MEDICAL STAFF
RULES AND REGULATIONS
OF
BAPTIST MEDICAL CENTER EAST

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I. PATIENT ADMISSION AND DISCHARGE TO BAPTIST MEDICAL CENTER EAST

1.1 The Medical Staff may admit any patient whose condition warrants hospitalization, if Baptist Medical Center East is capable of providing the physical and medical services needed. Exceptions to the general admission policies included but are not limited to the following:

1.1.1 Patients with infectious/contagious diseases shall be subject to isolation precautions as outlines in the Hospital Infection Control Manual.

1.1.2 In the event that the Hospital is unable to provide optimal care to a patient in the Emergency Room, the Emergency Services transfer policies shall be observed.

1.2 Each patient must be seen by a physician or their authorized designee and a progress note entered in the medical record at least each twenty four (24) hours. In the case of Hospice patients admitted for Respite Care, the authorized designee may be the Head/Charge Nurse or the Hospice Care Coordinator.

1.3 Patients shall be discharged only on a written order of the attending physician. At the time of discharge the attending physician should complete the medical record including a clinical resume containing the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instruction given to the patient and/or family, as pertinent. When written discharge instructions are utilized, a note shall be made in the record and a copy of the instructions shall be placed on file with the Medical Record Director.

1.4 Hospice General Inpatient (GIP) Status

1.4.1 Baptist Hospice has occasion to admit Hospice patients, both from home and patients already in the hospital into a non-inpatient status as a Hospice General Inpatient.

1.4.2 Hospice General Inpatients are Hospice patients whose medical needs exceeds the reasonable abilities of the Hospice caregiver. In any case, a Hospice GIP is not considered or registered as a hospital inpatient (hospital inpatients are discharged as inpatients and readmitted as Hospice GIP).

1.4.3 The transfer of a patient to GIP status is technically a discharge and readmission into GIP status. At the time of transfer, a formal discharge summary must be completed.

1.4.4 Due to the fact that Hospice GIPs are not hospital inpatients, they are not subject to Sections 1.2 and 1.3 of these Rules & Regulations. Hospice GIPs will be seen no less than once per seventy two (72) hour period of their admission. The attending or Hospice Medical Director or their designee will be on call 24/7 for any patient needs.

1.4.5 Only patients enrolled in Hospice may be designated as Hospice GIP. Any Hospice GIP who voluntarily or otherwise ceases to be Hospice patient will immediately be discharged as a Hospice GIP.

II. MEDICAL RECORDS STANDARDS

2.1 A provisional diagnosis shall be written in the medical record at the time of admittance. In the case of an emergency the diagnosis shall be stated as soon as possible after admittance. Physicians shall be held responsible for giving such information as may be
necessary to assure the protection of other patients from those who are a source of
danger from any cause whatever or to assure protection of the patient from self harm.

2.2 The medical record of all inpatients shall reflect the following:

2.2.1 A H&P must be performed within 30 days of the admission date. A H&P must be
performed within 30 days for OP service which requires an H&P. (H&P's older
than 30 days may not be used.) When using an H&P obtained within 30 days of
admission, the physician must document on the H&P or the Progress Note, a
review and update within 24 hours of admission or prior to surgery or a
procedure (or such other timeframe as required by Joint Commission). An
appropriate assessment addressing the patient's current status is done
regardless of whether there were any changes in patient's condition since the
H&P was composed. This update should be dated and signed by the physician.
The H&P must be performed by a member of the Medical staff who has been
granted privileges to do.

2.2.2 A complete History & Physical will include a past medical history, the present
complaint, impressions, or indications for admission and/or surgery; a current
physical exam including exam of the head, heart, lungs, abdomen and
extremities; a listing of planned procedure; an authentication by the physician
and the date signed.

2.2.3 When H&P has not been dictated or written prior to surgery or when the H&P has
not been placed on the Medical Record, the procedure will be canceled, unless
the attending surgeon states in writing that this procedure is due to an
emergency condition with no time to perform a complete H&P.

2.3 The Medical Record of Non- Inpatient Procedures:

2.3.1. Non-inpatient procedures requiring a history and physical include but are
not limited to:
   2.3.1.1 Ambulatory Surgery
   2.3.1.2 Invasive radiology procedures
   2.3.1.3 Endoscopy
   2.3.1.4 Procedures involving use of sedation

2.3.2 The Scope of the assessment non-inpatient procedures which require a brief
H&P will be limited to:
   2.3.2.1 Cardiac & Respiratory
   2.3.2.2 Current medications
   2.3.2.3 History & physical exam of the operative system
   2.3.2.4 Airway assessment & anesthesia sedation history for
      patients who may receive moderate sedation

2.4 The medical record of a patient scheduled for ambulatory surgery, endoscopy, or
inpatient surgery shall, in addition, reflect the following:

2.4.1 A preoperative diagnosis recorded and authenticated by the responsible
practitioner.

2.4.2 Evidence of appropriate informed consent. The practitioner with clinical
privileges who informs the patient and obtains the consent should be identified in
the record. The signature of the patient or other individual empowered to give
consent should be witnessed. Administrative policies and procedures shall be
followed in obtaining all consent, particularly those relating to abortions,
sterilizations, unconscious patients, unaccompanied unemancipated minors, obtaining photographs, and observation of a surgical procedure.

2.4.3 A pre-anesthesia/sedation evaluation of the patient, performed by an anesthesiologist/physician, which includes the pertinent clinical information considered by the anesthesiologist/physician supporting the patient's suitability for anesthesia/sedation and the anesthesiologist's/physician's choice of anesthesia/sedation.

2.4.4 A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or procedures requiring anesthesia services.

2.5 The attending practitioner shall be held responsible for the timely preparation of a complete Medical Record. The following time frames shall be observed:

2.5.1 A complete history and physical examination shall, in all cases, be dictated or written within twenty-four (24) hours of admission.

2.5.2 Interval history and physicals reflecting subsequent changes may be used when a patient is readmitted within 30 days for the same or related procedure.

2.5.3 Delinquent Medical Records-

One of the primary responsibilities of Medical Staff membership is the timely completion of the patient medical record. It is the responsibility of the physician(s) providing services to each patient to complete their portion of the medical record no later than thirty (30) days after the discharge of the patient. Should the physician(s) fail to meet this critical responsibility, the following steps will be taken:

2.5.3.1 At the beginning of each month physician(s) will received a letter cosigned from the chief of staff and CEO of his/her number of delinquent charts. In addition, the Horizon Patient Folder (HPF) section of the electronic medical record will indicate the physician(s) incomplete record status upon login.

2.5.3.2 Incomplete records will fall into the following priority categories:

1. Incomplete – Record(s) is/are 15 days or less post-discharge.

2. Warning/Probationary – Record(s) is/are between 15 and 30 days post-discharge.

3. Delinquent/Subject to Suspension – Record(s) is/are 31 days post-discharge or older

2.5.3.3 If the physician has not completed the identified delinquent record(s) within fifteen (15) days of the initial notification, (chart now delinquent 45 days) then he/she will automatically be placed on probation until the delinquent record is completed. The physician will receive a phone call from either the CEO, Department Chair, Medical Records Director or a combination of all of these as a reminder to complete delinquent records.

2.5.3.4 If the Medical Record is not completed by the time the chart is 60 days old the physician is automatically suspended. The physician must
complete all charts plus pay a $25 fine per chart in order for hospital privileges to be reinstated.

2.5.3.5 Any physician who, because of medical record delinquency, has had his/her privileges temporarily interrupted six (6) times during any medical staff year shall be subject to having his/her privileges suspended for a period of twenty-eight (28) days. During this period of suspension, the physician may have no activity in the hospital, other than emergency call.

2.5.3.6 Any physician on temporary interruption or twenty-eight (28) day suspension will be required to take citywide emergency call, but he/she will not be allowed to admit, consult, accept patient transfers from any other physician, and/or perform procedures (except in an emergency) during the period of the suspension.

