MEDICAL STAFF

BYLAWS, RULES AND REGULATIONS

REVISIONS:

August 1992	**August 1996**	**February 2000**	**August 2005**	**December 2013**
August 1993	**November 1996**	**August 2000**	**August 2006**	**December 2014**
August 1994	**February 1997**	**August 2001**	**August 2007**	**December 2015**
January 1995	**August 1997**	**February 2002**	**December 2008**	
August 1995	**February 1998**	**January 2003**	**December 2009**	
March 1996	**September 1999**	**May 2005**	**December 2010**	

MEDICAL STAFF BYLAWS

1.0 NAME

The name of this organization shall be the Medical Staff of St. Claire Regional Medical Center, Inc., Morehead, Kentucky, hereinafter referred to as the Medical Staff.

2.0 PURPOSES/RESPONSIBILITIES

The purpose of this organization shall be:

2.1 To insure that all parties admitted to or treated in any of the facilities, departments, or services of the Medical Center receive a high standard of personalized, continuous quality care produced and delivered with appropriate attention to economy and efficiency by practitioners appropriately privileged through the Medical Staff process. (MS.03.01.01 & MS.03.01.03)

2.2 To insure a high level of professional performance of all Medical Staff and Allied Health Professionals through an appropriate delineation of staff privileges and a continuous review and evaluation of the clinical Medical Center practice of the Staff and Allied Health Professionals.

2.3 To provide and participate in continuing medical education and to assist in maintaining high educational standards for the medical and allied health personnel in the Medical Center. (MS.12.01.01)

2.4 To cooperate with hospital affiliated medical schools and educational institutions for the purpose of providing clinical instruction for physicians in training and students in medicine and other health related sciences.

2.5 To provide a means whereby issues concerning the Medical Staff and its members and the Medical Center may be discussed by the Medical Staff with the Board of Directors and the Medical Center President/CEO.

2.6 To initiate and maintain rules and regulations for self-government of the Medical Staff. (MS.01.01.01 EP 1)

2.7 To amend and adopt bylaws (MS.01.01.01 EP 1, EP 2)

2.8 To establish standards of patient care, treatment and service

2.9 To oversee the quality and safety of patient care, treatment and services provided by practitioners privileged through the Medical Staff process. Licensed independent practitioners are responsible for the oversight activities of the organized medical staff. The organized medical staff through its designated mechanisms provides leadership and participates in organization-wide activities to improve quality of care, treatment, services and patient safety and also provides oversight in the process of analyzing and improving patient satisfaction. (MS.05.01.01 & MS.05.01.03 & MS.06.01.01)

2.10 To be accountable to the Board of Directors for the quality and medical care, treatment and service to patients

2.11 The organized Medical Staff enforces the Medical Staff Bylaws, Rules and Regulations and Polices by recommending action to the Medical Center Board of Directors in certain circumstances and by taking action in others. (MS.01.01.01 EP 6)

3.0 MEDICAL STAFF MEMBERSHIP (MS.01.01.01 EP 12)

3.1 MEMBERSHIP

Membership to the Medical Staff of St. Claire Regional Medical Center shall be extended only to professionally competent physicians, dentists, and surgical podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership in itself does not entitle the applicant to be eligible for clinical privileges. However, an applicant must be a Medical Staff member to be considered for the granting of clinical privileges as set forth in 7.0.

3.1.1 Medical Staff membership/privileging is not required for licensed practitioners ordering outpatient diagnostic services or programs.

3.2 QUALIFICATIONS FOR MEMBERSHIP (MS.01.01.01 EP 13 & EP 26)

3.2.1 Only physicians (M.D. and D.O.), dentists and surgical podiatrists licensed to practice in the State of Kentucky and who meet the established criteria as defined in these Bylaws, Rules and Regulations shall qualify for membership of the Medical Staff. Required education will consist of graduation from a medical school approved by the Council of Medical Education of the American Medical Association or American Osteopath Association, or from a dental school approved by the council on Dental Education, or from a foreign medical school acceptable to the Medical Licensing Board of the State, or from a college of podiatric medicine accredited by the Council on Podiatry Education of the American Podiatry Association or approved by the State licensing board and successful completion of a one-year surgical residency, or one-year postgraduate training program in podiatric surgery or podiatric orthopedics. The President/CEO may permit a physician serving as a locum tenens for a member of the Medical Staff to practice in the Medical Center provided the locum tenens applicant has submitted a complete application and the application has been processed in the same manner as a permanent staff member as outlined in Medical Staff policy #10-0203-02, and the application has been approved by the Departmental Chair concerned and by the Medical Staff President. Physicians serving as locum tenens more than once for a total of 90 days in a 12-month period, or who serve for a period longer than 90 days, shall apply for Associate Medical Staff membership and renewal/extension of privileges. Each applicant must be able to document his/her background, experience, training and demonstrated competence, physical and mental health status, adherence to the ethics of his/her profession, good reputation, ability to work with others, and ability to comply with rules and regulations of the Medical Staff, based in part on his/her past performance and training programs or as a member of other hospital staffs or in his/her practice of medicine, with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by him/her in the Medical Center will be given a high quality of medical care. No physician, dentist, or surgical podiatrist shall be entitled to membership of the Medical Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that he/she is duly licensed to practice medicine, dentistry, or surgical podiatry in this or in any other state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.

3.2.2 Additional Requirements

Upon request for Medical Staff membership and privileges the applicant shall specify in the application and agree to the following:

3.2.2.1 To maintain and provide documented evidence of malpractice liability coverage as required by the Medical Center after consultation with the Medical Staff.

3.2.2.2 To provide a statement of an ethical pledge that includes:

3.2.2.2.1 refraining from fee splitting or other inducements relating to patient referral;

3.2.2.2.2 provision of continuous care to patients, which requires Active and Associate staff members to participate on the practitioner emergency on-call schedule. An appropriately privileged doctor of medicine or osteopathy is on duty or on call at all times. All practitioners on the on-call schedule are responsible for providing coverage for the specialty/service either by being personally available or arranging coverage by another practitioner who has been granted

privileges at the Medical Center. A practitioner may not be required to accept assignment on the emergency on-call schedule as outlined in Medical Staff policy provided another staff member(s) from the practitioner's specialty/ service is available and agrees to do so;

3.2.2.2.3 the medical history and physical examination are completed and documented by a physician, a maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. Also see RR 4.0.

3.2.2.2.4 refraining from the delegation or responsibility for diagnosis or care of hospitalized patients to practitioners who are not qualified to undertake the responsibility;

3.2.2.2.5 that consultation will be sought when necessary;

3.2.2.2.6 that except in case of emergent initial stabilization, treatment of immediate family members who are hospitalized or who present for invasive procedures is strongly discouraged. For the purpose of these Bylaws, immediate family is defined as spouse, child, parent, brother, sister, grandparent, or grandchild.

3.2.2.2.7 that they will abide by the Bylaws, Rules and Regulations of the St. Claire Medical Staff and the Polices of the Medical Center. (MS.01.01.01 EP 5)

3.2.2.2.8 that they will accept departmental assignments and committee and/or service line assignments as outlined in Medical Staff Bylaws, Rules and Regulations.

3.2.2.2.9 refraining from provision of services within the Medical Center premises which are counter to the teachings of the Medical Center's sponsoring organization, and;

3.2.2.2.10 that those reviewing or providing information relative to credentialing staff membership and privileges are released from civil liability.

3.2.2.3 To provide information relating to the following:

3.2.2.3.1 previously successful or currently pending challenges to any licensure or registration (state or district Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration.

3.2.2.3.2 voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital.

3.2.2.3.3 previous professional liability claims and action.

3.2.2.4 Provide the names of associates, partners or others who will be available for the care of patients in the primary practitioner's absence. This listing shall include only those with medical staff privileges and shall be updated upon application or reappointment.

3.2.3 Acceptance of membership of the Medical Staff shall constitute the Staff member's agreement that he/she will comply with directives of a Catholic Hospital including but not limited to the Ethical and Religious Directives for Catholic Health Care Services as attached to these bylaws and the currently accepted principles of medical ethics and moral standards of the American Medical and Dental professions, Bylaws, Rules and Regulations of the Medical Staff and Medical Center Bylaws and policies as established by the Medical Center Board of Directors.

3.3 CONDITIONS AND DURATION OF APPOINTMENT

3.3.1 Initial appointments and reappointments to the Medical Staff and approval of privileges shall be made by the Board of Directors. The Board of Directors shall act on appointments, reappointments, privileging or revocation of appointments and/or privileging only after there has been a recommendation from the Medical Staff as provided in these Bylaws.

3.3.1.1 The organized Medical Staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

3.3.2 The decision to grant or deny a requested privilege is an objective and evidence-based process. Prior to granting of a privilege the resources necessary to support the requested privilege are determined to be currently available or available with in a specific time frame. (MS.06.01.01)

All initial appointments and privileging to any category of the Medical Staff must serve a provisional appointment of no less than one year. For provisional status regarding additional privileges see 7.1.3. All initial appointments and privileging shall be subject to the focused professional practice evaluation requirements set forth in 3.4. The decision to grant, limit or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within 180 days.

3.3.3 Reappointments and privileging shall be made not to exceed a two year period. Medical Staff members exceeding 75 years of age are eligible for appointment/reappointment for a one-year period.

3.3.4 Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Directors, in accordance with these Bylaws. The prerogatives of Medical Staff members under this section are general in nature and may be subject to limitation by the Bylaws, Medical Staff Rules and Regulations, Medical Center policies, or by special condition attached to a particular membership.

3.3.5 No applicant shall be denied Medical Staff membership or privileges on the basis of sex, race, creed, color, or national origin.

3.3.6 Any member of the Staff who has a contract with the Medical Center which requires membership on the Staff shall not have his/her staff privileges terminated without the same due process provisions as must be provided for any other member of the Staff unless otherwise stated in the member's contract with the Medical Center.

3.3.7 Termination of the contractual relationship between the Medical Staff member and the Medical Center shall be accomplished in accordance with the terms of the contract between the Medical Staff member and the Medical Center.

3.4 PROFESSIONAL PRACTICE EVALUATION REQUIREMENTS (MS.08.01.01)

3.4.1 Professional Practice Evaluation is the process whereby St. Claire Regional Medical Center evaluates the privilege-specific competence of the practitioner as defined in Medical Staff policy #10-0211-01. The Medical Staff, pursuant to these Medical Staff Bylaws and Medical Staff policies #10-0211-01 and #10-0211-04, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence. (MS.09.01.01)

3.4.2 The PPE includes an assessment for proficiency in the following six areas of general competencies: patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. The PPE is conducted as follows:

3.4.2.1 The Initial Professional Practice Evaluation (IPPE) is a focused, termed evaluation for all newly appointed practitioners or all existing practitioners who have been granted new privileges;

3.4.2.2 The Focused Professional Practice Evaluation (FPPE) is a focused, termed evaluation recommended by the Department Chair, Vice President of Medical Affairs (VPMA) or Medical Staff Executive Committee when there is a quality or safety concern with a practitioner's privilege-specific competence or practice; (MS.01.01.01 EP 30 & EP 33)

3.4.2.3 The Ongoing Professional Practice Evaluation (OPPE) is a continuous evaluation of all practitioners to identify professional practice trends and opportunities for improvement that impact

quality of care and patient safety. Collected information on established performance measures is shared regularly with the Medical Staff as defined in Medical Staff policy #10-0211-01. (MS.08.01.03). The Medical Staff, pursuant to these Medical Staff Bylaws, Medical Staff policies #10-0211-01 and #10-0211-04, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence. (MS.09.01.01)

3.4.2.4 The Medical Staff identifies and manages matters of individual health for licensed independent practitioners as outlined in Medical Staff policy #10-0211-04.

3.5 TELEMEDICINE

3.5.1 No physician may provide clinical care of a patient at the Medical Center via telemedicine without clinical privileges granted in accordance with these Bylaws. If the distant site is accredited by The Joint Commission, credentialing and privileging decisions from the distant site may be utilized in the credentials review process. (MS.13.01.01)

4.0 CATEGORIES OF THE MEDICAL STAFF

4.1 THE MEDICAL STAFF (MS.01.01.01 EP 15)

The Medical Staff shall be divided into Active, Associate, Consulting, Courtesy, and Honorary categories. For Active, Associate, Consulting, and Courtesy appointment, application must be made according to the regular appointment process with reappointment application every two years. All Medical Staff applying for initial membership and privileges shall be assigned a provisional staff status category, i.e. Provisional/Active, and shall remain under the provisional status for a period of no less than one year as set forth in 3.3.2.

4.2 THE ACTIVE MEDICAL STAFF

The Active Medical Staff shall consist of physicians, dentists, and surgical podiatrists qualified for staff membership who are located closely enough to the Medical Center to provide continuous care to their patients, who regularly admit patients or who are otherwise regularly involved in the care of patients in the hospital, and who assume all the functions and responsibilities of membership of the Active Medical Staff which includes participation on the practitioner on-call schedule as referenced in 3.2.2.2.2, consultation assignments and peer review activities. Members of the Active Medical Staff shall be appointed to a specific department, may serve on committees and may be required to attend meetings, and may be eligible to vote and to hold office. (MS.01.01.01 EP17)

4.3 THE ASSOCIATE MEDICAL STAFF

The Associate Medical Staff consists of physicians, dentists, and surgical podiatrists qualified for staff membership who may occasionally admit patients to the Medical Center, or who provide consultation, or are otherwise regularly involved in the care of patients in the Medical Center. They must give assurance of providing continuous care to the patients they admit to the Medical Center, which includes participation on the practitioner on-call schedule as referenced in 3.2.2.2.2 Associate Staff must be a member in good standing of the active or associate staff of another accredited, licensed hospital; physicians may be exempt from this requirement, provided information regarding ongoing monitoring and evaluation of professional performance, judgment, and clinical or technical skills is readily available. Members of the Associate Medical Staff shall be appointed to a specific department, may attend staff meetings and may be appointed to committees. Medical Staff members in this category generally do not have voting privileges and may not hold office or serve as chair of a department or committee.

4.4 THE CONSULTING MEDICAL STAFF

The Consulting Medical Staff consists of physicians, dentists, and surgical podiatrists qualified for staff membership and requested privileges who provide consult service to other Medical Staff members. Consulting Staff are practitioners of recognized professional ability who order diagnostic services or programs and perform procedures as requested in the Medical Center. Members of the Consulting Staff may not admit patients. By the nature of their practice or the location of their home and office, Consulting members cannot fulfill the obligation of Active or Associate memberships.

