of the patient's condition.

Patients presenting to the Emergency Department with acute psychiatric symptoms will be evaluated prior to discharge from the Emergency Department.

GENERAL CONDUCT OF CARE

- 1. A general consent form, signed by or on behalf of every patient admitted to the Medical Center, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Medical Center.
- 2. The practitioner's orders must be written clearly, legibly and completely.
- 3. All previous orders are canceled when patients go to surgery.
- 4. All drugs and medications administered to patients shall be those listed in the latest edition of the American Hospital Formulary Service. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance

with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration.

5. Any qualified practitioner with clinical privileges in this Medical Center can be called for consultation within his area of expertise.
6. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultation.

MEDICAL RECORDS RULES AND REGULATIONS

1. The attending practitioner shall be responsible for the initial preparation and the continuing maintenance of the patient's medical record.
2. The attending practitioner shall not withdraw from a case until an order has been entered on the patient's medical record transferring the patient to the service of another qualified member of the Medical Staff who has agreed to accept the patient and the transfer. All documentation required prior to transfer is the responsibility of the initial attending practitioner. Subsequent to the date of transfer, the second practitioner shall document on the medical record acceptance of the transfer and shall be responsible for the continuing maintenance and completion of the patient's medical record.
3. The history and physical shall be recorded in the medical record before beginning a procedure, or within 24 hours of the patient's admission to the Hospital, except in life threatening emergencies. The history and physical shall consist of chief complaint, present illness, relevant past history, social and family history, inventory of body systems, physical examination including impression and the course of action planned.

If a complete physical examination that has been performed within 30 days prior to admission, a durable, legible copy of this report may be used in the patient's hospital medical record, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission. The legible copy must be resigned, dated and timed to evidence current information.

4. The history and physical shall be dictated or written within 5 days prior to the patient's admission to Parkside or not exceeding 48 hours after admission.
5. The complete INPATIENT medical record shall consist of:
 - (a) Inpatient face sheet/Consent for treatment;
 - (b) Complete history and physical;
 - (c) Physician orders and Progress notes;
 - (d) Nursing notes;
 - (e) Ancillary reports;
 - (f) When applicable, consultation reports, operative reports, consent for treatment, pathology reports and autopsy reports.
 - (g) Discharge summary;
 - (h) Other items as required by the Executive Committee;
 - (i) All appropriate signatures.
6. a progress note shall be entered on the medical record of Hospital patients every 24 hours by a practitioner. Parkside at Hutcheson Nursing Home extended care patients shall have progress note entered on the medical record weekly. Progress notes of nursing home residents will be entered monthly.

7. Inpatient Respite Care is short-term patient care provided in either the acute inpatient or nursing home setting to a hospice patient only when necessary to relieve the family members or other persons caring for the individual. Respite care is provided for up to five (5) consecutive days at a time. The attending practitioner will visit the patient upon admission to write admission and discharge orders. Additional visits by the practitioner will be made only if required by changes in the patient's condition. A short form history and physical or the Hospice Assessment Form will be acceptable means of documenting the patient's history and physical.
8. No operation shall be performed until the history and physical examination has been recorded or a summary entered on the progress notes including pertinent history, except in an emergency that is certified in writing by the attending surgeon. An "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in imminent danger and any delay in administering treatment would add to that danger.
9. The discharge summary should be dictated or written within 15 days of the patient's discharge from the Medical Center. Discharge summaries are not required on patient charts for stays less than 48 hours.
10. The discharge summary should consist of a brief review of the history and physical findings and other significant diagnostic findings; treatment; response to treatment and course in the Medical Center; condition at the time of discharge from the Medical Center; final disposition; final diagnosis, prognosis and discharge instructions including diet, activity medication, and follow-up given to the patient or responsible person.
11. Operative reports shall be dictated, or written immediately after surgery. If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then an operative progress note will be entered in the medical record immediately after surgery. Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care, for example, the post-anesthesia care unit".
12. Consultation reports shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient and consultant's opinion and recommendations. When operative procedures are involved, the consultation report shall be recorded prior to the operation, except in emergency situations so verified by the record.
13. The obstetrical record shall include a current history and physical or a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital prior to the patient's admission. However, an interval admission note shall be entered on the patient's medical record and the note shall include pertinent additions to the history and any

subsequent changes in the physical findings. The legible copy must be resigned and dated to evidence current information.

14. The Medical Record shall include documentation regarding the use of restraints. A physician's verbal or written time limited order is obtained for each use of restraint and there is documentation within the medical record that the needs of the patient are attended.
15. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
16. Abbreviations and symbols may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations shall be kept on the file in the Medical Record Department.
17. The final diagnosis shall be recorded in full, without the use of abbreviations or symbols, dated and signed by the attending practitioner at the time of discharge.
18. A practitioner's routine or standing orders when applicable to a given patient, shall be affixed to the patient's medical record and properly dated and signed. Verbal physician orders must be authenticated by the physician or other authorized practitioner, or by a physician or other authorized practitioner taking responsibility for the order within 48 hours. If the individual receiving the order immediately repeats the order to the prescribing physician or other authorized practitioner and verifies the order is correct, the order must be authenticated within 30 days. The individual receiving the order shall document with stamp or otherwise, that the order was "repeated and verified".
19. A medical record shall not be permanently filed until it is completed by the attending practitioner or is ordered filed by the Medical Records Committee.
20. All medical records are the property of the Medical Center and may be removed from the Medical Center's jurisdiction and safekeeping only in compliance with a court order, subpoena or statute. In addition, medical records may not be removed from the Medical Center President. Unauthorized removal of medical records from the Medical Center shall be grounds for suspension of the practitioner for a period of time to be determined by the Executive Committee.
21. In case of readmission of a patient to the Medical Center, all previous medical records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another practitioner. No chart will be reopened once the patient is discharged, regardless of diagnosis or time frame.
22. Written consent of the patient shall be required for release of medical information to persons not otherwise authorized to receive this information.