2.5.3.7 Timeline for Completion of Delinquent Records

2.5.3.7.1 HPF (online charting system) will list Incomplete Record Priority at Log In by physician:

- **Incomplete** – record is incomplete 15 days or less post discharge
- **Warning** – Record is 15 -30 days post – discharge
- **Delinquent** - Record is 31 days post discharge

2.5.3.7.2 **First of Month** – Physician notified in writing the number of delinquent records.

(chart greater than 30 days post discharge)

- Joint letter from COS and CEO

↓ (if not completed)

2.5.3.7.3 **15 Days after initial notification** – Physician is notified and placed on probation

(chart now greater than 45 days post discharge)

- CEO or Medical Records Director, or Department chair will call the physician

↓ (if not completed)

2.5.3.7.4 **15 Days after second notification** – Physician is suspended and required to make a payment of $25 per delinquent record. Charts must be completed and payment received in order to re-establish privileges.

(chart now > 60 days post discharge)

The suspension letter is sent from the chief of staff

2.5.3.7.5 Six (6) interruptions of privileges in one medical staff year will result in a 28 day suspension of privileges.
2.5.4 The prenatal record of an obstetrical patient will be sent to the Labor and Delivery unit at thirty-six weeks of gestation for review by the nursing staff and inclusion in the patient's medical record.

2.5.5 Dictated reports and verbal orders may be authenticated by physicians practicing within the same group.

2.6 Entries in the Medical Record may be made by the following individuals on designated forms: Physicians, Registered Nurses, Licensed Practical Nurses, Dieticians, Pharmacists, Social Workers, Rehab Therapists, Respiratory Therapists, trainees in recognized educational programs and AHP's acting within the scope of their delineation of privileges. Limited entries may be made by Nursing Assistants and Unit Clerks in accordance with Nursing Administration Policies, approved by the Medical Staff. All entries must be legible, complete, dated, time, and authenticated.

2.6.1 All Nurse Practitioners (NP) and Physician Assistants (PA) licensed in the State of Alabama with a valid NPI number may order diagnostic tests and procedures. Outpatient procedures will not require a physician signature. The ordering practitioner is responsible for assuring the facility has the correct fax number in order to receive diagnostic reports.

2.7 To avoid misinterpretation, only symbols and abbreviations which have been approved by the Medical Staff may be used in the Medical Record. Each abbreviation or symbol should have only one meaning.

2.8 Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken out of the hospital without permission of the Administrator. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner or another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

III. DOCUMENTATION

3.1 All diagnostic and therapeutic orders shall be in writing. Verbal orders of authorized practitioners shall be accepted and transcribed by Registered Nurses, including members of the Special Limited Staff who are RNs and who are credentialed to receive verbal orders, or to a N.P. or a P.A. who is a member of the Allied Health Staff, Registered Pharmacists, Physical Therapists, Medical Technologists, Licensed Practical Nurses, Social Workers, Respiratory Therapists, Registered Dieticians, Radiology Staff Technologists, and Registered Polysomnographic Technologists. All orders dictated shall be written on the appropriate Medical Record form by the person to whom it was dictated. The name of the practitioner and the name and title of the person recording the order shall be included. The responsible practitioner shall authenticate, date and time all verbal orders as soon as possible within 48 hours. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action. Verbal orders given by a practitioner on call for another practitioner may be authenticated by either practitioner. A document left unsigned by a Locum Tenum who is no longer available becomes the responsibility of the sponsoring physician to complete.

3.2 Documentation for Restraints
3.2.1 Two types of scenarios for restraint use are recognized: behavioral and acute medical/surgical. **Behavior management restraints** are used in an emergency or crisis situation in which a patient’s behavior becomes aggressive or violent; and behavior presents an immediate, serious danger to his/her safety or that of others and applied to patients in the hospital and psychiatric health settings. **Acute medical/surgical restraints** are used to limit mobility or temporarily immobilize a patient in relation to a medical, post surgical or dental procedure in which the primary reason for use directly supports the medical healing of the patient.

3.2.2 The two methods of restraints are chemical restraints and physical restraints. **Chemical restraint** is the use of medication to control behavior or to restrict the patient’s freedom of movement and **IS NOT** a standard treatment for the patient’s medical or psychiatric condition. Physical restraint is any method of physically restricting a person’s freedom of movement, physical activity or normal access to his or her body. Physical force may be human, mechanical, or a combination thereof attached to the patient’s body that he/she cannot easily remove. Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.

3.2.3 Orders for restraint/seclusion must contain the following elements: Date and time; Reason for Restraint/Seclusion, Type of Restraint/Seclusion, Duration (time limit) for Restraint/Seclusion; Signature of Physician, date and time signed. **Restraint orders may NEVER be written as a PRN order or as a standing order.**

3.2.4 Orders must be given by a licensed independent practitioner (Physician). For Baptist Health, a physician is defined as having an unrestricted Alabama license or a limited Alabama license. Residents who meet the above criteria must have education in the use of restraints.

3.2.5 Acute Medical/Surgical restraints may be ordered for no more than a 24 hour time period. The physician must be notified within 12 hours of initiated and verbal ordered received. The verbal order must be signed within 24 hours (as stated in 3.1 above). The physician must have examined the patient within 24 hours.

3.2.6 **Behavioral Management** restraints may be ordered for no more than 4 hours (adults) or 2 hours for age 9-17. The physician must be notified immediately and must perform a face-to-face evaluation of the patient within one (1) hour of initiation. The physician is to document the assessment on the form provided. A qualified, licensed, registered nurse can provide the physician with an assessment when the original order is about to expire and can renew the order for up to 4 additional hours. The physician must examine the patient face-to-face at least every 8 hours.

3.3 **Renewal of Outpatient Recurrent Orders** – All orders for outpatient procedures or services will expire one (1) year from the date of the original order. Such an order may be renewed in writing with the date and signature of the physician.

3.4.1 Practitioners utilizing standing/protocols or routine orders shall place an original signed copy on file in the Nursing Informatics Office. Such orders shall be reviewed every two years at the time of the physician’s reappointment. Standing orders must be authenticated by the practitioner each time they are used. Problems arising from the utilization of standing orders shall be resolved by the Department Chair, the Administrator and the practitioner. Standing orders shall not replace or cancel orders written for a specific patient.

3.5 **Use of Stamps**
Practitioners shall not be allowed to use signature rubber stamps on medical record documentation such as orders, progress notes, H & P, etc. The stamp may be used for
hospital business such as credential files and only by the physician and not by hospital personnel.

IV. CONSULTATION REQUIREMENTS

4.1 It is the duty of the Medical Staff through its Department Chair to see that members of the staff do not fail to seek consultations as needed. Consultation is required in the following situations:

4.1.1 Where the medical problem goes beyond the clinical privileges which have been granted to the practitioner;

4.1.2. When requested by the patient, or immediate family, when the patient is unable to make the request;

4.1.3 Where the diagnosis is obscure;

4.1.4 In unusually complicated diseases where specific skills of subspecialists or other practitioners may be needed;

4.1.5 In instances in which the patient exhibits severe psychiatric symptoms

4.2 **Routine, Stat, Urgent Consults**

4.2.1 Any request for a consult by a non-ED on call physician on a patient may be declined by the physician who is consulted based upon an inability to timely see the patient or if the consulted physician does not feel he/she can address the patient’s issue(s). If a consult request is declined by the physician initially consulted, then the consult will go to the physician on ED call for the consulted specialty. Hospital staff should carefully document date, time and to whom they communicated consult information.

4.2.2 (4.2.1) **Routine consults** are communicated by the unit secretary/nurse/other to the office and/or physician. These patients should be seen within 24 hours. During after hours, weekends and holidays (week day 5 p to 8 a; weekends Friday 5 p to Monday 8 a). The consulted physician should be spoken with directly by staff members.

4.2.3 (4.2.2) **Urgent consults** are communicated physician to physician, and it is determined mutually when the patient will be seen based on the patient’s condition. If a consult is called by the hospital staff, it is automatically assumed it is not an urgent or stat consult.

