

## Credentialing & Supervision of Residents Workgroup

Thursday, January 10, 2013, 9-10:00 am

Via WebEx Videoconference

**Group Purpose Statement:** To develop best practice examples of resident credentialing and supervision policies for rural GME sites.

### Meeting Agenda

Facilitator: Kara Traxler, Rural GME Development & Support Manager, RWHC					
Members: Betty Ingersoll, Grant Regional Health Center; Bonnie Laffey, RWHC; Janet Kindschi, St. Clare Hospital; Jean Volkey, RWHC; Jackie Sill, Divine Savior Healthcare; Kim Goffard, UW Fox Valley Family Medicine Residency; Lori Baumgart, RWHC; Michelle Grosch, UW Madison Family Medicine Residency; Morgan Nagel, Bellin Health; Nicole Clapp, Grant Regional Health Center; Rosa Retrum, UW Fox Valley Family Medicine Residency; Tammi Nodolf, Upland Hills Health					
Guests: none					
Time:	Agenda Item:	Type:	Notes/Follow-Up:	Person(s) Responsible:	Due Date:
9:00	Introductions/ Check-In Ground Rules Agreement on Purpose Statement	Information Sharing			
9:10	Background – General Information	Information Sharing			
9:15	Credentialing <ul style="list-style-type: none"> <li>What is required – for hospital, JCAHO, clinic?</li> <li>Creating a template</li> <li>How can Collaborative/Co-Op help?</li> </ul>	Discussion			
9:30	Supervision Based on: <ul style="list-style-type: none"> <li>Requirements of ACGME</li> <li>Requirements for billing</li> <li>Hospital or clinic setting</li> <li>Hospital being part of an approved GME program or not</li> <li>Experience level of resident</li> </ul> How do we proceed?	Discussion			
9:50	Summary – Assignments	Decision			
10:00	Adjourn				

# Credentialing & Supervision of Residents

## Background & Credentialing Draft

### Background

- Residents may or may not be licensed, must always be under the supervision of a physician, may not bill, do not have privileges.
- Residents participate most often in a 3-6 week block rotation. Occasionally they may train longitudinally (i.e. 1x/month), but this is usually after completing a block rotation.
- The resident's schedule is prepared by the rotation site and indicates where they will spend their day and who the supervising physician is for the day. The supervising physician may also be called a preceptor, staffer, attending, faculty, or teaching physician.
- The schedule may not be written so that it violates any duty hours. The resident tracks their duty hours. It is the joint responsibility of the resident to speak up if a situation arises which would violate duty hours; and the supervising physician to notice if there is fatigue or other impairment which would threaten patient safety. Duty Hours and Fatigue Management are training modules which supervising physician are required to complete on a yearly basis. The GME Support Manager is available to do training on duty hours and assist in creating the schedule.
- The educational content of the rotation is explained in the Goals & Objectives, which is a document written by the residency program and included with the Program Letter of Agreement. It should be distributed to all of the teaching physicians.
- After completion of the rotation, the main supervising physician is required to complete an evaluation of the resident. It is either sent from the residency or delivered by the resident.
- After completion of the rotation, the resident is also required to evaluate the rotation and supervising physician.

### Credentialing Draft


- Personnel Info (birthday, address, phone, etc.)
- Name of supervising physician
- List of requested services/privileges
- Letter from residency indicating resident status and standing
- Letter stating background check on file (may want your own for JCAHO)
- Liability coverage letter
- Licensing/DEA Info (if applicable)
- Medical school graduation location/year
- Life Support Documentation
- Proof of Immunizations
- HIPAA training attestation
- OSHA training attestation
- Social Security number for EHR access
- Signed Physician Agreement for Resident Supervision

- Scheduled orientation program including, but not limited to, safety, infection control, confidentiality, privacy, emergency/security procedures, and compliance programs
- Scheduled orientation to EHR

## **Supervision of Residents – info from AAMC – with examples (from AAMC website – 12-17-12)**

### **AAMC :Revisions to Medicare Carrier Manual Instructions for Teaching Physicians**

#### **Current**

On November 22, 2002, the Centers for Medicare and Medicaid Services (CMS) published changes to the Carrier Manual Instructions (CMI), Section 15016, Supervising Physicians in Teaching Settings. The revisions are located at [CR# 2290 PDF](#) . The revisions were effective on the date they were issued.

While the teaching physician regulation that was effective on July 1, 1996 remains unchanged, the revised CMI makes important positive changes in the documentation requirements by reducing the amount of personal documentation that the teaching physician must provide when a resident also writes a note. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. Further, the revisions clarify other issues, including the use of documentation by students, and updates regulatory references. The instructions should be carefully reviewed by each institution.

#### **Background**

Of special interest to AAMC members have been the federal government's payment rules when a teaching physician provides care to a Medicare beneficiary while simultaneously teaching a resident. The Health Care Financing Administration (HCFA, now CMS) first established guidelines for billing practices of teaching physicians in 1967. The requirements were again addressed in 1969 when HCFA issued Intermediary Letter 372 (IL-372), which delineated the criteria to be met by teaching physicians before submitting a bill for payment of services. Questions continued to be raised about when and to what extent the physical presence of the teaching physician was required for billing Medicare. Adding to the confusion were the inconsistent interpretation and enforcement of the rules by local Medicare carriers.

In December 1995, HCFA published new regulations, effective July 1996, that detailed when a teaching physician could appropriately bill Medicare for patient care services in which a resident also is involved. The regulations were intended to reduce substantially the ambiguities engendered by the previous HCFA guidelines. They require, with one narrow exception, that the teaching physician be present to perform or observe the "key portion" of any service or procedure for which payment is sought and provide further guidance on the documentation required in the medical record to substantiate that such services were performed. Soon after the rules were issued, CMS also published a revised CMI to provide additional information needed to implement the new rules. Despite the increased clarity under the new rules and CMI, some of the documentation requirements were considered to be overly burdensome and impeded both the delivery of patient care services and the teaching process.

CMS has been examining the regulatory burden on physicians and attempting to provide relief when feasible. Over the past year, the Agency has worked with AAMC through the Group on Faculty Practice Steering Committee to identify burdensome aspects of the supervising physician requirements that could be addressed through revisions to the Carrier Manual Instructions rather than through changes in the regulation. The revised CMI should significantly reduce the documentation burden on teaching physicians for E/M services when a resident also is involved in the care of a patient. It is important to note that with very limited exceptions, a teaching physician still must write a

personal note and, unless the service is provided under the Primary Care Exception, must be present for the "key portion" of the service.

## **Summary of Revisions**

### **Definitions**

Among the definitions that CMS has added to the Carrier Manual Instructions are:

**Resident:** "The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents."

**Documentation:** "Notes recorded in the patient's medical record by a resident and/or teaching physician or others as outlined in specific situations regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify at a minimum the service furnished, the participation of the teaching physician in providing the service and whether the teaching physician was physically present."

