BAPTIST MEDICAL CENTER SOUTH

MEDICAL STAFF

RULES & REGULATIONS

Approval Dates:

Amended July 2005       Rules and Regulations Reorganized
Amended September 2005  Section 9.2.2
Amended October 2005    Section 2.1.1 and Section 10.12.15.1
Amended May 2006        Section 6.1.7 and Section 10.12.5
Additions May 2006      Section 9.2.7 and Section 10.15
Amended June 2006       Section 4.2; Section 9.2.1; Section 9.5; Section 10.6.1; and Section 15
Amended March 2007      Section 4.1; Section 9; Section 10.9; Section 10.10; Section 10.13; and Section 12
Amended July 2007       Section 9.5
Amended September 2007  Section 9.2
Amended January 2008    Section 4.1; Section 7.4.1; and Section 9.2
Amended March 2008      Section 1.4; Section 6.2
Amended May 2008        Section 2; Section 7.3; Section 9.2.1; Section 10.5; Section 12
Amended July 2008       Section 12
Amended September 2008  Section 6.1; 9.2; 12.11
Amended March 2009      Section 1.4; 2; 9.2
Amended July 2009       Section 1.4; 2.1; 2.2; 2.8; 6.2; 10.3
Amended September 2009  Section 10.7; 17
Amended November 2009   Section 1.4; 2.6
Amended January 2010    Section 9.2
Amended March 2010      Section 12.4
Amended May 2010        Section 12.5
Amended November 2010   Section 5
Amended January 2011    Section 10.14
Amended May 2011        Section 10.5
Amended July, 2011      Section 10.5; 10.6
Amended May, 2012       Section 7.3
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APPLICATION OF POLICY
In the event of any apparent or actual conflict between these Rules & Regulations and the Medical Staff Bylaws or other policies of the Hospital and/or its medical staff, the provisions of these Rules & Regulations shall control.

1. PATIENT ADMISSION AND DISCHARGE TO BAPTIST MEDICAL CENTER SOUTH

1.1 Only members of the Baptist Medical Center South medical staff with admitting privileges may admit patients to the hospital.

1.2 All patients admitted to the hospital must be seen by the admitting physician within twenty-four (24) hours of admission.

1.3 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.

1.4 A complete history and physical (H&P), and a planned course of action must be completed and on the patient’s chart within twenty-four (24) hours of admission. If completed by CRNP or LPA, must be co-signed within 24 hours. The H&P may be in dictated or written format and contains the following elements:
   a. Chief complaint/diagnosis/reason for admission;
   b. Patient’s personal history;
   c. Laboratory values;
   d. General physical exam;
   e. Current medications;
   f. Allergies; and,
   g. A plan for patient care.

   For Operative/Invasive/Obstetrical procedures, the H&P must also contain:
   a. Documentation of risks, benefits and alternatives discussed with patient;
   b. Past surgical history;
   c. Past anesthesia/sedation history;
   d. Anesthesiologists exam with ASA score (If applicable); and a plan for sedation or anesthesia.

1.4.1 The entire H & P must be performed and documented and in the record within 24 hours after an admission.

1.4.2 When using a H&P or pre-natal record performed prior to admission, it must have been completed within the past 30 days and contain all of the required elements listed in 1.3 above. In addition, any H & P done prior to admission must contain an update to the patient’s condition since the assessment(s) was recorded within 24 hours (must be made within 24 hours) after an admission or prior to any invasive and/or operative procedure. (6/06) This update must be attached to the history & physical / pre-natal record, usually by documenting the update directly onto the written H & P or pre-natal record. (2/05) This addendum should be dated, timed and signed by the physician.

1.4.3 H&Ps are required in non-inpatient settings for significant trauma (ED) or as outlined in Section 6.

1.5 Except in an emergency, no patient shall be admitted to the hospital unless and until a provisional diagnosis has been stated. In emergency cases, a provisional diagnosis shall be stated as soon as reasonably possible.

1.6 At the time of pre-admission or admission, the attending physician must advise the admitting office of any known or suspected contagious disease(s) which the patient may have, or of any problem with the patient which might be a source of danger to other patients and/or the hospital and medical staffs, including the danger of self-harm.

1.7 Should the admitting physician transfer care of the patient to another physician not in association with the admitting physician, then the admitting physician must write an order to that effect in the patient's chart. The physician to whom the patient's care is transferred shall become the physician of record, and will be responsible for the completion of the patient's medical record.
2. **MEDICAL RECORD STANDARDS**

2.1 The admitting physician shall be responsible for the preparation of a complete and legible medical record for his/her patient. All entries in the medical record, including all orders, are dated, timed and signed.

2.2 The medical record shall include:

a. The patient’s name, sex, address, date of birth, and authorized representative, if any;

b. Legal status of patients receiving behavioral health care services;

c. Any emergency care, treatment, and services provided to the patient before arrival, if any;

d. Any medications ordered or prescribed;

e. Any medications administered, including the strength, dose, and route;

f. Any access site for medication, administration devices used, and rate of administration;

g. Any adverse drug reactions;

h. Documentation and findings of assessments and reassessments;

i. Conclusions or impressions drawn from medical history and physical examination;

j. The diagnosis, diagnostic impression or conditions

k. The reason(s) for admission or care, treatment, and services;

l. Treatment goals, plan of care, and revisions to the plan of care;

m. Evidence of known advanced directives

n. Evidence of informed consent when required by hospital policy;

o. Diagnostic and therapeutic orders, procedures, tests, and results;

p. Progress notes made, dated, timed and signed by authorized individuals;

q. All reassessments and plan of care revisions, when indicated;

r. Any observations relevant to care, treatment, and services;

s. The response to care, treatment, and services provided;

t. Consultation reports;

u. Allergies to foods and medicines;

v. All physician orders, and any order, prescription or administration of a medication must be dated, timed and signed;

w. Any medication dispensed or prescribed upon discharge;

x. Any relevant diagnoses/conditions established during the course of care, treatment and services;

y. Health care associated infections;

z. Complications;

aa. Nursing notes;

bb. Vital signs;

c. Discharge plan and evaluation results;

dd. Records of communication with the patient regarding care treatment, and services, for example, telephone calls or e-mail, if applicable;

e. Patient-generated information if applicable (for example, information entered into the record over the WEB or in pre-visit computer systems);

ff. A concise **DISCHARGE SUMMARY** providing information to other caregivers and facilitating the continuity of care including the following information, either written as a final progress note or dictated:

1) the reason for hospitalization;

2) significant findings;

3) procedures performed and care, treatment, and services provided;

4) the patient’s condition and disposition at discharge;

5) medications prescribed; and,

6) instructions to the patient and family as appropriate including follow-up appointments, activity, diet.

7) final diagnosis

 gg. Certificate of death completed in a timely manner as described in Section 9.

2.3 No medical record will be considered complete until all requirements have been accomplished except on the order of the Utilization Review/Medical Records Committee after a thorough review of the circumstances. Death of a physician, physician no longer on the medical staff and/or relocated to another geographic locality are examples of
acceptable circumstances for the closing of an incomplete record. Any such action by the Utilization Review/Medical Records Committee must be recorded in their minutes and an appropriate excerpt from those minutes made a part of the incomplete medical record.

2.4 Members of the medical staff shall have access to patient medical records consistent with preserving the confidentiality of patient information.

2.5 The Utilization Review/Medical Records Committee shall approve any abbreviation to be used in medical records.

2.6 Authentication of patient record documentation can include written or electronic signature only. Rubber stamp signatures are only allowed on non-patient record documentation.

2.7 Written consent of the patient is required for release of medical information to persons not otherwise authorized by law to access this information.

2.8 Original medical records may be removed from the hospital only in accordance with Federal or State Laws, a court order, appropriate subpoena. All medical records are the property of Baptist Medical Center South.

2.9 Unauthorized removal of medical records from the hospital is grounds for suspension from the medical staff.

2.10 Delinquent Medical Records

2.10.1 A medical record is delinquent when it is not completed within thirty (30) calendar days following discharge.

2.10.2 A failure to complete any medical record within thirty (30) calendar days post discharge will result in the physician being given a notification of a pending temporary interruption of all hospital privileges. If the physician fails to complete the delinquent record(s) within the subsequent seven (7) additional calendar days then he/she will have their hospital privileges temporarily interrupted immediately and without further notice (other than the letter of confirmation of the temporary interruption).

2.10.3 A physician’s temporarily interrupted privileges shall be reinstated immediately upon completion of delinquent records.

2.10.4 Administration may grant individual physicians two extensions, on the time to complete medical records, per medical staff year.

2.10.5 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.

2.10.6 Physicians may not have their privileges reinstated at the end of the 28-day suspension unless all delinquent medical records have been completed. If the physician has completed his/her medical records and desires reinstatement before the end of the 28-day suspension, he/she must appear before the Medical Executive Committee to make that request.

2.10.7 Any physician suspended for twenty-eight (28) days due to medical record delinquency will have the prior six (6) delinquencies deleted from any calculations for the balance of the medical staff year.

2.10.8 Should a physician on the Provisional medical staff incur a twenty-eight (28) day suspension, he/she will remain on the Provisional medical staff for an additional year.

2.10.9 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 transfer from any other physician, and/or perform procedures (except in an emergency) during the period of said suspension.

3. DOCUMENTATION
Each patient must be seen by a physician or their authorized designee and progress notes entered in the medical record at least each twenty-four 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.

4. CONSULTATION REQUIREMENTS
Note: the ‘requested physician’ can be the actual physician requested or his/her covering physician
4.1 Consultation Requests:

4.1.1 If requested by another member of the BMCS medical staff, a physician member shall be required, as a privilege of medical staff membership, to consult on patients, and if the requested physician is unable to provide the consult, then the consultant or group representative, if unable to see the patient in consultation, will assist the attending physician in obtaining a reasonable alternative.

4.1.2 The consultant must see the patient in a timely fashion. The attending/requesting physician shall indicate to the nursing staff/unit secretary the urgency of the requested consult. This information shall be relayed to the consulting physician by the personnel transcribing the physician’s order. However, for stat or urgent consults, the requesting physician (ED physician or attending/covering physician) should personally notify the consultant.

i. Routine consults are communicated by the unit secretary/nurse/other to the office and/or physician. These patients should be seen within 24 hours.

ii. Urgent consults are communicated physician to physician and must be seen within 4 – 6 hours after the requesting physician speaks with the consulting physician.

iii. STAT consults are communicated physician to physician and must be seen as soon as reasonably possible. If, after talking with the referring physician, the consulted physician determines his/her availability will not meet the patient’s needs, then the consulted physician will assist the referring physician by suggesting an appropriate alternative consult source.