4.2.4 For ED and inpatient consults, **STAT consults** shall be communicated physician to physician to fully understand the patient’s situation and the need/reason for the consultation. STAT consults must be seen as soon as possible unless otherwise indicated by the requesting physician. If a consult is called by the hospital staff, it is automatically assumed it is not an urgent or stat consult.

4.2.5 **Obligations of Physicians to Respond to Consults when not on ER Call**

4.2.5.1 A physician is obligated to see a patient for whom he/she has provided care if it is for the same or related problem and *within a department
specific post care period. His/her covering physician would be under the same obligation if the original treating physician was unavailable.

4.2.5.2

*Medicine/FM : 30 days

*OB :  If the patient has presented for the same or a related problem within a 90 day post procedure period.

*ER: NA

*Surgery: “If the patient has presented for the same or associated problem within a 10 day post-care period for minor procedure and 90 day post-care period for a major procedure.

*Peds: 30 days

4.2.5.3 An unattached patient may request a physician other than the one who is covering the ER. The requested physician may see the patient, or he/she may decline, in which case the physician covering the ER is obligated to take the patient.

4.2.5.4 A physician who has had a patient encounter as a consultant (to include diagnostic testing) but did not provide direct care or follow up is under no obligation to see/take care of the patient in the future unless the physician is on ER call when the request for consultation is made.

4.3 In circumstances of grave urgency or where consultation is required by the rules of the Hospital, the Administrator shall, at all times, have the right to call in a consultant or consultants after conference with the Chief of the Medical Staff and/or member of the Executive Committee or Department Chair involved.

4.4 Follow up for Unattached Patients After Discharge
Unattached patients cared for in the hospital by the Hospitalist group will be referred for follow up with the appropriate physician who was on ER call on the day of the patient’s admission.

V. AUTOPSY REQUESTS

5.1 The Medical Staff should attempt to secure autopsies in all deaths, particularly in cases of unusual deaths and of medico-legal and interest. Consent for a autopsy shall be according to law and Administrative policy. When a autopsy is performed, provisional anatomic diagnoses should be recorded in the Medical Record within three (3) days, and the complete protocol should be made part of the record within sixty (60) days, unless extenuating circumstances prevail or special studies are required.

5.2 Medical staff indications for autopsy:

5.2.1 Deaths in which an autopsy would explain unknown or unanticipated medical complications.

5.2.2 All deaths in which the cause is not known with certainty of clinical grounds.

5.2.3 Deaths in which an autopsy would allay concerns of the public/family regarding death to provide reassurance to them regarding the same.
5.2.4 Any unexplained/unexpected deaths that occur during any dental, medical or surgical diagnostic procedures and/or therapies.

5.2.5 Any unexplained/unexpected deaths that occur within 48 hours of any dental, medical or surgical diagnostic procedures and or therapies.

5.2.6 Deaths of patients who participate in clinical trials approved by the Institutional Review Board.

5.2.7 Deaths associated with an adverse drug reaction and/or blood transfusion reaction.

5.2.8 Unexplained/unexpected deaths apparently natural and not subject to a forensic medical jurisdiction.

5.2.9 Natural deaths which are subject to or waived by a forensic medical jurisdiction, such as:

5.2.9.1 Persons arriving DOA in the hospital:

5.2.9.2 Deaths occurring in the hospital within 24 hours of admission.

5.2.9.3 Deaths in which a patient sustained or apparently sustained injury while in the hospital.

5.2.10 Deaths resulting from high risk infections and contagious diseases.

5.2.11 All obstetrical deaths.

5.2.12 All neonatal/pediatric deaths.

5.2.13 Death at any age when an autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplanted organs.

5.2.14 Known or suspected deaths arising from environmental or occupational hazards.

VI. SURGICAL STANDARDS

6.1 No physician shall be allowed to perform, or to assist in any operation unless he is a member of the Medical Staff and has been granted surgical privileges. A resident, intern or medical student may be allowed to scrub in OR cases and assist under the direction and supervision of the surgeon.

6.2 In the event the physician who performs a biopsy is not qualified to perform the definitive surgery or does not choose to perform the definitive surgery, a qualified second surgeon must be in the operating suite prior to the biopsy.

6.3 Post Operative Progress Note.

When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This note includes the following:

- The name(s) of the primary surgeon and assistant(s)
- Procedures performed
- Findings
6.3.1 Results of diagnostic testing performed at locations other than Baptist Medical Center East relevant to the surgery or procedure to be done must be incorporated into the chart before or within 24 hours of the procedure.

6.4 When a surgeon is on ED call at BMC East, he/she is obligated to take all ED consults and admissions as well as any requested inpatient surgical consults requested during his/her Call Period. The “Call Period” for ED call is twenty four (24) hours in duration, running from 7:00 a.m. to 7:00 a.m. the next day. ED or inpatient consults received during the Call Period (7 a.m. to 7 a.m.) will be the responsibility of the on call surgeon. Calls/consults made after the 7 a.m. cutoff will be the responsibility of the next surgeon on call notwithstanding the time when the patient first presented to the ED or was determined to need a consult.

6.5 A surgeon shall be obligated to see a patient on whom he has operated. “If the Patient has presented for the same or associated problem within a 10 day post-care period for minor procedure and 90 day post-care period for a major procedure”. A surgeon covering for him/her would be under the same obligation to see/treat the patient, if the original surgeon is not available.

6.6 An unattached patient may request a surgeon other than the surgeon on ED call. The requested surgeon is, however, under no obligation to see the patient. Should he/she decline, the surgeon covering the ED is still obligated to see the patient.

6.7 A surgeon who has had a consultative encounter with a patient, but who did not operate on the patient is under no obligation to take care of the patient in the future unless he/she is the surgeon on ED call when the patient presents to the hospital or a consult is requested.

6.8 Podiatrist Privileges

6.8.1 Privileges granted to podiatrists shall be based on their training, experience, demonstrated competence, judgement, current capability, and licensure. The scope and extent of their medical and surgical privileges shall be specifically delineated and granted in the same manner as all other medical and surgical procedures and shall be exercised under the overall supervision of the Chairman of the Department of Surgery.

6.8.2 A podiatrist member can not make an inpatient admission to the Hospital. They can, however, designate a physician member under the jurisdiction of the Department of Surgery and shall designate a physician member with appropriate privileges to have primary medical responsibility for the patient in the medical record upon admission. All podiatry patients must have a history and physical appraisal performed by the physician member. The podiatrist member shall be responsible for that part of the history and physical examination related to podiatry. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patient's hospitalization and shall signify willingness to do so in the medical record. The physician and the podiatrist shall assess, with consultation if necessary, the overall risk and effect of surgery on the patient's health.

6.8.3 Podiatrists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.
VII. EMERGENCY DEPARTMENT STANDARDS

7.1 There shall be an ER Physician, contracted by the Hospital, on duty 24 hours a day. The evaluation and treatment rendered to any patient who presents himself or is brought to the Emergency Department shall be the responsibility of the ER Physician.

Should a patient request treatment by his/her Attending Physician, that physician shall be notified and directions for care shall be implemented. If the patient's condition requires immediate medical attention, the ER Physician shall initiate treatment.

If the patient requires specialty consultation, the ER Physician will utilize rosters posted in the "Physician Call Schedule" book. Follow-up care for patients treated in the ER shall be under directions of their Attending Physician. If a patient does not have a personal physician, one will be assigned, using call rosters available in the Emergency Department.

7.2 The Emergency Call List will be as follows:

7.2.1 The Executive Committee shall appoint an Emergency Service Chief for each department who shall be responsible for the development, issuance, and management of an Emergency Room Call List and the Emergency Room Call Schedule for each specialty with the department. The names of the Emergency Service Chiefs shall be communicated to the Administrator at the beginning of each year.