Consulting members must be a member in good standing of the active or associate staff of another accredited, licensed hospital; physicians may be exempt from this requirement, provided information regarding ongoing monitoring and evaluation of professional performance, judgment, and clinical or

technical skills is readily available. Consulting Staff members shall be appointed to a specific department but shall not be eligible to vote or hold office in this Medical Staff organization. Where appropriate, Consulting Staff members may be appointed to committees.

4.5 THE COURTESY MEDICAL STAFF

The Courtesy Medical Staff consists of physicians, dentists, and surgical podiatrists qualified for staff membership but who wish to utilize only outpatient diagnostic services or programs of the Medical Center and will not hold privileges to admit or treat patients or perform procedures in the Medical Center. Courtesy members must be a member in good standing of the active or associate staff of another accredited, licensed hospital; physicians may be exempt from this requirement, provided information regarding ongoing monitoring and evaluation of professional performance, judgment, and clinical or technical skills is readily available. Courtesy Medical Staff members shall be appointed to a specific department but shall not be eligible to vote or hold office in this Medical Staff organization. Where appropriate, Courtesy Staff members may be appointed to committees.

4.6 THE HONORARY MEDICAL STAFF

The Honorary Medical Staff shall consist of physicians, dentists, and surgical podiatrists qualified for staff membership who are not active in the Medical Center and who are honored by emeritus positions. These may be:

4.6.1 Physicians, dentists, or surgical podiatrists who have retired from active hospital service and are honored for their service and contributions to the Medical Center and medical community.

4.6.2 Physicians, dentists or surgical podiatrists of outstanding reputation, not necessarily residents in the community.

Members of the Honorary Staff may attend Medical Staff department meetings and committees but shall be exempt from attendance requirements, may serve at the pleasure of the Medical Staff on committees and may attend any staff or Medical Center education or clinical program. The Honorary Staff may be eligible to vote but is not eligible to hold office, ordinarily does not admit patients or exercise privileges and shall ordinarily have no assigned duties.

5.0 ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

Allied Health Professionals (AHP's), acting as agents of a supervising physician, may provide clinical service within the Medical Center according to their privileges, job description, or protocols. They, however, are not eligible for Medical Staff membership. AHP's are eligible for privileges only if they:

5.1.1 Hold a license, certificate, other legal credential or have appropriate training as defined in the Rules and Regulations for the privilege requested;

5.1.2 Produce adequate documentation to demonstrate that the privilege requested is within the scope of the AHP's license, certificate or training;

5.1.3 Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by the AHP will receive care of the generally recognized professional level of quality and efficiency established by the Medical Center, and they are qualified to exercise clinical privileges within the Medical Center;

5.1.4 Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective profession; to work cooperatively with others in the Medical Center setting; and are willing to commit to and regularly assist the Medical Center in fulfilling its obligations related to patient care, within the areas of their professional competence;

5.1.5 Secure and maintain the sponsorship of a physician with Active Medical Staff membership and privileges at the Medical Center and who is privileged to provide sponsorship when required according to the Medical Staff policies, Rules and Regulations.

5.2 PROCEDURE FOR GRANTING PRIVILEGES (MS.01.01.01 EP 26)

5.2.1 AHP's must apply and qualify for privileges. Applications for initial granting of clinical

privileges and subsequent renewal thereof shall be submitted and processed as provided in 6.0 and 7.0 unless otherwise specified in the Medical Center Bylaws, Rules and Regulations.

5.2.2 Each AHP shall be assigned to the clinical department appropriate to his/her occupational or professional training and, unless otherwise specified in the Bylaws or Rules and Regulations, shall be subject to terms and conditions of these Bylaws as may logically apply to AHP's profession.

5.3 RESPONSIBILITIES

Each AHP shall:

5.3.1 Meet the responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and policies in addition to the Medical Center Bylaws and policies.

5.3.1.1 The organized medical staff specifies the minimal content and complexity of medical histories and physical examinations which may vary by setting or level of care, treatment and service.

5.3.2 Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing service.

5.3.3 Participate, as appropriate, in patient care studies and other quality review, evaluation, and monitoring activities required of AHP's, supervise initial appointees of his/her same occupation or profession, or of a lesser included occupation or profession, and perform such other functions as may be required from time to time.

5.3.4 Provide service under the sponsorship of an appropriately privileged Active Medical Staff member.

5.3.5 Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

5.4 MEDICAL SCREENING EXAMINATION

In addition to Physicians, the following may administer a medical screening examination to determine if the individual has an emergency medical condition or is in active labor: Physician Assistants, Advanced Registered Nurse Practitioners, and Certified Nurse Midwives. Labor and Delivery Nurses, and Emergency Department Nurses who have demonstrated current competence in the performance of a medical screening examination may administer a medical screening examination to determine if the individual has an emergency medical condition or is in active labor. Physician Assistants, Advanced Registered Nurse Practitioners, Certified Nurse Midwives, Labor and Delivery Nurses, and Emergency Department Nurses complete/sign a certification for transfer in consultation with a physician.

6.0 PROCEDURE FOR APPOINTMENT/REAPPOINTMENT

6.1 APPLICATION FOR APPOINTMENT (MS.01.01.01 EP 27)

6.1.1 All applications for appointment to the Medical Staff shall be in writing, signed by the applicant and submitted on a form which has been prescribed by the Board of Directors after consultation with the Executive Committee.

6.1.2 The application form shall include a signed statement that the applicant has received and read the Bylaws of the Medical Center and the Bylaws, Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application; and shall include a signed statement of the applicants willingness to appear for interviews in regard to his/her application.

6.1.3 The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. An application containing substantive falsification or omissions and/or a failure

to sustain the burden to producing adequate information is grounds for automatic termination of the application process. An applicant, whose application is not completed within six months after it is received by the Medical Staff office, shall be automatically removed from consideration for application for staff membership and privileges.

6.1.4 If deemed by criteria set forth in these Bylaws, Rules and Regulations and Medical Staff policies as eligible for application, the President/CEO shall send a notice to all Active Medical Staff members, advising the Medical Staff of the physician's or AHP's application and the initiation of the credentialing process. At this time members of the Medical Staff can offer any information of support or cause for limitations or denial of membership and privileges to the Chair of the Credentials/ Bylaws Committee.

6.1.5 The completed application is processed per Medical Staff policy #10-0203-02. The application and all supporting materials are then submitted to the Chair of each Department in which the applicant seeks clinical privileges and to the Credentials/Bylaws Committee for evaluation.

6.2 APPOINTMENT PROCESS (MS.01.01.01 EP 26 & 27 & MS.06.01.07 & MS.07.01.03)

6.2.1. The Credentials/Bylaws Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner or AHP and shall determine, through information contained in references given by the practitioner of AHP and from other sources available to the Committee, including an appraisal from a peer in the clinical department in which privileges are sought, whether the practitioner or AHP has established and meets all of the necessary qualifications for application. No incomplete or unresolved application will be considered eligible for the application process. Practitioners privileged through the Medical Staff process will practice only within the scope of their privileges. The organized Medical Staff pursuant to the Medial Staff bylaws evaluates and acts upon reported concerns regarding privileged practitioner's clinical practice or competence.

6.2.2 Within 40 days after receipt of the completed application for membership and/or privileges, the Credentials/Bylaws Committee shall make a written report of its evaluation to the Executive Committee. Every department in which the practitioner seeks clinical privileges shall provide the Credentials/Bylaws Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report.

Together with its report, the Credentials/Bylaws Committee shall transmit to the Executive Committee the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical Staff and/or that privileges be granted, or rejected for Medical Staff membership and/or privileging, or that the application be deferred for further consideration.

6.2.3 The Executive Committee shall review the applications and the recommendations of the Credentials/Bylaws Committee and within 40 days make its recommendation to the Board of Directors that the practitioner or AHP be provisionally appointed to the Medical Staff and/or that privileges be granted, that he/she be rejected for Medical Staff membership and/or privileging, or that his/her application be deferred for further consideration. All recommendations to appointment must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges. (MS.07.01.01)

6.2.4 When the recommendation of the Executive Committee to the Board of Directors is to defer the application for further consideration, it must be followed up within 40 days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for Staff membership and/or privileges.

6.2.5 When the recommendation of the Executive Committee is favorable to the practitioner or AHP, the President/CEO shall forward it, together with all supporting documentation, to the Board of Directors.

6.2.6 When the recommendation of the Executive Committee is adverse to the practitioner or AHP, in respect to either appointment or clinical privileges, the President/CEO shall promptly so notify the practitioner or AHP by certified mail, return receipt requested. This notice shall comply with all requirements contained in section 9.0. No such adverse recommendation need be forwarded to the Board of Directors until after the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in section 9.0.

6.2.7 If, after the Executive Committee has considered the report and recommendation of the hearing officer or committee, the Executive Committee's reconsidered recommendation is favorable to the practitioner or AHP, it shall be processed in accordance with section 6.2.5. If such recommendation continues to be adverse, the President/CEO shall promptly so notify the practitioner or AHP by certified mail, return receipt requested. This notice shall comport with all requirements contained in section 9.0. The President/CEO shall also forward such recommendation to the Board of Directors, but the Board of Directors shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in section 9.0.

6.2.8 At its next regular meeting after receipt of a favorable recommendation from the Executive Committee, the Board of Directors shall act in the matter. If the Board's decision is favorable to the practitioner or AHP, it shall issue its final decision in the matter, which shall include a delineation of the clinical privileges which the practitioner or AHP may exercise. This decision is communicated promptly to the practitioner. If the Board's decision is adverse to the practitioner or AHP in respect to either appointment or clinical privileges, the matter shall be referred to the Executive Committee pursuant to 6.2.9. If the Board's decision is still adverse after receipt and review of the Executive Committee's recommendation, the President/CEO shall promptly notify the practitioner or AHP of the adverse decision by certified mail, return receipt requested. Such notice shall comport with all requirements contained in section 9.0. Such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived all applicable rights under section 9.0 of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges that did not exist before. (MS.06.01.09)

If the Board's decision is still adverse after all of the practitioner's rights under section 9.0 have been exhausted or waived, it shall issue its final decision in the matter.

6.2.9 At its next regular meeting after all of the practitioner's rights under section 6.0 have been waived, or after receipt of the recommendation of the hearing committee, the Board of Directors shall act in the matter. If the Board's decision is adverse to the practitioner or AHP, it shall issue its final decision in the matter. If the Board's decision is favorable to the practitioner or AHP and therefore contrary to the prior adverse recommendation of the Executive Committee, the matter shall be referred back to the Executive Committee for its report and recommendation. After the Board has considered the Executive Committee's recommendation, the Board shall issue its final decision in the matter. The Board's final decision shall be conclusive. A decision to appoint shall include a delineation of the clinical privileges which the practitioner or AHP may exercise.

6.2.10 When the decision of the Board of Directors is final, it shall send notice of such decision through the President/CEO to the Secretary of the Medical Staff, to the Chair of the Executive Committee and to the Chair of the Department concerned, and by certified mail, return receipt requested, to the practitioner or AHP. Such notice shall include a copy of the Board of Director's final decision with a statement of the basis for the final decision.

6.2.11 St. Claire Regional Medical Center conducts Expedited Credentialing for initial appointment only when necessary to meet the need of the patient population. Expedited Credentialing is conducted for the purpose of granting medical staff membership and privileges in an expeditious manner. For the purposes of Expedited Credentialing, the Board of Directors delegates authority to a committee of at least two (2) members of the Board of Directors. This Committee meets as often as necessary upon notification from the Medical Center President/CEO. Guidelines for granting medical staff membership and privileges through the Expedited process are outlined in MS Policy # 10-0111-01. (MS.06.01.11)

6.3 REAPPOINTMENT PROCESS

6.3.1 Reappointment to the Medical Staff is subject to ongoing professional practice evaluation in the following general competencies: patient care and clinical judgment; medical/clinical knowledge; technical and clinical skills; practice-based learning and improvement; interpersonal and communication skills; professionalism; systems-based practice. Reappointment also includes evidence the licensed independent practitioner is competent and in good standing at other facilities where privileges are held. Participation in continuing education is considered in decisions about reappointment to membership on the Medical Staff or renewal or revision of individual clinical privileges. (MS.12.01.01)

The Credentials/Bylaws Committee shall review the reappointment application and all pertinent information available on each practitioner or AHP scheduled for periodic appraisal, including the recommendations from the Departments, for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

6.3.2 Each recommendation concerning the reappointment of an AHP's privileges or a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his/her ethics and conduct, his/her physical and mental health, his/her attendance at Medical Staff meetings and participation in Staff affairs, his/her participation in continuing medical education, his/her timely completion and accuracy in medical record documentation, his/her compliance with the Medical Center Bylaws and the Medical Staff Bylaws, Rules and Regulations, his/her cooperation with Medical Center personnel, his/her use of the Medical Center's facilities for his/her patients, his/her relations with other practitioners, and his/her general attitude toward patients, the Medical Center and the public. Review shall also be made of professional liability claims filed against the physician or AHP as reported in the reappointment application.

6.3.3 The Executive Committee shall make written recommendation to the Board of Directors, through the President/CEO, concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner or AHP then scheduled for periodic appraisal. The Executive Committee shall have the right to request any further documentation or reasonable evidence in support of compliance with requirements of 6.3.2.

When non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented. Thereafter, the procedure provided in section 6.2 shall be followed. Failure to advance an appointee from provisional to regular staff status shall be deemed a termination of staff appointment/privileges. A provisional appointee whose membership/privileges are so terminated shall have the rights accorded by these Bylaws to a member of the medical Staff who has failed to be reappointed/privileged.

6.3.4 In the event that relevant materials required for the appointment or reappointment application are not received within 60 days after the application is received or the reappointment notice was sent, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff office or the expiration of six months from the date the application was received or the reappointment notice was sent.

7.0 CLINICAL PRIVILEGES (MS.01.01.01 EP 14)

7.1 CLINICAL PRIVILEGES GRANTED

7.1.1 Every practitioner at this Medical Center by virtue of Medical Staff membership shall be entitled to exercise only those clinical privileges granted to him/her by the Board of Directors, except as provided in sections 7.2 and 7.3. Practitioners privileged through the Medical Staff process will practice only within the scope of their privileges. The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is objective, evidence-based and outlined in policy.(MS.06.01.05).

