PHYSICIANS SURGICAL HOSPITALS, L.L.C.

D/B/A

PANHANDLE SURGICAL HOSPITAL

AND

QUAIL CREEK SURGICAL HOSPITAL

PROFESSIONAL MEDICAL STAFF
RULES AND REGULATIONS

Adopted January 24, 2011

Amended October 23, 2013

Amended March 23, 2015

Professional Medical Staff Rules and Regulations

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INTRODUCTORY NOTE

TERMS

1. **"Board"** means the Board of Directors.

2. **"Bylaws"** means the current PSH Professional Medical Staff Bylaws.

3. **"Hospital"** means Physicians Surgical Hospitals, L.L.C. d/b/a Panhandle and Quail Creek Surgical Hospitals.

4. **"MEC"** means the Medical Executive Committee.

5. **"Medical Director"** means a physician who enters into a contract with the MEC to oversee the day-to-day operations of the Hospital.

6. **"PSH"** means Physicians Surgical Hospitals, L.L.C.

7. **"Practitioner"** means a physician (either M.D. or D.O.), dentist or podiatrist.

USE OF MASCULINE PRONOUNS

These Professional Medical Staff Rules and Regulations use the masculine personal pronouns (he, him, his). This is for convenience only and is not intended to exclude females. The Professional Medical Staff is committed to non-discrimination.

Section 1. Admission and Discharge

1. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated by the attending practitioner. The practitioner who admits the patient shall be the patient's attending practitioner unless it is documented in the patient's medical records that another member of the Professional Medical Staff will be the patient's attending practitioner. When an emergency requires the admission of a patient without a provisional diagnosis having been stated, the attending practitioner shall state a provisional diagnosis as soon after admission as is reasonably possible.

2. A member of the Professional Medical Staff who admits a patient to the Hospital shall be responsible for providing all necessary information to the Hospital before the patient is admitted.

3. Patients shall be admitted and treated by members of the PSH Professional Medical Staff, except in cases where emergency or temporary clinical privileges have been granted. Any practitioner providing coverage for a PSH Professional Medical Staff member or rounding on a patient located in PSH must be a member of the PSH Professional Medical Staff.

4. A member of the Professional Medical Staff serving as an attending practitioner shall be responsible for the prompt and accurate completion of his patient's medical records, for giving any special instructions which are required, and for transmitting reports on the condition of the patient to a referring practitioner and/or the individual designated by the patient. Whenever these responsibilities are transferred to another member of the Professional Medical Staff, a note documenting this transfer of responsibility shall be entered into the patient's medical records.

5. All admissions are subject to approval by the Administrator acting on behalf of the Board. The Hospital shall admit patients without regard to their race, religion, color, creed, national origin or economic status.

6. To the extent practical, patients will be provided with a time to report to the Hospital on the day of admission, except in the case of an emergency or urgent admission.

7. To the extent practical, patients who are admitted to the Hospital shall have any testing, which is performed after admission, performed by or under the direction of the Hospital laboratory.

8. Except as provided in paragraph 9, below, a patient shall be discharged from the Hospital only upon receipt of an order from the attending practitioner. At the time of discharge, the attending practitioner shall be responsible for seeing that the medical records of the patient are complete

insofar as is reasonably possible, for stating the final diagnosis, and for signing the medical record.

9. A patient who insists on leaving the Hospital against the advice of his attending practitioner shall be asked to sign a statement acknowledging that he is leaving the Hospital against the advice of his practitioner. If the patient refuses to sign the statement, this should be noted in the medical record. A patient shall not be detained or in any way restricted from leaving the Hospital because he refuses to sign this statement. Every reasonable effort should be made to counsel the patient regarding the danger of leaving against the advice of his practitioner. When the patient leaves the Hospital against his practitioner's advice, he will be discharged from the Hospital. At the time of discharge, the attending practitioner shall be responsible for seeing that the patient's medical record is complete insofar as is reasonably possible, for stating a final diagnosis, and for signing the medical record.

10. In order to facilitate the timely discharge of patients, practitioners, before beginning a scheduled surgery or other scheduled procedure, shall make every reasonable effort to discharge any of their patients who are ready to be discharged.

11. Patients will not be permitted to leave the Hospital on a pass except under special circumstances. The decision to permit a patient to leave on a pass shall be made by the Medical Director or his designee in collaboration with the attending practitioner.

12. In the event of an expected Hospital death, the deceased shall be pronounced dead by the attending practitioner, or the attending practitioner may designate a registered nurse or a physician assistant to pronounce the patient dead. Provided, however, that a practitioner must pronounce the patient dead if artificial means of support preclude a determination that the patient's spontaneous respiratory and circulatory functions have ceased. The body shall not be released until an appropriate entry has been made in the medical record and signed by the attending practitioner or his designee.

Section 2. Anesthesiology

1. The Anesthesiologist shall review the pertinent clinical records of each patient referred to him to confirm appropriate laboratory data is contained in the patient's clinical records.

2. The Anesthesiologist shall see each of his patients prior to the induction of anesthesia.

3. A record shall be maintained of all events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood factions.

4. The Anesthesiologist shall be responsible for his patient during the post-anesthetic recovery period. The Anesthesiologist will see that personnel providing post-anesthetic care are informed of any specific problems presented by the patient's condition. The Anesthesiologist is responsible for seeing that there is a post-anesthesia note in the patient's medical record.

5. The Anesthesiologist may delegate patient care duties, including some of those discussed in the preceding paragraphs, to a CRNA to the extent that such delegation is consistent with the clinical privileges of the CRNA and sound medical practice.

Section 3. Appointment and Reappointment Manual

1. Procedure for Appointment

Any application for appointment or reappointment, change in category, or change in clinical privileges shall be deemed complete only when the Hospital has received all the information it has requested in connection with the practitioner's application. The practitioner has the burden of timely producing all information supporting the practitioner's qualifications and suitability for the clinical privileges and Professional Medical Staff category requested and resolving any doubts about these matters. The practitioner's failure to sustain this burden within the time frame specified by the Professional Standards Committee, its designee or the MEC shall result in the immediate withdrawal of the application without further processing or consideration.

Submitting false information on the practitioner's application for appointment or reappointment for Professional Medical Staff membership and clinical privileges may result in the immediate withdrawal of the application without further processing or consideration, and may thereafter disqualify the practitioner from applying again in the future. Submitting false information includes the omission of material information from an application.

2. Application for Initial Appointment

The practitioner shall receive an application packet with instructions from the Professional Standards Committee or its designee. The practitioner shall complete the Texas Standardized Credentialing Application and the PSH Addendum. He shall then submit both to the Professional Standards Committee or its designee and together they will constitute his application.