7.2.2 Each Emergency Services Chief shall maintain a monthly Emergency Room Call List which contains the names of physicians who are eligible and available for assignment to the Emergency Room Call Schedule. The Emergency Services Chief shall allocate the days of call among the members of the Emergency Room Call List in accordance with the policy adopted by the departments and approved by the Executive Committee.

7.2.2.1 Each department's policies and procedures shall be in writing and shall specify the criteria used to determine Emergency Room Call List eligibility, availability, and allocation of days on the Emergency Room Call Schedule.

7.2.2.2 Members of the Active, Courtesy and Provisional Medical Staff are eligible to be included on the Emergency Room Call List and may be asked to take call.

7.2.2.3 In any case where a member of the Medical Staff fails to comply with Emergency Room Call List and Emergency Room Call Schedule participation requirements, the Executive Committee shall suspend said member's hospital privileges.

7.2.2.4 Any appeals of determinations made by the Emergency Service Chief regarding composition of the Emergency Room Call List or the allocation of days on the Emergency Room Call Schedule shall be submitted in writing to the Department Chair. The decision of the Department Chair may be appealed in writing to the Executive Committee.

7.2.2.5 Each service may develop, subject to review and approval by the Executive Committee, Emergency Room Call List and Emergency Room Call Schedule policies and procedures regarding eligibility, availability,
and scheduling so long as I) there is consensus within the service among all persons defined as eligible for Emergency Room Call List participation in Section 7.2.2.2 said policies and procedures are not more restrictive than are the eligibility criteria set out in Section 7.2.2.2 said policies and procedures are not inconsistent with the Medical Staff Bylaws and Rules and Regulations. In instances where consensus cannot be achieved, each physician who meets the eligibility requirements defined in 7.2.2.2 shall be considered eligible for inclusion on the Emergency Room Eligibility List and shall receive an equal portion of Emergency Room call on the Emergency Room Call Schedule.

7.2.2.6 All medical specialties represented on the Medical Staff should be available for Emergency Services through on-call coverage. If all of the specialties of the hospital cannot be on call at all times the following will apply:

7.2.2.6.1 If at least three or more physicians are on staff in a specialty, the call schedule must be entirely covered with each eligible physician being required to cover no more than every third day.

7.2.2.6.2 If only two physicians on staff are in a specialty, 2/3 of the days must be covered by the eligible physician.

7.2.2.6.3 If one physician on staff is in a specialty, 1/3 of the Schedule must be covered by the eligible physician.

7.2.2.6.4 Under 7.2.2.6.2 and 7.2.2.6.3 above, each physician must cover a Saturday and Sunday.

7.2.3 Physicians shall not arrange for coverage by a physician who is not privileged to provide services equivalent to themselves or accountable for arranging for the provision of equivalent services. Conversely, no physician shall accept coverage responsibilities for another physician without being willing and able to discharge all responsibilities for a physician, including Emergency Room coverage responsibilities, by either personally providing services or appropriately arranging for services.

7.2.4 The Emergency Room physician shall call another physician (or Chief of Service for advice) when the on-call physician or attending physician will not come to the hospital and see the patient when requested.

7.2.5 A list of procedures that may be performed in the Emergency Rooms and approved by the Medical Staff shall be maintained in the Emergency Services area.

7.2.6 The following guidelines must be followed to insure practitioner and hospital compliance with COBRA/OBRA Regulations:

7.2.6.1. Physicians on the ER call list shall be available to present to the Emergency Department for evaluation of patients when deemed necessary by the Emergency Department physician or other treating physician.

7.2.6.2. All individuals presenting to the hospital must be screened to determine whether an emergency medical condition exists or if the individual is in active labor.
7.2.6.3. Stabilizing treatment, within the capacity of the hospital, must be provided unless the medical benefits of transfer outweigh the risks.

7.2.6.4 All individuals transferred from the hospital must have a PHYSICIAN CERTIFICATE FOR TRANSFER signed by the transferring practitioner or verbal order given to a Registered Nurse and authenticated within twenty four (24) hours. On the PHYSICIAN CERTIFICATE FOR TRANSFER form the practitioner must list a summary of the risks upon which the certification is based and list a summary of the benefits upon which the certificate is based. If the transfer was necessitated as a result of a practitioner on the Emergency Room Call List having refused or failed to appear within a reasonable time to provide necessary stabilizing treatment, the name and address of the "on call" practitioner should be documented on the PHYSICIAN CERTIFICATE FOR TRANSFER.

7.2.6.5 The practitioner who transfers an individual must have a receiving physician and hospital who agree to accept the individual.

7.2.6.6 The practitioner who transfers an individual must provide an updated medical record which relates the condition of the individual, history and physical, preliminary diagnosis, treatment provided, and diagnostic test results to the receiving hospital.

7.2.6.7 The practitioner who transfers an individual must provide physician orders for the care of the patient during transport. These orders must provide for the same level of care the individual received while under the care of the practitioner.

7.2.7 The above guidelines apply to all transfers, whether emergent, non-emergent, or for medical testing.

VIII. THE CARE OF PSYCHIATRIC/SUBSTANCE ABUSE PATIENTS

8.1 Baptist Medical Center East does not provide psychiatric or substance abuse services. In the event of a psychiatric emergency, the hospital does provide arrangements for consultative or transfer services to an appropriate psychiatric facility. Should a patient arrive at the hospital with a psychiatric emergency or mental health management issue, the physician may contact a Case Manager for assistance in obtaining a consultation or transfer. In all cases, medical stabilization will take place prior to any transfer to a psychiatric facility.

IX. PATIENT CARE AND TREATMENT

9.1 The following rules shall be observed in the prescribing and administration of medications:

9.1.1 All preoperative orders are canceled and rewritten by the physician at the time of surgery and upon entry or transfer from ICU.

9.1.2 Only those drugs which have a physician’s written order and approved by the Medical Staff may be left at the patient’s bedside.

9.1.3 Patients may not take medications brought from outside the hospital unless the physician writes an order and the pharmacist identifies and relabels the drug and the patient signs a release. Drugs brought in by the patient and not used should be packaged and sealed, and either given to the patient’s family or stored and returned to the patient at the time of discharge, provided such action is approved by the responsible practitioner.
9.1.4 Patients requiring medications after discharge shall be given a prescription by the responsible practitioner.

9.2 The Medical Staff shall follow the hospital's policies regarding the use of restraints and/or seclusion for patients who require the use of these special procedures. Because these practices represent an exceptional constraint upon the patient's movement or ability to tend to certain needs, it is imperative that the use of these procedures be documented as clinically justified, that less restrictive interventions are attempted before escalating to more restrictive measures, and that the totality of the patient's condition be considered regarding any decisions to use seclusion or restraints. Orders for the use or seclusion or restraint must be time limited, written for a specific episode with specific start and stop times, and shall be subject to continuing frequent patient review per hospital policies.

X. MEDICAL STAFF STANDARDS

10.1 The Departmental meetings of the Medical Staff shall meet at regular, pre-established times each month, said times being determined by each medical staff department at the beginning of the medical staff year. The Medical Staff Executive Committee meeting shall be held on the second Tuesday of each month. The Departmental meetings shall precede the Medical Executive Committee as a rule.

10.2 Members of the medical staff who wish to change from courtesy to active staff must meet active staff requirements as outlines in Medical Staff Bylaws 8.3 and 12.4. If these requirements have not been met, the physician will remain courtesy.

10.3 When Medical Staff Members are unable to attend departmental meetings due to emergency situations, out-of-town planned vacations or out-of-town medical conferences, the physician should send a letter one (1) week prior to or one (1) after the scheduled departmental meeting expressing the reason for not attending and if approved by the Department Chair and Chief of Staff, the physician would be considered as having attended the meeting.

10.3.1 A medical Staff Member who arrives at a medical staff meeting after the voting on agenda items is concluded (excluding a vote to adjourn) or after agenda item reports are concluded, or following adjournment cannot be counted as having attended the meeting.

10.4 For Bylaws 9.3.3, the tenure of clinical chairman may be a 1 or 2 year term, to be determined by the Medical Executive Committee.