7.1.2 Each initial application for Staff appointment must contain a request for the clinical privileges desired by the applicant. The Medical Center collects information regarding each applicant's current license status, training, experience, competence and ability to perform requested privileges. Evaluation of all privilege requests shall be based upon the applicant's education, training, experience, demonstrated competence, references or other relevant information, including an appraisal by the clinical Department in which such privileges are sought. This appointment shall be based on established criteria as defined in the Medical Staff Rules and Regulations. A request for privileges should be completed to reflect the practitioner's pattern of practice. Privileges should not be requested simply because the practitioner may encounter a particular condition but should reflect the intended practice pattern of the practitioner and the technology available at the Medical Center. (MS.06.01.03)

7.1.2.1 Prior to granting a privilege, the resources necessary to support each requested privilege are determined to be currently available, or available within a specified time frame. Determination of whether sufficient space, equipment, staffing are in place or available within the specified time frame is made in an unbiased and consistent process. Processes outlined in Policy # 10-0211-19 are utilized when applicable. (MS.06.01.01)

7.1.3 Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the ongoing professional practice evaluation (OPPE) which evaluates the ongoing practice of practitioners to identify professional practice trends that impact quality of care and patient safety including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice as defined in Medical Staff Policy 10-0211-01. In order to obtain additional privileges, a member of the Medical Staff shall make written application on the prescribed form, which shall state the type of privileges desired, previous training and experience, and resume of cases. Such application shall be processed as if it were an initial application.

7.1.4 Privileges granted to dentists and surgical podiatrists shall be based upon their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist or surgical podiatrist may perform shall be delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and surgical podiatrists shall be under the overall supervision of the Department of Surgery Chairman. All dental and surgical podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry. However, qualified oral and maxillofacial surgeons are responsible for the complete history and physical examination. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

7.1.5 Provisional staff members shall be assigned to a Department where their performance shall be observed by the Chair of the Department or his/her representative until their conditions of probation have been fulfilled as defined in section 3.4.

7.2 TEMPORARY PRIVILEGES (MS.06.01.13)

7.2.1 The President/CEO of the Medical Center, or designee, after conference with the Medical Staff President and the appropriate Department Chair, shall have the authority to grant temporary privileges to a physician or allied health practitioner who is not a member of the Medical Staff for a limited time period not to exceed more than 120 days. The use of temporary privileges is acceptable when there is a need to fulfill an important patient care need; or when an applicant with a complete application is awaiting review and approval of the Executive Committee and the Board of Directors. Specific circumstances and process for granting temporary privileges is outlined in Medical Staff policy #10-0211-10. Practitioners privileged through the Medical Staff process will practice only within the scope of their privileges.

7.2.2 The President/CEO may permit a physician serving as a locum tenens for a member of the Medical Staff to practice in the Medical Center provided the locum tenens applicant has submitted a complete application and the application has been processed in the same manner as a permanent staff member as outlined in Medical Staff policy #10-0203-02, and the application has been approved by the Departmental Chair concerned and by the Medical Staff President. Physicians serving as locum tenens more than once for a total of 90 days in a 12-month period, or who serve for a period longer than 90 days, shall apply for Associate Medical Staff membership and renewal/extension of privileges.

7.2.3 Temporary privileges may be granted to a member of University of Kentucky Medical Center faculty who has been requested by a current Active Staff physician to provide consultation or assistance in performance of specific procedure(s). These temporary privileges may be granted for one year upon submission of letter of request and statement of intent from St. Claire Regional Medical Center Active Staff physician along with a copy of the applying physician's State license, DEA, certificate of malpractice coverage, and completed Temporary Privilege Form.

7.2.4 On the discovery of information or the occurrence of an event of a nature which raises question about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the President/CEO or Medical Staff President may, after consultation with the Department Chair responsible for supervision, terminate any or all of the practitioner's temporary privileges. In the event of any such termination, the practitioner's patients then in the Medical Center shall be assigned to another practitioner by the Department Chair responsible for supervision.

7.2.5 A practitioner shall not be entitled to the procedural rights afforded by section 9.0 because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

7.3 EMERGENCY/DISASTER PRIVILEGES

In the case of emergency or disaster, the President/CEO or Medical Staff President or their designee(s) may grant emergency privileges when the Medical Center and current staff members are unable to handle the immediate patient needs.

Any practitioner (physician, dentist, or allied health practitioner) to the degree permitted by his/her license, certification, or registration and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Medical Center necessary or desirable. After the initial disaster and within 72 hours of the time the volunteer practitioner presents to the organization, Administrative Staff will begin the process of verifying the credentials and privileges of the volunteer practitioner to include verification of licensure, medical school, training, current competence, and malpractice coverage.

Primary source verification of license is completed within 72 hours from the time the volunteer practitioner presents to the organization. It is recognized that during a disaster, resources used for verification such as internet and phone may not be available. In such case, every reasonable effort should be made as soon as possible to verify the credentials and privileges of the volunteer practitioner. Should a problem arise during the verification process, the President/CEO, VPMA, Medical Staff President or their designee has the option to terminate emergency privileges immediately. St. Claire Regional Medical Center makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted. The President/CEO or designee will determine the end of the disaster and make official declaration for the Medical Center. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and delay in administering treatment would add to that danger; a “disaster” is defined as a condition where the emergency management plan has been activated. Practitioners privileged through the Medical Staff process will practice only within the scope of their privileges.

7.4 LEAVE OF ABSENCE/REAPPOINTMENT

Any member of the Staff may request, in writing, a leave of absence for a period not to exceed his/her present term or appointment. If his/her absence exceeds his/her leave, he/she may apply for reappointment and be considered in a manner similar to a normal reappointment, upon the submission of a written report or other documentation of his/her professional or other activities during his/her absence.

8.0 CORRECTIVE ACTION (MS.01.01.01 EP 30 & EP 33)

8.1 PROCEDURE

8.1.1 Whenever the activities or professional conduct of any practitioner that has been granted clinical privileges or whose practice is outlined by job description or scope of practice are, or are reasonably probable of being detrimental to patient safety or to the delivery of quality patient care or are reasonably probable of being disruptive to Medical Center operations, corrective action against such practitioner may be requested.

Evaluation of such activities or conduct and steps taken prior to corrective action are outlined in Medical Staff Policy. Such activities or conduct of a practitioner recited above include, but shall not be limited to the following:

8.1.1.1 continuing to practice medicine outside the area of the practitioner's specialty for which he/she has not been granted privileges after being notified of such deviation;

8.1.1.2 failing to provide continuity of care by attendance to patients under his/her care;

8.1.1.3 failing repeatedly to provide timely and adequate consultation in the care of his/her patients;

8.1.1.4 falsifying patient's clinical records or providing false information on any Staff related matter; or unauthorized use of signature stamp or electronic signature or delegating signature stamp or electronic signature authorization to another person.

8.1.1.5 violating privileged communication between practitioner and patient; failing to protect the confidentiality and security of information and information systems.

8.1.1.6 interfering with any other Staff member and his/her patient;

8.1.1.7 making false statements to any third party about any Staff member or Medical Center employee;

8.1.1.8 intentionally striking or causing bodily injury to any Staff member or Medical Center employee;

8.1.1.9 fee-splitting or other inducements relating to patient referral;

8.1.1.10 unlawfully taking Medical Center property;

8.1.1.11 using fraudulent billing practices;

8.1.1.12 having such physical or mental disability or other condition that continued practice is dangerous to patients or to the public.

8.1.1.13 excessive use or abuse or being under the influence of alcohol and/or drugs or other mood altering substances which inhibits the provision of quality patient care or inhibits the practice of medicine with reasonable skill and safety to patients;

8.1.1.14 providing or having provided "ghost" surgical or medical services;

8.1.1.15 delegation of diagnosis or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake the responsibility;

8.1.1.16 any other violation of the Constitution, Bylaws, Code of Ethics, Integrity Standards, HIPAA and Rules and Regulations of the Medical Staff and Medical Center;

8.1.1.17 care falling below the recognized standard;

8.1.1.18 insurance fraud and abuse; and,

8.1.1.19 Medicare and Medicaid fraud and abuse.

8.1.2 The Executive Committee must take action within 60 days following the receipt of a request for corrective action and notify the President/CEO in writing of all action taken in connection therewith.

8.1.3 Any recommendation by the Executive Committee for probation, or reduction, suspension or revocation of clinical privileges or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in section 9.0 of these Bylaws. Notice of the recommendation shall be given by the President/CEO of the Medical Center by certified mail, return receipt requested, to the practitioner.

8.1.4 Any report, information, or accusation filed, or any action recommended under this section, shall be deemed a privileged communication. Each member of the Medical Staff waives any right of personal redress against the Medical Staff, the Ad Hoc Judicial Review Committee, the Board of Directors, or any member thereof, for disciplinary action taken under this section.

8.2 SUMMARY SUSPENSION (MS.01.01.01 EP 12 & EP 29 & 32)

8.2.1 In grave and unusual cases where immediate action must be taken to protect a patient's life or welfare, the Medical Staff President, VP Medical Affairs, an applicable Department Chair, or the Medical Center President/CEO may summarily suspend a Member of the Medical Staff.

Such summary suspension shall become effective immediately upon imposition and the person or body responsible therefore shall promptly give written notice of the suspension to the practitioner, the governing body, the Executive Committee, and the President/CEO. In such case the aggrieved party may request a prompt hearing before the Executive Committee to determine whether such suspension shall be continued pending the corrective action process and the initiation of a formal appeal process as outlined in section 9.0 of these Bylaws.

8.2.2 Immediately upon the imposition of a summary suspension, the Medical Staff President or the responsible Department Chair shall make the necessary arrangements to provide for proper and adequate patient care during the period of suspension. The wishes of the patient shall be considered in the selection of such alternative practitioners. Notification of any privilege changes are communicated to the Credentials/Bylaws Committee, Medical Staff Executive Committee and Medical Staff Departmental meetings.

8.3 AUTOMATIC AND TEMPORARY SUSPENSION (MS.01.01.01 EP 28 & 31)

8.3.1 Action by the State Board of Medical Licensure revoking or suspending a practitioner's license, shall automatically suspend all of his/her Medical Center privileges. Whenever a practitioner is placed on probation by the State Board of Medical Licensure, the practitioner's applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

8.3.2 Whenever a practitioner's Drug Enforcement Administration (DEA) certificate is suspended or revoked or has expired, the practitioner shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate for the term of the DEA action. Whenever the practitioner's DEA certificate is subject to an order or probation, his/her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon, and for at least the term of the probation.

8.3.3 For failure to maintain the amount of professional liability insurance required by the Medical Center, a practitioner's clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Executive Committee that he/she has secured the required professional liability coverage. A failure to provide such evidence within six months after the date of the automatic suspension shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership and clinical privileges.

8.3.4 When a practitioner is sanctioned by the Office of Inspector General (OIG) for Medicare/Medicaid violations, the practitioner will be automatically suspended. This action does not trigger a fair hearing and appeal process. The practitioner is notified of the reason for the automatic suspension. This administrative revocation of medical staff membership and/or clinical privileges requires no discussion on behalf of the medical executive committee (MEC) and the governing board for the automatic suspension to occur. Following the automatic suspension the MEC should review and consider the facts to determine if further corrective action is appropriate, including whether termination or denial of medical staff appointment and clinical privileges.

8.3.5. Notification of any privilege changes as above are communicated immediately to the Credentials/Bylaws Committee and Medical Staff Executive Committee and in Medical Staff Departmental meetings.

9.0 HEARING AND APPELLATE REVIEW PROCEDURE (MS.01.01.01 EP 34 & MS.10.01.01)

9.1 RIGHT TO HEARING AND TO APPELLATE REVIEW

9.1.1 When a practitioner receives notice of a recommendation from the Executive Committee which, if ratified by decision of the Board of Directors, will adversely affect his/her appointment to or status as a member of the Medical Staff, Allied Health Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before a hearing officer or committee appointed pursuant to section 9.4.1. If the recommendation of the Executive Committee following such hearing is still adverse to the practitioner, he/she shall then be entitled to an appellate review by the Board of Directors before the Board makes its final decision in the matter.

9.1.2 When any practitioner receives notice of a decision of the Board of Directors that will affect his/her appointment to or status as a member of the Medical Staff, Allied Health Staff or his/her exercise of clinical privileges, and such decision is not based on a prior recommendation by the Executive Committee with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing before a hearing officer or committee appointed pursuant to section 9.4.2, and if such hearing does not result in a favorable recommendation, to an appellate review by the Board of Directors before the Board makes it final decision on the matter.

9.1.3 All Hearings and Appellate Reviews shall be in accordance with the procedural safeguards set forth in this section 9.0 to assure that the affected practitioner is accorded all rights to which he/she is entitled.

9.1.4 The following actions or recommended actions shall constitute adverse actions:

9.1.4.1 Denial of Medical/Allied Health Staff membership (for independent Allied Health that are granted clinical privileges).

9.1.4.2 Denial of requested advancement in Staff membership status.

9.4.1.3 Denial of Staff reappointment.

9.1.4.4 Demotion to lower Staff Category of membership status.

9.1.4.5 Suspension of Staff membership until completion of specific conditions or requirements.

9.1.4.6 Summary suspension of Staff membership during the pendency of corrective action and hearings and appeals procedures.

9.1.4.7 Expulsion from Staff membership.

9.1.4.8 Denial of requested privileges.

9.1.4.9 Reduction in privileges.

9.1.4.10 Suspension of privileges until completion of specific conditions or requirements.

9.1.4.11 Summary suspension of privileges during the pendency of corrective action and hearing and appeals procedures.

9.1.4.12 Termination of privileges.

9.1.4.13 Requirement of consultation.

9.2 REQUEST FOR HEARING; WAIVER

9.2.1 The President/CEO shall be responsible for giving, within five days, written notice by certified mail, return receipt requested, to the practitioner of any adverse recommendation or decision which will affect his/her appointment to or status as a member of the Medical/Allied Health Staff or his/her exercise of clinical privileges. Such notice shall include notice that a professional review action has been proposed to be taken against the practitioner and a summary of the reasons for the adverse recommendation or decision. Such written notice shall also advise the practitioner of his/her rights to request a hearing in accordance with the procedures described in these Bylaws and shall contain a brief summary of the rights to which the practitioner will be entitled in the hearing under section 9.0 of these Bylaws. Within 30 calendar days after receipt of such notice, the practitioner may, by written notice delivered to the President/CEO by certified mail, return receipt requested, request a hearing.

9.2.2 The failure of a practitioner to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to an appellate review to which he/she might otherwise have been entitled on the matter.

When the waived hearing relates to an adverse recommendation of the Executive Committee, the same shall thereupon become and remain effective against the practitioner pending the Board of Director's decision on the matter. When the waived hearing relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board provided for in section 9.7.

In either event, the President/CEO shall promptly notify the practitioner of his/her status by certified mail, return receipt requested.