**Physically present:** The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

### **General Documentation Instructions and Common Scenarios**

CMS has clarified that for purposes of payment, Evaluation and Management (E/M) services billed by teaching physicians require that they personally document at least the following:

- a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- b. The participation of the teaching physician in the management of the patient.

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1 - The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.
- Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2 - The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3 - The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the a management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

#### **AAMC Teleconferences with CMS Staff on the Revisions**

On December 17, 2002 and January 9, 2003 the AAMC will be hosting two teleconferences with CMS staff to discuss the revisions with members. The teleconferences are open to individuals who work at AAMC member institutions only. Please note that AAMC will be collecting member questions about the changes prior to the call in order to provide CMS staff with the ability to address members' issues as effectively as possible. There will also be opportunities to ask questions of CMS staff during the calls.

If you have questions on the revised CMI, please contact Denise Dodero, Assistant Vice President, Division of Health Care Affairs at (202) 828-0493 or [ddodero@aamc.org](mailto:ddodero@aamc.org) or Ivy Baer, Director and Regulatory Counsel, Division of Health Care Affairs, 202-828-0490 or [ibaer@aamc.org](mailto:ibaer@aamc.org).

ACGME/CMS  
COMPARISON CHART – RESIDENT SUPERVISION

TERMS	ACGME	CMS – Teaching Physician Rules
GENERAL CONCEPTS	Progressive Responsibility	<p>Primary Theme is Billing for Services</p> <ul style="list-style-type: none"> <li>• Medicare only pays for services provided by the Teaching Physician.</li> <li>• Medicare allows use of Resident's notes to support billing of services provided by Teaching Physician.</li> </ul> <p><a href="#">IOM 100-04, Chapter 12, Section 100</a></p>
Resident	Any physician in an <b>accredited</b> graduate medical education program	<p>1) An individual who participates in an approved GME program;</p> <p>2) A physician who is not in an approved GME program but who is authorized to practice only in a hospital setting.</p> <p>3) Includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments.</p> <p>4) Status does not change even if hospital includes the physician in its FTE count of residents.</p>
Fellows	<p>Sub category of resident above – a physician in an <b>accredited</b> GME program Who has completed the requirements for eligibility for first board certification in the specialty</p> <p>Some also use the term “subspecialty residents”</p>	<p>1) Considered a Resident if in an approved GME program (see above).</p> <p>2) If not part of the GME program, then not considered a Resident and must be separately credentialed to bill.</p>
Licensure		Controlled by State Law

“Supervisor”	Supervising Physician can be a faculty member and in some cases may be a more advanced resident or fellow	Teaching Physician – A Physician (other than another resident) who involves residents in the care of his/her patients.

TERMS	ACGME (Progressive Responsibility)	CMS – Teaching Physician Rules (Billing)
Supervision		
	<b>Direct Supervision</b> – Supervising physician is physically present with the resident and patient.	<b>Physically Present</b> – Teaching Physician (TP) is located in the same room as the patient and/or performs a face-to-face service. <ul style="list-style-type: none"> <li>• E/M – non Primary Care Setting (with or without Resident)</li> <li>• Time-Based Codes (with or without Resident)</li> <li>• Entire Minor Procedures (≤5 min) with the Resident</li> <li>• Endoscopies (insertion through removal)</li> <li>• Key/Critical Portions of Surgery</li> <li>• Psychiatry (one-way mirror/video)</li> <li>• Complex/High-Risk Procedures</li> </ul>
	<b>Indirect Supervision with direct supervision immediately available</b> – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision	<ul style="list-style-type: none"> <li>• Medicare’s Primary Care Exception Clinic; TP supervises up to 4 residents, is on site and immediately available.</li> <li>• Surgery – TP can be immediately available during non-key/critical portions of surgery.</li> </ul>
	<b>Indirect Supervision with direct supervision available</b> – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.	No corresponding Teaching Physician standard for payment purposes.



	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	<ul style="list-style-type: none"> <li>Diagnostic Interpretations – TP must review interpretation. This review can occur with or without the Resident. Timing is a potential issue.</li> </ul>
<b>TERMS</b>	<b>ACGME (Progressive Responsibility)</b>	<b>CMS – Teaching Physician Rules (Billing)</b>
Immediately Available	Physically within the hospital or other site of patient care and available to provide Direct Supervision	Not Defined

# AAMC Teleconference on Medicare and ACGME Rules for Resident Supervision

Presentation by Linda M. Famiglio, MD FAAP

Chief Academic Officer, Geisinger Health System, Associate

Dean, TUSM, September 21, 2011



ACADEMIC AFFAIRS

GEISINGER

# Residency is organized through accreditation requirements

Accreditation Council for Graduate Medical Education

[acgme.org/acWebsite/dutyHours/dh\\_dutyhoursCommonPR07012007.pdf](http://acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf)

**American Osteopathic Association (AOA) is the accreditor for Osteopathic residency programs; similar requirements are published.**

Each sponsoring institution and each accredited program within the institution must demonstrate substantial compliance.

ACGME CPR effective July 1, 2011

# What is a residency?

**Residency** is an essential dimension of the transformation of the **medical student** to the **independent practitioner** along the continuum of medical education. ACGME CPR effective July 1, 2011

**Residency:** A program accredited to provide a structured educational experience designed to **conform to the Program Requirements** of a particular specialty. ACGME Glossary June 28, 2011

[http://acgme.org/acWebsite/about/ab\\_ACGMEglossary.pdf](http://acgme.org/acWebsite/about/ab_ACGMEglossary.pdf)

# What is a resident?

*Residency is an essential dimension of the transformation of the **medical student** to the independent practitioner along the continuum of medical education.* ACGME CPR effective July 1, 2011

## Medical Student

- PRE-RESIDENCY
- Has not yet graduated from an LCME or AOA accredited medical school
- Can not prescribe medications or procedures
- Participates in care delivery as part of their structured education
- Can not bill

# What is a resident?

*Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education.* ACGME CPR effective July 1, 2011

## Resident

- **Post - MEDICAL SCHOOL**
- **Has graduated from school**
- **Can prescribe medications or procedures**
- **Develops competency, in a progressive continuum towards independent practice**
- *Participates in care delivery as part of their structured education*
- *Can not bill*

# What is a resident?

- Any physician in an **accredited** graduate medical education program
- Often with a state-based restricted or training license
- The term Resident includes
  - Interns
    - Residents in their first year
    - Aka PGY-1, R-1.
    - Transitional year, Traditional Rotating Osteopathic Interns
  - Residents
  - Fellows