23. Free access to all medical records of all patients shall be afforded to members of the Professional 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 the records can be studied. Subject to the discretion of the Medical Center President, form members of the Professional 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 Medical Center.
24. The failure to complete a patient's medical record within 30 days of the patient's discharge from the Medical Center shall result in a temporary suspension of the practitioner's admitting and operating privileges, except for patients already scheduled for admission or surgery, as provided under Article VII, Section 3, Subsection H of the Bylaws of the Professional Staff. The Medical Records Department shall notify the practitioner of this temporary suspension by mail approximately 15 days prior to the suspension. There will be no further notification when the actual suspension is enforced. The Medical Records Department shall additionally furnish notice of this action to the admitting office, the operating room, the emergency room, the Medical Staff Office, and the Medical Center President or his designee. When a practitioner has had his admitting privileges temporarily suspended for failure to complete his medical records, he shall still be required to admit service admissions coming in through the Emergency Department. Practitioners with suspended admitting privileges due to failure to complete patient's medical records shall not be permitted to admit his patients to another practitioner on the Professional Staff.
25. Should a practitioner demonstrate habitual problems with timely completion of medical records, he will be required to appear before the Medical Record Committee. At that time, there will be opportunity for both the practitioner and the Medical Records Department to work out, if necessary, special arrangements to assist the practitioner. This meeting is intended to find helpful ways to assist the practitioner and there is no punitive implication. However, if the practitioner shows an unwillingness to help resolve an apparent problem, the Medical Records Committee is required to report the matter to the Executive Committee.
26. The Executive Committee will consider termination of staff privileges of staff members suspended for an excess of 50 incomplete charts and/or for staff members on continuous suspension count will be provided to the Executive Committee on a monthly basis.

MATERNAL/CHILD HEALTH RULES AND REGULATIONS

I. SCOPE OF SERVICE:

Hutcheson Medical Center defines the Maternal/Child Health areas as follows: The Labor & Delivery Unit, the Obstetrical/Gynecological Unit, the Newborn and Level II Nurseries and the Pediatric Unit.

II. UNIT SPECIFIC RULES AND REGULATIONS:

A. LABOR & DELIVERY UNIT:

1. Purpose: The Labor & Delivery Unit primarily serves childbearing women.

2. Admission Criteria:

- a. Patients admitted to this unit include those in labor, newly delivered, or experiencing complications of pregnancy.
- b. The prenatal record or history should be available at the time of admission on every patient admitted to the labor room. The record should include:
 - (1) Pre-natal history will not substitute for history and physical.
 - (2) Pertinent history, such as of previous labor and delivery, known allergies, and/or any medical problems or procedures which might be pertinent;
 - (3) Assessment of the course of the current pregnancy, and plans for management;
 - (4) The blood type, Rh factor and antibody screen, Rubella titer and results from the hepatitis B screening;
- c. Patients with known infectious illnesses in labor will be cared for in a separate labor and/or delivery room using Body Substance Isolation and clean-up techniques as determined by the Infection Control Committee.

3. Practitioner Responsibilities:

- a. Standing or printed orders should be verified by the attending practitioner immediately upon admission of the patient and signed upon his arrival. These orders may include laboratory testing, treatments, medications, intravenous fluids, fetal monitoring modalities, and other specific care guidelines.
- b. The attending practitioner or a qualified member of the obstetrical team under the practitioner's direction shall be responsible for:
 - (1) Initial stabilization of the newborn, including resuscitation as necessary.
 - (2) Infant thermoregulation.

(3) Initial physical examination of the infant, noting any anomalies.

- c. In the event radiological examinations are necessary, these shall be performed under the guidelines prescribed by the radiologist as to radiation protection and safety.

4. Consultation:

Cases involving serious problems of diagnosis or choice treatment;

- a. Cases involving significant complications lying outside the field of obstetrics; and/or
 b. Cases involving an illness, treatment or procedure exceeding the privileges of the attending practitioner.

5. General Rules and Regulations:

- a. All stillborn fetuses greater than 20 weeks gestation will receive a full body x-ray following delivery if an autopsy is not performed. Parental consent is not required. Additionally, placental from stillbirth deliveries should be sent to Pathology.
 b. In accordance with hospital policy, patients with gestation of less than 30 weeks will be transferred to a Level III Nursery facility for delivery.
 c. Visitors in the department will be allowed as defined in hospital policy and as deemed appropriate per the attending practitioner.

6. Discharge Procedure:

- a. Dismissed patients will receive discharge instructions, both written and verbal prior to release.
 b. If the patient's condition warrants a higher level of care, the patient will be transferred to the tertiary facility or ICU as appropriate.

B. OBSTETRICAL/GYNECOLOGY UNIT:

1. **Purpose:** The patients admitted to this unit are a mixture of postpartum, gynecological and if necessary, clean med/surg patients.

2. **Admission Criteria:**

- a. Patients admitted to this unit require care following delivery of a newborn or related to complications of pregnancy. Patients undergoing treatment or surgery for gynecological problems are also admitted to this area.
 b. Infections and potential infections should be identified and managed appropriately, in accordance with the Body Substances or Respiratory Isolation guidelines.