10.5 According to the Bylaws 8.3.1.C.2, the allowable active members for hospital based medical staff are as follows:
   - Hospitalist – 5
   - Anesthesia – 5
   - Radiology – 9
   - Emergency Medicine – 5
   - Pathology – 5

10.6 According to Bylaws 8.3.1.b, each clinical department has defined the time and/or distance per specialty to BMCE in order to provide timely continuous care to his/her patients. These are:
   - OB- live and practice within 30 minutes of BMCE
   - Surgery/Pathology/Anesthesiology – live and practice within a reasonable distance from BMCE
   - Pediatrics – live and practice within 30 minutes of BMCE
Members of the Medical Staff will be required to have $1 million/$3 million liability insurance. (Bylaws 3.3.1:h)

Physicians with Locum Tenum/Temporary Privileges

Physicians with Locum Tenum/Temporary Privileges are eligible to take call if they are a hospital based physician. Non-hospital based physicians may take call as determined by the Administrator/Department Chair on a case by case basis.

Temporary medical staff privileges cannot be granted until the provisions of Article 5.2 of the Medical Staff Bylaws are met and the medical staff/Credentials file has been reviewed and approved by the Credentials Committee and the Medical Executive Committee without questions, reservations or conditions. Because of the potential delay in obtaining final Governing Board approval due to their infrequent meeting schedule and the significant patient need in our service area, the Hospital Administrator may grant temporary privileges until the next scheduled Governing Board/Executive Committee/Credentials Committee of the Board Meeting.

Cellular phone use in hospital

While in the hospital, cellular phones should be switched to silent or vibrate mode.

Cellular phones should not be utilized during patient procedures or when providing patient care. Flexibility is provided in circumstances where emergent situations occur.

Physician coverage

Each practitioner is required to have coverage arrangements through one or more similar or appropriately credentialed physicians of like specialty on the medical staff. If the practitioner is going to be out of town or otherwise unavailable, it is his/her responsibility to contact and confirm the availability of the covering physician during that time, or to obtain appropriate alternative coverage. A failure to ensure such coverage shall constitute grounds for referral to the Medical Executive Committee.

Interpersonal Relationships

It is expected that physicians will show appropriate respect for colleagues and hospital staff, maintain appropriate restraint in stressful situations, adopt a leadership role in avoiding conflict and in conflict resolution and comply with the Code of Conduct.

Personal conflicts shall be resolved privately. Conflicts regarding patient care should not be discussed in the presence of patients and family members.

If a physician has concerns regarding hospital staff, procedures, other medical staff, or any issue regarding services at the hospital it is expected that the physician shall address their concerns in a professional and private manner. Physicians may contact the department manager, administrator, and/or quality management department for assistance in resolving patient care or other issues. In no circumstances is disruptive behavior appropriate.

Medical Staff Physician Misconduct Policy

Physician misconduct, as defined here, is offensive behavior that is disruptive to teamwork, efficiency, collegiality, and smooth functioning of the healthcare team.

Alabama law protects all peer review records and these records non-
10.12.3 Physician misconduct refers to those situations in which the conduct of the physician is blatantly unprofessional such as:
   a) Rude, condescending communication with fellow physicians, students, residents, hospital personnel and/or patients, families, visitors;
   b) Using loud, threatening verbal communication; using profuse profanity; any form of violence or intimidation;
   c) Rage, throwing instruments or equipment or purposeful destruction of same.
   d) Public display of discontent (radio, TV, newspaper) regarding a specific case, other medical staff, hospital staff or care; making derogatory comments or disparaging other medical staff in the medical record;
   e) Sexual harassment;
   f) Other undefined behavior not consistent with professional training and position.

10.12.4 Upon receipt of complaint of physician misconduct, the Department Chair, Chief of Staff and Hospital Administrator are informed of the complaint.

10.12.5 Review Activity:
   a) Administration or Quality Management shall obtain a Physician Misconduct Review Form (PMRF) and attach complaint. (See appendix A)
   b) Conduct an initial review to verify the facts surrounding the complaint. This may involve interviewing the complainant, witnesses, or other actions.
   c) Document review findings on the PMRF and inform Department Chair, Chief of Staff and/or Hospital Administrator.
   d) If the complaint was not validated note this on the PMRF. Inform the physician and the complainant of the outcome of the investigation. A copy of the complaint will not be retained. Prior complaints during this period should be investigated for patterns and trends.
   e) If the complaint was validated, follow the steps outlined below. All counseling actions are documented on the PMRF and will be permanently maintained in the physician’s file. In either situation, d) or e) above, the physician is informed of the complaint and offered an opportunity to respond in writing, which would be attached to the PMRF when received.

10.12.6 Counseling Actions for Valid Complaints: The intent of this section is to provide a venue for resolution of behavioral problems and grievances regarding physician behavior, minor and major, and to identify any potential trend. The process is not intended to be so potentially punitive that under-reporting occurs. The reviewing peers, in determining the severity of the complaint, will consider all circumstances during the review process including any appropriate attempts by the physician to remedy the situation (e.g. sincere remorse, written or spoken apology, psychological counseling). Depending on the severity of the action, the complaint may be referred at any point directly to the Behavioral Review Committee. (see 10.2.7.c)
   a) First Minor Offense: informal meeting with the physician wherein the complaint is discussed and the Department Chair or his/her designee provides physician counseling. This is documented on the PMRF.
   b) First Major/Second Minor Offense (within a two year time frame): more formal meeting where the complaint is discussed and the Department Chair and Chief of Staff provides physician counseling and a warning regarding potential (disciplinary) action(s) that may occur if further incidents of physician misconduct occur. This is documented on the PMRF.
   c) Second Major/Third Minor Offense (within a two year time frame): physician is referred to the Behavioral Review Committee. This committee is composed of the following persons: Chief of Staff, Chief of Staff-elect, Department Chairman and Vice-Chair, Hospital Administrator and one senior member of the Medical Executive Committee, preferably not in economic competition with the physician being counseled. The facility quality
The coordinator serves as recorder at the request of the Committee.

1. The initial meeting of the Behavior Review Committee will be independent of any meeting with the physician. The purpose of this meeting is to review all complaints and counseling efforts and to consult, as needed, the Alabama Physician Health Program (PHP) [alabamaphp.org] under the Medical Association of the State of Alabama (MASA) who will provide guidance and serve in an advisory capacity for the committee.

2. The committee will consider the recommendations and options offered by the PHP and may recommend one or several options be mandated to the physician. This committee also provides a warning to the physician that failure to comply with any mandate may result in corrective action, and that any further incidents will be automatically handled under the Corrective Action section of the Bylaws.

3. The proceedings of this committee are documented on the PMRF.

10.12.7 The Physician Misconduct Review Form (PMRF) and all documentation shall be retained (permanently) in the physician’s quality peer review file. The file is confidential and kept in a distinct and separate location from the physician’s credential file (located in the Quality Management Department). Access to this file is limited to the Chief of Staff, the General Counsel of Baptist Health, Hospital Administrator, the individual physician, and the Behavioral Review Committee.

XI. MEDICAL STAFF ONGOING PROFESSIONAL PRACTICE EVALUATION / PEER REVIEW

11.1 Ongoing Professional Practice Evaluation allows the hospital to identify professional practice trends that impact on quality of care and patient safety. The criteria used are established and approved by the Medical Staff departments.

11.1.1 Information may be obtained through:
- Review of medical records
- Direct observation (proctoring)
- Monitoring of diagnostic and treatment techniques
- Input from other individuals involved in the care of the patient

11.1.2 Information is factored into the decision to maintain, renew, or revoke existing privileges prior to or at time of renewal.

11.1.3 Issues identified through ongoing professional practice evaluation can result in an investigation and corrective action as defined in the Medical Staff Bylaws.