3. Effect of Application

By applying for appointment to the Professional Medical Staff, each practitioner:

- agrees to appear for interviews as requested;
- agrees to reside within a thirty (30) minute travel time to the Hospital if appointed to the Professional Medical Staff and granted clinical privileges, and also agrees to resign from the Professional Medical Staff if he no longer resides within a thirty (30) minute travel time to the Hospital, unless an exception to this requirement is granted by the MEC under appropriate circumstances;

- authorizes the Professional Standards Committee and/or its designee to contact and have discussions with individuals and organizations who have been associated with the practitioner and who may have information bearing on the practitioner's current competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide information;

- consents to inspection by the Professional Standards Committee and/or its designee of records and documents relevant to an evaluation of the practitioner's qualifications and ability to perform the requested clinical privileges, and authorizes all individuals and organizations in custody of such records and documents to permit both inspection and copying;

- releases from any liability, to the fullest extent permitted by law, all persons and entities involved in the credentialing process for their acts performed in connection with the credentialing process;

- releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the practitioner, including otherwise confidential information;

- agrees to sign the appropriate releases authorizing the applicable specialty board to disclose the practitioner's specialty board status to the Hospital;

- consents to the disclosure to other hospitals by the Professional Standards Committee and/or its designee of any information regarding the practitioner's professional or ethical standing that the Hospital or Professional Medical Staff may have, and releases all those involved in the gathering and release of such information from liability for so doing to the fullest extent permitted by law; and

- if appointed to the Professional Medical Staff and granted clinical privileges, agrees to promptly inform the Professional Standards Committee or its designee of any change in his specialty board status.

4. **Procedure for Approval of Application**

Review and Verification of Information: The Professional Standards Committee and/or its designee shall assess whether the practitioner meets all the qualifications for Professional Medical Staff membership by verifying, to the best of its ability, the accuracy and veracity of the information submitted by the practitioner, as follows:

- **Current licensure.** Document and verify from primary sources the practitioner's current licensure status.

- **Relevant education, training, and experience.** Document and verify from primary sources, whenever feasible, the veracity of the practitioner's disclosures regarding relevant education, training, and experience; query the National Practitioner Data Bank; confirm board certification or registered active candidate status from the applicable specialty board for individuals submitting applications for appointment on or after January 1, 2011. For individuals who submit initial applications for appointment before January 1, 2011, the requirement to confirm board certification or registered active candidate status does not apply.

- **Professional competence and performance.** Review at least three (3) written references from individuals in the same professional discipline as the practitioner who are knowledgeable about the practitioner's professional performance within the past two (2) years to attest to and confirm the practitioner's continuing professional competence and ability to perform the clinical privileges requested. For practitioners finishing a residency and/or fellowship, or practicing for less than two (2) years, one (1) reference must be from the program director of the residency and/or fellowship program at the institution where the practitioner received residency and/or fellowship training, and another reference from the Clinical Department Chair at that same institution. Additional references may include peers who are neither related to nor associated in practice with the practitioner, but who are personally acquainted with the practitioner's professional qualifications and current professional competence. Peer references will be asked for their opinions regarding the practitioner's current:

    - Medical/clinical knowledge
    - Technical and clinical skills
    - Clinical judgment
    - Interpersonal skills
    - Communication skills
    - Professionalism

- **Health status.** Confirm the absence of any substance abuse or health conditions that may adversely affect the practitioner's

ability to perform the privileges requested by contacting the director of the practitioner's residency or fellowship program, or by contacting the chair of service or staff at another hospital where the practitioner has privileges. The confirmation of the practitioner's health status may include a physical and/or mental health examination conducted by a health care professional of the Credentials Committee's choosing.

- **Malpractice claims history.** Verify the existence of any prior or current claims, lawsuits, settlements, or judgments.

Following receipt and verification of the foregoing information, the Professional Standards Committee or its designee shall review the application and supporting documentation. The Professional Standards Committee or its designee shall have up to four (4) months following receipt of an application to accomplish the verification and review functions described herein in order to determine whether or not the application is complete. If after four (4) months all necessary information has not been received from the practitioner or other sources, and all questions regarding the practitioner have not been satisfactorily answered, the application shall be deemed incomplete and immediately withdrawn without further processing or consideration. In such event, a report will not be made to the National Practitioner Data Bank and the practitioner shall not be entitled to a hearing.

Hospital Department Needs and Resources: The Hospital may decline to offer particular clinical privileges in connection with appointment or reappointment on the basis of:

- the Hospital's present inability to provide adequate facilities or support services for these clinical privileges; or

- the existence of an exclusive contract between the Hospital and a practitioner group for the provision of certain clinical services.

Declining to offer clinical privileges for either of these reasons shall not constitute a denial of clinical privileges and shall not entitle the practitioner to a hearing under the Bylaws.

Review by the Chairman of the Professional Standards Committee: Upon a determination that an application is complete, the application and all supporting documentation will be forwarded to the Chairman of the Professional Standards Committee so that he can review the application and make a recommendation to the Professional Standards Committee. The Chairman of the Professional Standards Committee may personally, or through a designee, conduct a personal or telephone interview with the practitioner. The Chairman of the Professional Standards Committee shall evaluate all matters that he deems relevant to arriving at a recommendation regarding clinical privileges. The Chairman of the

Professional Standards Committee, or a designee, may contact other individuals with personal knowledge of the practitioner's qualifications. After reviewing all pertinent information (but in no event later than thirty (30) days after receiving the completed application), the Chairman of the Professional Standards Committee shall make a recommendation to the Professional Standards Committee regarding appointment to the Professional Medical Staff and clinical privileges.

Professional Standards Committee Recommendation: Not later than ninety (90) days after receiving the recommendation of the Chairman of the Professional Standards Committee, the Professional Standards Committee shall make its recommendation. During such time, the Professional Standards Committee may interview the practitioner, seek additional information from the practitioner and/or request further review or input as it deems appropriate. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the Professional Standards Committee shall make a written recommendation to the MEC regarding appointment and clinical privileges to be granted, along with any special conditions.

MEC Recommendation: Not later than thirty (30) days after receiving the recommendation from the Professional Standards Committee, the MEC shall make its recommendation. During such time, the MEC may interview the practitioner, seek additional information from the practitioner, and/or request further review or input as it deems appropriate. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the MEC shall make a written recommendation to the Board regarding appointment and clinical privileges to be granted, along with any special conditions. If the MEC's recommendation, if accepted by the Board, would result in an adverse action requiring a report to the National Practitioner Data Bank, then the practitioner will be notified of the proposed recommendation and will have a right to a hearing pursuant to the Hospital's Fair Hearing Plan set forth in the Bylaws.

Board Action: The Board shall approve or deny the application not later than forty-five (45) days after receiving the MEC's recommendation. During such time, the Board may request further review or input as it deems appropriate before acting upon the application.

- If the action of the Board is favorable to the practitioner, written notice shall be sent to the practitioner regarding: (1) the Professional Medical Staff category to which the practitioner is appointed; (2) the clinical privileges granted; and (3) any special conditions attached to the appointment. Such notice shall be delivered not later than twenty (20) days following the action of the Board.