3. Practitioner Responsibilities:

- a. Standing or printed orders should be verified by the attending practitioner immediately upon admission of the patient, and signed upon his arrival. These orders may include: ancillary department testing, treatment, intravenous fluids, frequency of vital signs, medications and diet and activity.

4. Consultations:

- a. The Consultant's duties include reviewing the medical record, obtaining any necessary additional history, and examining the patient; and recording on the chart his/her findings and recommendations and his/her signature before recommended treatment is initiated.
- b. In an emergency situation requiring immediate treatment, a brief verbal consultation may be obtained before initiating treatment, and in this event, the consultant's opinion should be placed on the record within 24 hours.

5. GENERAL RULES AND REGULATIONS: Visitors in the department will be allowed as defined in hospital policy.**6. Discharge Procedures:**

- a. Disposition of patients is individualized based on patient needs at discharge.
 - (1) Patients will receive discharge instructions, both written and verbal prior to release.
 - (2) Any patient follow-up after discharge is managed through our discharge planning committee/Social Services.

C. NEWBORN NURSERY:**1. Purpose: The Newborn Nursery is a unit provided solely for the care of:**

- a. Normal full-term or pre-term neonates who have demonstrated successful adaptation to extrauterine life.
- b. Neonates requiring phototherapy.
- c. Convalescing neonates who have received Level II Nursery care.

2. Admission Criteria:

- a. Normal full-term or pre-term neonates who weigh more than 2000 grams at birth and have demonstrated successful adaptation to extrauterine life. Neonates, regardless of gestational age, who weigh less than 2000 grams will be admitted to the Level II Nursery.

- b. Neonates born outside the Labor and Delivery area but are placed in an isolette until proven not to be infected.
- c. Neonates returning from a referral hospital may be readmitted provided that both the referring physician and the physician who is assuming the care are in agreement that in their judgment the neonate is not infectious.

3. Practitioner Responsibilities:

- a. Standing or printed orders should be verified by the attending practitioner upon admission of the neonate, and signed upon his arrival.
- b. The attending practitioner must do an admission physical assessment within 24 hours of admission to the Nursery.
- c. A discharge assessment is required prior to discharge of the neonate.

4. Consultation: Any appropriate consultation may be made based on the needs of the neonate at the request of the attending practitioner.

5. General Rules and Regulations:

- a. All neonates will have a physical assessment and gestational assessment on admission. The physical assessment will be repeated every shift thereafter and/or prn if condition warrants.
- b. Registered Nurse and Licensed Practical Nurses may perform the following procedures without physician's orders:
 - (1) CPR;
 - (2) Gavage feeding;
 - (3) Suction;
 - (4) Chemstip (according to protocol);
 - (5) Placing neonate in radiant warmer or closed isolette;
 - (6) Culture suspicious drainage as outlined in Infection Control policies.
- c. BSI will be followed. Gloves will be worn at all times when in contact with neonate until after admission bath is given.
- d. Any ancillary personnel who must have contact with neonate are required to remove all hand jewelry, scrub hands and don a cover gown prior to contact.
- e. Standard Care Statements are used and individualized by use of appropriate protocol.
- f. Rooming-in of neonate with mother is allowed provided:
 - (1) Condition of mother and baby permits;
 - (2) Parental instructions received.
- g. No children are allowed to visit in the Newborn Nursery.

- h. In the event a neonate is to be adopted, all inquiries and decisions will be made by Social Services.
 - i. Referral to Social Services is made for neonates who are born to a single mother under the age of eighteen (18) and/or when there is question about a potential family in crisis that could compromise the care of neonate after discharge.
 - j. For the protection of all neonates, coded security locks are provided for all entrances to the Nursery. Only authorized personnel and physicians will have access to the codes.
6. **Transfer Procedure:** In the event the condition of a neonate deteriorates the attending practitioner will initiate transfer to the Level II Nursery.
7. **Discharge Procedure:**
- a. Discharge planning is initiated on admission.
 - b. Discharge instructions are consistent with the individual discharge plan and criteria. Instructions are given verbally and in detailed written form. The mother is given a copy of the instructions and the original remains on the chart.
 - c. Specific discharge criteria must be met prior to discharge.

D. LEVEL II NURSERY:

1. **Purpose:** The Level II Nursery is a unit receiving neonates requiring specialized care on a concentrated and continuous basis. An isolation room for a neonate with specific communicable disease is available.
2. **Admission Criteria:**
- a. Admission beyond six (6) neonates will be considered at the discretion of the attending neonatologist.
 - b. The Admitting Office will not consider the Level II Nursery for admission. Admission will be at the sole discretion of the neonatologist.
 - c. The neonatologist admitting a neonate to the Level II Nursery makes arrangements for the admission of the neonate with the Clinician on call and Charge Nurse to assure the availability of a bed, to inform the nurse of the status of the neonate, and to notify of any special equipment or supplies necessary for the neonate's care and anticipated treatment.
 - d. The following categories of neonates may qualify, but are not mandatory for admission to the Level II Nursery:
 - (1) Neonates requiring stabilization prior to transfer to a Level III facility;

- (2) Pre-term neonates of 2000 grams or less;
- (3) Neonates with oxygen requirements;
- (4) Neonates needing nutritional support including IV therapy;
- (5) Neonates requiring IV treatment of hypoglycemia;
- (6) Neonates receiving antibiotics for suspected sepsis;
- (7) Neonates requiring diagnoses and therapy for neonatal seizures;
- (8) Neonates requiring IV fluid and electrolyte therapy;
- (9) Convalescing neonates who have received tertiary care;
- (10) Neonates who are physiologically unstable or who are potentially seriously ill and require cardio-respiratory monitoring and close observation.