# Some modifiers of “Resident”

- **Categorical Resident:** Resident who enters a program with the objective of completing the entire program. This type of resident is an **accredited** resident.
- **Preliminary Resident:** Resident who is completing prerequisites for a specialty residency or who has not yet been accepted into a specialty residency. This type of resident is an **accredited** resident.
- **Chief Resident: Takes various forms-**
  - Position in the **final accredited** year of residency
  - Or in the **non accredited year after** the residency is completed (Medicine, Pediatrics), more like a non accredited fellow



# Fellow deserves further description

- **Fellow:**

- A physician in a program of GME ***accredited*** by the ACGME, AOA or the ABMS  
(American Board of Medical Specialties)
- Who has completed the requirements for eligibility for first board certification in the specialty
- Some also use the term “subspecialty residents”

# Fellow deserves further description

- Modifiers can add precision and clarity
  - Research fellow
    - IMPLIES the fellow is NOT in an accredited program but rather is assigned full time to research
  - Non-accredited or Non Standard fellow
    - The fellow is in training of some sort, but the training program is NOT an accredited one
    - This has implications for Medicare cost report as well as supervision requirements
  - ***Accredited*** fellow = **Resident** for our purposes

# More about Fellows

**Once specific state licensing requirements have been completed**, fellows may be eligible for two concurrent roles

1. Accredited Fellow:

Inside the structured, accredited educational program

2. Moonlighting as an Attending, Junior faculty or independent physician:

Outside the scope of the educational program

Generally requires unrestricted license

Third party payer credentialing often must occur

# How is supervision defined?

. . . graded and progressive responsibility is one of the core tenets of American graduate medical education.

Supervision in the setting of graduate medical education has the goals of

- assuring the provision of safe and effective care to the individual patient
- assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine

ACGME CPR effective July 1, 2011

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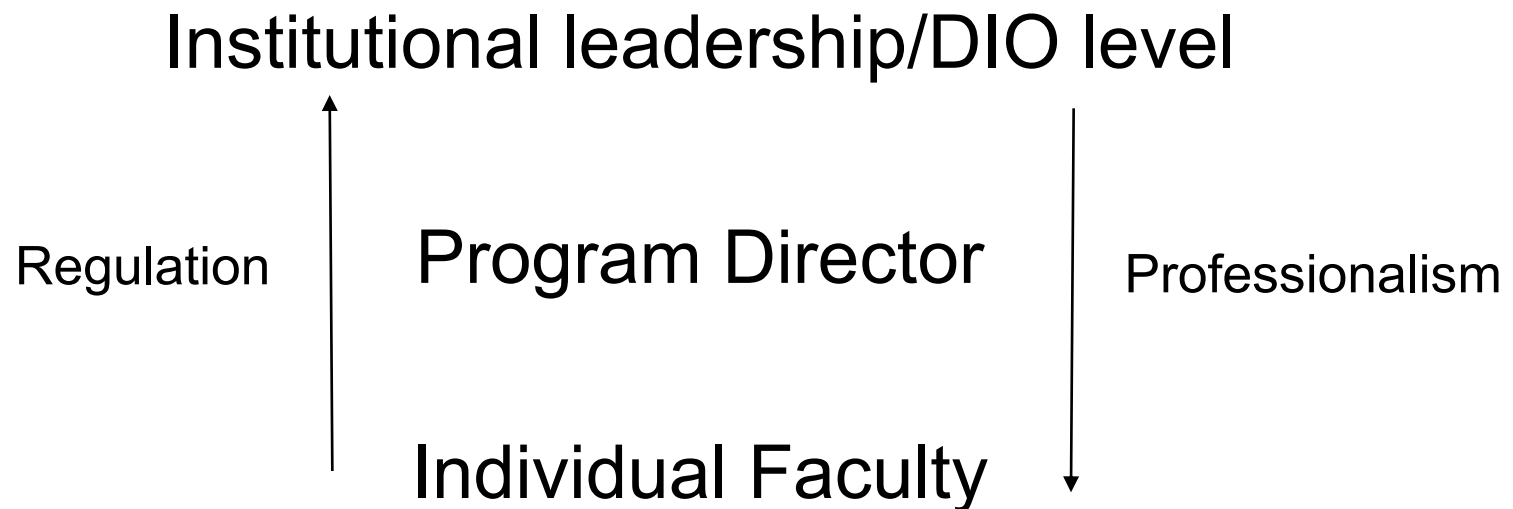
### 3 Goals of resident supervision

1. Patients must be safe and provided with quality care today
2. . . . And after the resident graduates
3. Residents must be educated in a humanistic environment where faculty model and residents demonstrate professionalism and effacement of self-interest.

Nasca, AAMC Reporter, Sept 2010

# Regulation versus Professionalism

At what level does monitoring of supervision occur?



# Supervision

May be exercised through a variety of methods.

- Some activities require physical presence of the supervisor.
  - The supervisor may be a more advanced resident
- Other activities can be adequately supervised by the immediate availability of the supervisor
  - Available in the institution, or by telephone and/or electronic modalities.
- In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

# Definitions of Supervision

## **Direct**

supervising physician is physically present with the resident and patient.

## **Indirect with direct supervision immediately available**

supervising physician *is physically within the site* of patient care, and is immediately available to provide Direct.

## **Indirect Supervision with direct supervision available**

supervising physician is *not* physically present within the site of patient care, but is immediately available by means of telephone and/or electronic modalities, and is available to provide Direct Supervision.

## **Oversight**

supervising physician is available to provide review of procedures/encounters with **feedback provided after** care is delivered.



# How does hospital-based faculty supervision of residents occur?

- Predominantly indirect supervision, with direct supervision immediately available
  - AM rounds
  - Daily huddles to “run the list”
  - Phone calls to review specific events (admit, transfer, RRT)
- Direct supervision
  - Presence during invasive procedures, “9/11 moments”, admission and discharge
  - *Senior resident to junior for H&P, Assessments, Orders*

# Some supervision specifics

- PGY-1 residents must be supervised during all patient care activities:
  - either directly or indirectly with direct supervision immediately available
- Continuity Clinic
  - Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients.
  - In Family Medicine: at least one supervising family physician freed of all other activities for every four residents
    - If only one resident, a single faculty member may be engaged in other activities to a maximum of 50%

- VI.C.1.**                    **The program must:**
- VI.C.1.a)**                    **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**
- VI.C.1.b)**                    **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**
- VI.C.1.c)**                    **adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
- VI.C.2.**                    **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**
- VI.C.3.**                    **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**
- VI.D.**                    **Supervision of Residents**
- VI.D.1.**                    **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**
- VI.D.1.a)**                    **This information should be available to residents, faculty members, and patients.**
- VI.D.1.b)**                    **Residents and faculty members should inform patients of their respective roles in each patient's care.**
- VI.D.2.**                    **The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.**
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.**
- VI.D.3.**                    **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.
- VI.D.3.b) Indirect Supervision:
  - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
  - VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
  - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
  - VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
  - VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

**VI.D.5.a).(1)**

**In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**

**VI.D.6.**

**Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**

**VI.E.**

**Clinical Responsibilities**

**The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.**

The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident.