- The practitioner will be an Associate Medical Staff member for a period of twelve (12) to eighteen (18) months. While an Associate Medical Staff member, the practitioner's practice will be monitored and evaluated by the Professional Standards Committee. The Professional Standards Committee will consider the results of such monitoring and evaluation, as well as other relevant matters, in determining whether or not to recommend the practitioner's advancement from the Associate Medical Staff. After receiving the Professional Standards Committee's recommendation, the MEC may advance the practitioner from the Associate Medical Staff or extend the practitioner's membership on the Associate Medical Staff for up to eighteen (18) months. If the practitioner is not advanced from the Associate Medical Staff, his Professional Medical Staff membership and clinical privileges will be terminated, and he will have the right to a hearing pursuant to the Hospital's Fair Hearing Plan.

- If the action of the Board is unfavorable to the practitioner in that it denies the practitioner Professional Medical Staff membership or clinical privileges he has requested, written notice shall be sent to the practitioner not later than twenty (20) days following the action of the Board. An unfavorable decision shall constitute a final professional review action if it is based on the practitioner's clinical competence or professional conduct.

5. **Contracted Services**

Practitioners applying for Professional Medical Staff membership by virtue of a contractual relationship to provide clinical services in the Hospital are not entitled to the automatic granting of Professional Medical Staff membership or clinical privileges by virtue of the contractual relationship. These practitioners shall follow the same procedures as other practitioners for requesting membership and clinical privileges. Unless the contractual relationship between the practitioner and the Hospital, or the practitioner's group and the Hospital, states otherwise, the practitioner's membership on the Professional Medical Staff and any associated clinical privileges shall be deemed automatically relinquished if the contractual relationship is terminated (either by termination of the contract or termination of the practitioner's association with the contracted group). In such event, there will not be a report to the National Practitioner Data Bank and the practitioner shall not have the right to a hearing.

6. **Procedure for Reappointment**

Application: At least six (6) months prior to the expiration date of a member's current Professional Medical Staff appointment, a reapplication form shall be sent to the member. Each practitioner must submit to the Professional Standards Committee or its designee a completed application at least ninety (90) days prior

to the expiration date of the member's current term of appointment. An application shall not be considered complete until all requested information has been received. The Professional Standards Committee, and/or its designee, shall determine whether the practitioner continues to meet the minimum eligibility criteria for Professional Medical Staff membership.

7. **Failure to Submit a Completed Reappointment Application**

If a member of the Professional Medical Staff does not submit a completed application by ninety (90) days prior to the expiration of his current term of appointment, the application shall be deemed incomplete and the member's clinical privileges will expire at the end of the current appointment period. If a member's Professional Medical Staff appointment expires because of an incomplete reappointment application, the member is not entitled to a hearing under the Bylaws. Any application submitted after the expiration date shall be processed as a request for an initial appointment.

8. **Leave of Absence**

Leave Status: A member of the Professional Medical Staff may obtain a voluntary leave of absence (not to exceed the earlier of one (1) year or the last day of the member's current term of appointment) from the MEC by submitting a written request to the Chief of Staff, Medical Director, and/or the Professional Standards Committee specifying the reasons and the approximate period of leave. The Chief of Staff, Medical Director, and/or the Professional Standards Committee will consider the request and make a recommendation to the MEC. The MEC shall make a final determination regarding the member's request. During a leave of absence, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. In exceptional circumstances, and upon demonstrating good cause, a leave of absence may be extended beyond one (1) year upon approval of the MEC, based upon recommendations from the Chief of Staff, Medical Director, and/or the Credentials Committee.

Reinstatement: To be reinstated, the member must submit a written request prior to expiration of his leave of absence.

- In circumstances when the leave of absence is due to illness, incapacity, impairment, or other causes that could affect the member's ability to exercise the clinical privileges granted to such member, reinstatement is conditioned upon a showing that:
    - The member has submitted to the Professional Standards Committee a written request for reinstatement at least thirty (30) days prior to the expiration of the leave, and has demonstrated that the reasons for the leave no longer exist;

- In case of impairment, the member has presented a letter from his primary treating practitioner assessing his ability to competently exercise his clinical privileges;

- The member currently meets all of the qualifications and requirements for membership set forth in the Professional Medical Staff Bylaws and these Rules and Regulations;

- The member currently meets the qualifications for the category of membership to which the member shall be reinstated; and

- The member has submitted such other information as requested by the Professional Standards Committee, the MEC, or the Board.

Reinstatement will be effective when approved by the Board upon the recommendation of the MEC.

Failure to Request Reinstatement: Failure to request reinstatement from a leave of absence shall be deemed a voluntary resignation from the Professional Medical Staff and shall result in automatic revocation of Professional Medical Staff membership and clinical privileges. A request for Professional Medical Staff membership subsequently received from a member who fails to request timely reinstatement shall be submitted and processed in the manner specified for applications for initial appointments.

9. **Continuing Duties after Appointment**

By accepting an appointment to the Professional Medical Staff and clinical privileges at the Hospital, the member affirmatively agrees to the following duties:

- Notify the Professional Standards Committee or its designee in writing within five (5) business days of any of the following:

  - Any material change to information submitted as part of an initial or renewal application for Professional Medical Staff membership;

  - The cessation of medical practice by the member at any health care facility for any reason (except for a voluntary resignation) for a period exceeding thirty (30) days;

  - The reduction of member's professional liability insurance coverage below the minimum limits required by the Hospital, or exclusion from coverage for any procedures

for which the member has or is seeking clinical privileges; and

- The practitioner's failure to continue to satisfy one or more of the minimum eligibility criteria for Professional Medical Staff membership.

- Provide and/or secure continuous care of the member's patients and seek consultation whenever necessary.

- Complete a medical history and physical examination in accordance with the requirements set forth in the Bylaws.

- Maintain an ethical practice, including refraining from the following: offering, soliciting, providing or accepting illegal inducements for patient referrals; allowing patient care services to be provided by a physician-in-training without the direct supervision of the responsible attending practitioner; and delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

- Notify the Professional Standards Committee or its designee immediately if at any time the member is no longer certified as a diplomat or a registered active candidate in good standing in the process toward certification by the applicable specialty board.

- Notify the Professional Standards Committee or its designee immediately if the member is no longer residing within a thirty (30) minute travel time to the Hospital and voluntarily relinquish Professional Medical Staff membership and clinical privileges. This duty is not applicable to members of the Honorary Staff.

Section 4. Autopsies

Indications for Autopsy: This Section lists generally accepted indications for an autopsy. NOTE: The Hospital will not ordinarily bear the cost of an autopsy; this is true even if the autopsy is ordered by a practitioner. If a member of the Professional Medical Staff wants to find out whether or not the Hospital will bear the cost of an autopsy, he may do so by contacting the Medical Director.

1. Deaths at any age when an autopsy may help to explain complications that are unknown or unanticipated to the attending practitioner.

2. Deaths in which the cause of death or a major diagnosis is not documented with reasonable certainty on clinical grounds.

3. Cases in which an autopsy may help to alleviate concerns of the family and/or the public regarding the death.

4. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.