3. **Criteria for Transfer:** Neonates in need of more specialized neonatal care may be transferred to a Level III facility. The decision to transfer is made by the neonatologist or referring physician/clinician.

The following guidelines are examples of patients who may require transfer:

- (a) Neonates requiring prolonged mechanical ventilation;
- (b) Neonates of less than 30 weeks gestational age;
- (c) Neonates with congenital malformation requiring surgical care of evaluation by other pediatric subspecialists;
- (d) Cardiac intervention

4. **Consultations:** Consultations may be obtained in cases involving any problems or diagnosis requiring sub-specialty consideration.

5. **General Policies:**

- a. All neonates will be placed on cardiac monitoring equipment upon admission to the unit.
- b. As much as is possible, all care will be programmed to occur at the same time in order not to tire the neonates.
- c. The R.N. (or Neonatal Clinician) will start IV fluids in the unit. Cathlon or angiocath will be used at the discretion of the nurse, or on the practitioner and/or clinician's order. The Level II nurse may administer blood or direct IV medication as ordered by the practitioner.
- d. Absolutely no medications are given without a Neonatologist's or practitioner's order, except emergency protocol.
- e. Vital signs are carried out as ordered by the practitioner and additionally at the discretion of the nurse.

6. **Discharge Criteria:** The Level II Nursery neonate must be:

- a. Nippling all feedings well, or breastfeeding well;
- b. Exhibiting minimal or resolving jaundice;

- c. Maintaining temperature will in open crib;
- d. Voiding and stooling;
- e. No longer benefiting from expertise of Level II care;
- f. Circumcision if requested should be done and without bleeding;
- g. Neonatal metabolic screen completed and hearing screening;
- h. Discharge order written;
- i. Any consults for home care must be requested.

Discharge planning begins early and detailed preparation for home care must be given well in advance of estimated day of discharge.

D. **PEDIATRIC UNIT:**

1. **Purpose:** The Pediatric Unit is a unit with admission limited to those patients between the ages of birth and eighteen (18) years.
2. **Admission Criteria:** General admission criteria are those patients with a diagnosis of (but not limited to):
 - a. Respiratory disorders;
 - b. Sepsis;
 - c. General surgery;
 - d. Trauma.

In periods of low Pediatric census, adults may be admitted to the Pediatric Unit as overflow, providing beds are available for Pediatric admissions (minimum of two rooms), and adult nursing care is available.

3. **Practitioner Responsibilities:**

- a. Standing or printed orders should be verified by the attending practitioner immediately upon admission of the patient and signed upon his arrival. Admission orders are to include laboratory, radiological procedures, patient's diet and activities, IV fluids and medications and vital signs.

4. **Consultation:**

- a. A pediatric consultation will be considered on request of the attending practitioner or parent/family request.
- b. Other appropriate consultations will be made, based on the patient's condition and diagnosis, and at the request of the attending practitioner.

5. **General Rules and Regulations:**

- a. Parents are strongly encouraged to stay with their child. All patients under seven (7) years of age must have an adult with them at all times.

- b. Transmissible infections will be isolated according to Pediatric Unit policy, until laboratory findings demonstrate no hazard.
- c. In the event of an emergency, the Medical Director of Pediatrics may direct therapy.
- d. A clear understanding of diagnosis and treatment plan will be provided for the patient and/or parent responsibility party.

DEPARTMENT OF SURGERY RULES AND REGULATIONS

1. **SCOPE OF SERVICE:**

The Operating Room Services areas are those units organized to provide care to patients undergoing surgical interventions requiring special resources such as anesthesia services, limited equipment, special personnel skills, or unique supplies or gastro-intestinal laboratory procedures. Care may be provided for the patient for the peri-operative phases of care that includes immediate pre-procedural preparation, intra-procedural care, and the immediate post-procedural recovery period of patients accessing the hospital as either inpatients or outpatients. In addition, the areas include the Same Day Surgery unit which provides pre-testing, pre-procedural preparation, and post-procedural care for the patient until approved discharge criteria and practitioner order allow patient dismissal.

Central Sterile is also contained under Operating Room Service and is defined as the central hospital area for the decontamination, reprocessing, and sterilization of reusable hospital supplies and decontamination and immediate preventative maintenance checks for certain designated types of reusable equipment.

Hutcheson Medical Center defines the Operating Room Service areas as follows: the Operating Room, the Recovery Room, the Gastro-intestinal Laboratory, the Same Day Surgery unit, and the Central Sterile area. All Department of Surgery Rules and Regulations apply to each of the above named areas.

II. **DEFINITIONS OF SURGICAL CASES:**

- A. **Elective** procedures are those cases for which a delay in surgery does not constitute a threat to the patient's health.
- B. **Semi-emergency or Urgent** procedures includes those cases for which surgical specialty practice standards recommend no greater delay in the commencement of surgical treatment than that of from 24 to 48 hours.
- C. **Emergency** surgery includes those cases for which any delay in surgery constitutes a threat to the patient's health and well being. The surgeon must be prepared to proceed immediately with the surgery at the time of posting.
- D. A surgical case can be upgraded in category at any time the surgeon deems such a move to be necessary; however, the upgrading of the case must be for the welfare of the patient and not for the convenience of the surgeon.

