St. Joseph Health
St. Jude Medical Center

GENERAL RULES AND REGULATIONS
OF THE MEDICAL STAFF

PURPOSE OF THE GENERAL RULES & REGULATIONS

The Medical Staff of St. Jude Medical Center has developed and adopted the following Rules and Regulations to establish a framework for Medical Staff activities and accountability to the Governing Body.

Individuals who have been initially appointed to the Medical Staff and individuals who have been granted clinical privileges are provided with these General Rules and Regulations and also with those that are specific to the Department and Clinical Service, if applicable, in which the individual has been appointed or that are specific to the Department(s) in which the individual has been granted clinical privileges. These individuals are requested to accept the professional obligations therein reflected, along with accepting clinical privileges. If significant changes are made in these Rules and Regulations or in the Policies of the Medical Staff, members of the Medical Staff and other individuals who have delineated clinical privileges are provided with revised texts of these materials.

The following Rules and Regulations specifically relate to the role of individuals with clinical privileges in the care of inpatients, outpatients, emergency care patients, and patients in hospital-sponsored home care services. Additional sources considered to be the policies of the Medical Staff which may be referenced in these Rules and Regulations include, but are not limited to, the following:

- **Protocol for Medical Staff Charting**
- **Medical Staff Practice Professional Evaluation Policy**

These Rules and Regulations are reviewed according to the frequency specified in the Medical Staff Bylaws. Policies of the Medical Staff are to be reviewed biannually. The Rules and Regulations are revised to reflect the hospital's current practices with respect to Medical Staff organization and functions. Amendments to the Rules and Regulations are by the manner of action outlined in the Medical Staff Bylaws.

RULE 1. ADMISSION OF PATIENTS

Except in case of emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible. The attending practitioner, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he suspects that the patient may be a danger to self or to others or afflicted with an infectious or contagious disease or condition. The attending physician shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's record the reason for his suspicions, and the precautions taken to protect the patient and others. The physician may make recommendations for the placement of patients within the hospital, but the final decision shall rest with the Administration of the hospital.

The hospital shall admit patients suffering from all types of diseases for which the hospital has appropriate resources. The physician shall be responsible for issuing proper orders and recommending approved and appropriate precautionary measures for all cases to clinical and nursing personnel.

1.1 Treatment of Family Members

Physicians will not be allowed to treat themselves or members of their immediate families. Immediate family members are defined as: Spouse, children, siblings, parents, mother-in-law, father-in-law, brother-in-law or sister-in-laws.

1.2 Emergency Treatment

In an emergency setting where there is no other qualified physician available, a staff member should provide treatment until another physician becomes available**.**

RULE 2. MEDICAL RECORDS

2.1 Content

The content of the medical record shall reflect the care given to the patient and shall be consistent with The Joint Commission, Conditions of Participation and Title 22 requirements and are defined in the medical staff charting protocol attached to these rules and regulations.

2.2 Completion

2.2.1. History & Physical

All inpatients shall have a complete history & physical completed within 24 hours of admission. Surgical patients (inpatient & outpatient) shall have history & physical completed before surgery. TCC shall have history & physical completed within 72 hours following admission.

2.2.2. Operative Reports

All operative reports (including cardiac catheterization patients) shall be dictated immediately following the procedure and no later than 24 hours following surgery. Reports of interventional procedures (tissue and non-tissue) shall be dictated immediately following the procedure and no later than 24 hours following the procedure.

2.2.3. Progress Notes

The progress notes shall be timely and legible. Physicians who have been counseled by their Clinical Department Committee for illegibility may be required to utilize an outside dictation service for progress notes documentation. The physician will be responsible for the cost of the transcription service. Non-compliance for use or payment of the service will result in corrective action by the Medical Executive Committee. The outside service must guarantee a four (4) hour turn around time.

2.2.4. Discharge Summary

All discharge summaries shall be completed at the time of discharge or no later 48 hours after discharge and will be deemed delinquent if not completed within 48 hours after discharge. All other completion requirements are documented in the Medical Staff Charting Protocol. The discharge summary shall be completed by the designated attending on the day of discharge.

2.2.5. Timely Completion of Medical Records

The medical record shall be completed within 14 days of discharge.

- For purposes of calculating whether the record is completed within fourteen (14) days of availability, days attributed to the delinquent physician's vacation, illness or leave of absence shall not be included. Physicians are strongly encouraged to contact the Health Information Service department proactively in the event of a vacation, illness or leave of absence.

- The records must be authenticated or signed by a physician, dentist, podiatrist or allied health practitioner. The attending physician will be responsible for the completion of the history & physical and discharge summary, unless otherwise established by policy or documented by the attending physician.

- Any medical record incomplete after 14 days will be considered delinquent and the practitioner will be subject to the suspension policy.

- It is acceptable to authenticate reports/entries of another physician providing the physician is familiar with the case, and the authentication/signature is that of the practitioner reading the report/entry.

- It is not an acceptable practice for someone to sign another's name without indication. If signing for another physician - sign your name, for - on the signature line.

All other completion requirements are defined in the Medical Staff Charting Protocol.

2.3. Incomplete Chart Approval

- A medical record shall not be permanently filed until the responsible physician completes it; or, as ordered by the Medical Executive Committee with recommendation from the Department/Quality Review Committee.

- No Medical Staff member shall be permitted to complete a medical record on a patient unfamiliar to him in order to retire a record that was the responsibility of another staff member who is deceased or permanently or protractedly unavailable for other reasons.

- A signed affidavit will be filed on the chart delineating the reason the chart was not completed.

2.4. Abbreviations & Symbols

Sheila Sloane's Book of Abbreviations and Eponyms shall be referenced to determine hospital-accepted abbreviations. An official record of approved abbreviations shall be kept in Health Information Services

Department and on each Nursing Unit. Final diagnosis and operative procedures shall be records in full, without the use of symbols and abbreviations.

2.5. Suspension

2.5.1. Operative/Procedure Reports

Shall be completed immediately following the completion of the procedure and in no case more than 24 hours following the procedure. The operating physician will be contacted by telephone on any surgical patient on whom an operative/procedure report is not yet completed and advised of the delinquency. The operating physician will be given an additional 24 hours to complete the operative/procedure report or his/her privileges will be temporarily suspended.

2.5.2. General Medical Records

- The medical record shall be completed within 14 days of discharge.
- For purposes of calculating whether the record is completed within fourteen (14) days of discharge, days attributed to the delinquent physician's illness or leave of absence shall not be included.
- Three weeks prior to the department Quality Review Committee meeting, each physician in the department having delinquent medical records will be sent a certified return receipt or email notice indicating that all delinquent medical records will need to be complete prior to the scheduled Quality Review Committee meeting.
- Physicians failing to complete all delinquent available charts by the Quality Review Committee date may be subjected to Medical Record suspension in accordance with Section 9 of the Medical Staff Bylaws.

2.5.2.1 Restriction of privileges will include:

- admitting privileges (surgeons may not admit),
- surgical privileges (surgeons may **not** schedule elective cases or procedures while privileges are restricted (this includes suspension for delinquent medical records, expired licensure, expired insurance or delinquent reappointment or delinquent dues). Cases already on the schedule will NOT be impacted by the restriction in privileges. Only emergency cases will be allowed to be scheduled.
- assisting at surgery,
- administering anesthetics,
- writing orders or attending patients admitted by an associate during the period of restriction.
- However, in the best interest of patient care, restricted physicians shall have the authority to provide medical coverage for patients already in the hospital at the time of such suspension.
- The Anesthesia Clinical Service Chairman and the Anesthesia Schedule Coordinator will be notified when an anesthesiologist has been placed on suspension.

The above policy shall only apply to those patients whose condition does not require immediate care of immediate admission to the hospital. The patient requiring immediate care, whether directed from the physician's office or admitted through the emergency department, will be treated

appropriately regardless of the "restricted" status of the physician. To apply the restriction policy as mentioned above in this type of situation may unduly jeopardize the patient.

2.5.3 Suspension Days Accumulation

Definition of Suspension Day: Any day a physician has privileges restricted for failure to complete delinquent medical records. (Date off suspension – the date on suspension = suspension days)

Accumulated Suspension Days: The sum total of suspension days in a rolling twelve (12) month period and will be the most immediate preceding twelve (12) months.

2.5.4. Fines/Penalties

Fines/penalties for accumulation of suspension days will be instituted as follows:

- At the accumulation of 60 days of suspension a $500 fine will be assessed
- At the accumulation of 90 days of suspension, the physician's automatic resignation will be accepted. The physician will be required to reapply to staff, pay the $800 application fee and a $2000 fine.

The only exception for non-compliance is an illness and must be accompanied by documentation of said illness. Physicians must complete all charts prior to vacation to avoid suspension days while on vacation.

2.5.5. Voluntary Resignation for Medical Record Suspension

Article 7.4-3 of the Medical Staff Bylaws states:

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee. Medical records delinquency that is repeated, flagrant, or egregious shall constitute independent grounds for corrective action under Section 7.2-1.

2.6. Reapplication to the Medical Staff

Reapplication to the Medical Staff as a result of "voluntary resignation" for accumulated ninety (90) days of suspension for medical record delinquency will be processed as follows:

- An abbreviated application process to be completed as defined in the rules and regulations.
- Application will be assessed a reapplication fee.
- Appointment cycle shall maintain an existing reappointment cycle so as not to exceed to two year period of time.

- A new privilege form will not be required to be submitted along with the application. Privileges in place at the time of voluntary resignation will be carried over to the reapplication
- Proctoring requirements will be consistent to those in place at the time of reapplication.

Reapplication to the Medical Staff as a result of "voluntary resignation" for sixty (60) plus days of suspension for medical record delinquency, will be assessed a reapplication assessment fee. The reapplication fee for a physician who resigned pursuant to failure to comply with Article VIII, Section 9 of the Medical Staff Bylaws will be assessed $2000.00 in addition to the routine application fee for the first reapplication. Subsequent reapplication assessment fees for the same reason will increase the reapplication assessment by double each time according the following schedule:

- First voluntary resignation: $800 Application fee plus a **$2000** reapplication assessment fee for a total of **$2800.00**
- Second voluntary resignation: $800 Application fee plus a **$3600** reapplication assessment fee for a total of **$4400.00**
- Third voluntary resignation: $800 Application fee plus a **$5200** reapplication assessment fee for a total of **$6,000.**
- There is no cap on the total amount to be assessed.