4.1.3 A satisfactory consultation shall include an examination of the patient and the medical record.

4.1.4 A written/typed consultation report, signed and dated by the consultant, must be included in the medical record.

4.1.5 When operative procedures are involved, the consultation report must be recorded prior to the operation, except in emergency cases.

4.1.6 The attending physician is responsible for requesting consultations where indicated.

4.1.7 It is the responsibility of the Clinical Department Chairman and the Medical Executive Committee to ensure that members of the medical staff order appropriate/necessary consultations.

4.1.8 A consultant must be credentialed in the field in which his/her opinion is sought.

4.1.9 A non-physician consultant must be approved by the Medical Executive Committee before seeing/treating patients.

4.1.10 Except in emergency situations, a consultation with another qualified physician is required in cases where the attending physician in his medical judgment finds that:

i. The diagnosis is obscure after ordinary diagnostic procedures have been completed

ii. There is doubt as to the choice of therapeutic measures to be used;

iii. For high risk patients undergoing major operative procedures;

iv. In situations where specific skills of other physicians may be needed;

v. There is a question as to whether the patient is “brain dead.”

vi. When otherwise required by the medical staff or hospital policies.

4.1.11 A patient has the right to request a consultation from a specialist and/or a second opinion, at his/her own expense.

4.2 ICU Consultation Policy

When a patient’s condition requires therapy, treatment or diagnostic services beyond the scope of practice and/or credentials of a physician practicing under the Medical Staff Rules & Regulations of Baptist Medical Center South, a subspecialty consult is required.

5. AUTOPSIES

5.1 Members of the medical staff are expected to pursue autopsies in at least the following cases:

5.1.1 unanticipated death; death following unexpected medical complications;

5.1.2 death occurring while the patient is being treated under an experimental drug or device, new procedure or unusual therapy;
5.1.3 intraoperative or intraprocedural death;
5.1.4 death occurring within 48 hours after surgery or an invasive diagnostic procedure;
5.1.5 death incident to pregnancy or within seven (7) days following delivery;
5.1.6 death of a neonatal or pediatric patient;
5.1.7 when there is concern regarding the possible spread of a contagious disease;
5.1.8 when there are concerns about an hereditary disease;
5.1.9 when the Alabama Organ Center requires it.
5.1.10 when a diagnosis has not been established (death occurred prior to being able to establish a diagnosis)

5.2 No autopsy shall be performed absent a signed request for autopsy by appropriate next of kin.

5.3 Provisional autopsy reports shall be recorded in the medical record upon receipt, and the complete autopsy report shall be made a part of the medical record when complete.

5.4 All autopsies will be sent to UAB department of pathology to be performed.

6. **SURGERY**

6.1 **Informed Decision Making**

6.1.1 A patient/surrogate has the right, before any decision regarding medical care, to obtain, from the physician responsible for coordinating his/her care, information regarding:

a. The nature of the proposed care, treatment, services, medications, interventions, or procedures
b. Potential benefits, risks, or side effects, including potential problems related to recuperation
c. The likelihood of achieving care, treatment, and services goals
d. Reasonable alternatives to the proposed care, treatment, and service
e. The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
f. When indicated, any limitations on the confidentiality of information learned from or about the patient.

6.1.2 The physician is to document in the medical record H & P or progress notes the above information and with whom it was discussed.

6.1.3 Once given this information, the patient has the right to participate in decisions involving his/her healthcare, including the right to refuse care, treatment, and services in accordance with law and regulation. (Treatment Refusal Form must be completed by the patient/surrogate decision maker when care, treatment, and/or services are refused.)

**NOTE:** Additional information regarding patient competency to make informed decisions is located in the Patient Care Manual, General Patient Care Section, Letter "I" located in each nursing unit and on the Baptist Health Intranet.

6.1.4 A signed informed consent, fully describing the invasive procedure to be performed, and any other probable procedures which may be performed, must be obtained prior to commencing the procedure, except in emergency situations where the medical situation is sufficiently life threatening to prohibit obtaining a proxy consent, or where the patient is incapable of giving consent, but the circumstances are so serious that there is not time for an adequate discussion between the physician and the patient. Emergency situations must be fully detailed in the patient's medical record.

6.1.5 Situations requiring an Informed Consent (discussion and documentation by the physician of risks, alternatives, benefits and complications)

a. Performance of operative procedures.
b. Invasive procedures including cardiac catheterizations, arteriograms, other invasive intra-arterial and/or other intravenous procedures.
c. Endoscopic procedures; insertion of chest tubes; insertion of tubes into body cavities for the purpose of instilling medications or drainage of fluids (excluding Foley catheters and NG tubes); physician procedures (example: bone marrow biopsy); insertion of catheters into central venous or arterial pathways to include PICC catheter placements by R.N.s, etc.
d. Administration of anesthesia of any level/type.

e. Transfusion of blood/blood products.

6.1.6 In accordance with Alabama law, a minor who has attained age fourteen (14) may consent to medical treatment without the necessity of parental consent.

6.1.7 Consent forms for invasive procedures may be kept in the physician's office and signed there by the patient. The original form must be made a part of the medical record. A consent form executed within a reasonable time of the date of the procedure will be acceptable, as long as there is not a material change in the patient's condition or additional procedures contemplated.

6.1.8 In cases where the attending physician is being proctored by another physician on a particular procedure, the informed consent signed by the patient (or other appropriate party) shall list the proctoring physician as "assisting" in the procedure. (5/06)

6.2 Operative and Invasive Procedures

6.2.1 Any inpatient or outpatient invasive procedure requiring anesthesia or conscious sedation must have the following in the medical record prior to the performance of the procedure—except in emergency cases:

6.2.1.1 History and physical examination;

6.2.1.2 The results of any indicated diagnostic tests;

6.2.1.3 Provisional diagnosis.

6.2.2 The Surgery Clinical Department shall identify those procedures where, because of an unusual hazard to life, another qualified surgeon shall be present as first assistant.

6.2.3 Immediately after operative & invasive procedures, an operative/invasive report must be entered into the medical record.

6.2.4 Operative/invasive reports, whether dictated or written immediately after a procedure, record the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss (if applicable), specimens removed or altered (if applicable), and postoperative diagnosis.

6.2.4.1 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 before the patient is transferred to the next level of care and includes: name(s) of primary surgeon(s) and his or her assistant(s), procedure performed, description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. (JC RC.02.01.03 EP7)

6.2.5 The completed (dictated) operative report is authenticated by the surgeon and made available in the medical record as soon as possible after the procedure.

6.2.6 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.

6.2.7 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.

6.3 Physician Responsibility for Instrument Use

6.3.1 It is the responsibility of the using physician to ensure that he/she does not use any instrument in a manner which is inconsistent with any conceivable use of such instrument, resulting in the destruction of said instrument or the repair of the same.

6.3.2 Any physician responsible for the destruction or non-availability of any instrument due to inconsistent usage or intentional destruction, shall be personally responsible for all costs involved in the replacement/repair of said instrument.

6.4 Pathology Specimens and Reports

6.4.1 Unless the surgeon orders that the specimen be handled in a different manner, all tissue removed or recovered in the course of an invasive procedure must be properly identified, preserved, and sent to the hospital pathologists for examination and pathological diagnosis.
6.4.2 Placentas, except cases involving multiple births or obvious abnormalities, shall be submitted at the discretion of the physician.

6.4.3 The pathologist’s written report shall be presumed conclusive as to all matters covered by same.

6.5 Therapeutic Termination of Pregnancy Committee

Any physician requesting to perform a therapeutic abortion must apply to the Therapeutic Termination of Pregnancy Committee for permission to perform same, pursuant to the most current policies of that comm.

7. EMERGENCY DEPARTMENT STANDARDS

7.1 Patient Presentation and Care in the Emergency Department

7.1.1 Patients presenting to the Emergency Department shall be treated/stabilized by the Emergency Department physician(s) who shall be responsible for referring the patient to the appropriate physician on call, based on the patient’s needs/condition, who shall admit the patient.

7.1.2 Patients presenting to the Emergency Department without a regular physician and who require admission for a problem that requires an internal medicine physician, may be referred to the Montgomery Internal Medicine Residency Program for admission and case management.

7.2 Call Schedule Policy

7.2.1 EMTALA regulations require that if a specialty service is provided at Baptist Medical Center South, that there be a call schedule, or other suitable arrangements, to provide the services of that specialty in the Emergency Department.

7.2.2 The Chief of Staff may appoint a person or persons who shall be responsible for the creation of a call schedule for each specialty providing services at the hospital, based upon inputs from the clinical departments, clinical department chairman and individual physicians. That schedule, as issued, is final.

7.2.3 If a call schedule, as submitted, does not have coverage for each day in the coverage period, then the Chief of Staff, acting independently or in concert with the affected clinical department chairman, shall assign eligible physicians to fill any open dates.

7.2.4 Should the physician on call refuse to come in to see the patient, then the Clinical Department Chair should be contacted regarding intervention and/or the assignment of a physician to accept the patient. If the Clinical Department Chair is unavailable, then the Chief of Staff should be contacted.