III. **UNIT SPECIFIC RULES AND REGULATIONS**

A. **Operating Room:**

- 1. **Purpose:** The Operating Room area consist of operating room suites and a central holding area all of which are staffed and supplied to receive and provide care to patients scheduled by their practitioner to undergo surgical

interventions requiring resources allocated to and commonly scheduled by the Operating Room.

2. **Admission Criteria:** Patients requiring the service of an anesthesiologist for surgical interventions or pain-control procedures other than those managed in the Maternal/Child Health Department or needing the special resources and supplies controlled by the operating room scheduling mechanism qualify for posting in the operating room. Any surgical intervention to be done under intravenous conscious sedation or local infiltration anesthesia may also be posted in the operating room; however, this is not required but is left to the judgement of the practitioner managing the patient's care.

B. Gastro-intestinal Laboratory:

1. **Purpose:** The Gastro-intestinal Laboratory is a unit staffed, equipped and supplied to care for the patient undergoing a gastro intestinal endoscopy procedure for diagnostic or therapeutic purposes.
2. **Admission Criteria:** Patients whose care requires the equipment, supplies, or special personnel skills commonly provided by the gastro-intestinal laboratory may be scheduled by their practitioner for endoscopy procedures in this area. Anesthetic services other than those of local infiltration anesthetics, intravenous conscious sedation, or intramuscular analgesics are not commonly available in this area and must be scheduled through the Operating Room and with the specific anesthesiologist if one is requested.

C. Recovery Room:

1. **Purpose:** Recovery room is a unit designed to provide care to post-anesthetic or post-procedural patients as determined by the anesthesiologist or practitioner providing their care.
2. **Admission Criteria:** All patients receiving a general anesthetic are automatically admitted to the recovery room. Those patients receiving other forms of anesthesia such as regional, intravenous conscious sedation or local infiltration anesthesia and undergoing a surgical intervention pain control procedure, or gastro-intestinal procedure may be admitted at their practitioner's request. Patients undergoing procedures in Radiology that are performed under anesthetics other than general inhalation anesthesia may be cared for in the recovery room post-procedural if adequate arrangements have been made in advance with and sufficient staff is available to meet all patient care needs adequately.

D. Same Day Surgery:

1. **Purpose:** The Same Day Surgery Unit is a unit designed to deliver pre-operative preparation and post-operative care for patients scheduled for undergo diagnostic or therapeutic procedures in the Operating Room or the Gastro-intestinal Laboratory of the hospital.
2. **Admission Criteria:** Patients are admitted to the Same Day Surgery Unit based on their practitioner's request communicated by the practitioner or his office to the Same Day Surgery unit. Requests are honored on a "first come, first serve" basis and are subject to bed availability and adequate staffing requirements. All efforts are made to accommodate admission requests.

IV. GENERAL RULES AND REGULATIONS**A. Practitioner Responsibilities:**

1. Practitioner's scheduling patients for surgical interventions in the Operating Room Services areas must be appropriately qualified and credentialed through the privilege delineation process of the Medical Staff to care for the patient's special needs or obtain a consult with the appropriate specialist(s) or subspecialist(s). Where procedure specific credentials are required, these must be granted through the Medical Staff mechanism for credential approval before the practitioner will be allowed to schedule these procedures in the Operating Room. Determination of procedures or special equipment requiring specific credentialing will be made by the Department of Surgery. The Department will then furnish a recommendation to the Credentials Committee of the Medical Staff regarding the mechanism for granting said privileges.
2. The attending practitioner and/or the practitioner designee, and the consulting practitioner have responsibility for coordinating the care of the patient.
3. All new surgical procedures to be performed in the operating room areas must be reviewed by the Chairman of the Department of Surgery. A new procedure is defined as one that has not been performed before on a routine basis and is recognized within the specialty as an advancement in patient care supported by technology and medical instrumentation. At the discretion of the Chairman of the Department of Surgery, an Ad Hoc Committee may be designated to review any new procedures and furnish a recommendation to the Department of Surgery for action. All special needs for equipment, supplies, and personnel resources must be considered by the Ad Hoc Committee members of the Operating Room management team.
4. Any practitioner requests for visitors to observe surgical procedures in the Operating Room or to attend patients in the Recovery Room must be

discussed with the Clinical Director of Operating Room Services, or in her absence, with the Head Nurse of the appropriate nursing unit in advance of the scheduled procedure. Requests to perform any function other than observe are subject to Professional Staff Rules and Regulation and are not permitted without approval from the Medical Staff office.

5. Coordinating and obtaining consultations are the responsibility of the individual practitioner.
6. The practitioner under whose name the surgical procedure is posted will be considered the primary practitioner. It will be the responsibility of this surgeon, or his designee, to physically identify the patient prior to the commencement of any surgical intervention.
7. In the event of two or more practitioner are to perform surgical interventions on the same patient, it is the responsibility of the posting practitioner to coordinate the care delivery with the operating room personnel. Clear communication must be furnished at the time of the surgical posting as to which practitioner/surgery will proceed first, second, etc. It is also the responsibility of the practitioner to arrange to be present and provide their specific portion of the patient's care as they have arranged with their fellow practitioners. Any changes in the schedule, up to and including a revision of the order of procedures, is the responsibility of the posting practitioner or his office to coordinate with the other involved practitioners.
8. The practitioner is responsible for initiating an order to obtain a surgical permit on the hospital approved from and in compliance with the current hospital administrative policy on informed consent. The surgical intervention to be performed should be specifically designated in the written order in the manner in which the practitioner wishes the procedure to be listed on any and all permits to be obtained by hospital personnel.
9. All practitioners entering the areas of Operating Room Services must fully comply with any dress code regulations appropriate to the area as well as any policies covering the consumption of food and beverages.
10. Practitioners needing pathology consultations for elective surgical procedures must furnish this information to the operating room scheduling personnel at the time of posting. The operating room will then assume the responsibility for conveying this request to the Pathology Department or the Clinical Laboratory for scheduling purposes.
11. All elective or urgent surgical cases will be posted in the posting book of the Operating Room. Scheduling will be done in such a manner as to maximize the utilization of personnel, equipment, and other limited