The third “voluntary resignation” for sixty (60) plus days of suspension for medical record delinquency, may be deemed reportable to the Medical Board of California under the California Business and Professions Code Section 805. (EMC 5/26/00)

2.6.1 Modified Application for Reapplication to the Medical Staff

The modified application will include the following:

- Applicant's professional qualifications and competency and California licensure;

- Applicant information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership;

- Applicant's professional liability insurance coverage and as to any professional liability claims, complaints, or causes of action that have been lodged against him and the status or outcome of such matters;

- Applicant information as to any pending administrative agency or court cases or as to administrative agency decision or court judgments in which the applicant is alleged to have violated or was found guilty of violating any criminal law (excluding minor traffic violations) or is alleged to be liable or was found liable for any injury caused by the applicant's negligent or willful act or omission in rendering services;

- Applicant information as to details of any prior or pending government agency or third party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare and Medi-Cal fraud and abuse proceedings and felony convictions;

- Applicant information pertaining to the condition of the applicant's physical and mental health as it relates to the clinical privileges requested;

- Certification of the applicant's agreement to terms and conditions set forth in Section 5.6.2. regarding the effect of the application;

- An acknowledgment that the applicant has received (or has been given access to) and read the Medical Staff Bylaws and Rules and Regulations, that he has received an explanation of the requirements set forth therein and of the appointment process, and that he agrees to be bound by the terms thereof, as they may be amended from time to time, if he is granted membership or clinical privileges and to be bound by the terms thereof without regard to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of this application;

- Cross coverage provider is identified and submits a letter agreeing to cross cover for the applicant;

- Current hospital affiliations

  Verification of the application information will include the following:
  - National Practitioner's Data Bank
  - OIG Sanction Data Bank
  - California Medical Board (805 report & licensure)
  - DEA number
  - Malpractice coverage & cases reported
  - New hospital affiliations since last reappointment

  Other processing of application, responsibilities of applicant, effects of application time period for processing and actions shall be consistent with that specified in the Medical Staff Bylaws, Article V.

2.7. Ownership & Release of Information

The medical record is the property of the hospital, and may be removed from the hospital only in accordance with court order, subpoena, or statute. Unauthorized removal of records from the hospital is grounds for suspension of the physician for a period to be determined by the Medical Executive Committee. Written consent of the patient shall be required for release of medical information to persons not otherwise authorized to receive this information. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for continuity of care and for bonafide study and research consistent with the individual patient.

2.7.1. Retention

Patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in a unit medical record system; and shall be safely preserved in an accessible manner for at least the minimum retention period required by law.

2.7.2. Special Studies

Medical records shall be made available for research projects to individuals who have obtained written approval from the Institutional Review Board. Justification of the request should include the subject, purpose of the study and the period of time.

Individually approved requests are limited to increments of twenty-five (25) records at on time and are placed in a designated area in the Health Information Services department for review. Generally, review of these records should be completed within ten (10) days. If the above criteria cannot be complied with, it should be brought to the attention of the Director of Health Information Services.

Subject to the discretion of Administration, former members of the medical staff shall be permitted free access of information from medical records of their patients covering the period which they attended such patients in this hospital.

. **2.8. Responsibility for the Record**

The attending physician is the clinician primarily responsible for care of a patient from the beginning of a hospital stay. If the patient has a private attending physician who arranged for that patient's admission to St. Jude Medical Center, and directs his/her care, this doctor is usually considered to be the attending physician at the hospital. If the attending physician changes during a patient's hospitalization, an order must be written after acceptance by the other doctor involved. Health Information Services personnel may designate the attending physician who was primarily responsible for the care of the patient during the hospitalization when an error has occurred in the original designation. The newly designated attending physician affects the medical record completion process, responsibility for clinical accuracy and legibility.

2.9. Consent

No surgical operation shall be performed without the written consent of the patient or his legal representative except in an emergency, which shall be defined as a condition in which delay might endanger the patient's life and health. The physician should carefully chart the medical determination that an emergency exists in the progress notes. If time permits, it is desirable to have another staff member verify by consultation in writing on the chart that an emergency exists.

2.10. Pathology

All material removed from a patient by operative procedure is the property of the hospital and shall remain in the hospital laboratory for a sufficient time to allow the pathologist to make a permanent record of the case.

2.11. OR Block Time

Surgeons must be in the operating room and ready to begin the operation at the scheduled time. Under most circumstances, the operating room will be held no more than 30 minutes. The case will be reassigned to the end of the operation schedule or another available time slot.

2.12. Consultations

2.12.1 General

It is the responsibility of the attending physician requesting the consultation to coordinate the consultation. All consultations are to be within 24 hours of the request. The two-tier process for consults is as follows:

- **Routine Consult** – The physician requesting the consult will identify the physician he wishes to consult. The nurse may call the designated consultant. If the consultant refuses to accept the request for a consult the nurse will contact the requesting physician who will then be responsible for contacting a consultant.

- **Urgent Consult** – The physician requesting the consult will contact the consultant directly.

The medical staff has developed criteria under which consultation will be required as defined in the Department Rules & Regulations. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.

Qualified physicians, who are not members of the Medical Staff of St. Jude Medical Center, may be called in consultation providing the primary attending physician maintains active control of the case. This physician may not write orders but must document his consultative findings and recommendations within the medical record. These physicians must comply with the requirements for temporary privileges as outlined in Section 6.5 Temporary Clinical Privileges of the Medical Staff Bylaws.

RULE 3. COVERAGE

3.1. Cross Coverage

Each staff member shall designate a physician in good standing, holding similar credentials and privileges at St. Jude Medical Center to be called in his absence. In the event that the practitioner is unavailable or otherwise unable to attend to the medical care and treatment of the practitioner's patients, the designated cross-coverage physician will assume care of the patients, to be called in his absence, or in case he cannot be reached in an emergency. If neither physician can be reached, the Nursing Supervisor initiates a call to the Department Chairman or the Chief of Staff in the absence of the Department Chairman. In the interim, the physician on call for emergency service may be called and may take any action necessary until the patient's own physician can be reached.

3.2. Definition of An Emergency

"Emergency" cases are defined as patients in dire circumstances.

RULE 4. EMERGENCY CARE

The method of providing medical staff coverage in the Emergency Department is through the use of a contract group whose members are members of the Medical Staff. In addition, the Medical Staff has an obligation to participate in the emergency service area in accordance with their Department Rules and Regulations. Specialists shall be available on an established schedule to provide consultation on the needs of emergency patients or to provide special services to emergency patients. Rosters designating Medical Staff members on call for primary coverage and specialty consultations are posted in the emergency care area. The call in the Emergency Department shall be identified by the individual Department/Clinical Services Rules and Regulations. Unless otherwise specified by those Rules and Regulations, the call in the Emergency Department shall be restricted to Active Staff and Provisional Staff practitioners. Other categories may participate at the discretion of the individual Department/Clinical Service rules and regulations. Criteria for physicians on emergency room call include the following:

4.1. Emergency Call Requirement

All Active Staff and Provisional Staff members are required to participate in emergency department specialty back-up call if their specialty is one of those required by the Paramedic Receiving Center criteria for a base station hospital. If the required specialty consists of four or fewer specialists on ER Call, Courtesy Staff members will be required to participate in emergency department specialty back up call.

Each medical staff department and clinical service may require participation by additional staff categories. If the department and clinical service requires participation by Provisional/Observation staff members, these members must comply with their department/clinical service proctoring protocols. Those physicians who have reached the age of 70 years of age or greater and who are not eligible for Senior Active status may have the option of either participating or not participating in the Emergency Department specialty back-up Call Panel.

4.2. Response Time

A two (2) hour physical response time is instituted for those patients admitted to the Critical Care Unit through the Emergency Department who have not yet been seen by the admitting or attending physician.

The response time for a physician when on call should be rapid enough to meet the requirements of the Joint Commission on Accreditation of Hospitals, Standard I Emergency Services for a Level II emergency service and the requirements of their Clinical Department. The Standard requires specialty consultation be available within approximately 30 minutes by members of the Medical Staff; initial consultation through two-way voice communication is acceptable.

4.3. Duty to Respond

The response to a call from the Emergency Room shall be equal for all patients regardless of their financial ability to pay, or insurance/Medi-Cal/Medicare status.

4.4. Emergency Back-up Coverage Protocol

All Active and Provisional Staff members, in the specialties noted below will be required to provide specialty back-up call coverage. The Clinical Departments/Clinical Services will be asked to evaluate the Active/Provisional Staff call panels for adequacy and may recommend additional categories for required participation. In addition to the matter of mandatory call, the following protocol was adopted relative to the management of the "unassigned" emergency department patients requiring admission to the hospital:

- The Emergency Department physicians will continue to see patients and triage in accordance with their specialty training.

- In case of surgical, medical or cardiac emergency, the Emergency Department physician has the prerogative to call the appropriate specialist on the call panel who should in turn contact the primary care physician on the call panel as part of the admitting team. If the primary care physician is called first, he/she should call the specialist on the call panel if a specialist is needed. If a determination is made that a specialist is needed after admission and the primary care physician is unable to obtain a specialist, the specialist on the call panel for the day of the consult request should be contacted for that consultation.

- On all surgical cases, the primary care physician will be asked to assist if the physician has assisting privileges, or the primary care physician may release that responsibility to the surgeon. The surgeon has the ultimate decision relative to whom his/her assistant will be.