**VI.F.**

**Teamwork**

**Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.**

**VI.G.**

**Resident Duty Hours**

**VI.G.1.**

**Maximum Hours of Work per Week**

**Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.**

**VI.G.1.a)**

**Duty Hour Exceptions**

**A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**

The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

**VI.G.1.a).(1)**

**In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**

**VI.G.1.a).(2)**

**Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

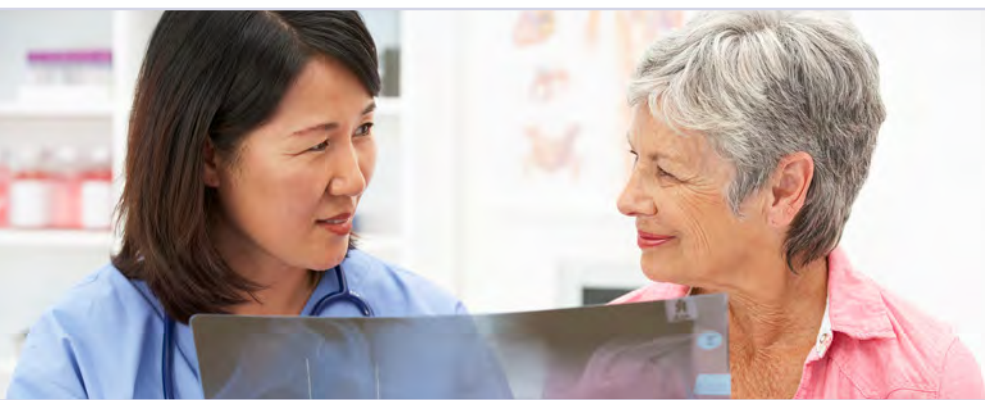
- VI.G.2. Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
- VI.G.3. Mandatory Time Free of Duty**
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- VI.G.4.b)** Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- VI.G.4.b).(1)** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- VI.G.4.b).(2)** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- VI.G.4.b).(3)** In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



FACT SHEET

# Guidelines for Teaching Physicians, Interns, and Residents







This publication provides the following information:

- Payment for physician services in teaching settings;
- General documentation guidelines;
- Evaluation and management (E/M) documentation guidelines;
- Resources; and
- Glossary.

## Payment for Physician Services in Teaching Settings

Services furnished in teaching settings are paid through the Medicare Physician Fee Schedule (PFS) if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident when a teaching physician is physically present during the critical or key portions of the service; or
- Furnished by a resident under a primary care exception within an approved Graduate Medical Education (GME) Program.

## *Services Furnished by an Intern or Resident Within the Scope of an Approved Training Program*

Medical and surgical services furnished by you, the intern or resident, within the scope of your training program are covered as provider services and paid by Medicare through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. These services may not be billed or paid under the Medicare PFS. If you are in an approved program and training in a nonprovider setting, the services furnished are payable in one of the following ways:

- 1) Through DGME and IME payments to the hospital(s), if, among other things, you:
  - Provide patient care activities and the hospital(s) incurs your salary and fringe benefits during the time spent in the nonprovider setting; or
  - For DGME purposes – Spend time in certain nonpatient care activities in certain nonprovider settings and the hospital(s) incurs your salary and fringe benefits during the time spent in the nonprovider setting; or
- 2) Through the Medicare PFS if, in part, the regulations concerning the hospital's receipt of DGME and IME payments are not met for the time you spend in a nonprovider setting, and the time you spend in the nonprovider setting is not counted by the hospital for DGME and IME payment purposes.



### ***Services Furnished by an Intern or Resident Outside the Scope of an Approved Training Program (Moonlighting)***

Medical and surgical services that you, the intern or resident, furnish that are not related to your training program and furnish outside the facility where you have the training program are covered as physician services when the requirements in the first two bullets listed below are met. Medical and surgical services that you furnish that are not related to your training program and furnish in an outpatient department or emergency room of the hospital where you are in a training program are covered as physician services when the requirements in all three of the bullets listed below are met. When these criteria are met, the services are considered furnished in your capacity as a physician, not in your capacity as an intern or resident.

- The services are identifiable physician services, the nature of which require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition;
- You are fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and
- The services furnished can be separately identified from those services that are required as part of the training program.

### ***Billing Requirements for Teaching Physicians***

You, as the teaching physician who involves residents in the care of his or her patients, must be identified as such on claims. These claims must comply with the requirements described in the General Documentation Guidelines and Evaluation and Management

Documentation Guidelines sections below. Claims must include the GC modifier, "This service has been performed in part by a resident under the direction of a teaching physician," for each service, unless the service is furnished under the primary care exception. When the GC modifier is included on a claim, you or another appropriate billing provider are certifying that you have complied with these requirements.

If you meet the requirements described in the Exception for Evaluation and Management Services Furnished in Certain Primary Care Centers section below, you must provide an attestation to the Medicare Contractor which states that these requirements have been met. Claims must include the GE modifier, "This service has been performed by a resident without the presence of a teaching physician under the primary care exception," for each service furnished under the primary care center exception.

### ***General Documentation Guidelines***

Both residents and teaching physicians may document physician services in the patient's medical record. The documentation must be dated and contain a legible signature or identity and may be:

- Dictated and transcribed;
- Typed;
- Hand-written; or
- Computer-generated.

A macro is a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user. The teaching physician may use a macro as the required personal documentation if he or she personally adds it in a secured or password protected system. In addition to the teaching physician's macro, either the resident or the teaching physician must

provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. If both the resident and the teaching physician use only macros, this is considered insufficient documentation.

### **Evaluation and Management Documentation Guidelines**

For a given encounter, the selection of the appropriate level of E/M services is determined according to the code of definitions in CPT® books and any applicable documentation guidelines. CPT® books are available from the American Medical Association.

When a teaching physician bills for E/M services, he or she must personally document at least the following:

- That he or she performed the service or was physically present during the critical or key portions of the service furnished by the resident; and
- His or her participation in the management of the patient.

On medical review, the combined entries into the medical record by the teaching physician and resident constitute the documentation for the service and together must support the medical necessity of the service. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

### ***Evaluation and Management Documentation Provided by Students***

Any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements (other than the review of systems [ROS] and/or past, family, and/or social history [PFSH], which are taken as part of an E/M service and are not separately billable). You, the student, may document services in the medical record; however, the teaching physician may only refer to your documentation of an E/M service that is related to the ROS and/or PFSH. The teaching physician may not refer to your documentation of physical examination findings or medical decision making in his or her personal note. If you document E/M services, the teaching physician must verify and redocument the history of present illness and perform and redocument the physical examination and medical decision making activities of the service.