11.2 Medical Staff Peer Review Process

11.2.1 Definitions

11.2.1.1 Peer Review Process - Ongoing and concurrent case reviews based on indicators approved by the Medical Staff or if therapy or care is out of the range of the usual and ordinary

11.2.1.2 Peer - A physician within the same specialty who is not involved in the care of the patient or in the same practice. (i.e. surgery reviews surgery, podiatry reviews podiatry, OB reviews OB, etc)

11.2.2 Participants in the Process – Initial review is completed by the QM Department. The review is then forwarded to the Department Chair for review and recommendations. If the Department Chair was involved in the case or is in the same practice, the case is either referred to another physician within the same specialty or is reviewed in the quarterly departmental meeting.

11.2.3 Selection of a Peer Review Panel for Specific Circumstances – The Department Chair may request the case to be presented at the Department Meeting that is held quarterly. If that is the case, only members of the medical staff, the
Administrator, and QM representative are present for the case review and is held in strictest confidence. Cases not resolved at the department level are forwarded to the monthly Medical Executive Committee for review/recommendation.

11.2.4 Time Frame for Review – The peer review process begins when the problem is identified with a reviewer response noted within three months. (Special circumstances may occur when this time frame can not be met)

11.2.5 External Peer Review – May be considered in some circumstances if there is not a peer, peers are members of the same group or in some instances of focused review.

11.2.6 Participation of Reviewer - When the review is complete the outcome may include:
- Management appropriate, no further action required
- Additional information requested
- Continue to monitor and trend
- Educational opportunity
- Communicate findings to physician
- Present at Departmental Meeting
- Refer to Medical Executive Committee

If there is action needed by the physician whose case is being reviewed, a letter will be sent giving an option of responding to the chairman in writing or in person.

11.2.7 Additional follow up to the process – The Quality Management Department will provide assistance to the Department Chairman at his/her direction by researching the literature and clinical guidelines when needed. Charts and review summaries will be maintained by Quality Management who will prepare quarterly reports for the Medical Staff Department meeting based on peer review/volume indicators and outcome measures. The completed review forms will be filed in the physician's individual quality file separate from the credential file.

XII. PROCTORSHIP/FELLOWSHIP POLICIES (FOCUSED PROFESSIONAL PRACTICE EVALUATION)

12.1 Focused Professional Practice Evaluation
12.1.1 Except as otherwise determined by the Executive Committee, all initial appointees to the medical staff and all members granted additional clinical privileges will be subject to a period of Focused Professional Practice Evaluation.

12.1.2 Focused Professional Practice Evaluation methods may include direct observation (both clinical and surgical proctoring), review of medical records (both concurrent and retrospective) monitoring clinical practice patterns, external peer review, and an evaluation of the physician’s interpersonal skill with peers, nursing and ancillary personnel as well as hospital administration.

12.2 Proctorship/ Fellowship Policies
12.2.1 If determined by the MEC and the Board that a physician does not meet the requirements (documented evidence of competency) to obtain privileges for certain procedures and/or privileges, or when a question arises regarding a currently privileged practitioner’s ability to provide safe, quality patient care; a proctorship may be required, regardless of specialty. Direct observation rather than number of procedures shall determine competency. In particular, obstetrical privileges granted to Family Practitioners shall be the joint responsibility of the departments of
Family Practice and OBGYN as recommended by the American Academy of Family Practice.

12.2.2 The particular type and term of proctorship will be specific to the privileges required. The minimum number of cases/procedures determined by the Department Chairman or as set forth in established circumstances as approved by the Medical Executive Committee. The proctoring physician/surgeon/oral surgeon may extend the proctoring period when in his/her judgement additional observation is warranted.

12.2.3 Where direct observation proctoring is involved, it shall be the responsibility of the member being proctored to schedule surgery/procedures requiring the presence of a proctor, at those times when a qualified proctor is available. Except in emergency situations, no procedure may be performed without the presence of a proctor until such times as the Medical Executive Committee has released the physician. All "emergency situations" will be reviewed by the Department Chairman and the Medical Executive Committee to ensure appropriateness.

12.2.4 In those cases involving direct observation proctoring, the departments of the hospital that are affected (surgery, endoscopy, etc.) will be advised of the proctoring requirements. No cases will be allowed to proceed without a proctor being present throughout the procedure.

12.3 Selection/Qualifications of Proctors

12.3.1 Each clinical department will be responsible for identifying/assigning physicians to act as proctors. The Department Chairman must approve all Proctors. Proctoring may be completed at another facility. In either choice, documentation of completion from the proctor must be provided to the CVO for submission to the Credentials Committee.

12.3.2 In order to serve as a proctor, a physician/surgeon/oral surgeon must currently be credentialed to perform the procedure in question and have met any specific requirements as to number of procedures performed, etc. Notwithstanding the foregoing, the proctor should have performed the procedure at least twice in the preceding twelve months (unless otherwise specified by Department Chairman and approved by the Medical Executive Committee).

12.3.3 In circumstances where a member of the medical staff does not meet the criteria in 12.3.2, an external proctor will be sought. In the case of a physician who is not a credentialed member of the medical staff, but who is licensed in the state of Alabama, the basic information required to be validated for such physician will be obtained with temporary privileges being granted to this facility:

12.3.3.1 A copy of their AL license;
12.3.3.2 A copy of their federal DEA certificate;
12.3.3.3 A copy of their Alabama controlled substance license;
12.3.3.4 Proof of adequate medical malpractice insurance for coverage in our state;
12.3.3.5 A written request from the medical staff member who is being proctored;

12.3.4 Provide evidence they are credentialed to perform this procedure at another facility; provide evidence of the number of procedures performed, if required by the specific proctoring criteria for the specific procedure.
12.3.5. In the case of physicians not licensed in the state of Alabama, a temporary privilege to practice in the state will be granted per 34-24-74 of the Code of Alabama. The documentation required by the hospital shall be the same as that required for an Alabama licensed physician - except for licensure in their state.

12.3.6. The proctor shall assist/observe the physician/surgeon/oral surgeon in performing each of the predetermined number of proctored procedures and such further number of procedures as deemed necessary by the proctor and approved by the Medical Executive Committee to demonstrate acceptable competence in the performance of the procedure.

12.3.7. The proctor shall prepare and submit a short written critique/review of each procedure proctored. The proctor shall review this assessment with the physician/surgeon/oral surgeon and it shall be made a part of the final report.

12.3.8. When the required number of cases, and any additional cases deemed necessary by the proctor, have been completed to the proctor’s satisfaction, the proctor shall submit a final report to the Department Chairman attesting to the physician/surgeon/oral surgeon’s competency. This report shall be copied to the Medical Executive Committee for action at their next meeting. Pending a final formal action by the Medical Executive Committee and the Board, the Department Chairman and the Hospital Administrator may grant the requesting physician/surgeon/oral surgeon temporary privileges to perform the procedure independently.

12.3.9. The proctoring report shall remain confidential and shall be handled as other medical staff peer review information. The Medical Executive Committee shall determine where the files will be kept, who will have access, when and in what format; the procedure for physicians to appeal the reports or question the proctor who wrote them; an policy on retention of proctoring reports.

XIII. PHYSICIAN WELL BEING PROGRAM

13.1 Physician Wellbeing Policy

This policy provides a process whereby a Healthcare Professional who may be experiencing, or may suffer from, a condition that could cause or is causing impairment can be identified and assisted to avoid patient harm. Such conditions that can and do cause impairment include but are not limited to the following: substance abuse or dependence, mental illness, disruptive behavior, physical disabilities, and senility.

It is the policy of this hospital to protect patients from harm. In this regard, the medical staff and organization leaders have established a process that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates early detection and confidential diagnosis, treatment, rehabilitation, and monitoring of physicians who suffer from a potentially impairing condition.

The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a physician is unable to safely perform the privileges he or she had been granted, the matter is forwarded to medical staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements (i.e. Alabama Code Sec. 34-24-361b requires reporting of any physician…”who may be unable to practice medicine with reasonable care and
safety to patients by reason of illness, drugs, inebriation...or as a result of any mental or physical condition.” To achieve these goals the medical staff has established this process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function.