9.3 NOTICE OF HEARING

9.3.1 Within 10 days after receipt of a request for hearing from a practitioner entitled to a hearing, the Executive Committee or the Board of Directors, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President/CEO notify the practitioner of the place, time and date of the hearing by certified mail, return receipt requested. The date of the hearing shall be at least 30 days after the date of the notice of hearing. A practitioner who is under suspension may request an earlier hearing date, in which case a hearing shall be held as soon as arrangements for such may reasonably be made. The notice of hearing shall also include a list of witnesses, if any, expected to testify at the hearing on behalf of the Executive Committee or the Board of Directors.

9.3.2 The notice of hearing shall contain a summary of the acts or omissions with which the practitioner is charged, a list of specific or representative patient charts under question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or decision.

9.4 COMPOSITION OF HEARING COMMITTEE (MS.01.01.01 EP 35)

9.4.1 A hearing related to an adverse recommendation of the Executive Committee shall be conducted by one of the following, as determined by the Executive Committee: an arbitrator mutually acceptable to the practitioner and the Executive Committee; a hearing officer appointed by the Executive Committee, provided that the hearing officer is not in direct economic competition with the practitioner; or a committee of Medical Staff members appointed by the Executive Committee, provided that no member of the Committee is in direct economic competition with the practitioner. No Medical Staff member who has actively participated in the formulation or consideration of the adverse recommendation or decision shall be appointed as a hearing officer or as a member of the hearing committee.

9.4.2 A hearing related to an adverse decision of the Board of Directors shall be conducted by one of the following, as determined by the Board of Directors: an arbitrator mutually acceptable to the practitioner and the Board of Directors; a hearing officer appointed by the Board of Directors, provided that the hearing officer is not in direct economic competition with the practitioner; or a committee appointed by the Board, provided that no member of the committee is in direct economic competition with the practitioner. At least one representative of the Medical Staff shall be included on this committee without a vote when feasible. No Medical Staff member who has actively participated in the formulation or consideration of the adverse recommendation or decision shall be appointed as hearing officer or as a member of the hearing committee.

9.5 CONDUCT OF HEARING

9.5.1 If the hearing is to be conducted before a committee, there shall be at least 4/5 of the members of the committee present when the hearing takes place, and no member may vote by proxy.

9.5.2 An accurate record of the hearing shall be kept. The mechanism for recording the hearing shall be determined by the hearing officer, committee, or arbitrator and may be accomplished by the use of a court reporter, electronic recording device, or detailed transcription. The practitioner shall have the right to obtain a copy of the hearing record upon payment of a reasonable charge associated with preparation thereof.

9.5.3 The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in section 9.2 and to have accepted the adverse recommendation or decision involved, and the same shall there upon become and remain in effect as provided in section 9.2.

9.5.4 Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the hearing committee, the hearing officer, or the arbitrator. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

9.5.5 The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her professional society. The Executive Committee or the Board of Directors, whichever is appropriate, and the affected practitioner shall have the right to have counsel present for the purpose of rendering advice or otherwise assisting in the exercise of any and all rights and prerogatives granted by these Bylaws.

9.5.6 Either a hearing officer, if one is appointed, the arbitrator or the chair of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

9.5.7 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely on the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The body whose action prompted the hearing and the practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning

any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The hearing committee, hearing officer, or arbitrator may call and/or question witnesses.

9.5.8 The Executive Committee, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Executive Committee shall be entitled to be represented by an attorney. The Board of Directors, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

9.5.9 The affected practitioner shall have the following rights at the hearing: to call, examine and cross-examine witnesses; to introduce written evidence; to present evidence determined to be relevant by the hearing officer, committee or the arbitrator, regardless of its admissibility in a court of law; to challenge any witness; and to rebut any evidence presented against him/her. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. Upon completion of the hearing, the practitioner shall have the right to receive a copy of the written recommendation or decision of the hearing officer or panel or arbitrator, including a statement of the basis for the recommendation or decision.

9.5.10 The hearing officer, committee or arbitrator may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing officer or committee or arbitrator may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened. The hearing shall be deemed finally adjourned when deliberations are completed. If a hearing officer is appointed in addition to a hearing committee, the hearing officer may attend the deliberations of the hearing committee in an advisory capacity.

9.5.11 Within 10 days after final adjournment of the hearing, the hearing officer, arbitrator or committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Board of Directors, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Board. Thereafter, the procedure to be followed shall be as provided in section 6.2 of these Bylaws.

9.5.11.1 At any hearing involving the denial of Medical Staff membership, denial of requested advancement in Staff Membership status, or denial of requested privileges, it shall be incumbent upon the petitioner initially to come forward with evidence in support of his/her position. In all other cases, the body whose decision prompted the hearing shall have the duty, initially, to come forward with evidence in support of such decision; thereafter, the burden shall shift to the petitioner to produce evidence in support of his/her position.

9.5.11.2 Subject to the foregoing, the petitioner shall bear the ultimate burden of persuading the arbitrator, hearing officer or hearing committee, by a preponderance of the evidence provided at the hearing, that the reasons for the decision, assigned by the body whose decision prompted the hearing, lacked foundation in fact or that the action or decision recommended by the body whose decision prompted the hearing was otherwise arbitrary or unreasonable.

9.6 APPEAL TO THE BOARD OF DIRECTORS

9.6.1 Within 30 days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Board of Directors deliver through the President/CEO by certified mail, return receipt requested, request an appellate review by the Board of Directors. Such notice may request that the

appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

9.6.2 The failure of a practitioner to request an appellate review to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to an appellate review on the matter.

When the waived appellate review relates to an adverse recommendation of a hearing officer or committee appointed by the Executive Committee or the Board of Directors, the same shall thereupon become and remain effective against the practitioner pending the Board of Director's decision on the matter. When the waived appellant review relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board provided for in section 9.7. In either event, the President/CEO shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

9.6.3 Within 10 days after receipt of a request for appellate review from a practitioner entitled to an appellate review, the Board of Directors shall schedule and arrange for an appellate review and shall, through the President/CEO notify the practitioner of the place, time and date of the appellate review by certified mail, return receipt requested. The date of the appellate review shall be at least 30 days after the date of the notice of appellate review. A practitioner who is under suspension may request an earlier date for appellate review, in which case an appellate review shall be held as soon as arrangements for such may reasonably be made.

9.6.4 The appellate review shall be conducted by the Board of Directors or by a duly appointed appellate review committee of the Board consisting of not fewer than six members, provided that no member of the Board of Directors who is in direct economic competition with the practitioner shall be permitted to participate in the appellate review.

9.6.5 At least five days prior to the date of the appellate review, the affected practitioner shall submit a written statement on his/her own behalf in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matter raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. The written statement shall be submitted to the Board of Directors through the President/CEO, by certified mail, return receipt requested.

A similar statement may be submitted by the Executive Committee of the Medical Staff, by the hearing officer or by the chair of the hearing committee appointed by the Board of Directors, and if such a statement is submitted, the President/CEO shall provide a copy thereof to the practitioner prior to the date of the appellate review by certified mail, return receipt requested.

9.6.6 The Board of Directors or the appellate review committee, whichever is appropriate, shall review the record created in the prior proceedings and shall consider the written statements submitted pursuant to section 9.6.5 for the purpose of determining whether the adverse recommendation or decision against the practitioner was justified and was not arbitrary or capricious. If oral argument was requested as part of the appellate review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The affected practitioner shall also have the right to have counsel present for the purpose of rendering advice or otherwise assisting in the exercise of any and all rights and prerogatives granted by these Bylaws.

A representative of the Executive Committee or the Board of Directors, whichever is appropriate, shall also be present and shall be permitted to speak in favor of the adverse recommendation for decision. Such representative shall answer questions put to him/her by any member of the appellate review body. The Executive Committee or the Board of Directors, whichever is appropriate, shall also have the right to have counsel present for the purpose of rendering advice or otherwise assisting in its presentation to the appellate review body.

9.6.7 New or additional matters not raised during the original hearing or in the report of the hearing officer or committee and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances, and the Board of Directors or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

9.6.8 If the appellate review is conducted by the Board of Directors itself, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Executive Committee for further review and recommendations. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve specified disputed issues. Such hearings shall comport with all applicable requirements contained in section 9.3, 9.4, and 9.5.

9.6.9 If the appellate review is conducted by a committee of the Board of Directors, such committee shall, within 15 days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues. Such hearings shall comport with all applicable requirements of sections 9.3, 9.4, and 9.5.

9.7 COMPLETION OF APPELLATE REVIEW PROCESS

9.7.1 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in section 9.6 have been completed or waived. When permitted by Medical Center Bylaws, all action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to act for the Board.

9.7.2 After completion of the appellate review process, the procedure to be followed shall be as provided in sections 6.2.9 and 6.2.10, whichever is applicable.

9.8 LIMITATION ON NUMBER OF HEARINGS AND APPELLATE REVIEWS

Not withstanding any other provision of these Bylaws, no practitioner shall be entitled as a matter of right to more than one hearing and one appellate review on any matter which shall have been the subject to action by the Executive Committee, the Board of Directors or a duly authorized committee of the Board of Directors.

10.0 OFFICERS (MS.01.01.01 EP 18)

10.1 OFFICERS OF THE MEDICAL STAFF (MS.01.01.01 EP 19)

10.2 The officers of the Medical Staff shall be:

- **10.2.1** President
- **10.2.2** President-Elect (Vice President)
- **10.2.3** Immediate Past President
- **10.2.4** Secretary-Treasurer

10.3 QUALIFICATION OF OFFICERS

Officers must be members of the Active Staff and are fully licensed doctors of medicine or osteopathy actively practicing in the hospital at the time of nomination and election and must remain members in good standing during the term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.3 ELECTION OF OFFICERS (MS.01.01.01 EP 21)

10.3.1 The Nominating Committee shall consist of three members of the Active Medical Staff appointed by the Medical Staff President. This Committee shall offer one or more nominees for each office and the member-at-large. Nominations may also be made from the floor at the time of the annual meeting.

10.3.2 Officers shall be elected at the annual meeting of the Medical Staff. Voting may be done by secret ballot. Office holders shall be selected by plurality vote and their selection approved by the Board of Directors.

10.4 TERM OF OFFICE

All officers shall serve a one year term from their election date or until a successor is elected. Officers shall take office October 1. Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Executive Committee, with the concurrence of the Medical Staff, and approval by the Board of Directors. An officer shall serve no more than two consecutive terms.

10.5 REMOVAL FROM OFFICE (MS.01.01.01 EP 20 &21)

Two-thirds of the Executive Committee may recommend by vote the removal of an officer of the Medical Staff to the Board of Directors if in their judgment the best interests of the Medical Center would be served thereby. Grounds for removal shall include but not be limited to mental and/or physical impairment, inability to perform the duties and responsibilities of the office, or active disciplinary action. Any vote taken on a motion to remove an officer from office shall be taken by secret ballot.

10.6 DUTIES OF OFFICERS

10.6.1 President: The President shall serve as the Chief Administrative Officer of the Medical Staff to:

10.6.1.1 Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

10.6.1.2 Serve as Chair of The Executive Committee and ex-officio member of all other committees without a vote;

10.6.1.3 Coordinate and cooperate with the President/CEO and VPMA in all matters of mutual concern within the Medical Center;

10.6.1.4 Appoint, in consultation with the Medical Center President/CEO, medical staff members to Medical Staff committees and other service functions of the Medical Staff, except the Executive Committee. The Executive Committee has the right of review and approval of Committee appointments. The President/CEO makes Medical Center committee and service line team appointments from the Medical Staff in consultation with the Medical Staff President. Medical Center staff are appointed to committees/service line teams by the President/CEO.

10.6.1.5 Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Medical Center President/CEO;

10.6.1.6 Receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

10.6.1.7 Be the spokesperson for the Medical Staff in its external professional and public relations;

10.6.1.8 Serve as a non-voting member of the Board of Directors.

10.6.2 President-Elect: In the absence of the President, shall assume all the duties and have the authority of the President. The President-Elect shall be a member of the Executive Committee and shall automatically succeed the President when the latter fails to serve for any reason.

10.6.3 Immediate Past-President: Shall act as an advisor to the President and shall be a member of the Executive Committee. In the absence of the President and the President-Elect, shall assume all the duties and have the authority of the President.

10.6.4 Secretary-Treasurer: Shall be a member of the Executive Committee. The Secretary shall keep accurate and complete minutes of all General Medical Staff meetings, call General Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. Shall pay authorized expenses and shall render a financial report upon request of the Medical Staff President.

11.0 CLINICAL DEPARTMENTS (MS.01.01.01 EP 36)

11.1 CLINICAL DEPARTMENTS AND SERVICES The Medical Staff shall have organized departmental services as follows:

11.1.1 MEDICINE - to include General Medicine and all recognized sub-specialties, Family Medicine, Internal Medicine, Pediatrics, Psychiatry, Neurology, Radiology, Pathology and Clinical Cytology, Emergency Medicine, and Radiation Oncology.

11.1.2 SURGERY AND OBSTETRICS - to include general surgery and all recognized surgical and obstetrical specialties and sub-specialties, dental and oral surgery, Anesthesiology, Otolaryngology, Ophthalmology, Pathology and Clinical Cytology, Radiology, Radiation Oncology, and Urology.

11.2 ORGANIZATION AND FUNCTIONS OF DEPARTMENTS (MS.01.01.01 EP 36)

11.2.1 Each Medical Staff Department is organized as a division of the Medical Staff and has a Chair, elected by the Active Medical Staff of the respective departments, who is responsible to the Executive Committee. The Department Chair is certified by an appropriate specialty board or comparable competence is affirmatively established through the credentialing process. The Department Chair is responsible for the ongoing, effective operation of the Department and for assessing and improving its activities.

By virtue of office, the Department Chair will serve as a member of the Executive Committee. Responsibilities of the Department Chair include but are not limited to the following:

11.2.1.1 Clinically related activities of the department.

11.2.1.2 Administratively related activities of the department, unless otherwise provided for by the Medical Center.

11.2.1.3 Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

11.2.1.4 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.

11.2.1.5 Recommending clinical privileges for each member of the department.

11.2.1.6 Assessing and recommending to the relevant Medical Center authority off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center.

11.2.1.7 The integration of the department or service into the overall functions of the Medical Center.

11.2.1.8 The coordination and integration of interdepartmental and intradepartmental services.

11.2.1.9 The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

11.2.1.10 The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

11.2.1.11 The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

11.2.1.12 The continuous assessment and improvement of the quality of care and services provided by the department.

11.2.1.13 The orientation and continuing education of all persons in the department or service.

11.2.1.14 The recommendations for space and other resources needed by the department or service.

11.2.1.15 Maintaining quality control programs, as appropriate.

11.2.2 Each Chair/Vice-Chair is to exhibit the following qualifications: shall be a member of the Active Staff; qualified by training, experience and demonstrated administrative ability for the position and is certified by an appropriate specialty board or affirmatively establishes comparable competence through the credentialing process. The Chair/Vice-Chair shall serve in this capacity for a one-year term, subject to approval of the Board of Directors.