resources. Regulations governing scheduling mechanisms will be outlined in a separate section of these Rules and Regulations.

12. An anesthesiologist shall visit the patient prior to the surgical intervention and be familiar with their history, physical examination and laboratory data. A note on the pertinent findings will be recorded on the patient's chart prior to the operation.
13. Hutcheson Medical Center will provide nurses, surgical technicians and/or physician's assistants to be utilized by the surgeon as surgical assistants. If the practitioner prefers, he may arrange to bring another practitioner to function as first assistant; however, this individual must be a credentialed member of the Professional Staff of this hospital. Notification that another practitioner will be furnished is needed at the time of posting and all arrangements, financial and otherwise, are the responsibility of the primary practitioner.
14. All known requests for second assistants must be furnished at the time of posting by the practitioner or his office personnel.
15. Any practitioner requesting the services of anesthesia (including anesthesia equipment common to the operating room) must schedule and coordinate the patient's care with the Operating Room even if the care will occur in another area of the hospital. Determination of the surgical nursing care support to be provided to these patients will be made by the nursing management of the operating room in conjunction with the practitioners providing the care.
16. An adequate and fully completed anesthetic record on the approved hospital form must be signed by the practitioner who administers the anesthetic for every case. A specific anesthesia record is not required for local anesthesia, but the operative surgeon must then describe the local anesthetic in his operative report.
17. A postoperative diagnosis must be made following surgery and entered on every pathology requisition. If requested by the nursing staff, the practitioner must furnish data required to complete the pathology requisition up to and including pertinent clinical data.
18. Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. The pathologists shall make examination, as he may consider necessary to arrive at a tissue diagnosis. His authenticated report will be made a part of the patient's record. Exceptions to sending specimens removed during a surgical procedure to the laboratory will be made only when the quality of care has not been compromised by the exception, and

when another suitable means of verification of the removal has been routinely employed, and when there is a authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but are not necessarily limited to, the following:

- a. specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, portion of the rib removed to enhance operative exposure, and intra-uterine devices (I.U.D); drains, prostheses, and other inorganic materials;
 - b. therapeutic radioactive sources the removal of which shall be guided by radiation safety monitoring requirements;
 - c. foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
 - d. specimens known too rarely, if ever, show pathological change, such as the foreskin from the circumcision of a newborn infant;
 - e. placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and
 - f. teeth, provided the number, including fragments, is recorded in the medical record.
 - g. Non-suspicious skin, fat and bone removed for cosmetic reasons.
19. Practitioners are to follow the policies and procedures contained in the policy and procedure manual of each unit specific manual regarding regulations pertaining to the care of patients in Gastro-intestinal Laboratory or in the Same Day Surgery area.
20. Patient care in the Recovery Room is directed by the anesthesiologist, or his designee, administering the patient's anesthetic. If the anesthetic was a local infiltration, then the practitioner requesting admission of the patient to the recovery area is the responsible practitioner and will direct the patient's care.

A. General Policies:

1. The Admitting Office will not assign patients to any unit of the Operating Room Services patient care areas. Patients are scheduled by the practitioner or his office directly with the unit where admission is being requested.
2. No patients are maintained overnight in the Recovery Room.

3. Visitors are not allowed in the operating rooms proper. In special cases involving pediatric patients, a parent or guardian may accompany a child to the operating room for the purpose of easing the anesthetic induction for the patient. This is only done with approval of the anesthesiologist responsible for the patient's anesthetic management and only in instances where it is felt that the patient would benefit from the presence of the support figure. Once induction is completed, the parent or guardian will be required to exit the operating room and return to the appropriate waiting area.
4. No medications are given without a practitioner order except as approved as part of an emergency protocol.
5. Recovery Room visitation: Only the necessary personnel will be allowed in the Recovery Room. Visitors are not permitted access to the Recovery area except in unusual circumstances and then only with the approval of the surgeon and/or anesthesiologist in charge.

Visitors are defined as anyone employed by the hospital, not involved in an educational program contracted for experience with the hospital, not functioning in an educational role of product demonstration or inservicing, or not approved through the Medical Staff office for temporary credentials.