5. Deaths of patients who have participated in clinical trials (protocols) approved by an Institutional Review Board.

6. Unexpected or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction.

7. Natural deaths which are subject to, but waived by a forensic medical jurisdiction, such as (a) persons dead on arrival at hospital, (b) deaths occurring at hospitals within twenty-four (24) hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.

8. Deaths at any age in which it is documented that an autopsy would disclose a known or a suspected illness which also may have a bearing on survivors or recipients of transplant organs.

9. Deaths known or suspected to have resulted from environmental or occupational hazards.

10. Deaths of children twelve (12) months or younger who die suddenly or who are found dead of unknown reasons.

Section 5. Committees of the Professional Medical Staff

1. The Standing Committees of the Professional Medical Staff are as follows:

   (a) Professional Standards Committee

   (b) MEC

2. Ad Hoc committees may be appointed to deal with particular matters.

3. New Standing Committees may be created by the MEC as they are needed to conduct Professional Medical Staff business.

Section 6. Consent to Treatment

1. No medical or surgical procedure requiring a patient's consent may be performed in the Hospital without first obtaining the written informed consent of the patient or his legally authorized representative, except as provided in this Section.

2. It shall be the responsibility of a practitioner performing a medical or surgical procedure to obtain the informed consent of his patient or his patient's legally authorized representative by fully explaining the risks and benefits of the procedure. Before beginning the procedure, an informed consent document (on a form approved by the Hospital) shall be signed by the patient or his legally authorized representative and properly witnessed.

3. Informed consent must be obtained from a patient or his legally authorized representative prior to the performance of any procedure of an experimental nature or the administration of any investigational drug at the Hospital. The attending practitioner shall be responsible for fully advising the patient of the risks associated with the experimental procedure or the investigational drug, and explaining the treatment alternatives available to the patient. The patient's consent shall be evidenced by the patient's properly witnessed signature on a form approved by the Hospital and Institutional Review Board.

4. In the event of an emergency (where immediate action is required to save the life of the patient or prevent possible permanent impairment to the patient), the informed consent of the patient or his legally authorized representative will not be required if consent cannot be obtained without delaying the necessary emergency treatment. In these emergency situations, the practitioner rendering treatment shall state in the medical record that delaying treatment while attempting to obtain informed consent would endanger the life of the patient or risk permanent impairment to the patient.

5. In the event a patient or his legally authorized representative shall refuse to consent to the performance of a medical or surgical procedure with the probable consequence that the patient will experience substantial adverse consequences, the practitioner shall be responsible for making an adequate report of the refusal in the patient's medical records.

6. Where questions arise, or unusual circumstances occur, that are not covered by this Section, the practitioner seeking informed consent shall promptly contact the Medical Director or his designee in order to confer with Hospital Administration before deciding how to proceed. Hospital Administration will make every reasonable effort to assist the practitioner in obtaining informed consent.

7. The lack of mental competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made by the practitioner is whether the patient has sufficient mental ability to understand his situation and to make a rational decision as to whether or not to consent to treatment. When a court has declared a patient incompetent, consent will be obtained from an individual authorized to make medical decisions for the incompetent patient.

8. The practitioner is responsible for communicating to the nursing staff the appropriate medical terminology to be used on the consent form.

Section 7. Consultations

1. Consultations will be utilized by the Professional Medical Staff as appropriate in the furtherance of providing quality care to patients at the Hospital.

2. A practitioner requesting a consultation shall contact the consultant himself, rather than asking a nurse to contact the consultant.

3. Consultants shall record and authenticate their findings and recommendations as a part of the patient's medical record.

4. Except in the case of a patient emergency, if a pre-operative consultation is required prior to a practitioner performing a procedure, anesthesia will not be administered until the practitioner has obtained the required consultation and the consultant has made a record of his consultation in the patient's chart. In the case of a patient emergency, the practitioner who performs the procedure without first obtaining a consultation shall document the circumstances that made it impractical for him to obtain a consultation before performing the procedure.

5. The Chief of Staff, Medical Director, or their designees shall have the authority to require a consultation when it appears to be in the best interest of a patient.

Section 8. Emergency Department

1. The Hospital's Emergency Department provides twenty-four (24) hour outpatient practitioner care. An "emergency" from the patient's perspective is a medical problem which the patient believes requires immediate medical attention.

2. Practitioners who see patients in the Emergency Department shall practice in a manner consistent with the Hospital's EMTALA Policy, which establishes procedures to ensure compliance with the Emergency Medical Treatment and Labor Act. Those practitioners who provide specialty on-call physician coverage for the Emergency Department shall adhere to the Hospital Policy providing a guideline addressing the role of the specialty on-call physician.

3. In the absence of a contractual agreement with PSH to the contrary, the Professional Medical Staff shall determine the division of responsibilities between its members with respect to providing Emergency Department coverage. In the event that the Professional Medical Staff members are unable to reach an agreement for dividing the responsibilities for Emergency Department coverage, then a Professional Medical Staff meeting shall be held and a decision shall be made by a vote of the majority of the eligible voting members present. The Chief of Staff or his designee will give the members of the Professional Staff at least seven (7) days notice of the meeting; this notice will state the purpose of the meeting. The division of responsibilities decided upon by the Professional Medical Staff will be submitted to the MEC for review and approval.

Section 9. Emotionally Ill Patients

1. Patients who become emotionally ill during their hospitalization shall be afforded appropriate mental health consultations.

2. Transfers from the Hospital to mental health facilities will be made when appropriate after considering the mental health needs of the patient and the medical condition of the patient.

Section 10. Impairment Policy

In this Section only, the term "practitioner" will refer to any health care provider credentialed through the Professional Medical Staff Services Office. Impairment as used in this Section refers to a practitioner who is not able to function in his usual manner due to the effects of drugs, alcohol, mental illness, physical illness, depression, anxiety or something of this nature. The intent of this Impairment Policy is to further patient safety while offering impaired practitioners the opportunity to enter into rehabilitation.

If anyone working in the Hospital has a reasonable suspicion that a practitioner is impaired in a manner that may impact the safety of patients, the following steps should be taken:

1. When an individual suspects a practitioner of being impaired, he should give an oral, or preferably a written report, to the Chief of Staff or Medical Director. The report must be factual and include a description of the incident(s) leading to the individual's suspicion that the practitioner is impaired. A practitioner may self-report his impairment to the Chief of Staff or Medical Director. All information submitted will be treated as confidential; this includes the identity of the person making the report.

2. If, after discussing the incident(s) with the individual who made the report, the Chief of Staff or Medical Director believes there is enough information to warrant an investigation, then he shall request that an investigation be conducted by one of the following:

    (a) An ad hoc committee of the Professional Medical Staff;

    (b) A standing committee of the Professional Medical Staff;

    (c) An outside consultant; or

    (d) Other individuals appropriate under the circumstances.

3. If the investigation produces sufficient evidence to support the suspicion that the practitioner is impaired, the Chief of Staff or Medical Director shall meet personally with the practitioner or designate another appropriate individual to do so. The practitioner shall be told that the results of an investigation indicate that the practitioner may suffer from an impairment that could affect his practice. The practitioner should not be told who made the initial report or be provided with information that would likely reveal the identity of the person who made the initial report.