### ***Exception for Evaluation and Management Services Furnished in Certain Primary Care Centers***

Medicare may grant a primary care exception within an approved GME Program in which you, the teaching physician, are paid for certain E/M services the resident performs when you are not present. The lower- and mid-level E/M services included under the primary care exception are shown in the chart below.

New Patient	Established Patient
CPT Code 99201	CPT Code 99211
CPT Code 99202	CPT Code 99212
CPT Code 99203	CPT Code 99213

The Healthcare Common Procedure Coding System (HCPCS) codes included under the primary care exception are shown in the chart below.

HCPCS Code G0402	Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment (effective January 1, 2005)
HCPCS Code G0438	Annual wellness visit, including personal preventive plan service, first visit (effective January 1, 2011)
HCPCS Code G0439	Annual wellness visit, including personal preventive plan service, subsequent visit (effective January 1, 2011)

For the exception to apply, a primary care center must attest in writing that all of the following conditions are met for a particular residency program:

- The services must be furnished in a primary care center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining DGME payments to a teaching hospital. This requirement is not met when the resident is assigned to a physician's office away from the primary care center or he or she makes home visits. The nonhospital entity should verify with the Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) that it meets the requirements of a written agreement between the hospital and the entity;
- Residents who furnish billable patient care without the physical presence of a teaching physician must have completed more than six months of an approved residency program;
- The teaching physician who submits claims under the exception must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability;
- The teaching physician may include residents who have completed less than six months in an approved GME Residency Program in the mix of four residents under his or her supervision; however, the teaching physician must be physically present for the critical or key portions of these services (i.e., the primary care exception does not apply in the case of residents who have completed less than six months in an approved GME Residency Program);



- The teaching physician must:
  - Have no other responsibilities, including the supervision of other personnel, at the time services are furnished by residents;
  - Have primary medical responsibility for patients cared for by residents;
  - Ensure that the care furnished is reasonable and necessary;
  - Review the care furnished by residents during or immediately after each visit. This must include a review of the patient's medical history and diagnosis, the resident's findings on physical examination, and the treatment plan (e.g., record of tests and therapies); and
  - Document the extent of his or her participation in the review and direction of the services furnished to each patient; and
- The primary care center is considered the patients' primary location for health care services. Residents must be expected to generally furnish care to the same group of established patients during their residency training.

The types of services furnished by residents under the primary care exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

The residency programs most likely to qualify for the primary care exception are:

- Family practice;
- General internal medicine;
- Geriatric medicine;
- Pediatrics; and
- Obstetrics/gynecology.

Certain GME Programs in psychiatry may qualify for the primary care exception in special situations (e.g., when the program furnishes comprehensive care for chronically mentally ill patients). The range of services residents are trained to furnish, and actually furnish, at these primary care centers include comprehensive medical as well as psychiatric care.



## Resources

### CPT® Books

<https://catalog.ama-assn.org/Catalog/home.jsp>

### Direct Graduate Medical Education and Indirect Medical Education

[http://www.cms.gov/AcuteInpatientPPS/06\\_dgme.asp](http://www.cms.gov/AcuteInpatientPPS/06_dgme.asp)

[http://www.cms.gov/AcuteInpatientPPS/07\\_ime.asp](http://www.cms.gov/AcuteInpatientPPS/07_ime.asp)

### Documentation Guidelines for Evaluation and Management Services

<http://www.cms.gov/MLNEdWebGuide/25EMDOC.asp>

### Medicare Information for Beneficiaries

<http://www.medicare.gov>

### “Physician” Section of MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers

[http://www.cms.gov/MLNEdWebGuide/Downloads/Guided\\_Pathways\\_Provider\\_Specific\\_Booklet.pdf](http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf)

### Teaching Physician Services

Chapter 12 of the “Medicare Claims Processing Manual” (Publication 100-04)

<http://www.cms.gov/Manuals/IOM/list.asp>



## Glossary

### Critical or Key Portion

The part or parts of a service that the teaching physician determines are a critical or key portion.

### Direct Medical and Surgical Services

Services to individual patients that are personally furnished by a physician or a resident under the supervision of a teaching physician.

### Indirect Medical Education Adjustment

An additional payment that a prospective payment hospital receives for a Medicare discharge when it has residents in an approved GME Program.

### Intern or Resident

An individual who participates in an approved GME Program or a physician who is not in an approved GME Program but who is authorized to practice only in a hospital setting (e.g., has a temporary or restricted license or is an unlicensed graduate of a foreign medical school). Also included in this definition are interns, residents, and fellows in GME Programs recognized as approved for purposes of DGME and IME payments made by FIs or A/B MACs. Receiving a staff or faculty appointment, participating in a fellowship, or whether a hospital includes the physician in its full-time equivalency count of residents does not by itself alter the individual's status as a resident.

### Medicare Physician Fee Schedule

The basis for which Medicare Part B pays for physician services. This FS lists the more than 7,400 covered services and their payment rates.

### Physically Present

When the teaching physician is located in the same room as the patient (or a room that is subdivided with partitioned or curtained areas to accommodate multiple patients) and/or performs a face-to-face service.

### Primary Care Center

An area located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining DGME payments to a teaching hospital.

### Primary Care Exception

An exception within an approved GME Program that applies to limited situations where the resident is the primary caregiver and the faculty physician sees the patient only in a consultative role (i.e., those residency programs with requirements that are incompatible with a physical presence requirement). In such programs, it is beneficial for the resident to see patients without supervision in order to learn medical decision making.

### Student

An individual who participates in an accredited educational program (e.g., medical school) that is not an approved GME Program and who is not considered an intern or resident. Medicare does not pay for any services furnished by these individuals.

### Teaching Hospital

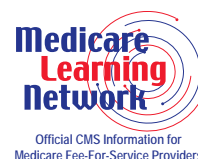
A hospital in which residents train in an approved GME Residency Program in medicine, osteopathy, dentistry, or podiatry.

### Teaching Physician

A physician, other than an intern or resident, who involves residents in the care of his or her patients. Generally, for the service to be payable under the Medicare PFS, he or she must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service.

### Teaching Setting

Any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the FI or A/B MAC under the DGME payment methodology or on a reasonable cost basis to freestanding Skilled Nursing Facilities or Home Health Agencies.



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://www.cms.gov/MLNProducts> and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to [MLN@cms.hhs.gov](mailto:MLN@cms.hhs.gov).

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# Medicare

## Carriers Manual

### Part 3 - Claims Process

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Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 1780

Date: NOVEMBER 22, 2002

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#### CHANGE REQUEST 2290

#### HEADER SECTION NUMBERS

15016 - 15018

#### PAGES TO INSERT

15-9 - 15-12.6 (10 pp.)

#### PAGES TO DELETE

15-9 - 15-12.5 (9 pp.)

**NEW/REVISED MATERIAL--*EFFECTIVE DATE: November 22, 2002***

***IMPLEMENTATION DATE: November 22, 2002***

Section 15016, Supervising Physicians in Teaching Settings, is revised to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues and update regulatory references.