The Alabama Physician Health Program, APHP, under the supervision of the statewide Alabama Impaired Physician Committee, AIPC, was created in Alabama by legislation (Alabama Code Sec. 34-24-400 to 406) to assist physicians and hospitals with the issues involving physician health. Activities of the APHP include education of physicians and other personnel, early identification of problem physicians, confidential investigation, intervention, referral for appropriate evaluation and treatment, and long-term monitoring of physicians. This hospital will work in partnership with the APHP and AIPC to achieve these shared goals to improve physician’s health and function.

Furthermore, it is imperative to involve APHP when possible since physicians with impairment issues must frequently respond to queries from agencies such as the Board of Medical Examiners, the Hospital Medical staff reappointment process, malpractice insurance companies and others regarding whether they have had or been evaluated for problems associated with impairment. Physicians involved with the APHP remain confidential, by state statute, in this process as physicians may refer inquiries to the APHP who are authorized to advocate on the physicians behalf before these agencies and to maintain confidentiality.

13.2 Physician Wellness Committee

One or more physicians shall be appointed by the Medical Executive Committee to serve as a resource for contact, referral, and consultation regarding individual physician health issues.

13.2.1 Objectives:

13.2.1.1 Education of the medical staff and other organization staff about illness and impairment recognition issues specific to physicians;

13.2.1.2 Self-referral by a physician and referral by other organization staff;

13.2.1.3 Early detection of conditions that can cause physician impairment;

13.2.1.4 Prevention of problems that can cause physician impairment;

13.2.1.5 Investigation of the credibility of a complaint, allegation, or concern;

13.2.1.6 Referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;

13.2.1.7 Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;

13.2.1.8 Monitoring of the affected physician and the safety of patients as appropriate depending on the diagnosis and treatment provider recommendations; and
13.2.1.9 Reporting to the medical staff leadership instances in which a physician is providing unsafe treatment.

13.2.2 Procedures:

13.2.2.1 Education and Early Detection

Educational programs will be provided, in cooperation with the Alabama Physician Health Program, to medical staff and other organizational staff on a regular basis. These programs will address a variety of topics, including but not limited to understanding impairment, disability, and illness; substance use disorders, mental illness, disruptive behavior, and physical illnesses that cause impairment. Staff will learn to identify these problems and learn how to refer physicians through appropriate channels for confidential investigation. Programs will be designed to provide information that offer the opportunity for prevention of problems, including: stress management, appropriate boundaries and professional conduct, etc.

Staff will be advised regarding the Alabama Physician Health Program and how it operates to support physicians and protect patient safety and how to initiate referral. The value of early detection of appropriate issues will be emphasized to avoid damage to the physician’s reputation and career and to protect patient safety. Staff will be educated regarding levels of concern including potential impairment associated with conditions that frequently cause impairment, relapse of previous conditions that cause impairment, and overt harm to patients. If risk to patients currently exists or if patients have been harmed staff will be advised to make emergency reports so that immediate action can be taken.

13.2.3 Referral

Referrals regarding physician health issues may be made to the Medical Director, Chairman of the Physician Health or Wellness Committee, or to the Alabama Physician Health Program (Direct phone: (334) 954-2596). In no event shall the appropriate referral be anyone who also sits on committees that oversee the disciplinary process of the hospital. Physicians seeking assistance are encouraged to self refer by offering strict confidentiality and compassionate assistance. Staff or physicians who are concerned regarding an individual physician may make a referral. Anonymous or confidential inquiries may be made. Information may be provided as to the rehabilitative non-disciplinary intent of the program. Allegations, concerns, or complaints will be reviewed and investigated with the utmost confidentiality.

13.2.4 Preliminary Investigation

Once referral of a concern is made to an appropriate authority a confidential investigation is conducted. If the referral is made to the Medical Director or Chairman of the Physician Wellness Committee a confidential inquiry will be made with the APHP regarding whether there is evidence of concerns available regarding the physician from other
If referral is made to the APHP confidential inquiry will be made with the Medical Director or Chairman of the Hospital Physician Health Committee to ascertain if there may be a legitimate problem. Confidential inquiry may also be made with a local member of the statewide AIPC. The goal of the preliminary investigation is to ascertain if the concern or complaint is credible and merits formal evaluation.

13.2.5 Intervention and Referral for Evaluation and/or Treatment

If preliminary investigation demonstrates credibility of a concern or complaint regarding a physician then an intervention with the physician will be conducted. The goal of intervention is to advise the affected physician that credible concerns have been established and that formal evaluation is recommended. In-depth discussion of the alleged problem(s) or concerns may be avoided at this stage in lieu of formal clinical evaluation.

An appropriate level and site of formal evaluation to be conducted will be determined following consultation with the APHP. Coordination of referral for evaluation will be made in concert with evaluation and/or treatment resources provided by the APHP. The APHP continuously reviews available evaluation and treatment programs verifying their expertise, effectiveness, cost, and excellence in evaluating and treating health professionals and maintains current information regarding appropriate referral sources.

13.2.6 Monitoring

Following evaluation and/or treatment a monitoring program will be developed based on evaluation and/or treatment providers recommendations in concert with the APHP. Monitoring will include recommended modalities to assure that the physician is accountable to maintain his/her health and provide safe care.

The monitoring program may be conducted by the Hospital and/or the APHP as appropriate following joint decision by both agencies. If the APHP conducts monitoring the Hospital must obtain a written release from the physician to obtain regular reports from APHP regarding compliance to the monitoring agreement. Monitoring modalities may include but not be limited to: urine drug testing, reports from psychologist or psychiatrists, reports from group therapy, reports from monitoring physician or worksite monitor, or periodic feedback from appropriate administrative personnel. Follow-up with treatment centers may be part of monitoring also. Failure to complete the required rehabilitation program will be forwarded to the Medical Executive Committee for consideration and recommendation of further action if indicated.

XIV. BAPTIST MEDICAL CENTER RESIDENCY PROGRAM

14.1 Baptist Medical Center is affiliated with the University of Alabama School of Medicine Montgomery Internal Medicine Residency Program (UASOM/MIMRP) and sponsors the Baptist Medical Center Family Practice Residency Program.

14.2 The Residency Program residents are graduate physicians who:
14.2.1 have been approved for participation in the program by the chairman/program director of the respective residency program;
14.2.2 are held accountable to the physician to whom he/she has been assigned and/or the physician for whom he/she is covering;
14.2.3 will be governed by the UAB/BMC Agreement covering graduate education activities or the BMC policy covering the Baptist Montgomery Family Practice Residency Program, as appropriate;

14.2.4 will be included in Quality Improvement, Utilization Review and Risk Management reviews;

14.2.5 may write patient care orders in the medical record; must be cosigned by the attending

14.2.6 may dictate history and physical examinations, discharge summaries and procedure reports; all dictated reports must be countersigned by the responsible physician;

14.2.7 may document daily progress notes; at minimum, one progress note per day will be countersigned by the responsible physician or he/she will document one progress note per day.

14.3 The University of Alabama School of Medicine Montgomery Internal Medicine Residency Program residents and the Baptist Montgomery Family Medicine Residency Program residents are responsible for the completion of the medical record on any patient assigned to their care. The requirements of Article IX. Section 4 of the Medical Staff Bylaws will therefore apply to residents as it would to any other physician on the Medical Staff. The hospital and the two residency programs will work together in the enforcement of suspensions for continued delinquencies.

14.4 Supervision of House Staff

14.4.1 Supervision of Internal Medicine House Staff. Supervision of the General Medical Service is the responsibility of the full time, part time and voluntary faculty as mutually agreed upon by the University of Alabama School of Medicine Montgomery Internal Medicine Residency Program and Baptist Medical Center East, and delineated in policies developed by those entities.

14.4.2 Supervision of the Family Practice House Staff. Supervision of the Family Practice House Staff is the responsibility of the full time and part time teaching faculty as mutually agreed upon by the chairman/program director of the Baptist Montgomery, Family Medicine Residency Program and Baptist Medical Center East, and delineated in policies as developed by those entities.