4. Depending upon the severity of the problem and the nature of the impairment, the Hospital has the following options:

   (a) Require the practitioner to undertake a rehabilitation program as a condition of continued Professional Medical Staff Membership and clinical privileges;

   (b) Impose appropriate restrictions on the practitioner's practice until the required rehabilitation program has been successfully completed and then consider lifting those restrictions; or

   (c) Suspend the practitioner's Professional Medical Staff membership and clinical privileges until the required rehabilitation program has been successfully completed and then consider reinstatement of the practitioner's Professional Medical Staff membership and clinical privileges.

5. The Chief of Staff or Medical Director shall seek the advice of Hospital legal counsel to determine whether the Hospital will be required to make any report to third-parties.

6. The original report and description of the actions taken in response to the report are to be kept in a confidential file by the Chief of Staff or Medical Director. If the investigation reveals that there is no merit to the report, the report shall be destroyed.

7. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussion of this matter with anyone outside of those described in this Section.

8. The corrective action and Fair Hearing Plan provisions contained in the Professional Medical Staff Bylaws are not applicable to practitioner impairment.

Rehabilitation

Hospital and Professional Medical Staff leadership shall assist the practitioner in locating a suitable rehabilitation program. The Hospital shall not reinstate a practitioner who has been suspended until it is established, to the Hospital's satisfaction, that the practitioner has successfully completed a rehabilitation program in which the Hospital has confidence.

Reinstatement

1. Upon sufficient proof that an impaired practitioner has successfully completed a suitable rehabilitation program, the Hospital will consider reinstating that practitioner to the Professional Medical Staff and restoring his clinical privileges.

2. When considering an impaired practitioner for reinstatement, the Hospital and its Professional Medical Staff leadership must consider patient care interest to be paramount.

3. The Hospital will request a letter from the director of the rehabilitation program requesting certain information. The practitioner must authorize the release of the requested information. The requested information may include the following:

   (a) Whether the practitioner has fully participated in the program;

   (b) Whether the practitioner is in compliance with all terms of the program;

   (c) Whether the practitioner attends program meetings regularly (if appropriate);

   (d) To what extent the practitioner's behavior and conduct are being monitored;

   (e) Whether, in the opinion of the rehabilitation program physicians, the practitioner is rehabilitated;

   (f) Whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and

   (g) Whether, in the program director's opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

4. The practitioner must inform the Hospital of the name and address of his primary care practitioner and must authorize the practitioner to provide the Hospital with information regarding his condition and treatment. The Hospital has the right to require an opinion from another practitioner consultant of its choice.

5. Assuming that all information the Hospital receives indicates that the practitioner is rehabilitated and capable of resuming patient care, the Hospital must take the following additional precautions when restoring clinical privileges:

   (a) The practitioner must identify two (2) practitioners who are willing to assume responsibility of the care of his patients in the event that he is unable or unavailable to care for them.

   (b) The Hospital shall require the practitioner to provide the Hospital with periodic reports from his primary care practitioner for a period of time specified by the Chief of Staff or Medical Director

stating that the practitioner is continuing treatment or therapy, as appropriate, and that his ability to treat and care for patients in the Hospital is not impaired.

6. The Chairman of the Professional Standards Committee or his designee, in collaboration with the Professional Standards Committee, shall monitor the practitioner's exercise of clinical privileges in the Hospital.

7. The practitioner must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of a member of the Hospital administration.

8. All requests for information concerning the impaired practitioner shall be forwarded to the Chief of Staff or Medical Director for response.

Education

The Professional Medical Staff and Hospital employees will receive educational material concerning the recognition of impairment.

Section 11. Medical Records

1. When used in this Section, the term "attending physician" shall mean the admitting practitioner unless a written note in the patient's medical record states that another practitioner has accepted primary responsibility for the patient.

2. The attending physician shall be responsible for the preparation of a complete and legible medical record for his patient. No part of the medical record may be written in pencil. The attending physician must authenticate any portion of the medical record he completes or for which he is responsible. The practitioner responsible for an entry in the order sheet or the progress notes shall indicate a date and time for such entry. Any late entry by a practitioner in the medical record shall state that it is a late entry and shall include a note explaining the reason for the addition, deletion, or change. It is never appropriate for a practitioner to make a late entry in a patient's medical record without explaining in the medical record the reason for the late entry.

3. Members of the Professional Medical Staff shall write progress notes to describe everything of a major aspect that happens to the patient, including pertinent information relating to his course of treatment while in the Hospital. Progress notes shall be written at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes. These clinical problems should be correlated with specific orders and with the results of tests and treatments. Every patient in the Hospital shall be visited by a practitioner at least once every twenty-four (24) hours and at least one (1) progress note shall be written or dictated for every patient every twenty-four (24) hours.

4. Symbols and abbreviations may be used only when the MEC has approved them. A record of approved abbreviations will be available for review in the Medical Records Department. A final diagnosis shall be recorded in full without abbreviations.

5. Medical records, including, but not limited to, x-ray films, electrocardiographic tracings, anatomical specimens, and microscopic slides, are the property of the Hospital and shall not be taken from the Hospital unless this is required by Court Order or Subpoena, except for authorized use in connection with peer review conferences, medical conferences, medical consultation and specimen preparation. Disposition of all medical records, diagnostic media and reports shall be by mutual agreement of the MEC and the Administrator. If a practitioner removes medical records from the Hospital without authorization, this will be reported to the MEC and the Administrator.

6. The attending and consulting practitioners are authorized to have access to the patient's medical record along with members of the Professional Medical Staff Committees. Written consent is not required to use medical records for: automated data processing; patient care evaluation studies such as retrospective audits and Professional Medical Staff monitoring functions; official surveys for Hospital compliance with accreditation, regulatory and licensing standards.

7. A medical record shall be maintained for every patient admitted as an inpatient, outpatient or Emergency Department patient.

8. The records shall include the following items when appropriate:

   (a) Identification data;

   (b) Admitting complaint;

   (c) History of present illness;

   (d) Past medical history;

   (e) Physical examination;

   (f) Laboratory data;

   (g) Diagnostic and therapeutic orders;

   (h) Special reports;

   (i) Progress notes;

   (j) Discharge summary:

      (1) Conclusions at termination of hospitalization, all included in the discharge summary;

      (2) Disposition of patient;

      (3) Patient's condition at the time of discharge;

      (4) A definitive final diagnosis based on the terms specified in the standard nomenclature of diseases of operations or current medical terminology;

   (k) Diagnostic reports;

   (l) Operative reports and pathological findings when appropriate;

   (m) Consultant reports;

(n) Autopsy reports;

(o) Evidence of informed consent.