11.2.3 In the event a Department Chair is unable to perform the duties and responsibilities of the office, the Department may recommend to the Board of Directors removal of the Chair by a two-thirds vote. The vote shall be taken by secret ballot.

11.2.4 Each Department shall have a Vice-Chair, who in the absence of the Chair, shall assume all the duties and have the authority of the Chair. The Vice-Chair shall automatically succeed the Chair when the latter fails to serve for any reason. The Vice Chair succeeds the Chair at the end of his/her term. The Vice Chair serves as a member of the Medical Staff Credentials Bylaws Committee the year prior to becoming Department Chair.

11.2.5 Each Department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Medical Center for the granting of clinical privileges in the Departments, its organization, including its Rules and Regulations. Departmental rules shall specify the manner of election of the Chair of the Department and his/her functions. Members of a Department shall be responsible to the Chair of their Department and through them to the Medical Staff President.

11.2.6 Reports of all departmental meetings shall be submitted by the Department Chair to the Executive Committee at its regular monthly meeting.

11.2.7 Department meetings shall be scheduled to comply with the requirements of the Joint Commission

12.0 COMMITTEES

There shall be standing Committees as established by the Medical Staff Rules and Regulations and Medical Center Committees/Service Line Teams as established by the Medical Center Performance Improvement and Patient Safety Plan. Other Committees may be established by the Medical Staff President or the Department Chair as deemed appropriate for the needs of the Medical Staff or Department.

12.1 COMMITTEE APPOINTMENTS

12.1.1 The Medical Staff President, in consultation with the President/CEO makes Medical Staff Committee appointments as defined in section 10.6.1.4 and the requirements established in the Rules and Regulations.

12.1.2 The President/CEO, in conjunction with the Medical Staff President, makes Medical Center Committee and Service Line Team appointments as defined in section 10.6.1.4 and the requirements established in the Rules and Regulations.

12.1.3 Other committees - The Medical Staff President or the Department Chair establishing other Committees may make the respective Committee appointments.

12.1.4 Vacancies - Unless otherwise specifically provided, vacancies on any Medical Center or other committee shall be filled in the same manner in which original appointment to such committee is made.

12.2 EXECUTIVE COMMITTEE (MS.01.01.01 EP 20 & EP 21 & EP 22; MS.02.01.01)

12.2.1 Composition: The Executive Committee shall be composed of no more than 15 total members and will include physicians that are the officers of the Medical Staff; the Chair of each Clinical Department; one Member-at-large elected by the Medical Staff; the VP of Medical Affairs/CMO; and, if not already represented, the Medical Director or designee of Emergency Services, Laboratory, SCR Family Medicine Services, and Program Director Hospitalist Group. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Executive Committee. The President/CEO shall be an ex-officio member of the committee. The Vice President for Quality and Resource Management and the Vice President for Patient Services/CNO shall serve as a resource. A representative from the Medical Staff Office may be invited to attend committee meetings as needed to address credentialing and privileging issues. The method of removal of officers is described under section 10 of these Bylaws. The method for selection of members of the committee that are not officers of the medical staff is described in section 12 of these Bylaws, as noted above. The method for removal of members of the committee that are not officers of the medical staff will be handled in the same manner as described for officers in section 10 of these Bylaws.

12.2.2. Purpose: The Executive Committee is delegated the primary authority over activities related to self-governance of the medical staff and over activities related to performance improvement of the professional services provided by individuals with clinical privileges. The purpose of the Executive Committee shall be to represent and to act on behalf of the Medical Staff (including the power to act on behalf of the organized medical staff between meetings of the organized medical staff), to coordinate the activities and general policies of the various Departments; to receive and act upon performance improvement data including reports of Medical Staff Committees and to implement policies of the Medical Staff. It shall recommend action to the President/CEO on matters of a medico-administrative nature; shall advise the Governing Body on matters of importance to the Medical Staff, fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Medical Center; review and recommend individuals for Medical Staff membership, termination, and for delineated clinical privileges for each eligible individual; and involve medical staff in performance improvement activities. (MS.01.01.01 EP 20)

The Executive Committee requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested. The Executive Committee must initiate and/or participate in Medical Staff corrective or review measures when warranted and report at each General Staff meeting. The meeting frequency is monthly.

13.0 MEDICAL MEETINGS

13.1.1 The annual meeting of the Staff shall be the last meeting before the end of the Medical Staff year of the Medical Center. At this meeting the retiring officers and Committees shall make reports, as may be desirable, officers of the ensuing year shall be elected, and recommendations for appointments to the various categories and services of the Medical Staff may be made.

13.1.2 All regular meetings of the Medical Staff shall be held at such day and hours as the Medical Staff President shall designate in the call and notice of the meeting. These meetings will be held at St. Claire Regional Medical Center for the purpose of transacting general business and analyzing the clinical work of the Medical Center.

13.2 SPECIAL MEETINGS

Special meetings of the Staff may be called at any time by the President or the Executive Committee and at the request of the Board of Directors, the President/CEO, or any five members of the Active Staff. At any special meeting no business shall be transacted except that stated in notice calling the meeting. Staff members shall be notified at their offices, either by mail or phone, at least 48 hours before time set for the meeting.

13.3 QUORUM

Fifty percent of the total membership of the Active Staff constitutes a quorum for General Medical Staff meetings. Fifty percent of the total membership of a given Department constitutes a quorum for Medical

Staff Department meetings. Fifty percent of the Medical Staff members of a given Committee constitute a quorum for Medical Staff committees as defined in Rules and Regulations. Fifty percent of the total membership constitutes a quorum for Medical Center committees/service line teams.

13.4 ATTENDANCE REQUIREMENTS

Each member of the Active Staff is required to attend at least 50 percent of the respective Departmental meetings and Annual General Medical Staff meetings. Members of the medical staff may be assigned to at least one committee or service line. Members must be present for a minimum of 50% of a meeting to be recorded in attendance. A noted pattern or trend of tardiness may be addressed to the individual by the Chair. Consideration may be given to excused absences. Attendance of the Executive Committee is mandatory. Any member of the Executive Committee who has not attended 2/3 of the monthly meetings may be replaced by the Chairman, with approval of the Board of Directors. Appointments to Medical Staff and Medical Center Committees and Services Lines are made by the Medical Center President/CEO in consultation with the Medical Staff President (Medical Staff Bylaws 10.6.1.4 and 12.1.2; Medical Staff Rules and Regulations RR5.0; Medical Staff policy 10-0211-20).

14.0 CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS: For the purposes of this section, the following definitions shall apply:

14.1.1 INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in section 14.5.2

14.1.2 MALICE means the dissemination of the knowing falsehood or of information with reckless disregard for whether or not it is true or false.

14.1.3 PRACTITIONER means a Staff member or applicant or an Allied Health Professional.

14.1.4 REPRESENTATIVE means a Board and any Director or Committee thereof; a Chief Executive Officer or his/her designee; a Medical Staff organization and any member, officer, Department or Committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

14.1.5 THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges or providing specified patient care services within this Medical Center, a practitioner:

14.2.1 Authorizes representatives of the Medical Center and the Medical Staff to solicit, provide and act upon information bearing on his/her professional ability and qualification.

14.2.2 Agrees to be bound by the provisions of this section and to waive all legal claims against any representative who acts in accordance with the provisions of this section.

14.2.3 Acknowledges that the provisions of this section are express conditions to his/her application for, or acceptance of, Staff membership and the continuation of such membership, or to his/her exercise of clinical privileges or provision of specified patient services at this Medical Center.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and privileged and shall not be disseminated to anyone other than a representative nor be used in any way except as provided herein or except as otherwise required by law.

Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Medical Center records.

14.4 IMMUNITY FROM LIABILITY

14.4.1 FOR ACTION TAKEN - No representative of the Medical Center or Medical Staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice after a reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

14.4.2 FOR PROVIDING INFORMATION - No representative of the Medical Center or Medical Staff and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileges or confidential information, to a representative of this Medical Center or Medical Staff or to any other healthcare facility or organization of health professionals concerning a practitioner or Allied Health Professional who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this Medical Center, provided that such representative or third party acts in good faith and without malice.

14.5 ACTIVITIES AND INFORMATION COVERED

14.5.1 ACTIVITIES - The confidentiality, privileged and immunity provided by this section shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

14.5.1.1 Applications for appointment, clinical privileges or specified services;

14.5.1.2 Periodic reappraisals for reappointment, clinical privileges or specified services;

14.5.1.3 Corrective action;

14.5.1.4 Hearings and appellate reviews;

14.5.1.5 Patient care audits;

14.5.1.6 Utilization reviews;

14.5.1.7 Other Medical Center, Department, Committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

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

14.6 RELEASES

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this section subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this section.

14.7 CUMULATIVE EFFECT

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

15.0 BYLAWS AMENDMENTS (MS.01.01.01 EP 1 & EP 2 & EP 4 & EP 8 & EP 24)
Medical Staff Bylaws may be adopted, amended, or repealed at any regular or special meeting of the Medical Staff provided notice of the proposed amendments has been given to the Medical Staff at least fourteen days prior to the meeting. The presence of fifty percent of the voting members of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of adoption, amendment, or repeal of any Bylaw. A two-thirds vote of those present at the meeting shall be required for adoption, amendment, or repeal of any Bylaw. Recommendations from the medical staff meeting(s) are forwarded to the Credentials/Bylaws Committee, then to the Executive Committee. The Executive Committee will forward recommendations for amendment to the Board of Directors. Amendments shall become effective when approved by the Board of Directors. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Bylaws of the Medical Staff. Medical Staff Bylaws are compatible with Medical Staff Rules and Regulations, Medical Center Polices and compliant with law and regulations. Amendment of the Medical Staff Bylaws cannot be delegated.

16.0 RULES AND REGULATIONS AMENDMENTS (MS.01.01.01 EP 4 & EP 8 & EP 24)
The Medical Staff shall adopt such rules and regulations as may be necessary for the conduct of its work. The Medical Staff Rules and Regulations are compatible with Medical Staff Bylaws, Medical Center policies and compliant with law and regulation. These shall relate to the proper conduct of Medical Staff organizational activities, as well as, embody the level of practice that is to be required of each practitioner in the Medical Center. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended by two-thirds of those present at any regular meeting provided a quorum is present, and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the Active Medical Staff. Recommendations arising from the medical staff meeting(s) are forwarded to the Credentials/Bylaws Committee, then to the Executive Committee. The Executive Committee will forward recommendations for amendment to the Board of Directors. Such changes shall become effective when approved by the Board of Directors.

In cases of a documented need for an urgent amendment to Rules and Regulations or to Medical Staff Policies necessary to comply with law or regulation or accreditation standards, responsibility is delegated by the Medical Staff to the Medical Executive Committee. The Medical Executive Committee may provisionally approve an urgent amendment without prior notification of the Medical Staff and the Medical Staff is notified immediately by Medical Executive Committee. The Medical Staff then has the opportunity for retrospective review and comment of the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment stands and will be forwarded to the Medical Center Board of Directors. If there is a conflict over the provisional amendment process for resolving conflict between the Medical Staff and the Medical Executive Committee is implemented as in Bylaw 20.0. **(MS.01.01.01 EP 11)**

17.0 ADOPTION (MS.01.01.01 EP 2)
Recommendations from the Medical Staff for Bylaws, Rules and Regulation amendments must be approved by the Board of Directors before adoption. Normally action shall be taken by the Board within 90 days of submission from the Medical Staff. This period can be extended with notice of cause to the Medical Staff.
Adoption of the Medical Staff Bylaws cannot be delegated.

18.0 POLICIES (MS.01.01.01 EP 4 & EP 8 & EP 9 & EP 24)
General Medical Staff policies arising from Committees, Service Line Teams, or Departments shall be reviewed by the Departments of Surgery and Medicine for further input. After appropriate review, input and recommendations from the Departments is submitted to the Executive Committee. Action on the policy is the responsibility of the Executive Committee. When the Medical Executive Committee adopts a policy or an amendment thereto, it communicates this to the Medical Staff. Medical Staff policies are compatible with Medical Staff Bylaws, Medical Staff Rules and Regulations and are compliant with law and regulation.
Any Medical Center policies affecting physician practice shall be presented to the Executive Committee for concurrence and comment.

19.0 BIENNIAL REVIEW
The Bylaws, Rules and Regulations shall be reviewed biennially, or as indicated by regulatory changes, by the Credentials/Bylaws Committee. Recommendations for revisions shall be made as required by sections 15.0 and 16.0.

General and Departmental Medical Staff policies shall be reviewed biennially, or as indicated by regulatory changes, by the policy recommender. Notice of such a review and the action taken shall be presented to the original reviewing Department of Medicine and/or Surgery.

20.0 CONFLICT RESOLUTION (MS.01.01.01 EP 10)

Should conflict arise between the organized Medical Staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a Rule, Regulation, Policy or an amendment thereto, the written concern is presented by a representative of the organized Medical Staff to the Medical Executive Committee together with the Chairman and two voting members of the Medical Center Board of Directors. The written concern is concurrently forwarded to the entire Medical Center Board of Directors for comment. Reasonable effort is made to resolve the conflict to the satisfaction of both parties and to the betterment of patient care and safety. Should the conflict remain unresolved a final decision is made by the Medical Center Board of Directors at their next meeting. Any appeals may be made directly to Medical Center Board in writing 10 business days prior to the meeting. The Board of Directors determines the method of communication with the organized Medical Staff and the Medical Executive Committee regarding these matters. Final action on these matters is the responsibility of the Medical Center Board of Directors.

21.0 CONSTRUCTION OF TERMS AND HEARINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or affect of any provision of these Bylaws.

MEDICAL STAFF RULES AND REGULATIONS

RR1.0 ADMISSION/DISCHARGE GUIDELINES

Admission to St. Claire Regional Medical Center shall be accomplished with the utmost regard for the patient's benefit and in accordance with a plan for medical treatment. It is therefore understood that in some instances, the care and treatment of a patient will be best carried out in other facilities equipped to handle special patient care problems, or problems that require intensive, tertiary care services.

RR1.1 ADMISSION

RR1.1.1 Patients shall be admitted to the Medical Center without regard to age, sex, race, financial status, or religious preference. There will be no discrimination against patients with contagious diseases.

RR1.1.2 If a patient requiring emergency admission has no attending practitioner, he/she will be assigned to an appropriate practitioner according to the on-call list.