- A mandatory call system is required in order to meet the criteria requirements of the Paramedic Receiving Center (PRC), Medicare (CMS) and Title 22. Required on-call panels are those specialties necessary to meet the requirements of the Paramedic Receiving Center. Family Medicine and Internal Medicine will combine

Department members into one Primary Care Call Panel. Specialties excluded from mandatory call will be Allergy, Dermatology, Neurology and PM&R as they do not practice primary care.

- The following specialty ER Call Panels are required in order to be in compliance with the PRC guidelines:

Designated Specialties		
Anesthesiology	Orthopedic Surgery	Dental or Oral Surgery
Cardiology	Otolaryngology	Neurosurgery
Family Medicine	Pediatrics	Ophthalmology
General Surgery	Plastic Surgery	Psychiatry
Gynecology	Cardiovascular Surgery	Urology
Internal Medicine	Vascular Surgery	Neurology
Obstetrics	(General Surgeons with Vascular surgery privileges)	

- Based upon the above-noted protocol, all medical staff members with hospital privileges to practice the specialties which require on-call panel support of the Emergency Department and who also maintain Active and/or Provisional Staff status must participate on the required on-call panels as an obligation of medical staff membership. Each clinical department will be given the prerogative of determining additional categories of Staff membership whose members may be required to participate, e.g. Senior Active, Courtesy, Provisional/Observation. This decision will be left to the discretion of each department and/or clinical service.

- Required on-call panels are those specialties necessary to meet the requirements of the Paramedic Receiving Center. Family Medicine and Internal Medicine will combine Department members into one Primary Care Call Panel. Specialties excluded from mandatory call will be Allergy, Dermatology, and PM&R.

4.5. Emergency Medicine Physician – Transition Orders

Emergency Medicine physicians are responsible for the care of patients while the patient is physically present in the emergency department under their care. However emergency physicians may write transition orders that appear to extend control and responsibility for the patient into the inpatient area. This should not be considered admitting privileges and it is understood that the admitting physician retains responsibility for providing inpatient/observation care. (EMC 5/11)

4.6 ER Call Responsibility

The physician on call is required by the Medical Staff Bylaws to respond to the ER and assess the patient for all cases, if requested by the ED physician. If the physician feels that he/she is unable to manage the severity of the case then he/she must document this in the medical record.

The physician on call is required to secure a consultation with an appropriate specialist who is a member of the medical staff. If these efforts are unsuccessful, the ER physician will assist the on-call physician with securing a transfer to another facility/appropriate level of care.

RULE 5. HOME HEALTH CARE

The hospital provides a home care program to serve those patients whose medical, nursing, social, and related health needs can be met in their place of residence. Each patient receiving home care services shall be under the care of a physician and shall be informed as to the identity of the physician primarily responsible for his/her care. The responsibility of physicians and other professionals in the delivery of health care services in the home care program is clearly identified in the policies and procedures of St. Joseph Home Health Agency. The Medical Staff shall assure that the quality of care provided to home care patients is appropriate.

RULE 6. OUTPATIENT SURGERY SERVICES

Surgical services are provided to both inpatients and outpatients. The policies and procedures are consistent with those applicable to inpatient surgery, anesthesia, and post-operative recovery. These requirements are defined in the charting protocol.

The Medical Staff is responsible for assuring that a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care provided through the Outpatient Surgery Service is implemented.

RULE 7. ADMITTING PRIVILEGES

Qualified diagnostic radiologists may be granted admitting privileges for invasive radiology procedures on an individual basis with appropriate consultation.

Qualified Anesthesiologists may be granted admitting privileges for pain treatment or therapy on an individual basis.

RULE 8. AUTOPSIES

Staff Members shall attempt to secure consent to meaningful autopsies. Every staff member should be encouraged to obtain an autopsy in cases where diagnosis is unclear. Autopsies are encouraged in the situations identified by the College of American Pathologists:

- Deaths in which an autopsy would explain unknown or unanticipated medical complications.
- All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
- Deaths in which an autopsy would allay concerns of and/or to reassure the family and/or the public regarding the death.
- Unexplained or unexpected deaths during or following any dental, medical or surgical diagnostic procedures and/or therapies.
- Deaths of patients participating in clinical investigations.
- Unexpected or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction.
- Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (i) persons dead on arrival at hospitals, (ii) deaths occurring in hospitals within 24 hours of admission, and (iii) deaths in which patient sustained or apparently sustained an injury while hospitalized.
- Deaths resulting from high risk infectious and contagious diseases.
- All obstetric deaths.
- All perinatal and pediatric deaths.
- Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
- Deaths known or suspected to have resulted from environmental or occupational hazards.

An autopsy may be performed only if authorized in accordance with law. (The persons who may consent to autopsies are identified by the CHA *Consent Manual*). It shall be the duty of all staff members to seek consent for autopsies whenever possible.

Except in coroner cases, all autopsies shall be performed by the Hospital pathologist or his/her designee. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist within 24 hours (excepting weekends and

holidays) after completion of the autopsy. The complete protocol should be made a part of the record within 60 days. Exceptions may be made when consultation on an autopsy precludes prompt completion. The Pathologist shall notify the attending physician when the autopsy is being performed.

8.1. Coroner's Cases

The law requires death to be reported to the coroner in the following circumstances:

- Violent, sudden, or unusual deaths.
- Unattended deaths.
- Deaths wherein the deceased has not been attended by a physician in the 20 days before death.
- Deaths related to or following known or suspected self-induced or criminal abortions.
- Known or suspected homicide, suicide, or accidental poisoning.
- Deaths known or suspected as resulting in part from or related to an accident or injury, either old or recent.
- Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration.
- When the suspected cause of death is sudden infant death syndrome.
- Death in whole or in part occasioned by criminal means.
- Deaths associated with a known or alleged rape or crime against nature.
- Deaths in prison or while under sentence.
- Deaths known or suspected as due to contagious disease and constituting a public hazard.
- Deaths from occupational diseases or occupational hazards.
- Deaths of patients in state mental hospitals serving the mentally disabled and operated by the Stated Department of Mental Health.
- Deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services.
- Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

The coroner also asks for reports of deaths due to drug addiction, pneumoconiosis and therapeutics misadventures as well as deaths during or within 24 hours after operations.

RULE 9. PHYSICIAN ADVISORS FOR CASE MANAGEMENT

Physician Advisors will be available for the Case Management nurses for problems requiring physician expertise. These may be during the pre-admission, admission, concurrent, or retrospective review process.

The Case Management nurse will first attempt to discuss the problem with the attending physician or his/her designee; and resolve the problem. If this problem cannot be resolved with the attending physician, the physician advisor will be called to assist in making a determination and possible interaction with the attending.

The Physician Advisor may be requested to assist with the review of cases requiring an appeal.

RULE 10. TEMPORARY PRIVILEGES FEE

Temporary privileges may be granted in accordance with the Medical Staff Bylaws. A fee of $400.00 is required for the granting of temporary privileges.

RULE 11. MALPRACTICE INSURANCE REQUIREMENTS

The minimum limits for malpractice insurance coverage are $1,000,000 per occurrence and $3,000,000 aggregate.
A low risk specialty classification has been created wherein $500,000/$1,000,000 malpractice insurance limits would be accepted. This low risk specialty classification includes the following specialties:

- Allergy/Immunology

- Dermatology without radiation or plastic repair
- Family Practice with no surgery, surgery assist, or obstetrical privileges

Any medical staff member who might have a financial problem should submit a letter to the Board of Trustees for individual consideration.

RULE 12. CME PROGRAM FOR NON STAFF PHYSICIANS

Non-staff physicians and non-staff Allied Health Professionals may attend the Continuing Medical Education program provided they pay an annual assessment of $200.00 to cover the costs of the luncheon/programs and that they carry a valid license that is clear and in good standing with the Medical Board of California. The Medical Staff Services Department will provide these physicians with a report at the end of the year. (An exception is provided for California State University physicians who pay the same assessment as that of a medical staff member.)

RULE 13. FAILURE TO COMPLETE PROCTORING – REAPPLICATION

The term of proctoring for initial appointment shall extend for a minimum period of time or cases as defined in the Department rules and regulations. The term "Observation" will be added to the Medical Staff category to indicate that proctoring is required on clinical privileges. The initial proctoring period shall be twelve (12) months. The period of proctoring may be extended in increments of not more than twelve (12) months each, for a total proctoring period of not more than twenty-four (24) months. If an initial appointee fails within that initial proctoring period to complete proctoring on the minimum number of cases, his/her Medical Staff membership or particular clinical privileges, as applicable, shall be terminated, unless the applicant has shown progress toward completion of his/her proctoring requirements during the initial proctoring period (the first 12 months) by completing at least sixty percent (60%) of his/her proctoring requirements, then the Department chairman may recommend to the Medical Executive Committee that the practitioner's provisional appointment be extended for an additional twelve (12) months. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases, the change in Medical Staff category or Department assignment or the additional privileges, as applicable, shall be terminated.

The Medical Executive Committee chairman shall give the initial appointee so affected written notice that his/her Medical Staff membership and/or clinical privileges have been terminated because he/she failed to satisfactorily complete the proctoring requirements and that the affected practitioner has the right to request the Limited Hearing pursuant to Section 8.2. Thereafter the procedure set forth in Article 8.2 shall be followed. This request is subject to the Limited Hearing and Appeal as it applies in Section 8.2. The term "Observation" will be removed upon completion of proctoring requirements or at such time that privileges are removed or relinquished.

Reapplication to the Medical Staff as a result of "automatic termination" for failure to complete the proctoring requirement within the initial or subsequent proctoring period, will be assessed a reapplication fee. The reapplication fee for a physician who was terminated for failure to comply with Article 5.6-4of the Medical Staff Bylaws will be assessed $600.00, in addition to the routine application fee for the first reapplication. Subsequent reapplication assessment fees for the same reason will increase the reapplication assessment by double each time according the following schedule:

- First voluntary resignation $600 Application fee plus the $600. Reapplication assessment fee for a total of $1200.00.
- Second voluntary resignation $600 Application fee plus a $1200 reapplication assessment fee for a total of $2400.00.
- With no cap on the total amount to be assessed.