7.3 Emergency Department Call Participation Requirements for Active, Courtesy, and Provisional Medical Staff

Reference Medical Staff Bylaws 3.3.1 (G), 8.3.1(b) and 8.3.1(c)(2) (10/03) Rewritten April 2005

7.3.1 All Active/Courtesy/Provisional medical staff members are required to provide on-call coverage in their specialty for the emergency department pursuant to EMTALA regulations. This obligation shall include:

a. ED patients presenting for treatment who do not have a private physician.

b. Responsibility for the admission, consultation and/or follow-up care for the particular problem for which the patient presented at the Emergency Department and for which a request to come in to see/treat the patient was initiated.

c. In the event, the on-call physician is unable to see/treat the patient then, he/she is responsible for assisting in locating another physician by suggesting appropriate alternatives of their same specialty to see/treat the patient.

d. If on-call for his/her specialty, to be available to respond by telephone within 15 minutes of the initial receipt of a request for assistance/consult by an emergency department physician.

e. If on-call for his/her specialty, to be physically located such that he/she can respond in person within 30 minutes after a request for assistance is made by the emergency department physician to examine/treat an Emergency Department patient.
f. To otherwise respond in person in accordance with a timeframe agreed upon by the emergency department physician and the consulted physician provided continuous quality care is maintained.

g. If a physician cannot respond within 30 minutes, or within the time agreed upon with the emergency room physician, the consulted physician is expected to cooperate with the ED physician to identify an appropriate alternative physician or facility to take the patient.

h. An on-call specialist may schedule elective surgery or have simultaneous on-call duties at other hospital(s) within a twenty (20) mile radius of Baptist Medical Center South as long as the physician can respond to a call from either hospital within the required timeframe.

i. A refusal by the on-call specialist to come in to see the patient or a failure to see the patient within the time frame set by these Rules & Regulations, when so requested by the ED physician, shall be deemed to be detrimental to patient safety and the delivery of quality patient care; contrary to the Medical Staff Bylaws and Rules & Regulations; and below applicable professional standards, and as such will result in a Corrective Action procedure under Article VI of the Medical Staff Bylaws.

j. The attached flow sheet reflects the specific steps to be taken in securing an on-call specialist:
Patient receives a medical screening examination and is deemed to be an "Emergent" patient (i.e., "Acute symptoms of sufficient severity including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part") Patient is stabilized to the extent possible and the appropriate on-call specialist is called (responsibility of ED MD and/or the primary RN)

Specialist coming in to see patient w/in 30 minutes or time frame agreed upon by ED physician and specialist. Agreed upon timeframe is documented in Medical Record.

Specialist cannot come in

1. Specialist assists in locating/identifying another similarly privileged specialist or ED MD or primary RN will contact one or more of the following in no particular order:
   1. Partners of specialist
   2. Other specialist in same specialty
   3. Chief of specialty
   4. ED Director

   If no physician has responded after 15 minutes, then call:
   5. Administrator on call
   6. Nursing Supervisor

   All efforts to contact the physician should be documented in the Medical Record.

If unable to reach or locate an appropriate specialist within forty-five (45) minutes, ED MD or the primary RN will contact other Baptist Health facilities regarding their capacity to take the "emergent patient" or other non Baptist Health facilities regarding their capacity to take the patient. All efforts to contact the on call physician should be documented in the Medical Record.

If patient agrees, then stabilize and transfer the emergent patient to an alternative facility by appropriate mode with appropriate support personnel.

Immediate report to the Administrator and/or designee

Administrator (or his/her designee) to notify Quality Management to begin case investigation to prepare for medical staff leadership review

Administrator (or his/her designee) to notify medical staff leadership (Chief of Staff; Division Chief) to investigate case and develop a corrective action plan based on section 7.3 of BMCS Rules and Regulations with report to MEC.

Contact Information:
Quality Manager
334-286-2366
7.3.2 **Dispute Resolution** (To be handled subsequent to the matter in question)

a. An on-call physician who has responded to a call from the emergency department physician and who has come in to examine/treat the patient, but who believes that the request was inappropriate, may submit a complaint setting out said position to the Hospital Administrator.

b. The Chief of Staff and/or Chief of Staff-Elect, Hospital Administrator, Department Chair of the complaining physician’s department, the Chair of the Emergency Department, and the Medical Director of the Emergency Department shall review the written complaint and if the Committee determines it appropriate and necessary may take oral testimony from the parties.

c. A determination of the appropriateness of the consult will be made and communicated to the physician issuing the complaint.

d. The decision may include physician education and/or system changes if deemed appropriate.

e. Patterns and trends in behavior related to on-call coverage may result in corrective action via the Rules and Regulations (Physician Misconduct) up to corrective action via the Bylaws (Article VI).

7.4 **Emergency Department Call Rotation Participation at Baptist Medical Center South (BMCS)**

7.4.1 The following specialties must produce a schedule for the purpose of on-call coverage for the BMCS emergency department in accordance with EMTALA/CMS Regulations as follows: Cardiology; EENT; Gastroenterology; General Surgery; Vascular Surgery; Neurosurgery/Spines; OB/GYN; Ophthalmology; Orthopedics; Pediatric Neurology; Pediatrics; Thoracic; Urology.

7.4.2 The individual specialties/sections may vote to allow physicians over a particular age to discontinue participation in BMCS ED coverage. A vote to allow same shall be made by those specialty/section members who are willing to participate in the BMCS Emergency Department Call Rotation.

7.4.3 In the event of conflicting interpretations of EMTALA provisions, consensus will be reached between hospital, medical staff, and individual physician representatives/ counsel, and/or any official CMS opinion (if available). During this period of negotiation, ED coverage will be maintained at the same level, as was present when the request was first made or in the event an entire section cannot produce an agreeable call schedule, all section staff members will be on call until the issue is resolved.

7.5 **Responsibility of Hospital to Report Noncompliance.**

In accordance with EMTALA/CMS Regulations, the hospital shall be required to report any on-call physician’s failure to respond to a request to come in to see an Emergency Department patient within 72 hours of such request/failure to respond.

8. **CARE OF PSYCHIATRIC / SUBSTANCE ABUSE PATIENTS**

8.1 Patients known or suspected to be suicidal should have a psychiatric consultation and unless contraindicated by medical or surgical reasons, should be admitted/transferred to Meadhaven or another appropriate facility.

9. **PATIENT CARE AND TREATMENT**

9.1 **General Use/Investigational Drugs**

9.1.1 Drugs used in the hospital must meet the standards of the United States Pharmacopoeia, National Formulary, or New and Non-Official Drugs. Any proposed exception must be approved by the Pharmacy & Therapeutics Committee and the Medical Executive Committee.

9.1.2 Investigational drugs must be reviewed and approved by the Pharmacy & Therapeutics Committee and the Institutional Review Committee before their use in the hospital.

9.2 **Physician Orders / Verbal Orders**

9.2.1 All orders for treatment must, per CMS Regulations, be in writing and legible, dated, timed and signed by the physician. Personnel who received verbal/telephone orders from physicians must write down and read back the
order to the physician to ensure the accuracy of the order. The hospital 'Medication Use' policy defines who can administer medications.

9.2.2 A physician's verbal order dictated to a Registered Nurse (RN), or a Licensed Practical Nurse (LPN) when an RN is not available, including members of the Special Limited Staff who are RNs and who are credentialed to receive verbal orders, or to a N.P. or P.A. or to another physician shall be considered as being "in writing" if transcribed and signed by the person taking the order, listing the physician giving the order, and the time and date received. A physician's verbal order concerning diet may be given to a dietician, a physician's verbal order concerning discharge planning and social issues may be given to a social worker/case manager, a physician's verbal order for approved* PRN medications or respiratory therapies* (*reference Sleep Disorder Policy) during sleep studies may be given to a sleep lab technician or polysomnographic technologist, a physician's verbal order concerning rehabilitation therapy may be given to a physical therapist, a physician's verbal order for respiratory therapy may be given to a respiratory therapist, and a physicians verbal order for a radiographic procedure may be given to a radiology technician. All verbal orders must be recorded in the patient's chart.

9.2.3 All verbal orders must be signed by the ordering or attending physician within 48 hours of being given, with the exception of orders for restraints, or Allow Natural Death (AND) designations, which must be signed by the ordering or attending physician within twenty-four (24) hours of being given. Verbal orders may be faxed to the physician's office for signature, or an email directive will also be accepted.

9.2.4 Medication orders may only be given by a physician or a member of the Allied Health Staff who is credentialed to order specific medications under the direct supervision of a physician. Any medication order made by a member of the Allied Health Staff must specify the physician supervisor as well as the person placing the order and must be cosigned by the supervising physician within twenty-four (24) hours.

9.2.5 Individual/group physicians may formulate "standing/protocol or routine orders" for their patients. There must be documentation of approval by the physician of any original standing/protocol or routine order. Such orders shall be reviewed every two years at the time of the physician's reappointment and filed with Clinical Informatics.

9.2.6 The Medical Executive Committee may formulate and approve "standing orders" for emergency/life threatening situations for the purpose of expediting care for a patient when a physician is not readily available and time is of the essence in saving the life of the patient.

9.2.7 Orders are re-written upon entry to or transfer from an ICU. Orders stayed while in surgery are re-instated post-op unless modified.

9.2.8 All orders for outpatient procedures/services will expire one (1) year from the date of the original order. Such an order may be renewed/reissued, but in any event, must have originally and if renewed/reissued, have been in writing, dated, and signed by the physician.

9.3 Patient Deaths / Requests for Organ & Tissue Donation

9.3.1 In the event of a patient death, the deceased shall be pronounced by the attending physician or his/her designee, within a reasonable time, and an appropriate entry made in the medical record.

9.3.2 At the time of death, or prior to death in those cases where death is imminent, in compliance with state and federal statutes, an assessment of the patient as a possible organ/tissue donor will be performed using the Alabama Organ Center (AOC) Routine Referral Donor form.

9.3.3 The AOC Routine Referral form shall include:
   a. A determination of suitability of any specific organs or tissues for donation;
   b. A statement as to the patient's proxy/surrogate's desire to donate organs/tissue; and,
   c. The physician will be notified if the patient is a suitable candidate of organs/tissue.
9.4 Administration of Anesthesia and Conscious Sedation

9.4.1 Anesthesia

9.4.1.1 Anesthesia may be administered by MD Anesthesiologists and CRNAs in the following areas:
(a) Operating Rooms including SDSC
(b) Labor, Delivery, Recovery
(c) Other locations where invasive procedures are performed

9.4.2 Conscious Sedation

9.4.2.1 Conscious Sedation may be administered by MDs and Registered Nurses trained in the administration of Conscious Sedation in the following areas:
(a) Bronchoscopy Lab
(b) Endoscopy Lab
(c) Emergency Department
(d) Critical Care Units
(e) Echocardiography Lab
(f) Cardiac Cath Lab
(g) Radiology/MRI Unit
(h) Operating Rooms
(i) PACU
(j) Same Day Surgery Center
(k) Outpatient Department

9.5 Restraint and Seclusion Policy (7/07)

9.5.1 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.

9.5.2 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.