PROGRESSIVE CARE UNIT RULES AND REGULATIONS

I. UNIT SPECIFIC RULES AND REGULATIONS

1. **PURPOSE**: The Progressive Care Unit is established for patients requiring a specialized intermediate level of care on a concentrated and continuous basis. It is a multi-purpose unit serving patients who have need of cardiac monitoring or close observation, meeting PCU admission criteria.
2. **ADMISSION CRITERIA**: The following categories of patients may qualify but are not mandatory for admission to the Progressive Care Unit:
 - a. Patients meeting the admission criteria to the Intensive Care Unit or the Coronary Care Unit and who are stabilized sufficiently in the opinion of their physician to be admitted or transferred to the Progressive Care Unit.
 - b. Elective pacemaker implantation or revision of previously implanted pacemaker and follow up.
 - c. Cardiac arrhythmias.
 - d. Patients requiring specialized monitoring and care.
 - e. Syncope.
 - f. Patients being stabilized on anti-arrhythmic drugs.
 - g. Patients on Cardiac Rehabilitation.
 - h. Hemodialysis of non-critical patients.
 - i. Post-operative patients requiring cardiac monitoring and/or specialized care and observation.
 - j. Patients receiving chemotherapy.
3. **The Following Categories of Patients DO NOT Qualify for Admission to the Progressive Care Unit:**
 - a. Patients who meet the admission criteria for the Intensive Care or Coronary Care Units in the acute phase of their illness.
 - b. Critically ill patients who require intensive nursing observation and skills.
4. **The Following Categories of Patients Qualify for Transfer to the Progressive Care Unit:**
 - a. Patient hospitalized in the Critical Care areas who have recovered sufficiently from their illness or surgery to be transferred out of the Intensive Care or Coronary Care Unit, but who will still require a specialized level of care and/or monitoring.

- b. Patients hospitalized in the moderate care areas who develop problems requiring cardiac monitoring or other problems which would qualify for admission to the Progressive Care Unit, but who do not require intensive care.

II. **GENERAL RULES AND REGULATIONS:**

A. **PRACTITIONER RESPONSIBILITIES:**

1. The activities of the Progressive Care Unit shall be guided by the Special Care Unit Committee, under the auspices of the Executive Committee of the Medical Staff.
2. The physician directors for the Special Care Units shall also serve as the physician directors for the Progressive Care Unit.
3. The attending physician, his physician designee in his absence, and the consulting physician have complete responsibility for the care of the patient. In the event of an emergency, the physician director of the Progressive Care Unit may direct therapy until the attending physician can be contacted.

B. **ADMISSION PROCEDURE:**

1. There shall be a physician's order for admission to the Progressive Care Unit.
2. The RN in charge makes bed assignments after consultation with the Admitting Nurse or ER Registration Clerk.
3. The Progressive Care Unit is of questionable benefit to the following categories of patients:
 - (a) Patients who have been determined a "NO CODE" and for whom no new treatment is to be initiated.
 - (b) Patients in non-acute phase of a chronic or terminal illness.
 - (c) Patients presenting problems of physical control.

C. **DISCHARGE CRITERIA:**

1. All transfers from the Progressive Care Unit shall be initiated by the attending physician or consulting physician and shall be determined by the patient's condition, morbidity status, and rehabilitation potential.
2. In the event a bed or a telemetry unit is urgently needed, the attending physician, or consulting physician, of the patient deemed most stable by the nurse in charge, will be contacted and transfer requested. If the attending or consulting physician cannot be reached, the appropriate physician director shall have the authority to transfer a patient.

The criteria for discharge (dismissal) from the Progressive Care Unit shall be as follows:

- (1) Patients shall be discharge from the Progressive Care Unit only on written order of the attending physician.
- (2) Discharge criteria from the Progressive Care Unit shall include hemodynamic, respiratory and neurologic stability within normal limits for the patient with an absence of acute signs of infection or complications as seen in the opinion of the attending physician.

III. GENERAL POLICIES:

1. Patients will be placed on telemetry only with a physician's order.
2. Vital signs every four (4) hours; as ordered by the physician or as necessitated by patient's condition.
3. No medications are given without a physician's order except emergency protocol.
4. In the event of a cardiac/respiratory arrest or a life-threatening arrhythmia, the specially trained nurse may perform the following resuscitative measures until a physician arrives:
 - (a) External cardiac massage;
 - (b) Pulmonary ventilation;
 - (c) Cardioversion of ventricular tachycardia , or fibrillation by Precordial electric shock; and
 - (d) Administer emergency protocol drugs.

NOTE: Defibrillation is performed only by specially trained nurses who have been authorized to perform the procedure.

CRITICAL CARE UNITS RULES AND REGULATIONS

I. DEFINITIONS

A Special Care Unit is one that provides intensive care continuously on a 24 hour basis with a concentration of qualified professional staff and supportive resources, and with patient admission by need, rather than by diagnosis. The average nurse/patient ratio is 1:2.

Other than unit specific rules and regulations, all general rules and regulations apply to the critical care unit.

II. UNIT SPECIFIC RULES AND REGULATIONS

INTENSIVE CARE UNIT:

- 1. Purpose:** The Intensive Care Unit is a multipurpose unit receiving medical and surgical patients in whom intensive care would be beneficial.
- 2. Admission Criteria:** The following categories of patients may qualify, but are not mandatory for admission to the Intensive Care Unit:
 - a. Acute MI, confirmed or to rule out, to include myocardial contusion after chest trauma;
 - b. Angina, unstable;
 - c. Arrest Cardiac/Respiratory;
 - d. Cardiogenic Shock;
 - e. Clinically significant ventricular or supraventricular arrhythmias;
 - f. Congestive Heart Failure;
 - g. Pacemaker Insertion & Follow-up;
 - h. Pericardial Disease;
 - i. Pulmonary Embolus;
 - j. Syncope;
 - k. Patient with the potential for hemodynamic compromise or potential for an acute event;
 - l. Acute intoxication from poisoning (to include drug overdose);
 - m. Acute neurological injuries (to include TIA);
 - n. Acute renal failure;
 - o. Acute respiratory failure;
 - p. Burns, depending upon degree and total body surface involved;
 - q. Diabetics in ketoacidosis or hyperosmolar state;
 - r. G.I. bleeding;
 - s. Malignant hypertension requiring parenteral medications;
 - t. Post-op patients, high risk or who developed unexpected physiological events during surgery or recovery period;
 - u. Shock – septic, hypovolemia, neurological;
 - v. Any patient with a serious medical illness for which recovery could be expected with intensive care; and

- w. Patient meeting admission criteria to Med-Surg when no bed is available and all efforts to obtain one is exhausted.