Additionally, the applicant will be required to interview with the Credentials Committee prior to approval of membership.

RULE 14. RESTRAINT

Refer to Hospital Administration Policy and Procedure for Restraints

Restraint shall only be used if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective. The use of restraint must be selected only when other less restrictive measures have been found to be ineffective to protect the patient or others from harm.

A physician order for the initiation and use of restraints stating clinical justification and time frame must be present. If the physician is not available to issue the order, restraint use may be initiated by a registered nurse based on an appropriate assessment of the patient. In this case, the physician must be notified within 12 hours of the initiation of the restraint, and a verbal or written order obtained and entered into the medical record. A written order based on examination of the patient by a physician should be entered into the medical record within 24 hours of the initiation of restraint. Exceptions to the need for a physician's order include: Restraint use that is associated with medical, dental, diagnostic or surgical procedures and is based on standard practice for the procedure; Restraint device used to meet the assessed need of a patient who requires adaptive support; Therapeutic holding or comforting of children; Time out for 15 minutes or less when its use is consistent with behavior management standards; Forensic or corrective restrictions used for security purposes; Helmets; and Medications administered as part of a psychiatric plan of care, or as adjuncts to procedural restraints or to induce sleep or to treat anxiety or agitation or to control behavior/restrict movement that is standard treatment for the patient's condition.

Behavior Management: In the event restraint is used in an emergency situation to manage an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient or others, a physician must perform a face-to-face evaluation of the patient within one hour on initiation of restraint or seclusion and enter a written order into the medical record.

Written orders for restraint are limited to a calendar day, except when used for behavior management (3.) where it is limited to four hours for an adult, two hours for children and adolescents ages 9-17 and one hour for patients under 9. In those instances the original order may be continued after RN assessment in accordance with these limits for up to 24 hours.

There shall be no PRN orders for restraint.

RULE 15. LABORATORY

When a patient is admitted to St. Jude Medical Center for a definitive surgical resection based upon a histiopathic diagnosis rendered at another institution, a copy of the outside pathology report must be included in the patient's chart to complete the medical record. Although it would be most desirable to have the pathology report available by the time of surgery, the scheduling of surgery will not be affected by this requirement. Failure to include the report will be considered a chart delinquency.

Appropriate pre-transfusion lab values are required to be on the chart prior to transfusion.

RULE 16. CONTRACT SERVICES

On annual basis, the Medical Executive committee shall evaluate and make recommendations on the services provided by physicians under exclusive hospital-based service contracts to the governing board.

Outside Laboratories - On an annual basis, an appropriate committee of the medical staff shall evaluate the services provided by outside reference laboratories and make appropriate recommendations to the Medical Executive Committee and Administration.

RULE 17. ESTABLISHMENT OF DUES & ASSESSMENTS

As defined in the Bylaws (Article 15.2) the following dues/assessments and reappointment Fees are established for the Medical Staff:

Annual Membership Dues	
Category	**Amount**
Senior Active	160.00
Active	310.00
Provisional	410.00
Community Supportive	410.00

Courtesy	510.00
*Telemedicine	100.00
AHP Annual Dues	260.00
Includes 60.00 for CME fees for all staff categories **Not a staff category*	
Assessments	
Initial Appointment	600.00
Reappointment – Medical Staff & AHP Staff (excluding employees of SJMC)	
Returned 120 – 61 days	250.00
Returned < 60 days (late)	500.00
AHP Appointment Application	300.00
Temporary Privilege Request	400.00
Medical Record Suspension Fines/Penalties Fines/penalties for accumulation of suspension days will be instituted as listed.	500.00 for 60 days 2,000.00 to reinstate
CME for non-staff Physicians	200.00

RULE 18. MEDICAL STAFF FUNDS
The Medical Executive Committee has delegated the authority to approve expenditures from the Medical Staff Funds to the Elected Officers (EMC 12/2007).

RULE 19. UNIVERSAL PROTOCOL TO PREVENT WRONG PERSON, WRONG PROCEDURE; SITE/SIDE OPERATIONS AND/OR PROCEDURES
All members of the medical staff will be required to abide by the Universal Protocol Policy.

RULE 20. SCREENING FOR TUBERCULOSIS
All members of the Medical Staff will be required to abide by the Screening for Tuberculosis Policy unless otherwise noted. Failure to comply with the Screening for Tuberculosis Policy will result in the physician's initial or reappointment application being deemed as incomplete. Exceptions to this requirement will be made for physicians who do not perform direct patient care i.e. Teleradiologist. (EMC 9/15/08)

RULE 21. MEDICAL SCREENING EXAMINATION REQUIREMENT
The following practitioners are authorized to conduct a medical screening examination to determine if an emergency medical condition exists:

Physician Assistants and Nurse Practitioners who have been granted practice privileges and are allowed to perform Medical Screening on all patients with an Emergency Severity Index (ESI) 3, 4 or 5. All ESI 3 patients must be seen by a physician prior to discharge.

Labor and Delivery: Physician members of the medical staff and Registered Nurses who have completed the competency program and are operating under an approved Standardized Nursing Protocol.

RULE 21. PROFESSIONAL CONDUCT
All members of the medical staff will be required to conduct themselves professionally and in a manner that promotes collegial interaction and exchange of information for the improvement of patient care, education of members and betterment of the Medical Staff**.** (Medical Staff Bylaws, Article III, Code of Conduct)

21.1 Impaired Physicians
In the case of a medical staff member who is impaired by chemical dependency and/or mental illness, the Chief of Staff and the

Chairman of his/her Department will meet and evaluate his/her status before (s)he can admit and treat patients at this hospital. At the discretion of the Chief of Staff and the Department Chairman, the physician who was impaired may be required to submit an independent physician's statement regarding his/her physical and/or mental status and ability to resume patient care responsibilities.

In the case of a medical staff member who is unable to practice medicine because of a short-term illness, a prolonged illness, or surgery that affects his/her ability to provide patient care in a generally recognized level of quality and efficiency established by the hospital, the medical staff member shall be required to notify the Department Chairman and, before resuming patient care responsibilities, may at the Department Chairman's discretion, be required to submit a physician's statement regarding his/her physical status and ability to resume patient care responsibilities.

If the independent physician's statement regarding the medical staff member's physical and/or mental status and ability to resume patient care responsibilities differs from the medical staff member's private medical doctor, a third opinion will be required. Reports will be submitted to the Chief of Staff and the Medical Executive Committee for resolution of the issue.

21.2 Medical Staff Discrimination or Harassment – Investigation & Disciplinary Procedures

Policy Prohibiting Harassment

It is a basic responsibility of Medical Staff membership to work cooperatively with physicians, nurses, hospital administration and others so as to not adversely affect patient care. Such cooperation is necessary to insure efficient and proper functioning of the healthcare team.

Examples of disruptive behavior include, but are not limited to: 1) Verbal abuse of other physicians, nurses, technicians or other employees; 2) Verbal abuse which is directed at large but is perceived by a member of a group to be problem behavior; 3) Delaying the progression of surgery or other procedures to reprimand nurses or staff; 4) Throwing instruments or other equipment; 5) Making false accusations of unprofessional behavior against other physicians; or 6) Any other aberrant behavior which, it reasonably appears, may lead to a compromise of quality of care, either directly or because it disrupts the ability of other professionals to provide quality of care.

Discrimination or harassment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition, age, sexual orientation, or marital status is prohibited by Federal and/or State law, as well as by the medical staff and hospital.

For the purposes of this policy and procedure, "sexual harassment" is defined as unwelcome or unwanted advances, requests for sexual favors and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with an individual's employment or creates an intimidating, hostile or offensive work environment. Violations of this policy regarding discrimination or harassment are grounds for corrective action in accordance with this policy and the Medical Staff Bylaws.

Reporting

Complaints involving discrimination or harassment where the person who is the alleged harasser is a member of the Medical or AHP Staff, by whomever received, should be referred immediately to the Chief Executive Officer or the Chief of Staff or designees. All such complaints shall be investigated and addressed as set forth in this policy and procedure. Requests by a reporting party that nothing be done about the event, and that it is for "information only" will not be granted.

Complaints involving discrimination or harassment, where the person who is the alleged harasser is a hospital employee, by whomever received, should be referred immediately to the Vice President, Human Resources and will be investigated and

addressed in accordance with hospital policies, except that if the complainant is a member of the Medical or AHP Staff, the Chief of Staff or designee shall be kept apprised of the status of the investigation.

As used in this document, the "AHP Staff" is meant to refer to a staff comprised of allied health practitioners who are neither hospital employees nor members of the medical staff but who have been granted privileges or other authorization to perform certain patient care services in the hospital under the auspices of the medical staff.

Initial Review Mutually Acceptable Resolution

a) An initial review of each discrimination or harassment complaint will be made by the Chief Executive Officer (or designee) Chief of Staff (or designee) and/or the Department Chairman. If any of these individuals is the alleged harasser, the President/CEO or Vice Chief of Staff in the case of the Chief of Staff, will appoint another individual to conduct the review.

b) The initial review shall consist of interviewing the parties involved in the dispute. The individual who has made the complaint will be assured that confidentiality will be maintained to the extent possible and that no retaliation will be permitted. However, the complainant should be told that the complaint will have to be shared with the physician or member of the AHP Staff who is alleged to have engaged in the inappropriate conduct.

c) The physician or member of the Allied Health Staff who is accused of discrimination or harassment will be advised of the hospital's and medical staff's strict policy against discrimination or harassment, and informed that the hospital will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the investigation, and that any violation of this policy will be considered an independent cause of discipline, regardless of the merits of the underlying discrimination or harassment charge.

d) The individual registering the complaint will be informed that he or she should contact the Chief Executive Officer or Medical Staff representative immediately if he or she believes that any further violation of the policy against discrimination or harassment has occurred, or if retaliation occurs.

e) The purpose of the interview with the complainant and the person who is the alleged harasser, is to determine whether the problem can be appropriately resolved to the satisfaction of both individuals without further investigation. If the parties can agree to a mutually acceptable resolution, the investigation can stop at this point. On the other hand if the parties cannot agree to a mutually acceptable resolution, or if the Chief Executive Officer and Medical Staff representative do not believe that resolution is appropriate then the problem should be resolved in accordance with the Informal Investigative Procedures set forth in Article IV.

f) If the investigation stops at this point, the Chief of Staff and President/CEO should be informed of the resolution of the dispute. A written summary of the resolution of the dispute shall be prepared. This written summary should be limited to a brief factual statement setting forth the resolution of the problem. The written summary, plus all interview notes, shall be maintained in the Medical Staff Office; however, because the writings are not the proceedings nor records of a medical staff committee, they will not be immune from discovery under Section 1157 of the Evidence Code.

g) Whenever feasible the Initial Review should be completed within seven (7) business days (excluding weekends and holidays) after receipt of complaint. In any event the Initial Review should be completed as soon as reasonably possible.

h) In all cases where the Initial Review appears to have resolved the issue, the Chief Executive Officer and Medical Staff Representative shall monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be as the Chief Executive Officer and Chief of Staff determine will be most effective

and may include follow-up interview if appropriate. Any recurrence will be immediately reported to the Medical Executive Committee and referred for formal investigation.