14.5 Responsibilities of House Staff. The duties and responsibilities of the house staff shall be according to policies mutually agreed upon by the University of Alabama School of Medicine Montgomery Internal Residency Program or the Baptist Montgomery Family Medicine Residency Program and Baptist Medical Center East, as the case may be, and shall make provision for a graduation of duties and responsibilities according to level of training of the individuals on the house staff.

14.6 Rights of Attending Physicians. In no case shall the duties and responsibilities of a member of the house staff supersede the duties and responsibilities of an attending physician who is a member of the medical staff of Baptist Medical Center East.

14.7 Participation. Participation on the part time voluntary faculty by attending physicians is entirely voluntary; non-participation shall in no way jeopardize the privileges of any medical staff member.

The roles, responsibilities, and patient care activities of the participants of graduate educational programs as well as the mechanism by which the
supervisory and graduate education program chairman/program director make
decisions about each participant’s progressive involvement and independence in
specific patient care activities is addressed in the policy and procedure manuals
of the respective programs. Quarterly, a list of the participant’s current
competencies is forwarded to the hospital and distributed to the patient care
areas.

14.8 **Duty Hours**: Participants of graduate educational programs are restricted to the
following duty (work) hours as mandated by the Accreditation Council for
Graduate Medical Education (ACGME):

14.8.1 Duty hours will not exceed eighty (80) hours per week, including
any in-house moonlighting sponsored by the institution.

14.8.2 There must be ten (10) hours between all duty
responsibilities.

14.8.3 Residents may not be on call for greater than twenty-four (24)
hours continuously. The resident may remain for an additional
six (6) hours for completion of patient care responsibilities and to
facilitate the transfer of care of patents to On Call residents.

14.8.4 All residents must have one (1) day off out of seven (7)
completely free of any educational or patient care
responsibilities.

14.8.5 It is the responsibility of the Graduate Medical Education
Committee and the Medical Executive Committee to insure that
strict adherence to these policies are complied with by the
respective residency programs and that a mechanism for
monitoring resident fatigue be in place.

14.9 **Annual Report to the Medical Executive Committee (MEC)**. Each respective
program will provide an annual report to the MEC for the purpose of
communicating about the safety and quality of patient care, treatment and
services; and any related educational and supervisory needs of the participant.

14.10 The medical staff must comply with residency review committee citations and
their resolutions.

14.11 House Staff (program participants) are not members of Baptist Medical Center
East Medical Staff as defined by these Bylaws and Rules and Regulations or
Medical Staff Bylaws, and have no recourse to hearing and appeal procedures
stated herein. All matters of corrective action, discipline, and quality concerns
shall be dealt with according to the policies of the University of Alabama School
of Medicine Dean’s Council for Graduate Medical Education and the Family
Medicine Residency Program as appropriate. The right to a fair hearing and
appeal is addressed under Item 14.9 above.

XV. **STUDENT ROTATION/SHADOWING REQUIREMENTS – MEDICAL & CRNP STUDENTS**

15.1 **Student Rotations – University Affiliated**

15.1.1 **Student Responsibilities**

15.1.1.1 Provide a letter from the University sanctioning the rotation that
outlines the specific dates of the rotation, the practitioner with whom
the student will be affiliated, proof of liability insurance, and
immunization status record.

15.1.1.2 Provide specific outline of clinical goals and objectives for the
experience.

15.1.1.3 Complete the Student Volunteer Hospital Orientation Packet.
15.1.2 Hospital Responsibilities

15.1.2.1 Provide a hospital name badge
15.1.2.2 Have a confidentiality agreement signed by the student
15.1.2.3 Maintain a file on the student
15.1.2.4 Send letter to the physician outlining his/her responsibilities for informed consent and requesting any other specific information such as specific duties the student may perform while on their rotation.
15.1.2.5 Provide additional department-specific orientation/training as required by the specific rotation (i.e. sterile technique for OR rotations)

15.2 Student Rotations – Privately Arranged

15.2.1 Under these circumstances, the hospital requires the physician to notify the hospital of the name of the individual who will be rounding with them or observing and the dates of the experience.
15.2.2 The student will be required to sign a confidentiality agreement.
15.2.3 The student will NOT be allowed to participate in any aspect of patient care except in those circumstances whereby the physician can demonstrate proof of liability coverage with their carrier for the student’s experience. In those cases, the physician and student must provide the same information as outlined in 1, a and b above except no letter from the university will be required.

XVI. CREDENTIALING IN A DISASTER

16.1 All physicians shall accept assignments issued in accordance with the Hospital Disaster Plan and abide by the provisions of this plan.

16.2 Credentialing Policy for Licensed Independent Practitioners in the event of a disaster.

16.2.1 Purpose: To verify the credentials of Licensed Independent Practitioners (LIPs) who may respond to the facility during an “emergency” or “disaster” and who is not a member of the facility medical staff. Emergency privileges are granted only when the disaster plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs. A “disaster” may be defined as an emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assessment to sustain patient care, safety, or security functions.

16.2.2 Verification Process:

16.2.2.1 All LIPs should be directed by hospital personnel to the Medical Staff office for verification of credentials and must present valid government-issued photo identification (ex. driver’s license, passport).

16.2.2.2 Additionally, at least one of the following must be presented by the LIP and, if possible, verified in order to be granted emergency privileges. A representative of the Medical Staff Office will complete the verification process as quickly as possible.

16.2.2.2.1 A current picture identification card from a health care organization that clearly identifies professional designation
16.2.2.2.2 A current license to practice medicine
16.2.2.2.3 Primary source verification of licensure
16.2.2.2.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.

16.2.2.2.5 Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.

16.2.2.2.6 Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster.

16.2.3 After reviewing the document, the Medical Staff Office representative will record the LIP’s name, date and time of the request for emergency privileges, the state license number and expiration date, and other pertinent information. If possible, copies of all documentation presented should be obtained for the facility’s records.

16.2.4 The Medical Staff Office representative shall, if possible, immediately attempt to:
- contact the facility at which the LIP is/was the most recently privileged to determine if the LIP is/was a member in good standing;
- attempt to contact the state medical licensure board to verify the license, and;
- attempt to contact the LIP’s malpractice insurance carrier.

16.2.5 In the event the above calls cannot be completed, emergency privileges may still be issued pending verification of good standing.

16.2.6 The Medical Staff Office representative shall bring the completed Emergency Privilege form (and supporting documentation) to the Command Center of the Facility and review the information with the person designated to grant emergency privileges.

16.3 The Chief of Staff, Administrator, COO, CEO or designee of these individuals have responsibility and authority to grant emergency privileges. It is the responsibility of these individuals or their designee to review the Emergency Privilege form and attached verification documents (if any). In addition, the LIP granted emergency privileges will be paired with a currently credentialed medical staff member at this time and that information will be added to the Emergency Privilege form by the Medical Staff Office representative.

16.4 Once the process is complete, the Medical Staff Office representative will return to the credential office, issue proper identification and have someone escort the individual to the command center. Someone from that area will be responsible for getting the emergently credentialed LIP to his/her assigned area and to his/her assigned (paired) facility medical staff member.

16.5 Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner’s licensure cannot be completed within 72 hours of the practitioner’s arrival due to extraordinary circumstances, the hospital documents all of the following:

16.5.1 Reason(s) it could not be performed within 72 hours of the practitioner’s arrival
16.5.2 Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services
16.5.3 Evidence of the hospital’s attempt to perform primary source verification as soon as possible
16.6 A LIP’s privileges granted in an emergency situation may be terminated at any time without any reason or cause. LIPs granted privileges in this circumstance are not entitled to the rights, privileges or responsibilities of medical staff membership.

16.7 A similar process will be implemented to verify the credentials of other medical professionals, such as Special Limited Staff categories requiring credentialing (CRNA, Physician Assistants, etc....).