9.5.3 Seclusion is the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. Seclusion is utilized in the Behavioral Health setting (Meadhaven) as a last resort when the patient’s behavior causes a serious disruption to the therapeutic environment.

9.5.4 Exclusions: use of adaptive support in response to an assessed physical need (postural support, orthopedic appliances), positioning devices for medical, surgical diagnostic purposes, use of handcuffs and other restrictive devices (forensic restrictions), helmets, time-out, physically redirecting or holding a child without permission for 30 minutes or less and side rails to protect patients from falling.

9.5.5 Alternatives to restraint and/or seclusion must be attempted to prevent use of restraint/seclusion whenever possible. The least restrictive restraint will be utilized. Refer to Restraint Policy for a list of alternatives.

9.5.6 The patient’s rights, dignity and well being will be protected and respected during the use of restraint/seclusion.

9.5.7 Orders for restraint/seclusion must contain the following elements: Date and Time; Reason for Restraint/Seclusion; Type of Restraint/Seclusion to be used; Duration (time limit) for Restraint/Seclusion; Signature of the RN when a Verbal Order is Received; Signature of the Physician, date and time signed. Restraint orders may NEVER be written as a PRN order or as a standing order.
9.5.8 Orders must be given by a licensed independent practitioner (LIP). An LIP is any practitioner permitted by both law and the hospital as having the authority under his/her license to independently order restraints, seclusion or medications for patients. A doctor of medicine or osteopathy may delegate the task of ordering restraints to Physician Assistants and Advanced Practice Nurses to the extent recognized under the State law. 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.

9.5.9 **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 initiation and a verbal order received. The verbal order must be signed within 24 hours. The physician must have examined the patient within 24 hours.

9.5.10 **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.

9.5.11 In the psychiatric setting, the treatment team, including the physician, is to conduct a debriefing after each episode with the patient and his/her family if possible. The physician must document the debriefing on the form provided.

9.5.12 Data will be collected, aggregated and reported to the Medical Staff at least quarterly.

9.6 **Inpatient Response Requirements (Private Patients)**

All Active/Courtesy/Provisional medical staff members, who have patients in the hospital, shall be required to:

9.6.1 Be available to arrive at the hospital within a reasonable time regarding a change of condition of his/her patient, or have arranged for a physician with the same privileges to be available to respond to calls regarding the patient.

9.6.2 A call for assistance relative to an inpatient should be responded to by telephone within 15 minutes of receiving the request for assistance, notwithstanding the hour of the day or night. If the physician is involved with the immediate care of another patient, he/she should, to the extent possible, have that message transmitted to the calling party to allow notice of the delay and the possible need to consult with another physician.

10. **MEDICAL STAFF STANDARDS**

10.1 **Interpersonal Relationships**

10.1.1 Physicians on the Baptist Medical Center South staff, because of the nature of the practice of medicine in a hospital environment will on a daily basis, find themselves working side by side with and directing the work of non-physician personnel as well as physicians in training. It is expected that physicians will conduct themselves in a manner consistent with their professional training and position. This includes ongoing awareness of the physician role as leader in the healthcare team, and potential role model for any individual in training. It is also expected that physicians will show appropriate respect for colleagues and hospital staff, maintain appropriate restraint in stressful situations, and adopt a leadership role in avoiding conflict and in conflict resolution.

10.1.2 Personal conflicts should be resolved privately. Constructive criticism is educational, but potentially embarrassing in public. Conflicts regarding patient care should not be discussed in the presence of patients and family members. This creates mistrust in the system and the individuals involved.

10.1.3 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 would address their concerns in a professional and private manner. Physicians may contact the department manager and/or quality management department for assistance in resolving patient care or other issues. In no circumstances is disruptive behavior appropriate.
10.1.4 See Section 10.2 regarding the process for handling physician misconduct and/or unprofessional, disruptive behavior.

10.2 Medical Staff Physician Misconduct Policy

10.2.1 This section provides a mechanism for the Chief of Staff, or his/her designee, in collaboration with the Department Chair and/or Hospital Administrator, to address situations involving physician misconduct that do not rise to the level requiring Corrective Action as outlined in the Bylaws. This section does not pertain to specific incidents involving quality of care. Any specific incident or case involving quality of care should be referred to quality management to be addressed as per Section 12 of these Rules and Regulations.

10.2.2 Physician misconduct, as defined here, is offensive behavior that is disruptive to teamwork, efficiency, collegiality, and smooth functioning of the healthcare team. This behavior, although not necessarily related to a specific incident of patient care, nevertheless, can decrease overall quality of care by adversely affecting teamwork, retention or hiring of the best staff, and maintenance of good morale. Criticism that is offered in good faith in an appropriate manner and in an appropriate setting with the aim of improving patient care should not be construed as disruptive behavior and is welcomed.

10.2.3 Alabama law protects all peer review records and these records non-discoverable.

10.2.4 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, and/or hospital personnel;
   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.

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

10.2.6 Review Activity:
   a) Obtain Physician Misconduct Review Form [PMRF] (Appendix A) and attach complaint.
   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. This document will remain in the physician’s file for a minimum of 5 years. Prior complaints during this period should be investigated for patterns and trends.
   e) If the complaint was validated, follow the steps outlined in Section 12.8.
   f) 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.

10.2.7 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.

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: 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: 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 manager serves as recorder at the request of the Committee. The initial meeting of the 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 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. 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.

d) The proceedings of this committee are documented on the PMRF.

10.2.8 The Physician Misconduct Review Form and all documentation shall be retained (permanently) in the physician’s quality peer review file. The file is kept in a distinct and separate location from the physician’s credential file. 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.

10.3 Meetings of the Medical Staff

10.3.1 The annual meeting of the medical staff will be held on the third Monday in October of each year, unless rescheduled by the Medical Executive Committee.

10.3.2 The Chief of Staff and/or the Medical Executive Committee may call such other general meetings of the medical staff as they deem necessary.

10.3.3 A Medical Staff member who arrives at a regular or called 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 Department Chair Tenure  (Reference Bylaws 9.3.3 10/2003)

Each clinical department chair shall serve a two (2) year term and the clinical department Vice Chair shall serve a two (2) year term as vice chair and then a two (2) year term as chair as determined by the Medical Executive Committee (11/10/03).

10.5 Hospital Based Physicians/Department Chairs

Should there be a change in the leadership of a hospital based physician group (Radiology, Anesthesiology, Pathology or Emergency Department physicians), and should the new Director of the group not already be an Active Medical Staff Member (per Section 8.3), then he/she may still assume the role and responsibilities of the Department Chairperson for the hospital based group, for the lesser of one year, or the time necessary to otherwise achieve Active status as set forth in Section 8.3 of the Bylaws, notwithstanding the requirements of Section 9.3.1 of the Bylaws, relative to Department Chair qualifications.
10.6 Medical Staff Officer Tenure (Reference Bylaws 10.4)
Terms of office for Chief of Staff, Chief of Staff-Elect and Immediate-Past Chief of Staff are two (2) years, beginning on January 1st of the year following the election. This will be effective January 1, 2012. The term of office for Secretary/Treasurer is one (1) year, beginning on January 1st of the year following the election.

10.7 Physician Coverage
All active, courtesy and provisional medical staff members shall meet the following requirements:
10.7.1 Have inpatient and Emergency Department coverage arrangements for his/her practice with another physician of like specialty who also has similar privileges at BMCS.
10.7.2 If there is a case of a specialty, where there are ever less than three (3) physicians on the medical staff with specific privileges/abilities, then the Emergency Department will have to be notified if there is not appropriate coverage available for the specialty for specific days.
10.7.3 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.
10.7.4 A failure to ensure such coverage shall constitute grounds for referral to the Medical Executive Committee. The committee shall then take such corrective action as is deemed appropriate in light of the facts presented, including but not limited to, suspension of medical staff membership and/or limitation or loss of clinical privileges.

10.8 Locum Tenens Physicians
10.8.1 Written requests for temporary privileges outlining the patient care need for locum tenens physicians along with completed medical staff application and clinical privileges must be received by the Credentials Verification Office no later than fifteen (15) working days of the date when the locum tenens physician will begin coverage. (6/06)
10.8.2 Each request must be accompanied by a completed medical staff application and delineation of privileges, and written confirmation of malpractice insurance coverage.

10.9 Temporary Medical Staff Privileges
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 application/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.

10.10 Unplanned Leave of Absence
10.10.1 Should a physician or oral surgeon member of the medical staff temporarily close down his/her practice (not to include vacation, or approved leave of absence per Section 4.10 et seq. of the Medical Staff Bylaws) for medical or personal reasons, then that physician/oral surgeon shall be deemed to have effected a voluntary surrender of his/her privileges, unless the absence is excused by either the Chief of Staff or the Medical Executive Committee.
10.10.2 The physician/oral surgeon may at any subsequent time apply for a formal leave of absence pursuant to Section 4.10 of the Medical Staff Bylaws.
10.10.3 Prior to the anticipated return date the physician/oral surgeon shall request reinstatement to the Medical Staff. The Medical Executive Committee may hold such hearings, interviews, or reviews as it shall deem necessary and may request such information as it deems necessary to determine the physician/oral surgeon’s fitness and ability to reassume his/her privileges at BMCS. The Medical Executive Committee shall then make a recommendation concerning the reinstatement of the physician/oral surgeon’s privileges in accordance with Sections 4.1 through 4.8 (excluding Section 4.3) of the Medical Staff Bylaws.
10.10.4 Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A physician/oral surgeon whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a physician/oral surgeon so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

10.11 Changes in Clinical Privileges
10.11.1 A physician on the medical staff may submit a written request for additional clinical privileges at any time.
10.11.2 No additional clinical privileges will be granted unless the requesting physician meets already established criteria, or exhibits sufficient competence and/or training in the opinion of the Credentials Committee.
10.11.3 The NPDB will be queried when new clinical privileges are requested.

10.12 Changes in Liability Insurance
Members of the Medical Staff are required to notify the Credentials Verification Office for any changes in professional liability insurance at the time of initial appointment, at reappointment, and/or any time in-between such timeframes.