Informal Investigative Procedures

a) When a harassment or discrimination complaint cannot be resolved to the mutual satisfaction of the parties, the matter should be investigated by a Joint Investigating Committee. The Joint Investigating Committee shall consist of the Chief Executive Officer; the Vice President, Human Resources; the Chief of Staff or designee, and Chair (or designee) of the Department to which the person who is the alleged harasser is assigned. When the complainant involves a hospital employee, the Vice President, Human Resources may be required to conduct a parallel investigation. The Investigating Committee shall include at least one member of each sex, if the complaint is of sexual harassment. If any of these individuals is unavailable or is the subject of the complaint, the President/CEO (concerning the Chief Executive Officer or the Vice President, Human Resources) or the Medical Executive Committee (concerning the Chief of Staff or Chair of the Department) will appoint another individual to the Committee for purposes of addressing that specific complaint.

b) The initial review shall consist of interviewing separately each party involved, including witnesses. The interviews shall begin with introductions and an explanation/overview of the mediation and corrective action procedures and goals under this policy and procedure. The importance of maintaining confidentiality of the information exchanged during the discussions shall be emphasized.

c) The individual who has made the complaint will be assured that, in any event, confidentiality will be maintained to the extent possible and that no retaliation will be permitted against the complainant. The complainant will also be told that the complaint will have to be shared with the member of the Medical or Allied Health Staff who is alleged to have engaged in the inappropriate conduct.

d) The member of the Medical or Allied Health Staff who is accused of discrimination or harassment will be reminded of the hospital's and medical staff's strict policy against discrimination or harassment, and informed that the hospital and medical staff will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the hospital's and medical staff's investigation. The person who is the subject of the complaint shall also be informed that any violation of this policy will be considered an independent cause of discipline, regardless of the merits of the underlying discrimination or harassment charge.

e) The individual registering the complaint will be informed that he or she should contact any member of the Joint Investigating Committee immediately if he or she believes that any further violation of the policy against discrimination or harassment has occurred, or any retaliation has occurred.

f) Written documentation of the investigation and any resulting recommendation will be maintained throughout the process. The Joint Investigating Committee shall have access to the notes and written summaries compiled during the Initial Review.

g) The investigation shall consist initially of a private interview of the complainant with the Joint Investigating Committee. Whenever feasible this interview should occur within seven (7) working days after the appointment of the Joint Investigating Committee to learn the factual allegations, to determine whether there are any witnesses and to assess what kind of remedial action the complainant is requesting. In any event, this interview should be completed as soon as reasonably possible.

h) Recommended remedial measures could include, but not be limited to, written admonition, censure, reprimand or warning; written, private or public apology; agreed upon remedial actions. Any written warning will describe the

unacceptable conduct and specify the improvement and actions (e.g. attendance at a sensitivity training seminar) needed, as well as the consequences for further problem behavior.

i) The Joint Investigating Committee should interview any individuals who may have information pertinent to the matter being investigated. The physician or member of the Allied Health Staff who is the subject of the investigation should be interviewed to obtain his or her account of events.

j) Once the investigation is completed, the Joint Investigating Committee will present its findings and recommendations in writing to the President/CEO and Chief of Staff. The Joint Investigating Committee may make a determination that no inappropriate conduct occurred and that no further action is required. The Joint Investigating Committee may make a determination that inappropriate conduct occurred, but that the parties have agreed to a mutual resolution of the problem including certain remedial actions. Alternatively the Joint Investigating Committee may make a determination that inappropriate conduct occurred but that the parties could not reach a mutually acceptable resolution to the problem. In that case, the Chief of Staff should refer the written findings and recommendations of the Joint Investigating Committee to the Medical Executive Committee. The Medical Executive Committee shall determine what, if any, remedial actions should be taken. Because the Joint Investigating Committee's report is not the proceedings or records of a medical staff committee, it will not be immune from discovery under Section 1157 of the Evidence Code.

k) The person filing the complaint and the physician or member of the Allied Health Staff against whom the complaint was filed will be informed of the findings and recommendations of the Joint Investigating Committee.

l) In all cases where the informal investigation appears to have resolved the issue, the Chief Executive Officer and relevant Department Chair shall monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be that which the Joint Investigating Committee determines will be most effective and may include follow-up interviews if appropriate. Any alleged recurrence of harassment will be immediately referred to the Medical Executive Committee for possible corrective action.

m) Whenever feasible, the informal investigative process outlined in this section should be completed within ten (10) to fifteen (15) working days, except for follow-up activities and monitoring, which shall continue as long as is deemed necessary by the Joint Investigating Committee. In any event the informal investigative process should be completed as soon as reasonably possible.

n) A hospital employee who makes false allegations of discrimination or harassment against a member of the Medical or Allied Health Staff, shall be subject to appropriate Hospital disciplinary action, which could include termination of employment. A Medical or Allied Health Staff member who makes false allegations of discrimination or harassment against another member of the Medical or AHP Staff or against a hospital employee shall be subject to appropriate discipline by the Medical Executive Committee.

o) Even where the dispute appears to have been fully resolved by the informal investigation, the medical staff shall be free to continue to investigate and/or to take any further corrective action which it may deem appropriate.

Formal Corrective Action

a) Where the dispute has not been resolved via the initial review or informal investigation process set forth above, or if there is recurrence of a dispute that was earlier deemed to be resolved, the Joint Investigation Committee will present a report in writing on the investigative efforts and the Committee's current findings and recommendations to the hospital's President/CEO and to the Medical Staff's Medical Executive Committee. In that case, the Medical Executive Committee shall determine what, if any, remedial actions should be taken.

b) Appropriate remedial actions may range from letters of admonition, censure, reprimand or warning; imposition of terms of probation or special limitations upon continued medical staff membership; written private or public apology; and medical/psychiatric evaluation by a professional of Medical Executive Committee's choice; to restriction, suspension or revocation of Medical staff or Allied Health Staff Membership.

In the event that it is determined that the conduct was so serious that it warrants placing formal restrictions upon staff membership or privileges, such as would provide grounds for a hearing under Medical Staff Bylaw the Medical Executive Committees shall follow the procedures outlined in Corrective Action, of the Medical Staff Bylaws when the alleged harasser is a Medical Staff member or the grievance process outlined in the Advance Practice AHP Rules & Regulations. In that event, the investigation conducted by the Joint Investigating Committee, as set forth above, shall substitute for the investigative process set forth in Article 7, Section 7.2-3, unless the Medical Executive Committee determines that additional investigation is required. When the conduct involves a member of the Allied Health Staff, the procedures set forth in the Medical Staff Bylaws shall be followed, except that the investigation of the Joint Investigating Committee shall substitute for any required initial investigation, unless it is determined that additional investigation is required.

c) Except for the final decision, all documents created as part of the formal corrective action investigation, as well as any subsequent appeal, shall be considered the proceedings and records of a Medical Staff committee and they will be immune from discovery under Section 1157 of the Evidence Code.

d) When formal corrective action has been pursued, the person filing the complaint and the member of the Medical or Allied Health Staff against whom the complaint was brought will be informed of the final decision of the Hospital's Board of Trustees.

Administrative/Investigative Leave of Absence

a) If harassment or discrimination allegations are of physical violence or conduct which is "seriously disruptive of hospital operations," and if the facts available to the decision-maker support such allegations (i.e., there is corroborating or otherwise reliable physical or testimonial evidence) immediate action shall be taken to provide appropriate interventions to insure the safety of the complainant and to stabilize the work situation. The President/CEO, Chief of Staff and Chief Executive Officer, or designees, will immediately meet and confer in person or by telephone and attempt to assess the validity and seriousness of the allegations. If the group is of opinion that the report of problem behavior is valid and seriously disruptive of hospital operations, the person who is the subject of the complaint shall immediately be placed on administrative leave of absence by the Chief of Staff, Medical Executive Committee or President/CEO.