**DISCLAIMER:** The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

- o Make fee schedule payments only for physicians' services to individual patients as defined in §15014.C.1;
- o The physician (or other entity) must make its books and records available to the provider and the intermediary, as necessary, to verify the nature and extent of the costs of the services furnished by the physician (or other entity); and
- o The lessee's costs associated with producing these services, including overhead, supplies, equipment, and the costs of employing nonphysician personnel are payable by the intermediary as provider services. However, in the case of certain leasing arrangements involving hospital radiology departments, see §15022.B.3.

## 15016 SUPERVISING PHYSICIANS IN TEACHING SETTINGS

### A. Definitions.--For purposes of this section, the following definitions apply:

1. Resident means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
2. A student means an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student. See Section C. 2 for a discussion concerning E/M service documentation performed by students.
3. Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.
4. Direct medical and surgical services mean services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary for the hospital.
5. Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.
6. Teaching setting means any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.
7. Critical or key portion means that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
8. Documentation means notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in specific situations (section C) regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated, and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify, at a minimum, the service furnished,



the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

9. Physically present means that the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

B. Payment for Teaching Physicians.--Pursuant to 42 CFR 415.170, pay for physician services provided in teaching settings using the physician fee schedule only if:

1. Services are personally furnished by a physician who is not a resident;
2. A teaching physician was physically present during the critical or key portions of the service that a resident performs subject to the exceptions as provided below in Section C; or
3. A teaching physician provides care under the conditions contained in Section C. 3. which follows.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.

C. General Documentation Instructions and Common Scenarios.--

1. Evaluation and Management (E/M) Services.--For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- b. The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1.--

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.

- Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

#### Scenario 2.--

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

#### Scenario 3.--

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Following are examples of minimally acceptable documentation for each of these scenarios:

#### Scenario 1.--

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(**NOTE:** In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

#### Scenario 2.--

Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3.--

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Following are examples of unacceptable documentation:

- "Agree with above.", followed by legible countersignature or identity;
- "Rounded, Reviewed, Agree.", followed by legible countersignature or identity;
- "Discussed with resident. Agree.", followed by legible countersignature or identity;
- "Seen and agree.", followed by legible countersignature or identity;
- "Patient seen and evaluated.", followed by legible countersignature or identity; and
- A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

2. E/M Service Documentation Provided By Students.--Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

3. Exception for E/M Services Furnished in Certain Primary Care Centers.--Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

<u>New Patient</u>	<u>Established Patient</u>
99201	99211
99202	99212
99203	99213

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in section B applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(4) (ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.86(i).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- o Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- o Have the primary medical responsibility for patients cared for by the residents;
- o Ensure that the care provided was reasonable and necessary;
- o Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) and
- o Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- o Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- o Coordination of care furnished by other physicians and providers; and
- o Comprehensive care not limited by organ system or diagnosis.

**Residency programs** most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

4. Procedures.--In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

a. Surgery (Including Endoscopic Operations).--The teaching surgeon is responsible for the preoperative, operative, and post-operative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon **determines** which post-operative visits are considered key **or critical** and require his or her presence. If the post-operative period extends beyond the **patient's** discharge and the teaching surgeon is not **providing the patient's** follow-up care, then instructions on billing for less than the global package in §4824.B apply. During **non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure, i.e., he or she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.**

(1) Single Surgery.--When the teaching surgeon is present for the entire **surgery**, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

(2) Two Overlapping Surgeries.--In order to bill **Medicare** for two overlapping surgeries, the teaching surgeon must be present during the **critical or** key portions of both operations. Therefore, the **critical or** key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally **document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.** In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual **patient** and is not payable under the physician fee schedule.

(3) Minor Procedures.--For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

b. Anesthesia.--Pay an unreduced fee schedule payment if a teaching anesthesiologist is involved in a **single** procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure. **The teaching physician's physical presence during only the preoperative or post-operative visits with the beneficiary is not sufficient to receive Medicare payment.** If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist, pay for the anesthesiologist's services as medical direction.

c. Endoscopy Procedures.--To bill **Medicare** for **endoscopic** procedures (**excluding endoscopic surgery that follows** the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing starts **at the time of insertion of the endoscope and ends at the time of removal of the endoscope.** Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

5. Interpretation of Diagnostic Radiology and Other Diagnostic Tests.--**Medicare** pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed **by** or reviewed **with** a **teaching** physician.

If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

6. Psychiatry.--The general teaching physician policy set forth in section B applies to psychiatric services. For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service through the use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the physical presence requirement. In the case of time-based services, such as individual medical psychotherapy, see subsection 8 below.

Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

7. Time-Based Codes.--For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- o Individual medical psychotherapy (CPT codes 90804- 90829);
- o Critical care services (CPT codes 99291-99292);
- o Hospital discharge day management (CPT codes 99238-99239);
- o E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- o Prolonged services (CPT codes 99358-99359), and
- o Care plan oversight (HCPCS codes G0181 - G0182).

8. Other Complex or High-Risk Procedures.--In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

9. Miscellaneous.--In the case of maternity services furnished to Medicare eligible women, apply the physician presence requirement for both types of delivery as you would for surgery. In order to bill Medicare for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, delivery, and postpartum) and for deliveries only.



In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

Do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

**D. Election of Costs for Services of Physicians in Teaching Hospital.**--A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments for such services. A teaching hospital may make this election to receive cost payment only when all physicians who render covered Medicare services in the hospital agree in writing not to bill charges for such services or when all the physicians are employees of the hospital and, as a condition of employment, they are precluded from billing for such services. When this election is made, Medicare payments are made exclusively by the hospital's intermediary, and fee schedule payment is precluded.

When the cost election is made for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except when the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, when each physician agrees in writing to abide by all the rules and regulations of the medical staff of the hospital (or of the fund that is qualified to receive payment for the imputed cost of donated physician's services), such an agreement suffices if required as a condition of staff privileges and the rules and regulations of the hospital, medical staff, or fund clearly preclude physician billing for the services for which costs benefits are payable. The intermediary must advise the carrier when a hospital elects cost payment for physicians' direct medical and surgical services and supply the carrier with a list of all physicians who provide services in the facility. You must ensure that billings received from these physicians or hospitals are denied.

Ask the intermediaries in your service area for listings of teaching hospitals that have elected cost payment and for listings of physicians whose services are payable to hospitals on a cost basis. Flag your system to deny claims for physicians services furnished in listed hospitals and to reject claims for the services of listed physicians when hospitals are not identified on the claim form. For rejected claims, determine the hospitals where the physicians provided the services, denying those performed in listed hospitals, and paying those performed in hospitals that have not elected to receive cost payment. (For more information about the teaching hospital cost election, see §2148 of the Provider Reimbursement Manual, Part 1.)