10.13 Active Duty Military Physicians
10.13.1 Active duty military physicians requesting medical staff appointment and privileges at Baptist Medical Center South to treat active duty military personnel, active duty military dependents and retired military personnel must meet the requirements of medical staff membership and appointment/reappointment as outlined in Article III and Article IV of the Medical Staff Bylaws, but, in accordance with Federal Statutes, shall not be required to have an active Alabama license or Controlled Substance Certificate, a Federal DEA, or maintain in force professional liability insurance due to their coverage under the Federal Tort Claims Act (FTCA). This medical staff appointment and privileges to practice at Baptist Medical Center South shall be contingent upon their continued assignment at Maxwell Air Force a continued association between Maxwell and BMCS regarding the care of military personnel.
10.13.2 Active duty military physicians shall not be eligible to vote or hold office and shall not be required to take emergency room call except for military patients. These physicians shall not be required, but are encouraged, to attend medical staff department meetings and may volunteer to serve on medical staff committees.

10.14 Encounter Criteria – Active Status – Hospital Based Specialties
Physicians in hospital-based specialties are excluded from the encounter criteria as noted in the Medical Staff Bylaws Section 8.3.1.c.1, but must have worked at least twenty (20) days annually averaged over the preceding two (2) years at BMCS. Hospital-based specialties are defined as follows: anesthesiologists, emergency medicine physicians, pathologists, and radiologists. [Reference MEC Minutes 7/12/04- these criteria for active status for hospital-based specialties shall remain in effect].

10.15 Special Limited Staff
Special Limited Staff include the following: RN, LPN, Perfusionist, OrthoTech, Scrub Tech, licensed Social Workers, and Audiologists.
10.15.1 Special Limited Staff members must clearly identify themselves to other hospital personnel and to patients as being an assistant to a member of the medical staff.
10.15.2 Special Limited Staff members must wear a name tag which identifies their name, degree, if any, and their sponsoring medical staff member.
10.15.3 Special Limited Staff members are allowed to work only when their sponsoring medical staff member or another member of his/her group is present or on duty and within a reasonable proximity to the Special Limited Staff member.
10.15.4 Special Limited Staff members may not take call (or telephone calls) from the hospital, or make rounds for the medical staff member, when the latter is off duty, out of town, or unavailable.
10.15.5 Special Limited Staff members may not give verbal / phone orders to nurses,
and written orders may only be given as specifically directed by the sponsoring medical staff member.

10.15.6 The sponsoring medical staff member must countersign all notes and observations made by the Special Limited Staff member in the patient's medical record.

10.15.7 The sponsoring medical staff member is responsible for the proper performance of all procedures/tasks assigned by him/her to the Special Limited Staff member.

10.15.8 The sponsoring medical staff member is responsible for the proper conduct of the Special Limited Staff member within the hospital, and for their observance of the hospital's policies, rules and regulations.

10.15.9 Surgical Assistants must abide by the dress code and other regulations governing operating room personnel.

10.15.10 A registered nurse, who is a member of the Special Limited Staff, may be trained and credentialed to dictate discharge summaries for the physician who employs him or her. The physician shall be required to sign the report and takes responsibility for its contents, completeness, and accuracy.

10.15.11 Special Limited Staff members have a right to a fair hearing before a committee appointed by the Medical Executive Committee and an appeal before the Medical Executive Committee in the event of any adverse decision by the committee. The appeal decision by the Medical Executive Committee is final.

10.16 Allied Health Professionals

10.16.1 Allied Health Professionals include the following: Licensed Physician Assistants, Certified Registered Nurse Practitioners, Certified Registered Nurse Anesthetists, Physician Extenders, Psychologists, Clinical Counselors, and Speech Therapists. Allied Health Professional staff are not members of the Medical Staff and are not subject to the fair hearing and appellate procedures as outlined in Article VII, of the Medical Staff Bylaws. Allied Health Professionals have a right to a fair hearing before a committee appointed by the Medical Executive Committee and an appeal before the Medical Executive Committee in the event of any adverse decision by the committee. The appeal decision by the Medical Executive Committee is final.

10.16.2 Allied Health Professionals must clearly identify themselves to other hospital personnel and to patients as being an assistant to a member of the medical staff.

10.16.3 Allied Health Professionals members must wear a name tag which identifies their name, degree, if any, and their sponsoring medical staff member.

10.16.4 Allied Health Professionals may not take on-call responsibilities (or on-call telephone calls) from the hospital, or make rounds for the medical staff member when the latter is off duty, out of town, or unavailable.

10.16.5 Written orders may be given by licensed Physician Assistants and Nurse Practitioners as permitted by licensure. Other Allied Health Practitioners may enter written orders if permitted by licensure and their clinical privileges but their orders must be countersigned by their sponsoring medical staff member within 24 hours.

10.16.6 The sponsoring medical staff member is responsible for the proper performance of all procedures/tasks assigned by him/her to the Allied Health Professional member.

10.16.7 The sponsoring medical staff member is responsible for the proper conduct of the member within the hospital, and for their observance of the hospital's policies, rules and regulations.

10.16.8 A licensed psychologist or speech therapist may perform patient evaluations upon the order of a physician on staff at the hospital.

10.16.9 The Hospital Administrator may permit an Allied Health Professional member to serve in a locum tenens capacity for a specified period, to be determined based upon the specific identified need(s) of the hospital for the provision of safe, quality patient care delivery. (8/02)

10.16.9.1 The Allied Health Professional is required to submit the following: completed application form; a completed clinical privileges form; a copy of his/her Alabama license; and proof of adequate
malpractice insurance.

10.16.9.2 Before clinical privileges are granted by the Hospital Administrator, the following shall also be completed: verification of all licenses; query of the NPDB; and, verification of competency.

10.16.10 Certified Registered Nurse Practitioners and Licensed Physician Assistants may perform the history and physical and discharge summary. The physician must co-sign the H & P within 24 hours and the discharge summary within 30 days post discharge. The physician maintains responsibility for the completeness and accuracy of the content of the H & P and discharge summary. (11/04)

10.16.11 Certified Registered Nurse Practitioners and Physician Assistants may perform the Death Summary. The physician must co-sign within 30 days post discharge.

10.16.12 A Physician Extender (Emergency Department) may be credentialed to perform the following tasks/procedures:
1. collection of historical and physical data;
2. presenting data to the medical staff member so that he/she can analyze the patient's problem and determine appropriate additional diagnostic tests or therapeutic steps;
3. assisting the medical staff member by performing therapeutic procedures such as dressing changes, catheter insertion, drain removal, etc, and recording such procedures in the progress notes;
4. recording historical and physical data, progress notes and discharge summaries for inclusion in the patient's record;
5. suturing small superficial lacerations after the sponsoring medical staff member has examined the wound;
6. performing venipunctures and arterial punctures;
7. applying a cast after a fracture has been totally reduced by the sponsoring medical staff member;
8. excising or fulgurating small simple skin lesions;
9. assisting the sponsoring medical staff member in minor major surgery cases depending upon individual training and as specifically approved by the Credentials and Medical Executive Committees.

10.16.13 A Physician Extender cannot be approved to perform the following tasks and/or procedures:
   a) lumbar punctures
   b) thoracentesis
   c) paracentesis
   d) joint aspirations or injections
   e) reduction of fractures
   f) removal of foreign bodies from the cornea or ear
   g) to perform any procedure other than those specifically set forth hereinabove or specifically allowed by the Medical Executive Committee

10.17 Appointment of Special Limited Staff (SLS) and Allied Health Professionals (AHP)
   (See section 16 of the Bylaws)

10.18 Appointment of Special Limited Staff and Allied Health Professionals
   Members of the Special Limited Staff and Allied Health Professionals shall be reappointed every two (2) years.

10.18.1 Special Limited Staff and AHP personnel shall be required to notify the Credentials Verification Office of any change in employment status. This must be reported within thirty (30) days of the effective date of the change. Any change that would involve employment by another member of the medical staff must be accompanied by a newly executed statement of responsibility from the new sponsoring physician, new clinical privilege delineation form, and proof of malpractice coverage for that practice.

10.18.2 Failure to report a change of or additional employment will result in the immediate termination of privileges.

10.18.3 Certified Registered Nurse Anesthetists (CRNAs), Certified Registered Nurse Practitioners (CRNPs) and Licensed Physician Assistants (Pas) will serve a provisional period of one year not to exceed two years. At that time, following a performance review and approval of the sponsoring physician, reappointment
will be at two-year intervals.

10.18.4 Licensed and certified advanced practice nurses may be privileged to perform those tasks/procedures within the specialty scope of practice and with physician oversight as defined by the state statutes, in accordance with the collaborative practice agreement approved by the Alabama Board of Nursing and the Alabama Board of Medical Examiners. (5/06)

10.18.5 Licensed physician assistants may be privileged to perform those tasks/procedures within the specialty scope of practice and with physician oversight as defined by the state statutes, in accordance with the Job Description approved by the Alabama Board of Medical Examiners.

11. MEDICAL STAFF FILES
11.1 Medical staff files shall be maintained by the Medical Staff Coordinator. Medical staff quality files shall be maintained by the Quality Coordinators separate from the medical staff files.

11.2 A member of the medical staff may review his/her individual medical staff file at any time during normal business hours in the medical staff office.

11.3 Should detrimental or critical information be added to a physician's file, that physician must be notified and provided a copy of same within 72 hours of the time that information is placed in the file. The physician may submit a written response which shall be attached to the information and made a part of the file.

12. MEDICAL STAFF PEER REVIEW PROCESS
This process provides a mechanism for defining the process for professional practice review that includes establishment of generic screens, external review, and focused review (when required). The goal of this process is to improve all aspects of health care delivery. Quality Assurance material is protected pursuant to Section 22-21-8 of the Code of Alabama, 1975.

- For Additional Review Options see 12.2
- For Behavioral Issues see Physician Misconduct Section 10.2 of the Rules and Regulations
- Urgent / Emergent Review Process:
  If an event or issue is identified that has the potential to immediately impact patient safety, the QA/QI Committee Chairman, Chief of Staff, Department Chair, Hospital Administrator and legal counsel (upon the request of the administrator) are to be notified immediately. This group will consult the Bylaws if it is determined that an immediate temporary suspension of privileges is warranted. If warranted, the procedures within the Bylaws under Corrective Action will be followed. Otherwise, the peer review process shall be followed as outlined above.

12.1 Routine Review Process: begins at the time of initial appointment (provisional appointment) and is ongoing for the length of time the physician is a member in good standing of the organized medical staff.