Before the President/CEO or Chief of Staff imposes an immediate administrative leave of absence, he or she shall make reasonable attempts to contact the Medical Executive Committee. An administrative leave of absence imposed by the President/CEO or Chief of Staff which has not been ratified by the Medical Executive Committee with two (2) business days (excluding weekends and holidays) shall terminate. Such administrative leave of absence shall be effective immediately upon delivery of verbal notice thereof to the affected practitioner. Such verbal notice shall be confirmed by written notice provided to the practitioner within one (1) working day. Copies of the leave of absence notice shall be immediately delivered to the Medical Executive Committee of the medical staff and to the hospital's President/CEO. Such action is an alternative to, and is in no way dependent upon following the corrective action procedures set forth in the Medical Staff Bylaws.

b) Promptly, but in no event more than five (5) business days (excluding weekends and holidays) after imposition of an administrative leave which has not been canceled by the Medical Executive Committee, the Medical Executive Committee shall meet again informally to more fully consider the administrative leave of absence. The affected practitioner shall be given timely notice of and opportunity, but is not required, to attend such informal meeting. The meeting shall not be a full hearing but is intended to identify the alleged basis for the immediate action. This meeting

shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the medical staff bylaws with respect to hearings shall apply thereto. The Medical Executive Committee shall make a record of the interview.

c) Within Five (5) business days, (excluding weekends and holidays) following the informal meeting, the Medical Executive Committee shall issue a written recommendation regarding the administrative leave of absence. This recommendation may be that the administrative leave of absence be continued for a specified time and purpose, that it be lifted upon particular conditions, that the administrative leave of absence be terminated, that the affected practitioner's Medical Staff or Allied Health Staff membership or privileges be summarily suspended or terminated, that restrictions be imposed on the affected practitioner's practice, or such other action as may seem warranted.

d) If the Medical Executive Committee recommends any action that "constitutes grounds for hearing" in accordance with the Medical Staff Bylaws, it shall provide the practitioner with all notice and hearing rights guaranteed under Article 8.4 If the Medical Executive Committee does not recommend formal corrective action against the accused practitioner, the Committee shall submit any recommendations it may have to the Joint Investigating Committee in writing. In the event that an informal investigation is recommended, the procedures outlined in Section 8.4 above, shall apply. Generally, an Administrative leave imposed under this policy and procedure should not remain in effect for longer than twenty (20) days.

e) Immediately upon imposition of an administrative leave of absence, the Chief of the Medical Staff or responsible Department Chairperson shall have authority to provide for alternate medical coverage for the patients of the practitioner still in the hospital at the time of such leave of absence. The wishes of the patient shall be considered in the selection of such alternative practitioner.

f) This "administrative leave of absence" shall not constitute a "summary suspension" and will not be reported to the Medical Board of California or the National Practitioner Data Bank until such time as the physician or member of the Allied Health Staff has exhausted his or her hearing rights under the Medical Staff Bylaws. The "administrative leave of absence" will not be reported unless after a Judicial Review Hearing, it is determined that the action was taken for a "medical disciplinary cause or reason." as that term is defined in Section 805 of the California Business and Professions Code.

For purposes of this policy and procedure, "seriously disruptive of hospital operations" shall mean any conduct which involves physical assault or battery with the potential for bodily harm, any intentional actions which exposes an individual to bodily fluids, or any other conduct which is so outrageous that it seriously interferes with the hospital's ability to deliver quality patient care.

Such administrative leave of absence for investigative purposes shall not be considered a summary suspension of privileges, nor shall it be reportable to the Medical Board or National Practitioner Data Bank.

The purpose of the administrative leave is to immediately defuse the situation and allow time for the Medical Executive Committee to consider appropriate action. Deliberations should lead to a recommendation of attempted informal mediation or to a recommendation of formal corrective action. In either case there should be no need to continue the administrative leave. If the Medical Executive Committee determines that there is an imminent danger to the health of an individual presented by the accused Medical or Allied Health Staff member, the appropriate remedy would be summary suspension. If there is no immediate danger, the accused should be allowed to resume practice at the hospital and the usual corrective action mechanism should suffice.

RULE 22. PHYSICIAN ASSISTANT SUPERVISION

Supervising physician must countersign all entries within **7 days** of being seen and treated by their Physician Assistant.

22.1 Allied Health Professionals - Emergency Room First Call

At the discretion of the supervising/sponsoring physician ER first Call allows other appropriate licensed persons acting within their scope of licensure and practice privileges under the supervision of a treating physician/surgeon. At the discretion of ER treating physician they may request to communicate directly with the consulting physician and surgeon, and may require the consulting physician and surgeon to examine and treat the patient in person when it is determined to be medically necessary, as specified (MEC 3/28/12).

22.2 Physician Assistant/Nurse Practitioner (AHP) - Acting as first consult

At the discretion of the supervising/sponsoring physician can send their PA/NP to consults when acting within their scope of licensure and practice privileges under the supervision of a treating physician/surgeon. At the discretion of the treating physician they may request to communicate directly with the consulting physician and surgeon, and may require the consulting physician and surgeon to examine and treat the patient in person when it is determined to be medically necessary, as specified (MEC 7/15).

RULE 23. MEDICAL STAFF ELECTRONIC BALLOT PROCESS

Whenever an election for Elected Officers or for Medical Staff Bylaws are to be conducted secret ballots shall be done using an approved vendor authorized to perform electronic balloting services. The outside vendor will be approved by the Officers of the Medical Staff.

23.1 Electronic Secret Ballots

a) All Active & Senior Active members shall receive notification of balloting instructions by the authorized vendor. Instruction will include a username and password randomly selected by the authorized vendor.
b) Vote shall be cast within the designated time period as noted on the instructions sent by the authorized vendor.
c) The authorized vendor will automatically have the ability to tabulate results.
d) Upon close of vote, the results shall be certified and emailed by the authorized vendor to the Medical Staff Office who shall inform the Officers of the results.

23.2 Voting for Medical Staff Bylaws Process

a) As defined in Section 13.4 of the Medical Staff Bylaws in order to enact a change, the affirmative vote of a majority of the voting members casting valid ballots shall be required.
b) Voting for the Medical Staff Bylaws shall be by electronic ballot as defined under Section 33.1 Medical Staff Rules & Regulations.
c) As defined in Section 16.3 of the Medical Staff Bylaws the Bylaw changes adopted by the medical staff shall become effective following approval by the board of trustees.

23.3 Voting for Officers Process

a) As defined in Section 10.1.4 the chief of staff elect, the members-at-large, and secretary-treasurer shall be elected by secret ballot as defined in these General Rules & Regulations.
b) Voting for the Medical Staff Bylaws shall be by electronic ballot as defined under Section 33.1 Medical Staff Rules & Regulations.
c) As defined under Section 10.1.4 of the Medical Staff Bylaws a nominee shall be elected upon receiving a majority of the valid votes cast.

22.4 Nominee for Election Rules

a) All nominees for election are required to meet the general qualifications as defined in Section 10.1-2 of the Medical Staff Bylaws.

b) Each nominee shall have a photo and bio available on the website next to their name on the ballot.
c) All nominees will be required to have a professional photo taken by the vendor approved by Officers. Photos will need to be taken at least 1 week prior to the election.
d) All nominees will be required to submit a bio on the template approved by the Officers.
e) All bio's submitted by each nominee will be reviewed and approved by the Nominating Committee in order to be submitted for the electronic ballot. Bio's will be required to be submitted no later than 1 week prior to the election.
f) As defined in Section 15.6 all nominees for election are required to disclose in writing those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff, including, but not limited to, any contracts, salaries, stipends, exclusive arrangements with any hospital, indirect ownership interest(s) or control interest(s) in a competing entity, or any other arrangement that may put the nominee in direct competition with the hospital.
g) Any nominees can request an Active/Senior Active Staff Roster from the Medical Staff Office.
h) Nominees will not be allowed to post any information on any hospital bulletin board regarding their campaign for election.
i) Any disputes, concerns, disagreements or transgressions will be forwarded to the Nominating Committee Chair or Committee.

RULE 24 REQUIRED EDUCATION FOR MEDICAL STAFF & ADVANCE PRACTICE ALLIED HEALTH STAFF

The Medical Staff and Advance Practice Allied Health Staff shall be required to comply with educational requirements as determined by the Medical Executive Committee (MEC 1/12).

2.4.1 Annual Education

All members of the Medical Staff and Advance Practice Allied Health Staff (AHP) shall be required to complete the annual educational module as approved by the Medical Executive Committee. Any physician or AHP staff who fails to fulfill the annual educational requirement shall be forwarded to Medical Executive Committee for further action.

24.2 Crew Resource Management Training

All members of the Medical Staff and Advance Practice Allied Health Staff who hold privileges shall be required to complete the Crew Resource Management Training workshop. The Crew Training will be required as a condition for reappointment and advancement from Provisional/Observation status. Reciprocal Crew Training will be accepted to meet this requirement as long as documentation of completion has been provided to the Medical Staff Office. Failure to complete the Crew Training will result in the effected member not fulfilling criteria for reappointment, Provisional/Observation status and therefore deemed as a voluntary resignation.

24.3 Focused Professional Practice Evaluation (FPPE) Required Education

As part of the FPPE monitoring any member of the Medical Staff and AHP staff may be required to fulfill required education determined by the Department Chair and approved by MEC. Any physician or AHP staff who fails to fulfill the FPPE education shall be forwarded to Medical Executive Committee for further action.

24.4 Specialty Required Education

All members of a specific specialty or Department may be required to fulfill required education as recommended by the Department/Department Chair and approved by MEC, whenever a need has been identified based on performance improvement outcome data or to determine competency in order to be granted specific privileges. Any physician or AHP staff who fails to fulfill the required education shall be forwarded to Medical Executive Committee for further action.

RULE 25. POINT SYSTEM REQUIREMENTS FOR STAFF STATUS CATEGORY

The Point System only applies to Active, Senior Active and Courtesy Staff members.

25.1 QUALIFICATIONS

- **Active & Senior Active Staff**
  Members of the medical staff who currently hold or seek to hold the category of Active or Senior Active status are required to have a minimum of six (6) points in a two year period. Out of the total 6 points required 1 point must be obtained under the patient contacts requirement and 1 point must be obtained under the Committee Meeting Attendance requirement.

- **Courtesy Staff**
  Members of the medical staff who currently hold the category of Courtesy Status are required to have a minimum of two (2) points during a two (2) year period. Exception for good cause may be made by Credentials Committee.

- **Zero Points**
  If an Active, Senior Active, Courtesy member does not attend any meetings and has no patient contacts as defined they will be ineligible to be granted any points.

- **Patient Contacts**
  In order to qualify for the points noted below the following patient contacts can be counted: Admissions, Attending, Consultations, Surgeries/Procedures (primary or first assistants), History and Physicals and Discharge Summaries.