9. Emergency Department, DSU, and Observation records shall include the following when appropriate. These requirements do not apply to patients referred for diagnostic services only:

(a) Adequate patient identification;

(b) Information concerning the time of the patient's arrival, means of arrival, and persons transporting;

(c) Pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his arrival at the Hospital's Emergency Department;

(d) Description of significant clinical, laboratory, and radiological findings;

(e) Diagnosis and treatment given;

(f) Condition of the patient upon discharge or transfer; and

(g) Final disposition, including instructions given to the patient and/or patient's family member for necessary follow-up medical care.

10. All entries shall be dated, timed, and authenticated.

11. All significant procedures are to be recorded with dates. A significant procedure is one that carries an operative or anesthetic risk or requires specially trained personnel, special equipment, or facilities. These procedures include, but are not limited to, biopsies, lumbar punctures, angiographies, endoscopic and radiation therapies.

12. The requirements for timely completing a history and physical examination are set forth in Article X of the Professional Medical Staff Bylaws.

13. All orders (except verbal orders) must be dated, timed, and authenticated by the prescriber or another practitioner who is responsible for the care of the patient and who has been both credentialed by the Professional Medical Staff and granted privileges which are consistent with the written orders, provides care to the patient, assesses the patient, or documents information in the patient's medical record. Orders **MAY NOT** be sent via text message, SMS message, or email. All orders sent by these means **WILL NOT** be accepted. All verbal orders must be dated, timed, and authenticated within forty-eight (48) hours by the prescriber or another

practitioner who is responsible for the care of the patient and has been credentialed by the Professional Medical Staff and granted privileges which are consistent with the written orders. Whenever possible, orders for drugs and biologicals shall be in writing, dated, and signed by the individual responsible for the care of the patient. On those infrequent occasions when telephone or verbal orders must be used for drugs and biologicals, the orders shall be accepted only by authorized personnel and they shall be dated, timed, and authenticated within forty-eight (48) hours by the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the Professional Medical Staff and granted privileges which are consistent with the written orders. All orders written by medical students must be co-signed by the supervising practitioner before execution of the order. All verbal orders require verification (read-back) of the complete order by the person receiving the order. When an order is directly communicated by a practitioner to a nurse, registered pharmacist, certified physical therapist, certified respiratory therapist, licensed nuclear medical technologist, registered dietician, occupational/speech therapist, certified lab personnel, licensed radiological technologist, or other appropriately qualified person, the person receiving the order is responsible for assuring that the order is correct and is required to question any order that he suspects is not correct.

14. All operations and invasive procedures shall be fully described in writing in a post-procedure note prepared by the practitioner performing the operation or procedure immediately following such operation or procedure. The post-procedure note shall include the name of the practitioner performing the operation or procedure and practitioners assisting him; it shall also include findings, technical procedures used, specimens removed, and post-procedure diagnosis.

15. All operations and invasive procedures shall be fully described in an operative or procedure report prepared by the practitioner performing the procedure. The operative/procedure report shall include the following information: name of operation/procedure, name of the primary surgeon/physician and assistants, specimens removed, pre-operative and post-operative diagnoses, anesthesia used, estimated blood loss, and a full description of the findings--including normal and abnormal findings, organs explored or removed, and procedures, ligatures, and sutures used. In cases of cardiac catheterization, the report shall describe any valve abnormalities, the status of coronary arteries, and ventricular function. The operative/procedure report shall be dictated or written shortly following such operation or procedure, in no event later than twenty-four (24) hours following the operation/procedure. The pre-operative and post-operative diagnoses should be stated in the operative report and authenticated by the surgeon. Given the importance of the timely completion of operative/procedure reports, Administration will determine compliance on at least a monthly basis. A practitioner who is, for the first

time, delinquent for more than four (4) operative/procedure reports will be notified in writing of his delinquent operative/procedure reports. If the practitioner does not complete these operative/procedure reports within seven (7) days following the date shown on the written notice, he will not be allowed to post or perform operations or invasive procedures until he has completed the delinquent operative/procedure reports. A practitioner who has more than four delinquent operative/procedure reports for a second time in any 24 month period will be notified in writing of his delinquent operative/procedure reports. For a period of six months following the date shown on the written notice, the practitioner will not be allowed (except for emergent cases) to post or perform operations or invasive procedures if any of the practitioner's operative/procedure reports are delinquent. A practitioner who has more than four delinquent operative/procedure reports for a third time in any 24 month period will be notified in writing of his delinquent operative/procedure reports. Beginning on the date shown on the written notice, the practitioner will not be allowed (except for emergent cases) to post or perform operations or invasive procedures if any of the practitioner's operative/procedure reports are delinquent. This restriction will remain in place until the MEC notifies the practitioner in writing that the restriction is removed.

16. A progress note shall be recorded at the time of discharge stating the general medical condition of the patient at the time of discharge. NOTE: Patients hospitalized less than forty-eight (48) hours (not to include expirations) do not require a discharge summary, provided there is a complete discharge note recorded stating the patient's condition upon discharge and instructions for future, continuing, or follow-up medical care. For short-stay patients (less than forty-eight (48) hours), it may be possible to combine the history, physical, and discharge summary into one form.

17. Ancillary service departments should record information in the patient's medical record for the following reasons:

    (a) To answer the request of an attending physician for an ancillary consultant; and

    (b) To convey important information relating to the care and treatment of the patient to the attending physician.

    All entries by ancillary service department personnel should be clearly identified as to the department from which it comes, be dated, and bear the signatures of the appropriate personnel.

18. A practitioner who is registered with a current DEA number must sign an order for any drug that falls within the controlled substance category.

19. A discharge summary is required for all patients except when a patient stay is less than forty-eight (48) hours, unless the patient is discharged by reason of death.

20. The attending physician of record shall complete the discharge summary at the time of discharge, in no event later than fourteen (14) days post discharge, to allow for transcription and signing within thirty (30) days of discharge. It shall be a concise statement of the information regarding the patient's present illness, investigation, and treatment. The following information shall be recorded:

    (a) The reason for the patient entering the Hospital;

    (b) Pertinent laboratory, X-ray, and physical findings;

    (c) Any medical and/or surgical treatment;

    (d) The physical condition of the patient upon leaving the Hospital;

    (e) Any recommendations and arrangement for future care (to include diet, medications, restrictions or limitations, and access to follow-up care when applicable);

    (f) A necropsy report when indicated if it is available; and

    (g) Principal and secondary final diagnosis.

21. Practitioner signatures in the medical record shall be handwritten or by electronic signature (stamp signatures are **NOT** acceptable). Facsimile of original written or electronic signatures are acceptable for certifications of terminal illness for hospice.

22. Except as otherwise provided herein, all tissue removed during a procedure shall be sent to the Hospital pathologist who shall make such examinations as are deemed necessary in order to arrive at a pathological diagnosis. The pathologist shall develop a written report that shall be signed by him and made a permanent part of the patient's medical records. The Hospital pathologist need not review the following tissue specimens, provided that the attending physician verifies such specimens in the patient's medical records.