12.1.1 Case Identification
a. Cases that fail specific generic, Morbidity & Mortality, (M & M) or department-specific quality indicators as approved by the Medical Staff. [See 12.8, 12.9, and 12.10]
b. Other sources of referrals received verbally or in writing.

12.1.2 Quality Coordinator (QC) Review Responsibilities
a. Conducts an initial review of the case and records findings on the Physician Peer Review Form (PRF).
b. If there are potential quality concerns not related to the physician, these are summarized and forwarded to the appropriate hospital department manager.
c. If there are potential quality concerns related to a physician, these are summarized on the PRF and forwarded to the appropriate Department Vice-Chair.
d. The QC will research the literature and clinical guidelines at the direction of the Department Chair or Vice-chair, which will be provided to same.
e. QC will coordinate referral for departmental education, referral to the Morbidity and Mortality Committee, QA/QI Committee, Emergent, External, or Focused Review in collaboration with the Department Chair / Vice-chair.
f. Ensures all actions and recommendations are documented on the PRF.
g. In collaboration with the Vice-chair, notifies the physician in writing regarding the outcome of the review.
h. Files PRF in Quality Folder and maintains the most current two (2) years' data for review by the Department Chair for initial appointment or reappointment.

12.1.3 Department Chair - Peer Review Responsibilities
a. As outlined under section 10.2 of the Rules for Physician Misconduct.
b. Conduct the peer review process in the absence of a Vice-Chair as per Section 12.1.3.
c. In the absence of the Vice-chair, carries out the recommendations upon completion of the peer review process such as physician or departmental education.
d. Participate in any disciplinary process resulting from the peer review process as per the Bylaws

12.1.4 Department Vice Chair (or Designee) - Peer Review Responsibilities
a. Review case summary on PRF and applicable portions of the medical record as submitted by the QC.
b. The VC may do any of the following to complete a review:
   1. Request additional information from the QC; request literature reviews, clinical guidelines, policies, etc…
   2. Refer the case to a peer in the department with similar privileges as the physician being reviewed.
   3. Contact the physician whose case is being reviewed to gain additional information or clarification.
   4. Determine the peer review recommendations (listed in Section 12.6 below).
   5. Present the case at the M & M Committee (see Section 12.3).
   6. Request opinion from other appropriate committees such as Ethics Committee (maintaining confidentiality).
c. Carries out the recommendations upon completion of the peer review process such as physician or departmental education.

12.2 Request for Additional Review Options
12.2.1 External Review: External review may be considered in the following circumstances:
   a. There is not a peer available. (Peer is a member of the same specialty with comparable hospital privileges).
   b. When the only available peers are in direct economic competition with the physician being reviewed, are within the same practice or affiliated, or any situation where the available peer reviewers may be considered unacceptable to perform the review. An exception may be waived if the physician/physician group in question agrees to a specific internal reviewer.
   c. When the standard of care is thought to have been significantly breached and the Department and QA/QI Chair, Vice-Chair or designee, or legal counsel determines that a second opinion is needed.
      1. Legal counsel may assist with the selection of a specific external peer reviewer.
      2. The results of all external review results will be forwarded to the quality management department to ensure protection under the peer review process.

12.2.2 Physician Focused Review: When there are indications of a potential pattern or negative trend in a physician’s practice (patterns), additional research extending beyond the current case being reviewed may be conducted in the form of a focused review. The focused review of an individual physician shall be handled as follows:
   1) May only be instituted by the Department Chair, the Chair of a medical staff committee or Chief of Staff.
   2) The institution of the focused review must be authorized in writing, signed by the appropriate medical staff member, and forwarded to the chair of the QA/QI committee.
   3) Where an individual physician is the sole subject of a focused review, the
chair of the QA/QI committee shall notify the physician of the focused review as well as the purpose of same.

4) The focus of the review is documented in writing and is specific regarding what elements / practice pattern is to be reviewed; the number of cases to be reviewed; the time frame from which the cases will be obtained; and the date the review is to be completed.

5) The QA/QI Chairman can determine how the review is to be conducted
   - External review.
   - Internal review by a physician of the same specialty as that of the physician being reviewed.
   - Appoint a quality review committee made up of the Chairman of QA/QI, the Department Chair, Department Vice-Chair, and at least two other representatives from QA/QI.

6) The QC will organize the data and distribute it to the reviewer(s).

7) The results of the review are presented to the QA/QI committee for further action or recommendations. The QA/QI Chairman shall notify the physician under review in writing and/or personal meeting of the outcome.

8) The appropriate department chairman and any involved committee chairman shall likewise be notified of the outcome.

9) Documentation of the completed process will be placed in the physician’s quality file.

12.3 Morbidity and Mortality Committee: composition & responsibilities

a. The committee is established as a sub-committee under the QA/QI Committee.

b. The vice-chairs of Medicine and Surgery will serve as the co-chairs of this committee.

c. The term of co-chair appointment coincides with the term of the Department Chairs.

d. The vice-chairs of the medical staff departments serve on this committee. Others, such as chairs of ED, Radiology, Anesthesia, and Pathology are asked to attend on a PRN basis as applicable to the case(s) being presented.

e. When other specialists are needed, the reviewer should seek input from that specialist prior to the meeting or invite the specialist to the M & M Committee meeting.

f. Cases are referred to the M & M Committee as specified in Section 12.1.1 when additional expert opinion(s) are needed for determining appropriate physician peer review recommendations (refer to Section 12.6). Decisions regarding the peer review recommendations are recorded on the Physician Peer Review Form.

g. The committee will keep a permanent record (minutes) of its proceedings which are kept on file in the QC office. Peer review is protected under Code of Alabama 22-21-8, 1975.

h. The vice-chairs of M & M, or their designees, are expected to present a summary of cases reviewed at each QA/QI Committee meeting.

i. If the M & M Committee finds serious case mismanagement, the case will be presented to the QA/QI Committee for additional input and guidance of appropriate Physician Peer Review Recommendations.

12.4 Trauma PI/Peer Review Committee: Composition & Responsibilities

a. The committee is established as a sub-committee under the QA/QI Committee.

b. The Trauma Program Medical Director will act as chair for the committee.

c. Representatives from Anesthesiology, Neurosurgery, General/Trauma Surgery, Emergency Medicine, Orthopedics, and Radiology serve on this committee.

d. When other specialists are needed, the reviewer should seek input from that specialist prior to the meeting or invite the specialist to the Trauma PI/Peer Review Committee meeting.

e. Cases reviewed by the Trauma PI/Peer Review Committee include any trauma death within 24 hours of arrival and any case that is felt may have opportunities for improvement.

f. The committee will keep a permanent record (minutes) of its proceedings which are kept on file in the QC office. Peer review is protected under Code of Alabama 22-21-8, 1975.

g. The Trauma Program Medical Director or designee, is expected to present a summary of cases reviewed at each QA/QI Committee meeting.
h. If the Trauma PI/Peer Review Committee finds serious case mismanagement, the case will be presented to the QA/QI Committee for additional input and guidance of appropriate Physician Peer Review Recommendations.

i. The Trauma PI/Peer Review Committee will meet at least quarterly with meetings more frequently as deemed necessary.

12.5 Neonatal Morbidity & Mortality Committee: Composition & Responsibilities

a. The committee is established as a sub-committee under the QA/QI Committee.

b. A Neonatologist will be named to act as chair for the committee.

c. The Neonatologists, Neonatal CRNP’s, Unit Manager, QI Coordinator, and other persons designated by the Neonatologist are asked to attend.

d. In as much as the Neonatologists are the same between Baptist Medical Center and Baptist Medical Center East, this committee will be combined for learning and education purposes with cases from both facilities discussed.

e. When other specialists are needed, the reviewer should seek input from that specialist prior to the meeting or invite the specialist to the Neonatal M&M Committee meeting.

f. Cases reviewed will include deaths, fractures and significant trauma, Necrotizing Enterocolitis with pneumatosis, perforation or surgical intervention (Not “R/O Necrotizing Enterocolitis” cases), other cases as recommended by physician, NICU educator, or QI coordinator.

g. The committee will keep a permanent record (minutes) of its proceedings which are kept on file in the QC office. Peer review is protected under Code of Alabama 22-21-8, 1975.

h. If the Neonatal M&M Committee finds serious case mismanagement, the case will be presented to the QA/QI Committee by the Neonatal M&M Chairperson for additional input and guidance of appropriate Physician Peer Review Recommendations.

i. The Neonatal Morbidity and Mortality Committee will meet at least quarterly with meetings more frequently as deemed necessary.

12.6 QA/QI Committee Review: Composition & Responsibilities

a. The committee is established to oversee the hospital’s quality improvement programs that shall include all aspects of clinical care rendered by physicians as well as services provided by the hospital.

b. The committee is made up of the vice chairs of the campus clinical departments and others as defined by the chief of staff.

c. Cases are referred to the QA/QI Committee from the M & M Committee, Trauma PI/Peer Review Committee, Blood Utilization Review Committee, Neonatal M&M Committee, Focused Review, or Urgent/Emergent Review.

d. The chairman of the QA/QI Committee is to be notified if a case is referred from M & M, Trauma PI/Peer Review, or Neonatal M&M.

e. The Vice-Chair or designated reviewer that presented the case at M & M is responsible for presenting the case to the QA/QI Committee.

f. The chairperson from the referring committee, or appropriate designee, is responsible for presenting the report and any case to the QA/QI Committee.

g. After presentation and discussion at QA/QI, the Committee may:
   - determine the particular Peer Review Recommendation(s); (see Section 12.8)
   - determine the need for External (12.2.1) or Focused (12.2.2) review.
   - Refer the case to the Medical Executive Committee (12.7)

h. The recommendations resulting from the QA/QI Committee and/or quality review committee will be documented on the Peer Review Form along with any subsequent actions.

i. The findings, records, and recommendations of this committee are considered peer review and are protected from discovery.

12.7 Referral to the Medical Executive Committee

The Chair of the QA/QI Committee may refer a case to the Medical Executive Committee as follows:
   - after the peer review process has completed the cycle through the QA/QI committee, OR
   - if the physician in question were considered to need disciplinary action under the Bylaws.