III. GENERAL RULES AND REGULATIONS

A. PRACTITIONER RESPONSIBILITIES:

1. Practitioners admitting to the Critical Care Units must be appropriately qualified and credentialed through the privilege delineation process of the Professional Staff to care for the patients' special needs or obtain a consult with the appropriate specialists or subspecialists.
2. The attending practitioner and/or the practitioner designee, and the consulting practitioner have responsibility for coordinating the care of the patient.
3. Practitioners admitting to the Critical Care Units must be available at least by telephone within 30 minutes for routine calls and 10 minutes for STAT calls or make arrangements for qualified and appropriately credentialed practitioner coverage. In the event of an emergency, the Critical Care Unit Medical Director or Emergency Department practitioner may direct care until the attending practitioner can be contacted.

B. CONSULTATION:

Consultation with the appropriate qualified and credentialed specialist or subspecialist will be required in the following circumstances:

1. Cardiogenic Shock;
2. Bradycardia requiring pacemaker insertion;
3. Thrombolytic therapy;
4. Any condition requiring invasive hemodynamic monitoring except arterial line;
5. Any condition in which prescribed treatment is not proving effective or diagnosis is obscure;
6. Cerebral hemorrhage;
7. Septicemia;
8. Major GI hemorrhages; and
9. Respiratory failure for more than 48 hours on the mechanical ventilator with inability to wean.

C. DISCHARGE CRITERIA FROM THE CRITICAL CARE UNITS:

1. Hemodynamic stability;
2. Absence of major and/or lethal arrhythmias;

3. Adequate treatment of the acute disease process so that intensive treatment and monitoring is no longer required. Length of stay in the units will be kept to a minimum in order to utilize the units as effectively as possible;
4. Terminal or chronically ill patients who can no longer benefit from intensive care nursing or no longer require monitoring;
5. All transfers from the Critical Care Unit shall be initiated by the attending or consulting practitioner and shall be determined by the patient's condition, morbidity status, and rehabilitation potential; and
6. Medications must be reconciled at the time of transfer or discharge.

D. ADMISSION PROCEDURE:

1. The Admitting Office will not assign patients to the Critical Care Unit; all inquiries relating to availability of beds or arrangements for admission must be directed to the respective unit and Clinical House Supervisor.
2. The practitioner admitting the patient makes arrangements for admission of the patient directly with the specific unit to assure the availability of a bed, to inform the nurse of the patient's condition, to give admission orders, and to notify of any special equipment or supplies necessary for the patient's care and anticipated treatment.

E. URGENT BED AVAILABILITY:

In the event a bed is urgently needed in the ICU, the attending or consulting practitioner of the patient or patients deemed most stable by the Registered Nurse in charge, will be contacted and transfer requested. If a bed cannot be made available through this process, the Medical Director of the Critical Care Unit shall have the authority to transfer a patient.

F. PATIENT WHERE CRITICAL CARE IS QUESTIONABLE:

Consultation with the Medical Director may be sought by the Registered Nurse in charge before admission or transfer of the following patients to the Critical Care Units:

1. A patient who has been determined a no code and no new treatment is initiated;
2. Patient who is terminally ill and intensive care would be futile; and
3. Patient in a non-acute phase of a chronic illness.

G. PEDIATRIC ADMISSION:

Due to the fact that ICU is not trained to care for children, the following guidelines will be followed:

1. The critical care unit accepts patients 18 and older with actual or potential life threatening medical or surgical conditions requiring specialized, continuous critical care on a twenty-four (24) hour basis.
2. Patients under 18 years of age requiring critical care services should be transferred to appropriate facilities. If receiving facilities cannot be accessed (i.e., receiving facility at capacity) the patient may be admitted to ICU with collaboration of the admitting physician with ICU medical director.

H. PHYSICIANS' ASSISTANTS

Physician assistants and nurse practitioners may treat patients in the Critical Care Units under the supervision of his/her employer within the same guidelines as other clinical areas.

IV. GENERAL POLICIES

A. All ICU patients will be placed on cardiac monitoring equipment upon admission.

B. Vital signs will be obtained every four (4) hours; or as ordered by the practitioner, or more frequently at the nurses discretion.

C. No medications are given without a practitioner's order except by emergency protocol or approved protocols.

D. In the event of a cardiac/respiratory arrest or a life-threatening arrhythmia, the specially trained Critical Care nurse may perform the following resuscitative measures until a practitioner arrives:

1. External cardiac massage;
2. Pulmonary ventilation;
3. Defibrillation or cardioversion per ACLS protocol by protocol electric shock; and
4. Administer emergency ACLS protocol drugs.

NOTE: Defibrillation is performed only by specially trained nurses who have been authorized by Hospital Administration to perform the procedure.

Adopted by the Professional Staff

Steve Perlaky, M.D.
Chief of Staff

03/24/09

Date

Approved by the Board

Richard Clark
Secretary of Board

03/24/09
Date