RR1.1.3 A member of the Medical Staff, or Allied Health Staff member with admitting privileges, shall be responsible for the medical care and treatment of each patient in the Medical Center, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the patient's condition to the referring practitioner and to patients and relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

RR1.1.4 Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

RR1.1.5 Each member of the Medical Staff shall provide alternate coverage for his/her patients as defined in the Bylaws section 3.2.2.4. In cases where alternate coverage is not immediately available, the President/CEO of the Medical Center, Medical Staff President, or Chair of the Department concerned, shall have authority to contact an appropriate member of the Medical Staff to provide care to the respective patient until the primary practitioner is available.

RR1.1.6 Within practical limits, all non-emergency and surgery in and outpatients will be pre-admitted and/or registered by their practitioner, with assistance from the Medical Center's admission personnel.

RR1.1.7 Patients are admitted based on the following order of priorities:

RR1.1.7.1 Emergency Admissions (i.e. those acutely life-threatening);

RR1.1.7.2 Urgent Admissions (i.e. those requiring timely action or attention to prevent further deterioration);

RR1.1.7.3 Pre-operative Admissions. This includes all patients already scheduled for surgery;

RR1.1.7.4 Routine Admissions.

In case of bed unavailability in the ICU/CCU, the ICU/CCU Medical Director or his/her designee, in consultation with the attending practitioners involved, shall decide which patients shall be admitted and discharged.

RR1.1.8 Transfer priorities shall be as follows:

RR1.1.8.1 Emergency Room to appropriate patient bed;

RR1.1.8.2 From ICU/CCU to general care area;

RR1.1.8.3 From temporary placement in an inappropriate geographic or clinical area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible practitioner.

RR1.1.9 The admitting practitioner shall be held responsible for giving such information actually known to the practitioner as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

RR1.1.10 The attending practitioner is required to provide documentation and comply with laws, regulations, the approved Case Management Plan and other third party payor requirements.

RR1.1.11 Except in emergency, consent for admission and procedures must be obtained from the patient or other appropriate person(s) as defined in Medical Center Administrative Policy #A10-0609-09. It is the responsibility of the practitioner to inform the patient sufficiently to give consent.

RR1.1.12 Pre-authorization guidelines for patients of Medicare and Medicaid or other payers will be followed as directed by the designated authority.

RR1.2 PATIENT CATEGORIES

RR1.2.1 Patients to be admitted may be divided into the following diagnostic or clinical categories. Their admission and treatment is contingent upon their attending practitioner's judgment as to the potential for a recovery at this Medical Center and the well-being of others.

RR1.2.1.1 Adult persons suffering from acute medical or surgical conditions.

RR1.2.1.2 Adult persons suffering from an acute episode of a chronic condition.

RR1.2.1.3 Adult persons requiring diagnostic testing or surgical procedures.

RR1.2.1.4 Obstetrical Patients:

RR1.2.1.4.1 For normal delivery;

RR1.2.1.4.2 For complications of pregnancy and/or labor;

RR1.2.1.4.3 For postpartum complications.

RR1.2.1.5 Pediatric Patients:

RR1.2.1.5.1 Children under the age of 14 years with acute medical/surgical conditions;

RR1.2.1.5.2 Children under the age of 14 years with an acute episode of chronic condition;

RR1.2.1.5.3 Children under the age of 14 years requiring diagnostic testing or surgical procedures.

RR1.2.1.6 Neonatal Patients:

RR1.2.1.6.1 Normal newborns without complications;

RR1.2.1.6.2 Full term or premature newborns with minor complications that can be safely and adequately cared for;

RR1.2.1.6.3 Full term and premature newborns with major complications until they are stabilized for transfer to a tertiary facility.

RR1.2.1.7 Patients suffering from mental health disorders.

RR1.3 DISCHARGES

RR1.3.1 Patients shall be discharged only on an order of the attending practitioner. Should a patient leave the Medical Center against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the discharge summary of the patient's medical record.

RR1.3.2 In the event of a Medical Center death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

RR1.3.3 It shall be the duty of all Medical Staff Members to secure meaningful autopsies whenever possible especially in cases of unusual deaths and of medical, *legal, and educational interest. The hospital informs the medical staff (specifically the attending physician) of autopsies that the hospital intends to perform. An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed by the Medical Center pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record and a complete protocol should be made a part of the record within one month. Refer to policy A10-0609-13 Autopsies.

** The hospital and medical staff will follow all relevant statutes pertaining to reasons to call a Coroner.*

RR2.0 CONDUCT OF CARE

RR2.1 The ethical and religious directives for Catholic Health Facilities as currently approved by the National Conference of Catholic Bishops shall be applicable with regard to medical practices for all practitioners practicing in St. Claire Regional Medical Center.

RR2.2 A general consent form signed by or on behalf of every patient admitted to the Medical Center, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Medical Center.

RR2.3 The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. In such case the nurse shall make immediate contact for clarification.

RR2.4 All previous orders are canceled when patients go to surgery.

RR2.5 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service or A.M.D. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the *Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

RR2.5.1 *Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, 1957, American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611, and American Society of Hospital Pharmacist, 4630 Montgomery Avenue, Washington, D.C. 20014.

RR2.6 Any qualified practitioner with clinical privileges in this Medical Center can be called for consultation within his/her area of expertise.

RR2.7 Consultation from a member of the Department of Surgery shall be requested for acute trauma patients in the care of an oral surgeon.

RR2.8 The attending practitioner is responsible for requesting consultation from a qualified consultant as per Medical Staff policy #10-0211-06. When ICU/CCU patients have complications beyond the scope of practice of the attending practitioner's privileges, appropriate consultation should be obtained. Particular times when consultation may be requested include but are not limited to the following situations:

RR2.8.1 When the patient is not a good risk for operation or treatment;

RR2.8.2 Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

RR.2.8.3 Where there is doubt as to the choice of therapeutic measure to be utilized;

RR2.8.4 In unusually complicated situations where specific skills of other practitioners may be needed;

RR2.8.5 When the patient exhibits severe psychiatric symptoms and is not under the care of a psychiatrist;

RR2.8.6 When requested by the patient or his/her family;

RR2.8.7 Amputation of extremities or genitalia or portions thereof except for circumcision;

RR2.8.8 Other situations when the attending practitioner deems consultation appropriate.

RR2.9 Physicians assigned and providing primary coverage in the Emergency Room shall not admit patients while serving in this capacity.

RR3.0 SERVICE UNITS

RR3.1 ICU/CCU UNIT

RR3.1.1 Patients may be considered appropriate for admission to the ICU/CCU Unit when the required level of care for the critically ill patient is not available on the general units of the hospital. Criteria for admission to the ICU/CCU Unit are outlined in hospital nursing policy #15-0109-09.

RR3.1.2 When requests for admissions exceed bed availability, a priority of need must be determined by the attending practitioners. In case a consensus cannot be reached, the matter is referred to the practitioner chair of the Critical Care Committee for a decision.

RR3.1.3 Criteria may be utilized in the determination of patient selection for transfer from the unit when bed availability is in question. Final determination is the judgment of the attending practitioner and/or the Critical Care Committee Chair as previously stated. Criteria for discharge from the ICU/CCU is outlined in hospital nursing policy #15-0109-10.

RR3.2 MENTAL HEALTH

RR.3.2.1 The Mental Health Unit at St. Claire Regional Medical Center has been established to provide short term in and outpatient services to persons suffering with various emotional and mental problems. Admissions to the Mental Health Unit will be in accordance with the following guidelines:

RR3.2.1.1 All physicians on the Active Medical Staff may admit patients to the Mental Health Unit.

RR3.2.1.2 If the admitting physician is not a psychiatrist, a psychiatric consultation should be requested within 24 hours of admission to the Unit.

RR3.2.1.3 Patients generally are admitted on a voluntary basis.

RR3.2.1.4 Patients who are experiencing an acute episode of a chronic or acute mental health problem may be admitted to the Mental Health Unit.

RR2.3.1.4.1 When a patient has experienced three acute episodes requiring inpatient hospitalization within a 12 month period, an evaluation of the efficacy of additional admissions to St. Claire Regional Medical Center's Mental Health Unit will be required.

RR3.2.1.4.2 Normally patients who have a chronic problem should not be admitted a fourth time in a 12 month period. These patients would better benefit from a long term treatment approach to their problem at a facility equipped to handle their specific illness. This referral will be effected as quickly as possible and with regards to the patient's physical ability to be transferred.

RR3.2.1.5 Patients known to represent a physical danger to other patients, hospital staff or others, or who tend to disrupt the treatment programs of the Unit should not be admitted to the Mental Health Unit. These patients should be transferred to an appropriately equipped facility capable of handling such specialized needs. Transfer for the patient's benefit, long term treatment and the safety of all concerned should be facilitated as quickly as possible.

RR3.2.1.6 Those persons, who, by court order are to have a psychiatric evaluation, will, if practical, have it done on an outpatient basis or at the jail premises. When it is deemed necessary for them to be evaluated on an inpatient basis, the safety and security of other patients, hospital staff and others will be given primary consideration. Those patients who represent a safety hazard will be referred to a facility capable of handling such specialized problems.

RR3.2.1.7 Patients whose physical condition is unstable are to be admitted to a medical floor and transferred to the Mental Health Unit when their physical condition is stabilized.

RR3.3 EMERGENCY CARE

RR3.3.1 The Medical Staff shall adopt a method of providing specialty and back-up medical coverage for the emergency services department. This shall be in accord with the Medical Center's basic plan for delivery of medical coverage for that service as outlined in Medical Staff policy.

RR3.3.2 An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

RR3.3.2.1 Adequate patient information;

RR3.3.2.2 Information concerning the time of the patient's arrival, means of arrival and by whom transported;

RR3.3.2.3 Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital;

RR3.3.2.4 Description of significant clinical, laboratory and roentgenologic findings;

RR3.3.2.5 Diagnosis;

RR3.3.2.6 Treatment given;

RR3.3.2.7 Condition of the patient on discharge or transfer; and,

RR3.3.2.8 Final disposition, including instruction given to the patient and/or his/her family, relative to necessary follow-up care.

RR3.3.3 Each patient's medical record shall be signed by a practitioner in attendance who is responsible for its clinical accuracy.

RR3.3.4 There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Medical Center's capabilities in conjunction with other emergency facilities in the community. Medical Staff members and AHP's shall participate in emergency services as directed or as indicated in the Disaster Plan.

RR4.0 MEDICAL RECORDS

RR4.1 The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current.

RR4.2 A complete admission history and physical examination shall be recorded within 24 hours of inpatient admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Medical Center, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded or signed by a member of the Medical Staff within 24 hours.

In such instances, an interval admission note that includes all additions to the history and any pertinent changes in the physical findings are recorded at the time of admission. The provider responsible for the patient is to review and sign the H&P if performed by another provider and document review and/or concurrence in the medical record. The medical staff defines the scope of medical history and physical examination when required for non-inpatient services and procedures as defined in Administrative policy A10-0609-29. (MS.01.01.01 EP 16)

RR4.3 The attending practitioner shall countersign (authenticate) the history and physical examination, operative note, short-stay record, emergency room report, and consult when they have been recorded by a person other than a licensed physician. However, orders written by an allied health professional may require countersignature based on scope of practice defined by law, Medical Staff Bylaws, Rules and Regulations, or job description.

RR4.4 Pertinent progress notes sufficient to permit continuity of care and transferability, shall be recorded at the time of observation. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

RR4.5 Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Other items to be included in the operative report are as follows: Indications for surgery and/or procedures, estimated blood loss, specimens removed, post operative diagnosis, and the name of the primary surgeon and any assistant. Operative reports shall be dictated immediately and on the chart within 24 hours following surgery for outpatients as well as inpatients. The dictated report shall be promptly signed by the surgeon and made a part of the patient's current medical record. It is recommended that in addition to the dictated report, a brief handwritten operative note should be made immediately in the patient's chart.

The handwritten note shall include all the elements of the dictated report. Any practitioner with undictated operative reports 24 hours following the day of the operation shall be automatically suspended from operative privileges except for any inpatients who have already been scheduled for surgery, or emergent cases. Suspension of operative privileges will be in effect until all operative reports are dictated.

RR4.6 Consultations shall show evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

RR4.7 The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. All patients who undergo caesarean section should have a history and physical examination separate and distinct from the prenatal record.

RR4.8 All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

RR4.8.1 Authentication means to establish authorship by written signature, identifiable initials or computer signature. The use of electronic signatures is acceptable under the following strict conditions:

RR4.8.1.1 The practitioner whose electronic signature represents is the only one who has possession of the electronic signature and is the only one who uses it; and,

RR4.8.1.2 The practitioner places in the administrative offices of the Medical Center a signed statement to the effect that he/she is the only one who has access to the unique password for the electronic signature and is the only one who will use it.

RR4.9 Only standard, recognized symbols and abbreviations should be used in the medical record. An official record of approved abbreviations should be kept on file in the Health Information Management Department.

RR4.10 Final diagnosis shall be recorded in full, on the discharge abstract and dated, signed and timed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

RR4.11 The clinical resume (discharge summary) shall include the reason for hospitalization, the significant findings, the procedures performed, treatment given, the condition of patient on discharge and any specific instructions given to the patient/family as pertinent. Instructions for physical activity, diet, medication, and follow-up should be included. A final progress note may be substituted for the resume of patients with problems of a minor nature who require less than a 48-hour period of hospitalization and for normal newborns and uncomplicated obstetric deliveries. This note should include instructions given to patient/family.

RR4.12 Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

RR4.13 Medical Records/patient medical information may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with court order/subpoena. All records are the property of the Medical Center. In case of readmission of a patient, all previous records/patient medical information shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.
Unauthorized removal or reproduction of medical records/patient medical information from the Medical Center is grounds for suspension of the practitioner for a period to be determined by the Executive Committee.

RR4.14 Free access to all medical records/medical information of all patients shall be afforded to members of the Medical Staff or qualified Allied Health Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Executive Committee has the authority to restrict approval of such studies. Former members of the Medical Staff or Allied Health Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Medical Center.

RR4.15 A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Information Management Committee.

RR4.16 A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

RR4.16.1 Verbal orders of authorized individuals are accepted and transcribed by qualified personnel. Each verbal order is dated and is identified by the names of the individuals who gave and received it. Individuals who receive verbal orders are qualified to do so and are authorized by the Medical Staff to do so as identified in policy #A10-0205-01 Physician's Orders.

RR4.16.2 The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. In such case the nurse shall make immediate contact for clarification.

