St. Joseph Health
St. Jude Medical Center

GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

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:

1. **Protocol for Medical Staff Charting**
2. **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.

Reviewed/Revised:					
1/21/97	6/98	11/22/02	1/27/05	7/08	1/12
2/21/97	5/99	2/21/03	5/19/06	2/09	
6/20/97	2/00	10/15/03	10/04/07	7/10	
8/22/07	6/20/00	9/24/04	4/07	3/11	
9/30/97	10/17/00	8/19/05	8/07	5/11	

1. **Admissions:** 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.

3. **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)

4. **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.

   4.1 **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**.**

5. **MEDICAL RECORD**

   5.1. **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.

   5.2. **COMPLETION**

   5.2.1. 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.

   5.2.2. 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.

5.2.3. **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.

5.2.4. 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. The discharge summary will be completed at the time of discharge or no later than. All other completion requirements are documented in the Medical Staff Charting Protocol.

5.2.5. **General**

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.

5.2.6. **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.

5.3. **ABBREVIATIONS AND 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.

5.4. **SUSPENSION**

5.4.1 **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.

5.4.2. **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.
- 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 Department 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.

5.4.3. 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.

Reporting of Accumulated Suspension Days: On a monthly basis the Health Information Service Department will submit to the departmental Quality Review Committees a report of the suspension activity of the members of the department. The report will include a list of the members of the department:

- Currently on suspension.
- Exceeding 30 days but less than 60 days who are at risk of voluntary resignation. QRC to recommend action as deemed appropriate.
- Exceeding 60 days along with the following:
  - ✓ Copies of Certified letters and return receipts
  - ✓ Copy of physician green sign-in card for the associated timeframe
  - ✓ Copies of follow-up letters
  - ✓ Summary intervention efforts with the physician (telephone calls, past interviews)

Department Quality Review Committee may elect to conduct a mandatory interview with any member of the department accumulating thirty (30) or more suspension days. The notice for mandatory interview will be submitted in accordance with Medical Staff Bylaws, Article 14, Special Appearances.

Health Information Services will send a follow-up letter to physicians who are currently on suspension and are approaching targeted accumulated suspension days (30 and 60 suspension days).

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

- At the accumulation of 30 days of suspension a $500 fine will be assessed
- At the accumulation of 60 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.

5.4.4. Voluntary Resignation

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.

5.4.5. Reapplication to the Medical Staff

Reapplication to the Medical Staff as a result of "voluntary resignation" for sixty (60) plus days of suspension for medical record delinquency

- will be done via an abbreviated application as defined in the rules and regulations.
- will be assessed a reapplication fee.
- will result in an appointment cycle consistent with the existing reappointment cycle so as not to exceed to two year period of time.
- will not require a resubmission of a privilege request list. 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)

5.4.6. 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 6.2.2 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.

- Compliance with the State of California requirements relative to CPR certification and with the applicant's Department rules and regulations relative to CPR certification requirements.

- 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 VI.

5.5. OWNERSHIP AND RELEASE OF INFORMATION

5.5.1. **Ownership and 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.

5.5.2. **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.

5.5.3. **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.

5.6. **ATTENDING PHYSICIAN**

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.

6. **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.

7. **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.

8. **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.

9. **CONSULTATIONS:**

9.1 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:

9.1. **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.

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

9.3 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.

10. **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.

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

11. **IMPAIRED PHYSICIAN:**

11.1. 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.

11.2. 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.

12. **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:

12.1. 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. 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.

12.2. 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.

12.3. 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.

12.4. 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.

12.5. All Active and Provisional Staff members, in the specialties noted in Section 12.6.4 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:

12.6 **EMERGENCY DEPARTMENT BACK-UP PROTOCOL**

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

12.6.2. In case of surgical or 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, the specialist on the call panel for the day of the patient's admission should be contacted for that consultation.

12.6.3. 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 assistant will be.

12.6.4 A mandatory call system is required in order to meet the criteria requirements of the Paramedic Receiving Center, Medicare (CMS) and Title 22. Required on-call panels are those specialties necessary to meet the requirements of the Paramedic Receiving Center. Family Practice 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		**Special Conditions***
Anesthesiology	Orthopedic Surgery	Dental or Oral Surgery*
Cardiology	Otolaryngology	Neurosurgery *
Family Practice	Pediatrics	Ophthalmology*
General Surgery	Plastic Surgery	Psychiatry*
Gynecology	Thoracic Surgery	Urology *
Internal Medicine	Vascular Surgery	
Obstetrics	(General Surgeons with Vascular surgery privileges)	

* These specialists must be available by phone for consultation, with a hospital policy for assuring appropriate level of care for emergency patients regarding specialty care is acceptable.

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 Practice 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.

13. **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.

14. **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.