12.8 Physician Peer Review Recommendations
Upon completion of the review process, a recommended action plan must be assigned and documented on the review form. The physician is notified of the outcome of the review regardless of the action taken.

a. **No Action Necessary**
   - Management of the patient was satisfactory.

b. **Provide Individual Physician Education**
   - Education may be provided verbally or in writing. If education is provided verbally, the date and content of the education is documented on the review form. If education is provided in writing, a copy of the letter is attached to the review form and is placed in the physician’s quality file. There may be times when a physician is required to attend an approved course for CME related to the opportunity for improvement. In this case, a time frame will be assigned in which the education is to be completed and will direct the physician to submit evidence of attendance to the QC. The QC will attach this to the physician’s review form in the quality file. This level of physician education will be reported in the QA/QI Committee.

c. **Departmental Education**
   - The potential quality assurance issues were identified as being variations that were process oriented, caused by multiple factors, and are not attributable to individual physician practice. The VC and/or reviewing committee determines what form of departmental education is appropriate. This may involve blinded case presentation by the VC or involved physician; a formally organized presentation by an outside source; or other alternative method. The date and content of the education is documented on the review form with any separate piece of documentation attached. These documents are then placed in the file of the involved physician quality file for tracking purposes.

12.9 **Physician Quality File**

12.8.1 The results of any case referred for physician peer review are made a permanent part of the physician’s quality file. At the time of initial appointment (following the provisional timeframe) or reappointment, the Department Chair receives a credential and quality file for each physician/AHP in the credentialing cycle, which contains the most current quality data, not to exceed a two-year time frame. Information contained within the file as a result of ongoing professional practice review is considered by the Department Chair when he/she makes a recommendation to the Credential Committee for continuing, limiting or revoking any existing privilege. Quality information prior to the two-year time frame is available upon the request of the Department Chair. The review of the Quality File is a part of the Credentialing process as outlined in the Medical Staff Bylaws.

12.8.2 The Quality File is considered confidential. The only persons who may have access to the file are the individual physician; Chief of Staff, Administrator, Department Chair, Department Vice-Chair, QA/QI Committee Chairman, Behavioral Review Committee. Quality Files are maintained in the Quality Management Department.

12.10 **Invasive Procedure Review Criteria**

A. Procedure not meeting IPR criteria.
B. Unsigned permit.
C. Discrepancy between op permit and procedure performed.
D. Inadequate removal of diseased tissue.
E. Unexpected tissue identified on pathological exam.
F. Discrepancy between pre-op/post-op and path diagnosis.

12.11 **Blood Usage Review Criteria**

A. Transfusion not meeting BUR criteria.
B. Transfusion meeting criteria for automatic review.

12.12 **Generic Occurrence Screening Criteria**

A. Readmission within 5 days for the same/similar diagnosis.
B. Complication from surgical/diagnostic/invasive procedure or anesthesia.
C. Unplanned admit during POD 1 following outpatient procedure.
D. Unplanned admit to ICU during POD 1 after surg/inv/dx procedure.
E. Unplanned return to OR/repeat procedure during POD 1 after surg/inv/dx procedure.
F. Unexpected laceration/perforation of organ.
G. Foreign body retained post procedure.
H. Cancellation of procedure after anesthesia administration.
I. Increase in procedure time due to equipment malfunction.
J. Patients leaving AMA with complaints against hospital/physician.
K. Unexpected death; death within 24 hours of operative / invasive procedure.
L. Discrepancy between autopsy finding and diagnosis at death.
M. Code Blue outside ICU involving complications.
N. Miscellaneous.
O. Malintubation greater than 3 attempts/reintubation.
P. Reintubation following procedures with anesthesia.
Q. Anesthesia “ends” more than 30 minutes after surgery completed.
R. Dental injury during procedures with anesthesia.
   a. Ocular injury during procedures with anesthesia.
   b. Significant birth trauma.
S. Suicide attempt after admission.
T. Autopsy.
U. Consults resulting in delay in treatment/services.

12.13 Professional Practice Evaluation

12.13.1 General Information
A. The organized medical staff leadership will develop criteria and triggers to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.
B. The process to facilitate the evaluation of each practitioner’s professional practice should be clearly defined.
C. Physicians and Allied Health Professionals (AHPs) will be evaluated with a focused and ongoing evaluation.
D. Evaluation will be used to determine whether to continue, limit, or revoke any existing privilege(s).
E. Focused and Ongoing Evaluations will be used for Credentialing and Re-Credentialing processes.
F. Issues identified through Ongoing / Focused Professional Practice Evaluation can result in an investigation and corrective action as defined in the Medical Staff Bylaws.

12.13.2 Focused Professional Practice Evaluation (FPPE)
A. Except as otherwise determined by the organized medical staff leadership, all Physicians and Allied Health Professionals who are granted new privileges or request additional privileges will be subject to a period of Focused Professional Practice Evaluation.
B. The Evaluation methods may include:
   i. Direct observation (clinical and surgical proctoring)
   ii. Review of Medical Records (concurrent and retrospective)
   iii. Monitoring clinical practice patterns
   iv. External Peer Review
   v. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel

12.13.3 Ongoing Professional Practice Evaluation (OPPE)
A. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a Practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.
B. Physician focused and ongoing evaluation will consist of six general areas to include:
   i. Patient Care
   ii. Medical / Clinical Knowledge
   iii. Practice-based Learning
   iv. Interpersonal Communication
   v. Professionalism
   vi. System-Based Practice
C. Issues identified through Ongoing Professional Practice Evaluation will be directed to the Department Chair (or Chief of Staff where appropriate) for further action.

13. PROCTORING POLICIES AND PROCEDURES

13.1 Except as otherwise determined by the Credentials Committee and the Medical Executive Committee, all initial appointees to the medical staff and all members granted additional clinical privileges may be subject to a period of proctoring.

13.2 Approved proctoring methods may include direct observation (both clinical and surgical), review of medical records (both concurrent and retrospective) and an evaluation of the physician's interpersonal skills with peers, nursing and ancillary personnel as well as hospital administration.

13.3 The particular type and term of proctorship will vary. The minimum number of cases/procedures determined by the Department Chairman or as set forth in established requirements to be reviewed, shall not be altered except in cases of extenuating circumstances as approved by the Credentials Committee with the concurrence of the Medical Executive Committee. The proctoring physician/surgeon/oral surgeon may extend the proctoring period when in his/her judgment additional observation is warranted.

13.4 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 time as the physician has been released by the Credentials Committee. All "emergency situations" will be reviewed by the Department Chairman and the Credentials Committee to ensure appropriateness.

13.5 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.

13.6 Selection/Qualifications of Proctors

13.6.1 Each clinical department will be responsible for identifying/assigning physicians to act as proctors.

13.6.2 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.

13.6.3 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 physicians shall be:
   a) A copy of their AL license;
   b) A copy of their federal DEA certificate;
   c) A copy of their Alabama controlled substance license;
   d) Proof of adequate medical malpractice insurance for coverage in our state;
   e) A written request from the medical staff member who is being proctored;
   f) 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.

13.6.4 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 in 25.6.3 – except for licensure in their state.

13.6.5 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 Credentials Committee to demonstrate acceptable competence in the performance of the procedure.

13.6.6 The proctor shall prepare and submit a short written critique/review of each procedure proctored. The proctor shall review this assessment with the
When the required number of cases, and any additional cases deemed necessary by the proctor, has 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 Credentials Committee for action at their next meeting. Pending final formal action by the Credentials Committee and approval 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.

14. PHYSICIAN HEALTH / WELL-BEING POLICY AND PROGRAM

14.1 Policy Statement

14.1.1 This policy is intended to provide a process whereby the possibility that a physician on the hospital's medical staff is experiencing, or suffers from, a physical, mental, chemical or emotional impairment can be investigated. The policy also provides a course of action if a physician is determined to have an impairment and facilitates confidential diagnosis, treatment and rehabilitation for physicians. An impairment is a condition that, if left untreated, could adversely affect patient care at the hospital.

14.1.2 All physicians accepting membership on the Baptist Medical Center South Medical Staff agree, if the aforementioned circumstances are identified or voluntarily revealed, to submit to appropriate professional evaluation for diagnosis and treatment of the condition or concern, to include substance abuse testing, immediately upon the request of the Administrator and/or the Chief of Staff, Clinical Department Chairman, or in their absence, any other member of the active medical staff. Any refusal to submit to appropriate professional evaluation shall result in the immediate suspension of clinical privileges and medical staff appointment pending an investigation of the allegations.

14.2 Preliminary Report and Investigation

14.2.1 If any individual working in the hospital has a reasonable suspicion that a physician appointed to the medical staff has an impairment (physical, mental, emotional or chemical), the following steps should be taken:

14.2.1.1 If the physician is deemed to present an immediate risk to patients, then this situation should be reported immediately to the Administrator and/or the Chief of Staff. If neither of these are available, then the chairman of the physician's clinical department shall be called in.

14.2.1.2 If the physician is present in the hospital and there is a reasonable suspicion that he/she is impaired but not a threat to patient safety, then an oral or, preferably, a written report shall be made to the Administrator or the Chief of Staff. The report does not have to include conclusive proof of impairment, but shall include a factual description of the incident(s) leading to the individual's belief that the physician may have an impairment.

14.2.1.3 The Administrator and the Chief of Staff, Clinical Department Chair, or in their absence, any other member of the active medical staff shall meet with the physician to determine for themselves whether the physician is exhibiting behavior or other signs of possible impairment and to determine whether the physician is taking medication for a medical condition. If deemed necessary, accompany the physician to an appropriate location where blood and urine samples will be obtained in accordance with this policy. All chemical substance testing shall be accomplished through a coded number and the physician's name shall never appear on any request for or report of results.

14.2.1.4 If the Administrator and/or Chief of Staff, after reviewing the written report, any test results, and following the initial conference with the physician, believe that there is sufficient evidence to warrant a further investigation, they may direct that a further inquiry be made and a full report prepared by:
(a) the Clinical Department Chairman; or,
(b) an ad hoc committee of the medical staff; or,
(c) an outside consultant; or,
(d) any appropriate individual(s) designated by the Administrator and/or Chief of Staff; or,
(e) any combination of the above.

14.2.1.5 If it is determined that sufficient evidence exists that the physician has an impairment, the Administrator and Chief of Staff shall meet personally with that physician or shall designate an appropriate individual to do so. The physician shall be informed that the results of an investigation indicate that the physician suffers from an impairment that affects his/her practice. Every effort will be made to provide help for the physician, both from the standpoint of coverage for his/her practice and help with the identified impairment.