RR4.17 The medical record shall be completed including all practitioner signatures within 30 days of discharge. The medical record of a patient readmitted within 30 days of discharge shall be completed including all practitioner signatures within 30 days of discharge from the most recent hospitalization. The discharge summary shall be written or dictated within 14 days after discharge. Failure to comply with these standards shall result in immediate restriction of admitting privileges. The practitioner shall be notified either in person, by telephone or letter by the Health Information Management Department. The practitioner shall remain suspended until such records are complete. Exceptions to these standards may be made as in the case of practitioners on vacation or on leave from practice, and when delay is caused by transcription or equipment failure. Exceptions shall be defined in writing and approved by the Director of Health Information Management Department. Such restriction shall remain in force until records are completed or excuse authorized by the Chair of the Information Management Committee or Medical Center President/CEO.

RR5.0 COMMITTEES/SERVICE LINE TEAMS

The Committees described herein, or in the Performance Improvement and Patient Safety Plan or Medical Center policies, are established to improve the quality of care and services provided by the Medical Center and its Medical Staff. Medical staff members are assigned to committees and/or service line teams with objectives for specific processes or functions. Medical Staff participation is essential and enables the Medical Center to plan and provide systematic and organization-wide improvement. Meeting frequency is sufficient for committees and service line teams to accomplish their objectives. The Medical Staff President or the Department Chair may establish other committees as deemed appropriate for the needs of the Medical Staff or Department. Refer to the Performance Improvement and Patient Safety Plan and/or Medical Center policies for a description of committees, and service line teams, and the performance improvement process.

RR5.1 EXECUTIVE COMMITTEE (see Bylaws section 12.2)

5.2 CREDENTIALS/BYLAWS COMMITTEE

RR5.2.1 Composition: The Credentials/ Bylaws Committee shall consist of at least five members of the Active Staff selected on a basis that will ensure representation of the major clinical specialties, the Medical Center-based specialties and the Medical Staff-at-large. Members of this Committee shall not be the Department Chair. The Committee meets quarterly.

RR5.2.2 Purpose: The Credentials/ Bylaws Committee shall review and evaluate the qualifications of all applicants for Medical Staff membership, and clinical privileges and for Allied Health Professionals practicing under delineated privileges, job description or scope of practice and make recommendations for membership, privileges and scope of practice in accordance with sections 6.2.2 and 6.3.1 of the Bylaws.

It shall make a report to the Executive Committee on each applicant for Medical Staff membership, clinical privileges, or scope of practice, including specific consideration of the recommendations from the Departments in which such applicant requests privileges. The Committee shall review every two years all information available regarding the competence of staff members and as a result of such reviews make recommendations for the granting of privileges, reappointment and the assignment of practitioners to the various departments and services.

The Committee shall be responsible for the process to assess current competency for approved delineated privileges. The Committee shall investigate, in accordance with the Medical Staff Bylaws procedures and policies, any breach of conduct that is reported to it and review reports that are referred by the Executive Committee and by the Medical Staff President.

RR5.3 INVASIVE PROCEDURE/BLOOD UTILIZATION COMMITTEE

RR5.3.1 Composition: The Invasive Procedure/Blood Utilization Committee is composed of at least one member from each Medical Staff clinical department, pathologist, laboratory administrative director and/or designee, surgery director and/or designee, and a quality management representative. The Committee may include representatives from anesthesia and other services where invasive procedures are performed. The Committee meets at least quarterly.

RR5.3.2 Purpose: The purpose of the Invasive Procedure Committee is to continuously improve the selection and performance of surgeries and procedures, and other invasive and non-invasive procedures. Emphasis is placed on the selection of the appropriate procedure, patient preparation for the procedure, performance of the procedure, patient monitoring, post procedure care, and post procedure education.

RR5.3.3 Purpose: The purpose of the Blood Utilization Committee is to review and improve the ordering of appropriate blood and blood components; distribution, handling, and dispensing of blood and blood components; administration of blood and blood components; and, monitoring of the effects of blood and blood components on patients.

RR5.4 PHARMACY AND THERAPEUTICS COMMITTEE

RR5.4.1 Composition: The Pharmacy and Therapeutics (P & T) Committee consists of at least two representatives of the Medical Staff and one from pharmacy services, nursing services, and administration. The Pharmacy Director, or designee, acts as recorder for the Committee. The Committee meets at least quarterly.

RR5.4.2 Purpose: The Pharmacy and Therapeutics (P & T) Committee serves as the organizational line of communication between the Medical Staff and Medical Center services regarding safe medication usage. The Committee is responsible for the development and surveillance of all drug utilization policies and practices within the Medical Center in order to assure optimum clinical results and a minimum potential for hazard.

The Committee assists in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, adverse drug reactions, and other matters relating to drugs in the Medical Center. It also performs the following specific functions:

- Serves as an advisory group on matters pertaining to the choice of available drugs
- Coordinates overall drug usage evaluation with the Medical Center
- Plans suitable educational programs for professional staff related to drug use
- Develops and reviews periodically a Formulary of drugs for use in the Medical Center
- Prevents unnecessary duplication in stocking drugs and drugs in combination having identical

amounts of the same therapeutic ingredients or identical therapeutic effects

- Evaluates clinical data concerning new drugs or preparations requested for use in the Medical Center
- Establishes standards concerning the use and control of investigational drugs and of research in the use of recognized drugs
- Reviews antibiotic usage in conjunction with the Infection Control Committee
- Improves medication safety through evaluation and implementation of appropriate standards, guidelines, and processes

RR5.5 CANCER CARE COMMITTEE

RR5.5.1 Composition: Medical Staff membership includes representatives of Surgery, Medical Oncology, Pathology, Radiation Oncology, and Radiology. The Committee membership is multidisciplinary and includes representatives of the Medical Center services involved in the care of/services for cancer patients. These members represent Nursing Service, Home Care/Hospice, Social Services, Quality Management, Administration, and the Cancer Liaison Physician. The Oncology Data Specialist will serve as the Committee Recorder. The Committee meets quarterly.

RR5.5.2 Purpose: The Cancer Care Committee serves as an oversight committee for all cancer related activities of St. Claire Regional Medical Center. The Committee is responsible for planning, initiating, evaluating, and improving cancer care services as referenced in policy #A13-0409-07.

RR7.0 APPOINTMENT AND MEDICAL STAFF PRIVILEGES

RR7.1 PROCEDURE

RR7.1.1 Each prospective Medical Staff Member shall make application in accordance with the Medical Staff Bylaws and on forms prescribed for making application.

RR7.1.2 The application for a prospective Medical Staff Member will be routed to the appropriate Medical Staff Department for their review and recommendations.

RR7.1.3 The recommendation for Medical Staff membership will carry with it a delineation of privileges based upon categories in accordance with the Rules and Regulations. This granting of privileges is utilized as a guide and is intended to include privileges as normally considered within the area of service for which the practitioner applies for privileges. Restrictions may be placed on the privileges granted to the practitioner when the Medical Staff determines cause for restriction or if documented evidence of competence and training has not been given.

RR7.1.4 It is the responsibility of the applicant to provide information and references supporting the application and the request for specific privileges.

RR7.1.5 All material supplied by an applicant will be treated in a confidential manner and becomes the property of St. Claire Regional Medical Center.

RR7.2 DEPARTMENT OF SURGERY

RR7.2.1 Eligibility to perform surgical procedures at St. Claire Regional Medical Center as a responsible surgeon is based on an individual's training, experience and demonstrated proficiency. Members of the Department must meet one of the following criteria:

RR7.2.1.1 Certified by an American Surgical Specialty Board approved by the American Board of Medical Specialties.

RR7.2.1.2 If obtained in a country outside the United States graduate surgical education which satisfies the training requirements of the particular American Surgical Specialty Board involved and is eligible to obtain Board Certification.

RR7.2.1.3 Satisfactorily completed training in an approved surgical residency program as defined for the respective specialty.

RR7.2.2 All applicants for initial appointment and privileges must provide evidence of Board certification in the primary area of practice or shall become Board Certified within five (5) years of completion of an approved residency program. Failure to obtain certification will result in review of status and possible recommendation of termination of privileges and Medical Staff membership. Physicians with full membership and clinical privileges prior to January 1, 2001 may be grandfathered. Recertification is strongly recommended but not required.

RR7.2.3 ANESTHESIA

Category 1: Permits local infiltration anesthesia, topical application, minor nerve blocks and conscious sedation.

Requirements: All members of the Medical Staff shall be granted Category 1 privileges.

Category 2: Permits performance of specific anesthesia procedures under specific conditions in addition to local infiltration, topical application, minor nerve blocks and conscious sedation.

Requirements: Granted on the basis of qualifications and competence.

Category 3: Permits full privileges in administration of anesthesia and management of patients for anesthesia service. Permits procedures to include at least:

a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures;
b. The support of life functions under the stress of anesthetic and surgical manipulations;
c. The management of problems in pain relief;
d. The management of problems in cardiac and respiratory resuscitation;
e. The application of specific methods of respiratory therapy;
f. The clinical management of various fluid, electrolyte, and metabolic disturbances.

Requirements: Training as required for Anesthesiology Board Certification.

RR7.2.4 CORE SURGERY

Category 1: Permits assistance in surgery.

Requirements: All members of the Medical Staff shall be granted Category 1 privileges.

Category 2: Permits minor procedures entailing lesser risk than Category 3. Procedures and care permitted may include:

a. Suturing of simple or complex lacerations not involving tendons or major nerves;
b. I & D abscess;
c. Simple skin biopsy or excision;
d. Removal non-penetrating corneal foreign body;
e. Uncomplicated removal foreign objects from bodily orifices;
f. Care of the uncomplicated burn patient;
g. Chest tube placement.
h. Endotracheal intubation

Requirements: Physicians with minimal formal training and experience for procedures or training as required for Family Practice or General Surgery Board Certification.

RR7.2.4.1 GENERAL SURGERY

Category 3: Permits major or complex procedures, entailing significant risk. It does not in itself permit major procedures within sub-specialty areas.

Requirements: Training as required for General Surgery Board Certification.

Category 4: Permits major procedures generally attributed to sub-specialty.

Requirements: Training as required for Board Certification of sub-specialty such as: Urology, Obstetrics/Gynecology, Otorhinolaryngology, Ophthalmology, Orthopedics, Plastic & Reconstructive, and Neurosurgery.

RR7.2.5 OBSTETRICS/GYNECOLOGY

Category 1: These privileges are limited to the diagnosis and therapy where minimal threat to life exists.

Requirements: Physicians with minimal formal training in the discipline but with training and

experience in the care of specific conditions or training as required for Family Practice Board Certification.

Category 2: These privileges are for the major diagnosis and therapy but with no significant threat to life.

Requirements: Physician with significant graduate training in the specialty related to diagnosis and therapy, i.e. -- full six months of training and experience in approved training program and/or completion of a family practice residency program which includes obstetric training, and/or experience in the care of specific conditions.

Category 3: These privileges are for major diagnosis and therapy with possible serious threat to life.

Requirements: Physician with completed training in the specialty of obstetrics and gynecology, and who is Board Certified or Board Eligible.

Category 4: Unusually complex or critical diagnosis and therapy with possible serious threat to life.

Requirements: Physician with significant formal training beyond completion of residency requirements related to diagnosis or therapy (acquisition of additional privileges related to new technologies should be based on appropriate formal education, experience, and performance under observation).

RR7.2.6 ORAL AND MAXILLOFACIAL SURGERY AND DENTISTRY

Category 1: Permits general dentistry procedures and assisting oral surgeons with Category 2 privileges.

Requirements: These privileges may be granted on the basis of qualification and competence. Current certification in basic CPR is required.

Category 2: Permits major oral surgical procedures, but does not include management of malignant disease. Consultation is required for treatment of acute trauma patients and other patients with complications.

Requirements: Training as required for Board Certification or Oral and Maxillofacial Surgeon. Current certification in Advanced Cardiac Life Support.

Category 3: Permits major oral surgical procedures, history and physicals, but does not include management of malignant diseases. Consultation is required for treatment of acute trauma patients and other patients with complications.

Requirements: Same as for category 2 and evidence of competency to conduct a complete history and physical examination.

RR7.2.7 PODIATRY (SURGICAL)

Category 1: Privileges in Category 1 Podiatric Core include privileges to admit, evaluate, diagnose, provide consultation, order diagnostic studies, and perform surgical or non-surgical podiatric procedures on the toes and forefoot and perform simple rearfoot surgical procedures on patients of all ages presenting with injuries or diseases of the foot and ankle—except as specifically excluded from practice and except for those special procedure privileges listed below.

Requirements: Basic education and minimal formal training as listed above, plus documentation of the performance of at least 30 digital forefoot, and simple rearfoot surgical procedures in the past two years.

Category 2: Includes all privileges listed in Category 1 plus performance of complex rearfoot and ankle surgical procedures, except for those special procedures listed below.

Requirements: Basic education and minimal formal training as listed above, plus documentation of the performance of at least 20 rearfoot and ankle surgical procedures in the past two years.

Category 3: Special procedure privileges.

Requirements: To be eligible to apply for a special procedure privilege, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship or other acceptable experience, and provide documentation of

competence in performing that procedure consistent with the criteria set for in medical staff policies, bylaws, rules and regulations. Applicants must provide documentation of the performance of at least 8 specialized surgical procedures in the past two years for each procedure request.

RR7.3 DEPARTMENT OF MEDICINE

RR7.3.1 Eligibility to care for patients at St. Claire Regional Medical Center as a responsible physician is based on an individual's training, experience and demonstrated proficiency. Members of the Department must meet one of the following criteria:

RR7.3.1.1 Certified by an American Board of Medical Specialties;

RR7.3.1.2 If graduate education has been obtained in a country outside the United States, the training must satisfy the requirements of the particular American Specialty Board involved and the physician must be eligible to obtain Board certification;

RR7.3.1.3 Satisfactorily completed training in an approved residency program as defined for the respective specialty.

RR7.3.2 All applicants for initial appointment and privileges must provide evidence of Board certification in the primary area of practice or shall become Board Certified within five (5) years of completion of an approved residency program. Failure to obtain certification will result in review of status and possible recommendation of termination of privileges and Medical Staff membership. Physicians with full membership and clinical privileges prior to January 1, 2001 may be grandfathered. Recertification is strongly recommended but not required.

RR7.3.3 INTERNAL MEDICINE

Category 1: Physicians with these privileges may render emergency care and treat illness with no serious threat to life, that is uncomplicated, and that is expected to require only a short period of hospitalization.
When doubt exists as to the diagnosis or in cases where expected improvement is not apparent, consultation must be obtained.

Requirements: Based on competency and experience.

Category 2: Privileges in this category allow the physician to admit and care for patients with serious or life threatening illness. Physicians with these privileges are expected to request consultation in diagnosis, where expected improvement is not soon apparent and when specialized therapeutic or diagnostic techniques are indicated.