Number of Patient Contacts	Number of Points
1- 9	2
10-25	3
26-50	4
51+	5

25.2 Committee Meeting Attendance & Participation
In order to qualify for the points noted below the following attendance at Committee, Department or the General/Annual Staff meetings qualify for points as noted below:

Committee Meeting Attendance	Number of Points
At least 1 attended meeting or 25% attendance of meetings held.	1
50% attendance of meetings held.	2
More than 50% attendance of meetings held.	3
100% attendance of meetings held.	4

25.3 Proctoring or Retrospective Peer Review
One point may be allowed during each two year period for all staff categories for proctoring or retrospective peer review.

25.4 Responsibilities
It is the responsibility of the applicant to supply documentation of the first six (6) qualifying points for Active Category or the first two (2) qualifying points for Courtesy Category.

25.5 Department Chair Responsibility
It is the responsibility of the Chair of the Department or their representative to verify the documentation submitted.

RULE 26. DISPUTE RESOLUTION
In accordance with the Standards of the Joint Commission and the established values and mission of St. Jude Medical Center this policy contemplates that the Medical Staff, through its elected leaders, and the Board of Trustees will work collaboratively to promote justice and the common good through mutual respect, shared responsibility, joint planning, and equitable commitments of human and monetary resources to protect the safety and quality of care. It is further contemplated that certain disagreements described herein which arise between the Medical Staff and the Board of Trustees shall be resolved in a fair and orderly manner through the dispute resolution process described herein.

26.1 Values Content
Our value of excellence calls us to expect accountability for excellence in performance and for adherence to professional and organizational standards. Our value of dignity calls us to respect differing views, work collaboratively to resolve disputes, and always seek resolution that is in the best interests of safety and quality of care for the patients served.

26.2 Dispute Resolution Process
The Medical Staff and the Board of Trustees shall attempt to resolve disputes in accordance with the procedure described herein. The dispute resolution process shall only apply to disputes that are related to actions taken and/or authorized by either body in its official capacity and pursuant to the procedural requirements applicable to such action (e.g., an affirmative vote in the majority or super-majority, as the case may be, and when such body has a quorum for official action). This process shall not apply to those matters for which the fair hearing procedures contained in Medical Staff Bylaws. In addition, in the event that the dispute resolution process conflicts with provisions contained in the Medical Staff Bylaws (including policies and manuals related hereto), Hospital's Medical Staff Rules and Regulations, or any other organizational governance document (including but not limited to corporate bylaws and articles of incorporation) or St. Jude Medical Center, St. Joseph Health System, or the Sisters of St. Joseph of Orange (collectively, "Organizational Documents"), then the relevant provisions of the Organizational Documents shall control.

26.3 Dispute Resolution Procedure

26.3.1 Special Meeting
The Medical Staff or the Board of Trustees may call a special meeting ("Special Meeting") for the resolution of disputes. After gathering information regarding the conflict, the Special Meeting shall be held pursuant to a written request for the meeting, which request shall specify the nature of the dispute to be resolved. The Special Meeting shall be attended by representatives of the Board of Trustees and the Medical Staff, who shall attempt in good faith to resolve the dispute and shall have reasonable authority to do so. On mutual agreement, the dispute may be submitted to the Joint Conference Committee pursuant to the Medical Staff Bylaws for consideration and a non-binding recommendation to the Board of Trustees. Neither party shall be represented at the meeting by legal counsel unless the parties agree that both shall be so represented.

2.6.3.2 Mediation
In the event that the dispute has not been resolved after the Special Meeting, either the Medical Staff or the Board of Trustees may initiate mediation by delivering written notice to the other. Representatives of both the Medical Staff and the Board of Trustees shall attend and participate in the mediation, which shall be non-binding and without prejudice to any other rights or remedies which either the Medical Staff or the Board of Trustees may have. The mediation proceeding shall be conducted in Orange County,

California by an impartial third party mediator who shall have relevant healthcare experience and who shall be selected from those offered by Judicial Arbitration Services, Inc. ("JAMS") in accordance with its procedures. The mediator shall be given any written statement(s) of the Medical Staff or the Board of Trustees and may inspect any applicable documents. This meeting shall be attended by representatives of the Medical Staff and Board of Trustees with reasonable authority to resolve the dispute without legal representation at the mediation unless both parties agree. The comments or findings of the mediator shall be non-binding and without prejudice to the rights of the Medical Staff or the Board of Trustees. However, the parties shall make all reasonable efforts to resolve the dispute pursuant to this procedure without need for pursuit of further process. (MEC 5/12)

RULE 27. PROFESSIONAL GRADUATE MEDICAL EDUCATION PROGRAM

27.1 Medical Student & Physician Assistant Student Program Guidelines

It is the policy of the Medical Staff and the Hospital to allow members of the medical staff to participate in training of medical students and physician assistant under the conditions and requirements described below. Medical/Physician Assistant students in training programs may be assigned rotations with individual physicians on staff at St. Jude Hospital. The Hospital agrees to allow Medical/Physician Assistant students to have access to the Hospital as part of their training under the direction of their supervising physician(s). Activities of Medical/Physician Assistant students and their supervising physicians shall be under the direction of the Professional Graduate Medical Education Committee who reports to the Credentials Committee of the Medical Staff which shall establish mechanisms by which supervising physicians will make decisions about each Medical/Physician Assistant students involvement in patient care activities. Under no circumstances should a Medical/Physician Assistant students be allowed to participate in patient care without prior approval as outlined below.

- Medical/Physician Assistant students will not be required to pay an application fee
- Medical/Physician Assistant students are not members of the medical staff and are not entitled to the rights and prerogatives afforded to members of the medical staff as outlined in the Medical Staff Bylaws
- Scopes of Services for Medical/Physician Assistant students will be in effect for a time period as determined by their rotation

27.2 Definitions

Medical and Physician Assistant Student: actively enrolled in a medical school program and participating in an approved clinical rotation.

Supervising Physician: Member in good standing at St. Jude Medical Center Medical Staff authorized to supervise and/or provide resources for medical/physician assistant students. The supervising physicians must agree to participate in the teaching rotation and abide by the rotation program policies and procedures. The Supervising physicians must understand and comply with hospital policies and the Medical Staff Bylaws, Rules and Regulations.

27.3 Conditions & Requirements

An approved and executed affiliation agreement with the medical school or training program must be on file with the Hospital Administration prior to consideration for acceptance of a medical/physician assistant student.

- A Medical Staff member who wishes to serve as supervising physician for a medical/physician assistant student in the hospital must first contact the Medical Staff Services department and provide a completed application from the medical/physician assistant student.

- Once the above items are verified by Medical Staff Services, permission for the medical/physician assistant student to participate in patient care activities in the Hospital may be granted upon successful completion of orientation.

- An orientation to the Hospital will be conducted by Medical Staff Service Department and other designated individuals at the time permission to participate in patient care activities is received.

27.4 General Requirements & Scope of Service

Medical/physician assistant student in training programs shall not be considered as members of the Medical Staff. These clinicians shall be under the direct supervision of a member of the medical staff having responsibility for the actions of the medical/physician assistant student. Medical/physician assistant student may not perform any patient care services that the supervising physicians does not have privileges to perform.

27.5 Supervision Requirement

- Medical/physician assistant student are required to be under the direct supervision and in presence of their supervising physician who is a member of St. Jude Medical Center Medical Staff at all times.
- Medical/physician assistant student may not dictate H&P's, Op reports/discharge summaries, nor document progress notes, write or give verbal orders.
- Medical/physician assistant student may participate in physical exam, critical data analysis and disposition, history taking and have access to the medical records (under the direct supervision and in the presence of the supervising physician).
- Medical/physician assistant student may observe in the surgery with appropriate consent from the patient and surgeon of record.
- Medical/physician assistant student may participate in care and management of the patient, including invasive and non-invasive procedures, under the direct supervision of the supervising physician at all times with patient permission.
- Medical/physician assistant student may assist in procedure and may be performed when the attending physician agrees that the student has achieved the required level of competence.
- Medical/physician assistant student may not document in the medical record.

27.6 Completion of Rotation

Upon completion of the assigned rotation the medical/physician assistant student must turn in their Identification badge to the Medical Staff Services Department. Failure to do so will result in a $250.00 fine and a report to their affiliated teaching institution.

27.7. Resident and Fellows Student Guidelines

It is the policy of the Medical Staff and the Hospital to allow members of the medical staff to participate in training of residents and fellows under the conditions and requirements described below. Residents and fellows in training programs may be assigned rotations with individual physicians on staff at St. Jude Hospital. The Hospital agrees to allow residents and fellows to have access to the Hospital as part of their training under the direction of their supervising physician(s). Activities of residents, fellows and their supervising physicians shall be under the direction of the Professional Graduate Medical Education Committee who reports to the Credentials Committee of the Medical Staff which shall establish mechanisms by which supervising physicians will make decisions about each resident or fellow's involvement in patient care activities. Under no circumstances should a resident or fellow be allowed to participate in patient care without prior approval as outlined below.

- Residents and Fellows will not be required to pay an application fee.

- Residents and Fellows are not members of the medical staff and are not entitled to the rights and prerogatives afforded to members of the medical staff as outlined in the Medical Staff Bylaws.

- Scopes of Services for Residents and Fellows will be in effect for a time period not to exceed one year.

27.8 Definitions

Resident: An MD, or DO who is currently enrolled participant in good standing in a residency program approved by and in conformity with: The requirements of the Council of Education of the American Medical Association, the American Osteopathic Association Board of Trustees though the Committee on postdoctoral training and Bureau of Professional Education and/or residency training program of the respective specialty boards.

Fellow: An MD or DO who is currently enrolled participant in good standing in a fellowship program approved by and in conformity with the requirements of the Council of Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and Bureau of Professional Education or the residency training programs of the respective specialty boards.

27.9 Conditions & Requirements

An approved and executed affiliation agreement with the medical school or training program must be on file with the Hospital Administration prior to consideration for acceptance of a resident or fellow.