14.2.1.6 In the case of an impairment, the Chief of Staff shall contact the state medical society and/or state licensing board for the purpose of including the resources available from these organizations in the hospital's investigation, and to assist the physician in dealing with the problem.

14.3 Course of Action

14.3.1 If the investigation confirms the existence of an impairment, the following options are available:
(a) impose appropriate restrictions on the physician's practice;
(b) require the physician seek appropriate medical care for the diagnosis and treatment of the condition or concern;
(c) require the physician to participate in a rehabilitation program for substance abuse as a condition of continued appointment and clinical privileges;
(d) determine the physician's privileges in the hospital to have been voluntarily relinquished until rehabilitation/treatment has been completed, if the physician does not agree to take a leave of absence.

14.3.2 In the case of substance/chemical abuse, if the matter cannot be handled internally, or jeopardizes the safety of the physician and/or others, the hospital shall seek the advice of hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other governmental agencies, and what further steps should be taken.

14.3.3 The preliminary report and a written description of the actions taken by the Administrator or Chief of Staff shall be disposed of in the following manner:
(a) If action has been taken on the basis of the report and investigation, the report and a written description of the actions taken shall be documented.
(b) If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the physician's file, and the physician's activities and practice shall be monitored until it can be established that there is, or is not, an impairment.
(c) If the investigation reveals that there is no merit to the report, the report should be destroyed and no reference to it should be made in the physician's file.

14.3.4 The Administrator or Chief of Staff shall inform the individual who filed the preliminary report that appropriate action was taken.

14.4 Rehabilitation and Reinstatement

14.4.1 Administration and medical staff leadership shall assist the physician in locating appropriate rehabilitation/treatment resources. An appropriate program is one in which these parties have confidence and which they believe will be of value to the physician.

14.4.2 Upon sufficient proof that a physician has successfully completed an appropriate
rehabilitation/treatment program, the hospital may, in its discretion, consider that physician for reinstatement to the medical staff.

14.4.3 In considering an impaired physician for reinstatement, patient care concerns shall be paramount.

14.4.4 The process of reinstatement shall proceed as follows:

(a) The physician must authorize the release of information by the treating physician/program director and the hospital shall then obtain a letter from that source regarding the following concerns:

(1) whether the physician is actively participating in his/her recovery (physical, mental, emotional, chemical);

(2) whether the physician is in compliance with the terms of the program;

(3) whether and to what extent the physician's conduct is monitored;

(4) whether, if appropriate, the physician attends Alcoholics Anonymous (AA) meetings regularly (or similar meetings depending on the impairment);

(5) whether a follow-up program, in addition to such support meetings as AA, has been recommended to the physician, and if so, a description of such program;

(6) whether, in the opinion of the physicians participating in the impaired physician's rehabilitation, the physician is rehabilitated; and

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

(b) The physician must provide BMCS with the name and address of his or her primary care physician, and must authorize that physician to release information regarding his or her condition and treatment. BMCS shall obtain information regarding the precise nature of the physician's condition and the course of treatment, as well as the primary care physician's answers to the questions posed in Paragraph 4(a)(6) and (7), above.

(c) BMCS also has the right to require an opinion from other physician/consultants of its choice.

(d) If all the information received is sufficient to indicate, to the satisfaction of BMCS, that the physician is rehabilitated and capable of resuming the care of patients, BMCS shall take the following additional measures when restoring the physician's clinical privileges:

(1) the physician shall be required to arrange for periodic reports to the hospital from his or her primary physician, for a period of time specified by the Administrator and the Chief of Staff. Such reports shall address whether the physician is continuing treatment or therapy, as appropriate, and whether his or her ability to care for patients in the hospital is in any manner impaired;

(2) if the impairment is a drug or alcohol addiction, the physician shall be deemed to have agreed to submit to an alcohol or drug screening test upon request;

(3) the physician shall be required to identify two physicians on the medical staff who are willing to assume responsibility for the care of the physician's patients in the event of his or her subsequent inability or unavailability to practice and have so indicated in writing; and

(4) the physician's exercise of clinical privileges in the hospital shall be monitored by the appropriate department chairperson or by a physician designated by the department chairperson for a period of at least two years; two additional years (for a total of four years) of monitoring are strongly recommended. The nature and extent of the monitoring shall be determined by the Credentials Committee after its review of all of the circumstances, and a records of the matter shall be retained in the physician's file.
15. **CREDENTIALING POLICY for LICENSED INDEPENDENT PRACTITIONERS in the EVENT of a DISASTER**

15.1 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. An "emergency" or "disaster" may be defined as any officially declared emergent situation, whether it is local, state, or national. Disaster privileges are granted on a case-by-case basis and only when the following two conditions are present:
   a. the emergency management plan has been activated; and,
   b. the hospital is unable to meet immediate patient needs.

15.2 Verification Process:
   a. All LIPs should be directed by hospital personnel to the Medical Staff Office for verification of credentials.
   b. A representative of the Medical Staff Office will complete the verification process as quickly as possible.
   c. Volunteers considered eligible to act as licensed independent practitioners in the hospital must at a minimum present a valid government-issued photo identification issued by a state or federal agency (driver’s license or passport) and at least one of the following:
      1. A current picture hospital ID card that clearly identifies professional designation
      2. A current license to practice
      3. Primary source verification of the license
      4. Identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
      5. Identification indicating the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
      6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a LIP during a disaster
   d. After viewing the documents, 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.
   e. The Medical Staff Office representative shall, if possible, immediately attempt to: contact the facility at which the LIP is/was 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.
   f. In the event the above calls cannot be completed, emergency privileges may still be issued pending verification of good standing provided the requirements listed in Section 15.2.c.1-6 are met.
   g. 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.

15.3 Individuals responsible for granting disaster privileges.
   a. The Chief of Staff, Administrator, COO, CEO or designee of these individuals have responsibility and authority to grant emergency privileges.
   b. It is the responsibility of these individuals or their designee to review the Emergency Privilege Form and attached verification documents (if any) supplied by the Medical Staff Office and to assign a supervising physician.
   c. Supervision of LIP: 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.

15.4 Once the process is complete, the Medical Staff Office representative will return to the
15.5 Primary source verification of licensure begins as soon as possible after the immediate situation is under control, but no longer than 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (no means of communication or lack of resources), it is expected it be done as soon as possible. In this case, there must be documentation of the following documented on the Emergency Privilege Form: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

15.6 The hospital makes a decision within (based on information obtained regarding the professional practice of LIP) 72 hours related to the continuation of the disaster privileges initially granted and, if necessary, renews the disaster privileges at least each 72 hours until the privileges are terminated.

15.7 A LIP’s privileges granted in an emergency situation may be terminated at any time without any reason or cause. LIPs granted privileges in these circumstances are not entitled to the rights, privileges or responsibilities of medical staff membership.

15.8 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...).

16. **BAPTIST MEDICAL CENTER RESIDENCY PROGRAMS (10/04)**

16.1 Baptist Medical Center South serves as the primary teaching hospital for the University Of Alabama School of Medicine Montgomery Internal Medicine Residency Program and is the sponsoring institution for the Baptist Montgomery Family Medicine Residency Program.

16.2 The Residency Program residents are graduate physicians who:
   a) have been approved for participation in the program by the Chairman / Program Director of the respective residency program;
   b) are held accountable to the physician to whom he/she has been assigned and/or the physician for whom he/she is covering;
   c) will be governed by the UAB/BMC Agreement covering graduate education activities or the BMC policy covering the Baptist Montgomery Family Medicine Residency Program, as appropriate;
   d) will be included in Quality Improvement, Utilization Review and Risk Management reviews;
   e) may write patient care orders in the medical record;
   f) may dictate history and physical examinations, discharge summaries and procedure reports; all dictated reports must be countersigned by the responsible physician;
   g) may document daily progress notes; at minimum, one progress note per day will be countersigned by the responsible physician or he will document one progress note per day.

16.3 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 Section 9 of these Rules and Regulations 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.

16.4 **Supervision of House Staff**

16.4.1 **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
South, and delineated in policies developed by those entities.

16.4.2 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 South, and delineated in policies developed by those entities.

16.5 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 South, 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.

16.6 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 South.

16.7 Participation: Participation on the part time voluntary faculty by attending physicians is entirely voluntary; non-participation shall in now way jeopardize the privileges of any medical staff member.

16.8 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.

16.9 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):

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

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

16.9.3 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 patients to On Call residents.

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

16.9.5 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.

16.10 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 participants.

16.11 The medical staff must comply with residency review committee citations and their resolution.

16.12 House Staff (program participants) are not members of Baptist Medical Center South Medical Staff as defined by these Rules & Regulations or Medical Staff Bylaws, and have no recourse to hearing and appeal procedures stated therein. 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 Section 12.10 above.

17. HOSPICE GENERAL INPATIENT PATIENT (GIP) STATUS

17.1 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.

17.2 Hospice General Inpatients are Hospice patients whose medical requirements exceed the level of care that can be provided in the home setting or 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).

17.3 Hospice GIPs require an H&P upon admission and a D/C Summary upon discharge. The Hospice GIP may be under the directed care of his/her attending physician or the Hospice Medical Director or his/her designee. The hospital staff will supplement the Hospice nurses relative to the daily care of the patient.

17.4 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 one 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.

17.5 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.
APPENDIX A
(Reference Section 10.2)

PHYSICIAN MISCONDUCT REVIEW FORM - CHECKLIST

Physician Name: ___________________________ Original Date of Complaint: ______________________

1. Date Received in Administration: __________________________

2. Potential quality concerns: [ ] No [ ] *Yes
   *(forward to Quality Management Department: date: ______________)

3. Initial review: Date: __________ By: _________________________________________________

   Notes:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

   [ ] This is not a valid complaint. Reviewed with complainant: __________
   [ ] This is a valid complaint. Reviewed with physician: __________

   [ ] First Offense: Date of Physician counseling: _____________________

   [ ] Second Offense: Date of Meeting: _____________________

   Discussion:
   ___________________________________________________________________________________
   ___________________________________________________________________________________

   [ ] Third Offense: Date of Behavioral Review Committee: _____________________

   Notes:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

RECOMMENDATIONS:
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________