This category may include, but is not limited to the following procedures: ECG Interpretations, Pulmonary Function testing and interpretation, Arterial Puncture & Cannulation, Arthrocentesis, Paracentesis, Bone Marrow Aspiration and Biopsy, Lumbar Puncture, Placement of Central Venous Catheter, Skin Biopsy and Thoracentesis, and Endotracheal Intubation.

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in Family Practice.

Category 3: Privileges in this category allow the physician to admit and care for patients with serious or life-threatening illnesses and also act as consultants to others. This category may include, but is not limited to the following procedures: ECG Interpretations, Pulmonary Function testing and interpretation, Arterial Puncture & Cannulation, Arthrocentesis, Paracentesis, Bone Marrow Aspiration and Biopsy, Lumbar Puncture, Placement of Central Venous Catheter, Skin Biopsy and Thoracentesis, and Endotracheal Intubation.

Physicians with these privileges are, in turn, expected to request consultation when:

a. diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
b. unexpected complications arise which are outside this level of competence;
c. specialized treatment or procedures are contemplated with which they are not familiar.

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine, although not necessarily at the level of the sub-specialist.

Category 4: Privileges in this category allow the physician to render care within a given field, on a par with that considered appropriate for a sub-specialist. Privileges at this level do not automatically confer granting of privileges in other categories. They are qualified to act as consultants and should, in turn, request consultation from within or from outside the Medical Center staff whenever needed.

Requirements: Sub-specialty training in a particular field and/or specialty.

RR7.3.4 PEDIATRICS

Category 1: Physicians with these privileges may render emergency care and treat illness with no serious threat to life, that is uncomplicated, and that is expected to require only a short period of hospitalization. When doubt exists as to the diagnosis or in cases where expected improvement is not apparent, consultation must be obtained.

Requirements: Granted on the basis of qualifications and competence.

Category 2: Privileges in this category allow the physician to admit and care for children requiring routine hospital care. Physicians with these privileges may provide care for life threatening illness, including intensive care and neonatal nursery care of critically ill babies with appropriate consultation, if indicated. Consultation is required where expected improvement is not soon apparent and when specialized therapeutic or diagnostic techniques are indicated. This category permits but is not limited to the following procedures: Circumcision, Lumbar Puncture, Laryngoscopy at Delivery, and, Peripheral Arterial Puncture.

Requirements: Training and/or experience and competence on a level provided by specialty training in Family Practice.

Category 3: Privileges in this category allow the physician to admit and care for children with life-threatening illnesses including those requiring intensive care. Physicians with these privileges may act as consultants to others and may, in turn, be expected to request consultation when:

a. diagnosis or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
b. unexpected complications arise which are outside this level of competence;
c. specialized treatment or procedures are contemplated with which they are not familiar.

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training such as in Pediatrics.

Category 4: Privileges in this category allow the physician to diagnose and treat diseases. This category permits but is not limited to care of the following conditions: Neonatology, Cardiology, Endocrinology, Allergy, Pulmonary Medicine, and, Infectious Diseases. Privileges in this category allow the physician to admit and care for children requiring intensive care.

Requirements: Training and/or expertise acquired only during sub-specialty training or similar experience.

RR7.3.5 EMERGENCY MEDICINE

Category 1: Permits initial care and treatment of patients as required in emergency situations.

Requirements: All members of the Medical Staff shall be granted category 1 privileges.

Category 2: Permits treatment of all manner of emergencies on an initial basis, and treatment of patients based on experience and competence. Does not permit admitting and continued care of inpatients.

Requirements: Board Certification for Emergency Medicine or a Family Medicine specialty, or demonstrated training and competence.

RR7.4. PATHOLOGY/RADIOLOGY/RADIATION MEDICINE (serving under both departments)

RR7.4.1 PATHOLOGY

Category 2:

Clinical Pathology: Permits operation, supervision and interpretation of data generated in the complete clinical laboratory.

Anatomic Pathology:

Diagnosis and interpretation of surgical pathology specimens obtained for frozen section, paraffin sections, special stains and special procedures.

Diagnosis and interpretation of gynecological and non-gynecologic cytology specimens using routine stains, special stains, and special procedures.

The performance of autopsies and clinicopathologic reporting of the results.

Requirements: Training as required for Pathology Board Certification.

RR7.4.2 RADIOLOGY

Category 1 Diagnostic Radiology: Privileges in this category include consultation, performance and interpretation of diagnostic radiology procedures to include:

a. Routine Radiology
b. Fluoroscopy
c. Mammography--Needle Localizations*
d. Venography
e. Hysterosalpingography
f. Arthrography
g. Sialography

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in radiology.

*Must meet FDA requirements for mammography. See Radiology Privileges Addendum.

Category 2 Special Imaging: Privileges in this category include consultation, performance and interpretation of special imaging modalities including:

a. Ultrasound
b. Computed Tomography
c. Cardiac Computed Tomography Angiography
d. Magnetic Resonance

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in radiology.

Category 3 Invasive/Interventional Procedures: Privileges in this category include consultation, performance and interpretation of invasive and interventional procedures. These privileges are to include the performance of any interventional techniques that are a natural extension of the designated procedure. Procedures include:

a. Angiography
b. Angioplasty and Endovascular Stent Placements
c. Endobiliary Stent Placement
d. Kyphoplasty
e. Lymphangiography
f. Myelography
g. Percutaneous Aspiration and Biopsies
h. Percutaneous Drainage Procedures
i. Transcatheter Embolization
j. Vena Cava Filter Placement

Requirements: Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training in radiology.

Category 4 Nuclear Medicine: Privileges in this category include consultation, performance and interpretation of Nuclear Medicine procedures to include:

a. Diagnostic Procedures

b. Therapeutic Procedures

Requirements: Physicians and these privileges are expected to have training and experience as required for board certification in Radiology and/or Nuclear Medicine. If applicable, submit documentation of previous licensing by the State of Kentucky Radiation Control Branch or other agreement states or NRC.

RR7.4.3 RADIATION MEDICINE

Category 1: Privileges in this category include consultation, prescription, and planning of therapeutic radiation procedures including: Radiation treatment planning, Simulation, Interpretation of treatment planning radiographs, Prescription of megavoltage external beam radiation.

Requirements: Physicians with these privileges are expected to have training and experience as required for board certification in Radiation Oncology. If applicable, submit documentation of previous licensing by the State of Kentucky Radiation Control Branch or other agreement states or NRC.

RR7.5 RESIDENTS

RR7.5.1 Residents in formal educational programs in training in the Medical Center who are working solely in a training capacity do not need to be credentialed or privileged through the Medical Staff process. They do not hold membership on the medical staff and are not granted specific clinical privileges. They are permitted to function clinically only in accordance within written training protocols developed by the Graduate Medical Education Committee in conjunction with the residency training program. Clinical faculty at St. Claire will be responsible for supervision and for assessing the quality of patient care provided by the resident. Mechanisms for supervision, assuming progressive responsibility and assessing quality are outlined in policy #10-0211-18. The Graduate Medical Education Committee provides periodic reports to the Medical Executive Committee and the Board of Directors regarding the performance of residents, patient safety issues, and quality of patient care provided by the residents. Residents are subject to these Bylaws, Rules and Regulations and Medical Center and Medical Staff policies. (MS.04.01.01)

RR7.5.2 Residents or Fellows providing coverage for a member of the Medical Staff may be granted privileges for the practice of a medical specialty as warranted by training, qualifications and competence. The process for granting clinical privileges is set forth in these Bylaws, Rules and Regulations and Medical Staff Policy. The requirements relating to medical staff membership and board eligibility and/or certification set forth in these Bylaws, Rules and Regulations shall be waived for residents during the term of their residencies. The Medical Staff member for whom the resident is providing coverage may be requested to provide to the Credentials Committee review and verification of the competency of the resident at any time deemed necessary but no less than annually (MS.04.01.01)

RR7.6 ALLIED HEALTH PROFESSIONALS

RR7.6.1 NURSE ANESTHETIST

RR7.6.1.1 Nurse Anesthetists are RN's with a State license. They are graduates of Nurse Anesthetist School recognized by the Council on Accreditation of American Association of Nurse Anesthetists. The Nurse Anesthetist is eligible for the examination of the AANA or has successfully passed the qualifying examination of AANA, holds a license of CRNA and maintains the necessary number of educational points to qualify yearly for the AANA Continuing Education Program. They must provide satisfactory personal references.

RR7.6.1.2 They perform anesthesia and related patient care under the direct and/or indirect supervision of the Chief of Anesthesiology or the attending physician in a given situation. The physician may delegate to a nurse anesthetist any task or procedure which he/she feels are commensurate with the nurse anesthetist's training and ability with the understanding that the physician is responsible for the actions of the nurse anesthetist.

RR7.6.2 NURSE PRACTITIONERS

RR7.6.2.1 Nurse practitioners are graduates of National League of Nursing Accredited Program for Health Nurse Clinicians. They are certified by the American Nurses Association within two years.

Their duties will be under the direct or indirect supervision of physicians. They are able to perform any tests or procedures within their training or ability. They are able to be involved in teaching and counseling of patients. They must also have letters of reference.

RR7.6.2.2 The physician may delegate to a nurse practitioner any task or procedure which he/she feels are commensurate with the nurse practitioner's training and ability with the understanding that the physician is responsible for the actions of the nurse practitioner.

RR7.6.2.3 All Nurse practitioners who prescribe medications and controlled substances shall do so exclusively under a Collaborative Agreement for Advanced Registered Nurse Practitioner's Authority for Nonscheduled Legend Medications (CAPA-NS) and/or Controlled Substances (CAPA-CS), respectively as outlined in policy #10-0211-14.

RR7.6.3 PHYSICIAN ASSISTANTS

RR7.6.3.1 Physician assistants are skilled persons qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant. Physician assistants are graduates from a physician assistant training program approved by the American Medical Association and certified by the National Commission on Certification of Physician Assistants within two years of eligibility.

RR7.6.3.2 The Physician Assistant is an extension of the physician and shall practice hereunder only within the scope of his/her certification as defined in Kentucky State Law; and as limited by these rules and regulations and the delineation of his/her privileges by the Credentials Committee of the Medical Staff. The supervising physician must apply to the Kentucky Board of Medical Licensure for supervisory status. This physician may delegate to his/her assistant any task or procedure which he/she feels is commensurate with the assistant's training and ability with the understanding that the physician is responsible for the actions of the Physician Assistant.

RR7.6.3.3 A Physician Assistant shall practice hereunder only within the scope of his/her license/certification as defined in Kentucky State Law and as limited by these rules and regulations and the delineation of his/her privileges by the Credentials Committee of the Medical Staff.

RR7.6.4 NURSE MIDWIFE

The Nurse Midwife is a graduate of an accredited School of Nursing and an accredited School of Nurse Midwifery. The Nurse Midwife is certified by the American College of Nurse Midwives and is a member of the American College of Nurse Midwives (ACNM). The Nurse Midwife holds a registered nurse license and ARNP certification as a Nurse Midwife in the state of Kentucky. The Nurse Midwife must be of good ethical standing in his/her profession and must meet all requirements for allied health professionals set forth in these Bylaws, Rules and Regulations. The Nurse Midwife is located closely enough to the Medical Center to provide continuous care to his/her patients, may regularly admit patients for obstetrical care, assumes functions and responsibilities including, where appropriate, emergency obstetrical care, consultation assignments, and peer review activities.

The Nurse Midwife is responsible for the prompt completeness and accuracy of the medical record as set forth in these Bylaws, Rules, and Regulations for Medical Staff members. The Nurse Midwife shall be appointed to a specific department, and may be appointed to committees. The Nurse Midwife secures and maintains a professional association with member(s) of the Active Medical Staff of the Medical Center to include collaborative agreement, alternate coverage, consultation, and sponsorship. The physician(s) must hold and maintain Family Practice/OB-GYN privileges. The obstetrical and patient care services provided by the nurse midwife in the Medical Center are to be provided in accordance with protocols that have been reviewed and approved by Medical Staff members holding current Family Practice/OB-GYN privileges. The provisional appointment period for a Certified Nurse Midwife shall be the same as for Active Medical Staff members.

RR.7.6.4.1 All Nurse practitioners who prescribe medications and controlled substances shall do so exclusively under a Collaborative Agreement for Advanced Registered Nurse Practitioner's Authority for Nonscheduled Legend Medications (CAPA-NS) and/or Controlled Substances (CAPA-CS), respectively as outlined in policy #10-0211-14.

RR7.6.5 OTHERS

RR7.6.5.1 Personnel that provide a medical level of care, i.e., making medical diagnoses and/or medical treatment decisions are credentialed and privileged through the Medical Staff process outlined in these Bylaws, Rules and Regulations.

RR7.6.5.2 Personnel who are trained in specific areas to perform or provide assistance for specified tests or procedures that do not make diagnoses and/or medical treatment decisions are not credentialed or privileged through the Medical Staff process, rather their function within the Medical Center is defined by job description or scope of practice.

RR7.6.6 CLINICAL PSYCHOLOGIST

RR7.6.6.1 A Clinical Psychologist is a person qualified by academic training to provide specific testing and counseling services under the supervision and direction of a licensed physician.

RR7.6.6.2 The Clinical Psychologist must have graduated from an accredited university and must possess graduate degrees, as well as a current license, or be eligible for license in the Commonwealth. A master's level clinical psychologist must document appropriate supervision in accordance with Kentucky law.

RR7.6.7 OPTOMETRIST

RR7.6.7.1 An optometrist who is licensed by the Kentucky Board of Optometric Examiners to practice Optometry in the State of Kentucky may apply for privileges to practice Optometry within the Medical Center.

RR7.6.7.2 An optometrist shall not be entitled to privileges to practice within the Medical Center simply by virtue of the fact that he/she is duly licensed to practice optometry in the State of Kentucky.

RR7.6.7.3 An optometrist shall practice hereunder only within the scope of his/her license/ certification as defined in Kentucky State Law and as limited by these rules and regulations and the delineation of his/her privileges by the Credentials Committee of the Medical Staff.

RR7.6.7.4 An optometrist shall not be allowed to admit patients to the Medical Center. A physician member of the Medical Staff must be responsible for the overall medical care of any patient examined or treated by an optometrist within the Medical Center.

ADOPTED by the Active Medical Staff of St. Claire Regional Medical Center

9/23/15

Medical Staff Secretary/Treasurer Date

11-12-15

Medical Staff President/MEC Chair Date

Date: September 23, 2015
General Medical Staff

Date: November 12, 2015
Medical Staff Executive Committee

APPROVED by the Board of Directors of St. Claire Regional Medical Center

Chair, Board of Directors Quality/Credentials/Bylaws Committee
Date: December 2, 2015

Chair of the Board of Directors
Date: December 2, 2015