    The limited categories of specimens that may be exempt 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, or portion of rib removed only to enhance operative exposure;

(b) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(c) Traumatically injured body parts that have been amputated and for which examination for either medical or legal reason is not deemed necessary;

(d) Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

(e) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively (such as the foreskin from the circumcision of a newborn infant);

Teeth, provided the number, including fragments, are recorded in the medical record.

23. All medical records of discharged patients must be completed within thirty (30) days from discharge. Records not completed within this thirty (30) day period will be considered delinquent.

Every two (2) weeks, Medical Records will distribute to members of the Professional Medical Staff a report of charts that remain incomplete. This report will include the date at which the chart will be considered delinquent. Medical Records will provide to Administration a delinquent records list identifying those members of the Professional Medical Staff who did not complete records within the appropriate time frame.

A member of the Professional Medical Staff will not be considered delinquent on any chart that has not been made available to him. Members of the Professional Medical Staff who are inactive due to illness or other reasonable circumstances may be allowed an additional seven (7) days to complete their records following their return to practice. The Administrator or his designee may grant this extension.

Members of the Professional Medical Staff who appear on a delinquent records list will be notified by certified mail of the delinquency and of the existence of this rule. A member of the Professional Medical Staff who appears on three (3) delinquent records lists within a rolling twelve (12) month period will also be contacted by the Administrator or his designee to confirm the practitioner's awareness of the repeated delinquencies. Documentation of the notices of delinquency will be retained in the practitioner's Professional Medical Staff file.

A member of the Professional Medical Staff who appears on four (4) delinquent records lists within a rolling twelve (12) month period will be automatically suspended from the Professional Medical Staff for a period of thirty (30) days. The member will be notified of the suspension by certified mail and by contact from the Administrator or his designee. The suspension will terminate as scheduled only if all of the practitioner's medical records are completed. Any member who has been suspended under this rule and who appears on two (2) delinquent records lists within the twelve (12) months following the suspension shall again be suspended for thirty (30) days, and shall be referred to the MEC for review and possible additional disciplinary action.

24. In the event that a practitioner is reported to the MEC for delinquent records (including, but not limited to, history and physicals, post-procedure notes, operative/procedure reports, and discharge summaries), an appropriate notation will be made in the practitioner's credentialing file and considered when the practitioner seeks reappointment to the Professional Medical Staff.

25. Members of the Professional Medical Staff whose privileges are suspended or revoked for failure to complete delinquent medical records shall not have the right to request a hearing, but may explain by letter to the Administrator or his designee why the action is not appropriate.

Section 12. Medications

1. The Professional Medical Staff, working through the Pharmacy and Professional Standards Committee, maintains a Formulary of efficacious, high quality and cost effective medications. Written guidelines on how the formulary system works, how to request addition of drugs to the Formulary, and how to obtain drugs not on the Formulary will be maintained. A list of approved Formulary medications may be accessed through PSHNet.

   (a) **Medication Categories-** The Professional Standards Committee will evaluate and place each medication into one of the following categories:

   (b) **Unrestricted-** A drug routinely available and stocked by the pharmacy which may be prescribed freely within current good medical practices by practitioners at PSH.

   (c) **Restricted-** Drugs which are reserved by the Professional Standards Committee for use by a practitioner who is listed as an expert in the use of such products and/or the request is within the recommended "limits" as defined by the Professional Standards Committee for each agent in this category.

   (d) **Therapeutic Evaluation-** Drugs in this category will be made available in the institution for a specified period of time (6 - 12 months). Restriction will not routinely be placed on the use of the drug during this period. At the conclusion of this evaluation period, the Professional Standards Committee will decide whether to recommend continued inclusion or removal from the Formulary.

   (e) **Limited Availability-** A drug approved for Formulary inclusion, but its rare, non-acute use, short expiration, or high cost will prohibit it from being stocked. If not stocked, it will be obtained without question upon receipt of a written order or advance phone call.

   (f) **Investigational-** A drug that lacks approval by the Food and Drug Administration (FDA) for its intended use, but is approved for use within the Hospital by the Institutional Review Board. Distribution of the drug may be handled totally by the principle investigator or if desired, the pharmacy will stock the drug and distribute it only upon the written order of the principle investigator or other authorized individuals. Use of an investigational drug must be approved by the Professional Standards and Medical Executive Committees and an approved Institutional Review Board.

(g) **Non-Formulary Drug-** All drugs not included in the above categories are considered non-formulary. This includes specific brands of any formulary drug other than the brand selected for stock. Non-formulary drugs are not stocked in the pharmacy. A non-formulary drug can be made available to a specific patient as an exception if so justified by the requesting practitioner subsequent to contact by pharmacy. Use of non-formulary drugs will be monitored by the Professional Standards Committee.

2. A practitioner may prescribe a medication using either the generic or the brand name. When a medication or enteral nutritional product is ordered by a brand name, the Hospital pharmacy or dietary department is authorized to dispense a generically equivalent medication. Those generic medications purchased by the Hospital pharmacy for substitution use within the Hospital shall be selected from the FDA's Approved Prescription Drug Products with Therapeutic Equivalence Evaluations Manual and its quarterly updates. Use of this manual will assure that therapeutic equivalence is maintained.

3. Therapeutic interchanges and IV to oral interchanges may be performed automatically by pharmacists who assess the patient and follow criteria as approved by the Professional Standards Committee and the MEC. The practitioner is notified of the interchange by a sticker placed on the physician order section of the patient's chart.

4. All medication orders for inpatients are screened against the following criteria on a daily basis. Unless a stop date is specified, those orders meeting the criteria should be printed on a report which is reviewed by a pharmacist.

Ketorolac	> 5 days
Antiinfectives	> 7 days
Anticoagulants	> 7 days

Where appropriate, the pharmacist will notify the practitioner and request that the practitioner review the therapy and consider discontinuation of the medication. Upon review, the practitioner may renew or discontinue the order, or the practitioner may take no action. If no action to the renewal notification is taken, the medication order will remain active until future modifications are made to the order or until the patient is discharged.

5. Medications brought into the Hospital by a patient shall be routed to the pharmacy for identification only per practitioner order or as needed by nursing for proper identification. Once identified, these medications shall be either sent home with a member of the patient's family or stored on the nursing unit until dismissal, at which time they will be returned to the

patient. Under a specific practitioner order, a medication from a patient's home supply may be dispensed to that patient.

6. Prescription medications dispensed upon practitioner order for patients being discharged must be limited to a twenty-four (24) hour supply, with the exception of medications that cannot be routinely supplied from other pharmacies.

Section 13. Oral Surgery

1. Surgical procedures performed by dentists shall be under the overall supervision of the Medical Director.

2. All oral surgery patients shall receive the same basic medical evaluation as patients admitted for other surgical services. A practitioner member of the Professional Medical Staff shall be responsible for conducting the medical evaluation and documenting the evaluation in the patient's medical record.

3. A physician member of the Professional Medical Staff shall be responsible for any medical treatment an oral surgery patient may require during his hospitalization, and a dentist member of the Professional Medical Staff shall be responsible for appropriate dental treatment. The attending dentist shall be responsible for conducting the dental evaluation and recording it in the patient's medical record.