A Medical Staff member who wishes to serve as supervising physician for a resident or fellow in the hospital must first contact the Medical Staff Services department and provide a completed application from the resident or fellow. The application shall include proof of California medical license or interim permission from the Medical Board of California, , DEA certificate if applicable, and documentation from the school or training program that the individual is currently enrolled and in good standing.

Once the above items are verified by Medical Staff Services, permission for the resident or fellow to participate in patient care activities in the Hospital may be granted upon successful completion of orientation.

An orientation to the Hospital will be conducted by Medical Staff Service Department and other designated individuals at the time permission to participate in patient care activities is received.

27.10 General Requirements & Scope of Service

Residents and Fellows in training programs shall not be considered as members of the Medical Staff. These clinicians shall be under the direct supervision of a member of the medical staff having responsibility for the actions of the resident or fellow. Residents and fellows may not perform any patient care services that the supervising physicians does not have privileges to perform.

The following are the categories of services that may be performed by residents and fellows, as determined by the supervising physician under the conditions specified:

Patient Care Activity	Conditions
Perform History & Physical evaluations	The supervising physicians retains accountability for the H&P and must co-sign within 24 hours or prior to the performance of any invasive procedure.
Evaluate patients	Supervising physician retains accountability for the

	evaluation and must co-sign within 24 hours or prior to the performance of any invasive procedure.
Write Orders	Orders must be co-signed within 24 hours. Orders may be carried out prior to co-signature by the supervising physicians.
Write Progress Notes	Notes will be co-signed by supervising physician with 24 hours.
Observe surgical procedures in the operating room	Compliance with established policies and procedures relative to observations.
Scrub-in/observe surgical procedures in the operating room.	Supervising physician must be physically present.
Assist in the Operating Room.	Supervising physician must be physically present.

Upon completion of the assigned rotation the resident or fellow must turn in their Identification badge to the Medical Staff Services Department. Failure to do so will result in a $250.00 fine and a report to their affiliated teaching institution. In addition, all incomplete medical records must be complete.

RULE 28 PROFESSIONAL GRADUATE MEDICAL EDUCATION COMMITTEE

28.1 Composition

The Professional Medical Education Committee shall consist of members as the Credentials Committee may deem appropriate who currently serve as preceptors for either Physician Assistant students, Medical Students, Residents or Fellows. The Professional Medical Education Committee shall be comprised of no less than three members of the medical staff. The Chair of the Professional Medical Education Committee shall be a physician member who currently serves as a preceptor and is appointed by the Chief of Staff.

28.2 Duties

The Professional Medical Education Committee shall perform the following duties:

- Developing proposed policies and procedures for ensuring appropriate supervision and oversight for Physician Assistant students, Medical Students, Residents or Fellows;
- provides a formal mechanism for Physician Assistant students, Medical Students, Residents or Fellows participation in the development, review and evaluation of these students patient care responsibilities and functions
- at the training hospital;
- Shall be advisory to the Credentials Committee;
- Maintaining a record of all activities relating to Professional Medical
- Education functions and submitting periodic reports and recommendations
- to the Credentials Committee concerning those activities.

28.3 Meeting Frequency

The Professional Medical Education Committee shall meet as often as necessary at the call of its chair on an as needed basis. It shall maintain a record of its proceedings and shall report its activities and activities and forward recommendations to the Credentials Committee.

RULE 29. CRITICAL CARE INTENSIVIST PROGRAM

Rationale for Program: Studies show that having full time Intensivists staffing an ICU, providing 24 hour per day and 7 day a week coverage, is associated with lower mortality rates and is a widely accepted safety initiative. Intensivists are familiar with the complications that can occur in the Critical Care Unit (CCU) and are better equipped to minimize errors.[1] Further, the provision of a standard level of Critical Care for all patients at St. Jude Medical Center is a goal of this program.

The St. Jude Medical Center Intensivist Program follows evidence-based guidelines for care established by the Society of Critical Care Medicine (SCCM). The SCCM critical care model calls for a multidisciplinary team approach that has a well-documented record of:

- Improving patient survival rates and quality care
- Decreasing procedure complications
- Promoting medication safety

Patients in the CCU generally have life-threatening illnesses or conditions such as cardiac arrest, respiratory failure, strokes, severe trauma or resistant infections, or other conditions that are potentially life threatening and require a high level of monitoring. Because of their unstable conditions, these patients must be monitored much more closely than patients in regular hospital wards. Studies have shown that having an Intensivist act as the team leader in providing critical care definitely improves the quality of care for these patients.

29.1 Definitions

Critical Care Unit: St. Jude Medical Center's Critical Care Unit located in the Southwest Tower Critical Care Unit and the 4N Critical Care Unit consisting of a mixed Medical / Surgical / Cardiovascular/ Neurology/ Neurosurgical service including adult and geriatric patients. Patients above the age of 14 may be admitted to the Critical Care Unit after consideration on a case by case basis. The critical care patient is characterized by the presence of, or being at high risk for, life threatening problems. The indication for patient placement within the critical care unit is a patient who, after multidisciplinary evaluation, requires continual interdisciplinary assessment and intervention in order to restore stability, prevent complications, and achieve and maintain an optimal response to care.

Intensivist: A member of the Medical Staff who has been granted Critical Care privileges and provides 24 hours/seven days a week (24/7) critical care coverage as part of the Critical Care Intensivist Program.

29.2 Scope of Services

- The Intensivist is physically present within the hospital while providing coverage as an Intensivist.
- Critical Care Program Expectations: 1) Return CCU pages within fifteen minutes; 2) Arranges for a five minute response time by an Intensivist to reach CCU patients in cases of an emergency; 3) 95% compliance for the above indicators to be at target performance.
- Manage (admitting or attending physician) or co-manage (consulting physician) all CCU patients.
- The Intensivist may or may not be the admitting physician.
- Available to provide critical care expertise on a consultation basis for patients outside the CCU.

- The Intensivist reserves the right to consult upon any patient admission to the CCU or throughout the CCU stay based on quality of care need, triage determination and/or compliance with admission, discharge, transfer criteria established by usual practice on the St Jude CCU service. In cases of clinical disagreement, the ultimate authority to make decisions rests with the Intensivist, excepting patients under the primary care of Neurosurgeons, Cardiothoracic Surgeons and Vascular Surgeons, where the primary clinical responsibility is within those disciplines.

- Lead daily, multi-disciplinary team rounds within CCU.

- Provide in-house coverage for all patients requiring mechanical ventilator support or management, excepting those managed by physicians currently privileged to do so.

RULE 30. HIPAA COMPLIANT COMMUNICATION PLATFORM

The efficiency and expediency in communicating a patient's condition by text message is an accepted practice. In order to improve and expedite patient care and safety, many physicians have requested the ability to have immediate/point of care contact with members of the care team. Also, in order to improve the transition of care at hospital discharge, the ability of the hospital-based physician to communicate with the ambulatory provider/PCP via a "texting" feature is encouraged. However, texting about a specific patient may only be performed if the patient's information is kept protected and shielded from inadvertent or deliberate disclosures. To that end, the Medical Staff has approved a HIPAA Compliant Communication Platform ("HCCP") to be downloaded on a provider's phone and used when texting about a specific patient with a care team member.

30.1 HCCP Requirement

All members of the Active, Senior Active, Courtesy and Provisional Medical Staff and Allied Health Professional Staff ("Members") are required to download, activate, and maintain activation on their mobile devices of the hospital's approved HCCP to receive and send patient specific text messages to and from care team members. Any other form of texting will not be recognized and may be considered to be non-compliant with Hospital and Medical Staff confidentiality requirements. The HCCP may be used to respond to messages from care team members but may not be used to transmit patient care orders.

The purpose of the HCCP is to improve patient care by communication of pertinent, non-urgent messages from other care team members. For example, ambulatory providers may receive FYI messages about their patients from a discharging provider with important follow-up care information. Similarly, providers with inpatients may receive clinical updates from other members of the care team.

30.2 Penalty for Non-Compliance

Failure to install and activate the HCCP within the time period established by the Medical Executive Committee shall result in temporary suspension of Medical Staff privileges. The suspension shall be the same as a temporary suspension for delinquent medical records and shall follow the same process and have the same force and affect as the temporary suspension set forth in Section 2.5 of these Rules and Regulations. Prior to imposing the temporary suspension, the provider shall receive written notice of the pending suspension. In the event of a provider is temporarily suspended evidence provided to the Medical Staff Office or Chief of Staff or his/her designee showing compliance shall result in lifting of the temporary suspension. A provider who is temporarily suspended for failure to download and activate the HCCP shall not have rights to a Hearing or Appeal as set forth in the Bylaws.

30.3 Texting Rules using HCCP

Texting of patient specific information outside of the HCCP via any non HIPAA compliant platform is prohibited.

RULE 31. STEERING COMMITTEE MEETINGS

For the purpose of improving the quality and efficacy of Hospital service lines, Administration and the Medical Staff may periodically form steering committees to jointly address operational and quality issues. These Steering Committees are thought leaders focused on improvement of specific service lines and are advisory to the Medical Executive Committee and Administration. As such, the committees may periodically review clinical cases and provider performance reports and make recommendations for improvement. The steering committees shall maintain the confidentiality of any patient or provider specific information and shall report to the Medical Executive Committee on a periodic basis.

31.1 COMPOSITION

Steering Committees shall include at least two Active Staff members of the Medical Staff, who may be designated by Administration and who are approved by the Medical Executive Committee.

31.2 DUTIES

The Steering Committees will be responsible for the following:

- Continuing education relative to quality assurance activities
- Case Review for educational purpose
- Presentation of scientific or educational papers
- Review of provider specific quality outcome data

Individual peer review cases are to be forwarded to the respective Department QRC.

31.2 MEETINGS

Each Steering Committee shall meet as often as necessary. It shall maintain a record of its proceedings and shall report its activities and recommendations to their respective Medical Staff Department or Patient Safety and Performance Improvement Committee.

[1] *The Leapfrog Group for Patient Safety*

APPROVED by the Medical Executive Committee on

July 11, 2017

APPROVED by the Board of Trustees on

July 19, 2017