15. **GENERAL PRIVILEGES:** In addition to the Department-specific privileges which are granted by the individual Departments of the Medical Staff, the following general privileges are granted to all Medical Staff members. Exceptions, if any, are identified:

All physician members of the Medical Staff, with the exception of members of the Emeritus Staff, are automatically granted privileges, unless otherwise specified, to:

15.1. Admit (exceptions: Emergency Medicine, Diagnostic Radiology*, Pathology, Anesthesiology**, and Affiliate/Consulting Staff members);

15.2. Order diagnostic and therapeutic services;

15.3. Chart in the patient's medical record;

15.4. Refer and request consultations;

15.5. Provide consultation within the scope of their privileges unless otherwise limited by individual Department Rules and Regulations;

15.6. Use all skills normally learned during medical school or residency for the assessment and treatment planning. Specific diagnostic and invasive procedures are defined within the Department-specific privileges request list.

15.7. 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)

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

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

16. **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:

a) Deaths in which an autopsy would explain unknown or unanticipated medical complications.
b) All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
c) Deaths in which an autopsy would allay concerns of and/or to reassure the family and/or the public regarding the death.

d) Unexplained or unexpected deaths during or following any dental, medical or surgical diagnostic procedures and/or therapies.
e) Deaths of patients participating in clinical investigations.
f) Unexpected or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction.
g) 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.
h) Deaths resulting from high risk infectious and contagious diseases.
i) All obstetric deaths.
j) All perinatal and pediatric deaths.
k) 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.
l) 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.

16.1 Coroner's Cases

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

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

17. **PHYSICIAN ADVISORS FOR CASE MANAGEMENT:**

17.1 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.

17.2 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.

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

17.3.1 The cases reviewed by the Physician Advisor will be presented to the Medical Staff Quality Review Committee for their review and acceptance.

17.3.2 Review and action will be recorded in the Medical Staff Quality Review Committee minutes.

18. **TEMPORARY CLINICAL PRIVILEGES:**

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.

19. 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.

20. 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.)

21. **REAPPLICATION AFTER FAILURE TO COMPLETE PROCTORING**

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 $ 800.00, 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 the $800. Reapplication assessment fee for a total of $1600.00.
- Second voluntary resignation $800 Application fee plus a $1600 reapplication assessment fee for a total of $2400.00.
- Third voluntary resignation: $800 Application fee plus a $3200 reapplication assessment fee for a total of $4000.00.
- 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.

22. **RESTRAINT** - Refer to Hospital Administration Policy and Procedure for Restraints

22.1 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.

22.2 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.

22.3 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.

22.4 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.

22.5 There shall be no PRN orders for restraint

23. 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.

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

25. Contracted 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.

26. 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.

27. **Establishment of Dues and Assessments:** As defined in the Bylaws (Article 15.2) the following dues/assessments and reappointment Fees are established for the Medical Staff:

Membership Dues (annually)		
	Category	Amount
	Senior Active	$100.00
	Active	$250.00
	Provisional	$350.00
	Community Supportive	$350.00
	Courtesy	$450.00
	Telemedicine	$100.00
Assessments		
	Initial Appointment	$800.00
	Reappointment	
	Returned 120 – 61 days	$250.00
	Returned < 60 days (late)	$500.00
	AHP Appointment Application	$300.00
	AHP Annual Fee	$100.00
	Medical Record Suspension (defined in 5.4.3 & 5.45)	
	CME Assessment (all categories & AHPs)	$60.00
	IRB Applications	$2,000.00
	Renewal Fees	$500.00

	Expedited Review	$250.00
	Temporary Privilege Request	$400.00
	CME for non-staff Physicians	$200.00

28. **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).

29. **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.

30. **SCREENING FOR TUBERCULOSIS** – (EMC 9/15/08)
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.

31. **MEDICAL STAFF DISCRIMINATION OR HARASSMENT: INVESTIGATION AND DISCIPLINARY PROCEDURES**

31.1 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.

31.2 Reporting

Complaints involving discrimination or harassment where the person who is the alleged harasser is a member of the Medical or Affiliate 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 Affiliate Staff, the Chief of Staff or designee shall be kept apprised of the status of the investigation.

As used in this document, the "Affiliate 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.

31.3 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 Affiliate 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.

31.4 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 Affiliate 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.

31.5 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.

31.6 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.

32. PHYSICIAN ASSISTANT SUPERVISION

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

32.1 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).

33. 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.

33.1 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.

33.2 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.

33.3 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.

33.4 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.

34. 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).

34.1 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.

34.2 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 stats. 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.

34.3 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.

34.4 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.

35. POINT SYSTEM REQUIREMENTS FOR STAFF STATUS CATEGORY

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

35.1 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

35.2 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

35.3 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.

35.4 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.

35.5 DEPARTMENT CHAIR RESPONSBILITY
It is the responsibility of the Chair of the Department or their representative to verify the documentation submitted.