**E. Services of Assistants at Surgery Furnished in Teaching Hospitals.**--

1. **General.**--Do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of subsections 3, 4, or 5 are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed. Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which you can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. Process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

“I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.”

Retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, investigate situations in which it is certified that there are never any qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the waiver of liability provision.

2. Definition.--An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery.) The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

3. Exceptional Circumstances.--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

4. Physicians Who Do Not Involve Residents in Patient Care.--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a nonteaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection 5 is met.

5. Multiple Physician Specialties Involved in Surgery.--Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, deny additional claims. Determine which procedures performed in your service area require a team approach to surgery. Team surgery is paid for on a “By Report” basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require the a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.



## 15018 PAYMENT CONDITIONS FOR ANESTHESIOLOGY SERVICES.

A. General Payment Rule.--The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is listed in subsection K, Exhibit 1. The way in which time units are calculated is described in subsection G. Do not allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. For example, do not allow separate payment for the surgeon's performance of a local or surgical

# THE MONROE CLINIC

## Medical Staff Bylaws

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## DEFINITIONS

1. The term “Medical Staff” means all licensed medical and osteopathic physicians, dentists and podiatrists with privileges to attend patients in the Hospital, clinic and branch offices.
2. The term “Governing Body” means the corporate Board of Directors of The Monroe Clinic.
3. The term “Medical Executive Committee” means the Executive Committee of the Medical Staff.
4. The term “Chief Executive Officer” means the individual appointed by the Governing Body to act in its behalf in the management of the organization.
5. The term “Hospital” means The Monroe Clinic.
6. The term “Practitioner” means a licensed Medical Doctor, Doctor of Osteopathy, Doctor of Podiatric Medicine or Doctor of Dental Surgery.
7. The term “Special Notice” means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.
8. The masculine pronoun, whenever used in these Bylaws, shall refer equally to both genders.
9. The term “Allied Health Professional” shall be used to describe those persons credentialed in accordance with these Bylaws to perform their area of expertise in the Hospital in accordance with Article 4 of these Bylaws.
10. The term “Investigation” means a process specifically initiated by the CEO, Medical Executive Committee or the Medico-Administrative Committee to determine the validity, if any, of a concern or complaint raised against a Medical Staff member or individual holding clinical privileges.

## ARTICLE 1 NAME

The name of the organization shall be The Monroe Clinic Medical Staff. The Medical Staff year runs from January 1 - December 31.

## ARTICLE 2 MEMBERSHIP

- 2.1 Nature of Membership. Membership on the Medical Staff of The Monroe Clinic is a privilege, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.
- 2.2 Qualifications for Membership.
  - 2.2.1 To be qualified for Medical Staff membership, Practitioners must:
    - (1) be licensed to practice in the state of Wisconsin.
    - (2) be licensed to practice in the state of Illinois if the Practitioner will be providing services in Illinois.

- (3) document their background, training, experience, demonstrated current clinical competence, ability to perform the privileges requested, their adherence to the ethics of their profession, their good reputation and ability to work with others, with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that they will provide care to patients at a generally recognized level of quality, in an economically efficient manner, taking into account patient needs, available facilities and resources and utilization standards in effect within the organization.
- (4) at all times maintain professional liability insurance coverage or a cash or surety bond meeting the requirements of Section 655.23 of the Wisconsin Statutes for Practitioners eligible to participate in the Wisconsin Injured Patients and Families Compensation Fund and, for other Practitioners, at such levels as may be specified by the Governing Body and, where requested, submit evidence of such financial responsibility.
- (5) as part of appointment and reappointment to the Medical Staff or at any other time upon request of the Governing Body or the Medical Executive Committee, document their ability to perform the essential functions of their profession, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients. The Medical Executive Committee or Governing Body may precondition appointment or reappointment upon the Practitioner's undergoing a health examination by a physician mutually acceptable to the Practitioner and the Medical Executive Committee or Governing Body.
- (6) for membership on the Active Medical Staff, be able to render continuous care and supervision of their patients, and agree to accept staff committee assignments, pledge not to receive from or pay to another Practitioner, either directly or indirectly, any illegal form of fee sharing, except when the Practitioner has performed that portion of the professional service that forms the basis for his portion of the fee, to accept on-call assignments, and to provide emergency care and emergency consultation within the scope of his privileges for patients admitted to or treated at the Hospital.
- (7) be willing to participate in the discharge of Medical Staff responsibilities.
- (8) not be currently barred from providing services in The Monroe Clinic under Chapter DHS 12 of the Wisconsin Administrative Code.
- (9) not be currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

2.2.2 An expectation of appointment or reappointment to the Medical Staff of The Monroe Clinic is specialty board certification (ABMS, Royal College of Canada, Australia or one of the British Isles or Osteopathic Board) or eligibility and active pursuit of certification.

Under unusual circumstances, an exemption from this requirement may be granted by the Governing Body. Please refer to the Medical Staff policy on Board Certification Requirements for Physicians.

- 2.2.3 Physicians who meet the board certification requirement by being certified but whose certification expires, may have up to one year from the date of expiration to become re-certified. At that point, if not successfully re-certified, membership in the Medical Staff ceases.

The Governing Body may choose to waive the requirement for certification. Waiver can be considered under two circumstances:

- (1) The Chief Executive Officer and the Medical Executive Committee determine that special circumstances warrant granting an exception for a board-ineligible physician. The Governing Body can choose to allow a physician by contract to remain uncertified.
- (2) The Chief Executive Officer and the Medical Executive Committee determine that special circumstances warrant granting an exception for a physician already on staff.

- 2.2.4 No Practitioner shall be entitled to membership on the Medical Staff or to the enjoyment of particular privileges merely by virtue of the fact that he meets the above criteria.

In order to have membership on the Medical Staff or have access to specific privileges, a physician who is a member of the Governing Body, administration or any leadership position must be subject to the same processes as all other members of the Medical Staff.

- 2.2.5 No person who is otherwise qualified shall be denied privileges by reason of race, gender, creed or national origin or on the basis of any criterion unrelated to the delivery of quality patient care in the organization, to professional qualifications, to the organization's purposes, needs and capabilities, or to community need.

While the recommendation of appointment to the Medical Staff shall be based primarily on the professional competence of applicants, the ability of the organization to provide adequate facilities and supportive services for the applicant and his patients, and patient care needs for additional staff members with the applicant's skill and training, shall also be considerations of the Governing Body in determining Medical Staff membership. To the extent the geographic location of the applicant and his practice affects the ability of the applicant to provide effective continuity of care for Hospital patients, it shall also be a consideration.