Section 14. Practitioner Complaints Concerning Hospital Employees

1. If a member of the Professional Medical Staff has a complaint concerning an employee of the Hospital, he may present his complaint to the employee's supervisor. If the Professional Medical Staff member believes that his complaint has not been adequately addressed by the employee's supervisor, he may contact the Chief of Staff or his designee to discuss his complaint.

2. Members of the Professional Medical Staff shall not attempt to reprimand or discipline Hospital employees.

Section 15. Practitioner Peer Review Process

Confidentiality of Process

The practitioner peer review process is confidential and protected by both state and federal laws. Peer review by the Professional Standards Committee will not constitute an investigation. An investigation of a practitioner's practice shall be initiated only when the MEC makes a determination that it is appropriate to do so.

Review by the Professional Standards Committee

1. **Indicators**

   The Professional Standards Committee will identify, review, and approve quality improvement indicators annually.

2. **Monitoring**

   Charts are selected for review by the Professional Standards Committee and/or quality improvement personnel, with an emphasis on deaths, complications, quality concerns, and invasive procedures that have high volumes and/or high risks. These criteria, rather than the identity of the practitioner, determine which charts are selected.

   When appropriate, a Case Summary Review will be prepared by a quality improvement nurse reviewer and submitted to the Professional Standards Committee for practitioner peer review.

3. **Procedures**

   Once a Case Summary Review has been submitted to the Professional Standards Committee for practitioner peer review, the Professional Standards Committee may designate that the practitioner peer review be performed by:

   (a) A member of the Professional Standards Committee as determined by a review rotation schedule; or

   (b) An external peer review. The following are examples of circumstances where external peer review, with the consent of the Administrator or his designee, may be used:

      (1) Legal concerns by the Committee;

      (2) Failure of the Committee to arrive at a consensus on a recommendation;

(3) Inability to find an appropriate specialist to review the Case Summary Review because the specialists on the Professional Medical Staff have personal or professional relationships with the practitioner under review, causing them to decline to serve; or

(4) Inability to find a member of the Professional Medical Staff with sufficient expertise concerning the medical issues presented by the Case Summary Review.

Whenever possible, the practitioner primarily responsible for peer review on a chart should be a practitioner who did not play a significant role in caring for the patient.

Once the Professional Standards Committee receives the results of the practitioner peer review, it will make a decision on how to proceed. The Professional Standards Committee is not bound by the findings of the reviewer, and can obtain additional information before deciding how to proceed.

The decision of the Professional Standards Committee may include, but is not limited to, one or more of the following:

(a) Determine no action is needed and close the case;

(b) Send an informational/educational letter to the practitioner in which a response is not requested;

(c) Send a letter to the practitioner requesting a response;

(d) Request that the practitioner appear before the Committee for a discussion of issues raised by the review;

(e) Require the practitioner to complete stated educational objectives and submit proof of completion to the Committee;

(f) Require monitoring using delineated criteria; and/or

(g) Require a proctor to supervise the practitioner on designated portions of the practitioner's practice at PSH, provided that approval by the proctor is not required before the practitioner is allowed to provide care to his patient.

If the Professional Standards Committee determines there is a substantial concern and the action they choose calls for monitoring or proctoring, the following procedures for focused review will be followed:

(a) Notify the practitioner in writing of the concern(s);

(b) Include pertinent medical record numbers; and

(c) State the plan for the focused review:

(1) Including the number of cases to be subject to the focused review*;* and/or

(2) Specifying time frame during which the focused review will continue; and

(3) Identifying if the focused review will be prospective or retrospective*;* and

(4) Listing criteria for focused review; and

(5) Stating when and where the results of the focused review will be reported.

During the period of focused review, the practitioner will be regularly updated regarding the existence of:

(a) Any significant improvement noted that will permit the focused review to cease and the proposed date for such cessation; or

(b) Any additional or continued concerns that would be cause for the focused review to continue, along with the additional number of cases or time period for the focused review to continue.

(c) Any unresolved concerns following focused review may be referred to the MEC. The MEC will have access to any and all materials compiled by the reviewer and/or the Professional Standards Committee. The referral to the MEC may or may not be accompanied by a specific recommendation for corrective action.

(d) If at any time the reviewer or the Professional Standards Committee, or any member of such Committee, reasonably believes that the conduct of any member of the Professional Medical Staff is detrimental to patient safety, detrimental to the delivery of quality medical care, or disruptive to Hospital operations, Article VI ("Precautionary Restriction or Suspension") of the Professional Medical Staff Bylaws will apply, and a written request for corrective action should be submitted to the MEC.

Section 16. Surgical Practice

1. Except in an emergency where immediate surgery is required by the patient's condition, anesthesia will not be given and surgery will not be performed until the clinical record contains a current authenticated history and physical examination report. The medical record must also contain any indicated laboratory reports, the clinical diagnosis, and the anticipated surgical procedure as indicated on the informed consent form.

2. When it is appropriate, specimens will be sent to the Hospital pathologists for pathological diagnosis. Each specimen shall be accompanied by a report stating the nature of the surgery, the pre-operative diagnosis and the post-operative diagnosis, and any special instructions for the pathologist.

3. The informed consent form for surgery shall be properly executed before the patient has received his pre-operative medication.

4. All surgical procedures shall be described in appropriate detail in the medical record. This should be accomplished as soon as practical following the procedure.

Section 17. Testing for Hospital Patients

1. Whenever possible, clinical and pathological laboratory services for Hospital patients shall be performed in or by the Hospital. Any testing which cannot be performed in or by the Hospital will be sent to an outside reference laboratory. The reference laboratory must be accredited by The Joint Commission, DNV Healthcare Inc., or the Commission on Laboratory Accreditation of the College of American Pathologists, and must meet all applicable federal standards for clinical laboratories.

2. The Medical Director or his designee must give his approval prior to tests being performed outside the Hospital when the same or similar tests could be performed in the Hospital.

3. All tissue examinations pertinent to the care of hospitalized patients, which are performed outside the Hospital, shall be reviewed by one of the Hospital pathologists. There will be an appropriate charge to the patient for this review.

Section 18. Treatment - Specific Provisions

1. Any procedure whose sole immediate effect is the termination of a fetus before viability or that of a viable fetus is never permitted. For the purposes of moral context, "before viability" is defined as the interval between conception and implantation of the embryo.

2. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the child is born, even if they will result in the death of the unborn child.

3. Uterine Curettage for complete or incomplete abortion - In these instances, the following rules govern:

   (a) A written statement signed by the attending practitioner that the fetus and/or placental tissue have been passed or a confirmatory report by the clinical laboratory to this effect is on the patient's record.

   (b) Procedures that are designed to empty the uterus of a living fetus still attached to the mother are not permitted.

4. In the case of an emergency where the patient's life or health is immediately threatened, the attending practitioner shall completely detail the causes and facts surrounding the performance of any emergency procedure resulting in termination of pregnancy in the patient's medical records.