- 2.3 Basic Responsibilities of the Medical Staff. Basic responsibilities of members of the Medical Staff include:

- 2.3.1 Provide his patients with care at the generally recognized professional level of quality and efficiency,
- 2.3.2 Abide by the:

- (1) Medical Staff Bylaws and all other adopted standards, policies, rules and procedures of the organization and Medical Staff,
  - (2) Ethical and Religious Directives for Catholic Health Care Services,
  - (3) Recognized code of ethics applicable to Practitioner's profession,
  - (4) Ethical principles adopted by the organization,
  - (5) Requirements for accreditation of the Joint Commission on Accreditation of Healthcare Organizations,
  - (6) Organization's "Commitment to Confidentiality" agreement,
  - (7) Organization's Corporate Compliance Program, including without limitation, the Standards of Conduct and any related education and training.
- 2.3.3 Discharge such staff, service, committee and organizational functions for which he is responsible by staff status, assignment, appointment, election or otherwise.
- 2.3.4 Prepare and complete in a timely fashion the required medical, patient and organizational records for all patients he admits or in any way provides care to in the organization.
- 2.3.5 Work with and relate to other Practitioners, residents, students, affiliated health professionals, members of professional review organizations and accreditation bodies in a manner essential for maintaining an organizational government appropriate to quality patient care.
- 2.3.6 Pledge not to receive from or pay to another Practitioner, either directly or indirectly, any part of any fee received except when the Practitioner has performed that portion of the professional service that forms the basis for his portion of the fee.
- 2.3.7 Provide for continuous care and supervision of patients, and delegate the responsibility for diagnosis or care of patients only to individuals who are qualified to accept the full range of responsibility delegated to them.
- 2.3.8 As a condition of appointment or reappointment, each member has a continuing obligation to immediately notify the Chief Executive Officer of, and to provide such additional information as may be requested regarding each of the following events:
- (1) the revocation, limitation or suspension of his professional license, DEA registration or state registration, any reprimand or other disciplinary action taken by any state or federal agency or the imposition of terms of probation or limitation by any state,
  - (2) loss of staff membership or privileges at any hospital or other health care institution; whether temporary, permanent or pending, including all suspensions,
  - (3) cancellation of his professional liability insurance coverage,



- (4) an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges by a Medicare quality improvement organization, the Department of Health and Family Services or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin, or the state of Illinois if Practitioner holds an Illinois license,
- (5) receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the organization,
- (6) any criminal conviction or pending criminal charge, and any finding by a governmental agency that the Practitioner has been found to have abused or neglected a child or patient, or has misappropriated a patient's property, or
- (7) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his representative of proposed or actual exclusion or any pending investigation of the individual in connection with any health care program funded in whole or in part by the federal government, including Medicare and Medicaid.

2.3.9 Discharge such other responsibilities as may be required by the Medical Staff, subject to the Governing Body's approval.

## 2.4 Leave of Absence and Reinstatement.

- 2.4.1 Any member of the Active, Associate, Limited Appointment or Courtesy Staff may obtain a leave of absence from the Medical Staff for a period of one year by submitting a written request to the Medical Executive Committee and the Chief Executive Officer. The Practitioner may apply, in writing, for an additional one year extension. Failure of a Practitioner to return or make an application for extension of leave shall constitute a resignation from the Medical Staff, and shall not be subject to any hearings or appellate review. A request for Medical Staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in Section 5.2, except that primary source verification need not be repeated.
- 2.4.2 If the Practitioner's period of appointment expires during his leave of absence from the Medical Staff, he will be required to apply for reappointment as specified in Section 5.3.
- 2.4.3 Upon return from leave of absence prior to the expiration of the Practitioner's then-current term of appointment, the Practitioner may be required by the Medical Executive Committee to submit a request for reinstatement in writing. The Medical Executive Committee will review the requests and make a recommendation to the Governing Body regarding reinstatement. The Practitioner may be required to submit such additional information as may be relevant to his request for reinstatement, including interval status information.

## ARTICLE 3 CATEGORIES OF MEMBERSHIP

3.1 Medical Staff Categories. The Medical Staff shall be divided into active, associate, limited appointment, courtesy and honorary.

### 3.2 The Active Medical Staff.

3.2.1 The Active Medical Staff shall consist of those Practitioners who may admit patients to the hospital division, who have completed at least one year of satisfactory performance on the Associate Staff, and are willing to assume all the responsibilities of Active Staff membership.

3.2.2 Active Staff members must:

- (1) provide care when appropriate to unassigned patients,
- (2) accept on-call responsibilities, as described in these Bylaws. Care must be provided regardless of the patient's payor class, race, creed, color, national origin, ancestry, religion, sexual orientation, marital status, age, newborn status, handicap or gender,
- (3) provide emergency service care and consultations,
- (4) participate in quality improvement activities, including the evaluation of Associate, Limited Appointment and Courtesy Staff members,
- (5) be willing to serve on committees and attend Medical Staff, department and committee meetings as provided in Article 10 of these Bylaws.

3.2.3 Practitioners in this category are able to exercise all clinical privileges granted to them by the Governing Body, vote on all matters presented at general or special meetings of the Medical Staff, the division/department and committees to which they are appointed. They may also hold office and chair committees or departments.

### 3.3 The Courtesy Staff.

3.3.1 Members of the Courtesy Staff will include Practitioners eligible for staff membership. They do not have regular, scheduled patient responsibilities. They do not have committee and meeting requirements of the Active and Associate Medical Staff. This category is for those Practitioners who have their primary practice within another organization. The Practitioner must be in good standing, currently on the Active Medical Staff (or equivalent staff category) at another hospital.

Practitioners in this category are normally appointed to fulfill an otherwise unmet need of The Monroe Clinic that cannot be met by Active Staff alone.

3.3.2 Members of the Courtesy Staff must:

- (1) participate in quality improvement and monitoring activities.

- (2) be available for (or make arrangements for) timely evaluation and treatment of postoperative complications and other potential emergent needs that may be attendant to care provided by the Practitioner.

3.3.3 Practitioners in this category are able to exercise all clinical privileges granted to them by the Governing Body. They are also welcome to attend Medical Staff and applicable department meetings, but are not eligible to vote or hold office. They are eligible to serve on any Medical Staff committee other than the Medical Executive Committee, and the Credentials Committee.

A member of the Courtesy Staff will be limited to a total of twelve (12) cases in a twelve (12) month period. For purposes of this limitation, a case includes any inpatient admission (but not including readmissions of the same patient for the same episode of illness), any outpatient surgery or other procedure performed on The Monroe Clinic's hospital premises that does not result in an inpatient admission, and any other episode of direct patient care or treatment that occurs on The Monroe Clinic's hospital premises. A member of the Courtesy Staff who reaches the limit of a total of twelve (12) cases within a twelve (12) month period, and upon performing a thirteenth (13th) case, must apply for membership to the Active Medical Staff. He thereby accepts all the responsibilities thereof.

#### 3.3.4 Term of Appointment.

New applicants to the Courtesy Staff will be appointed, on a provisional basis, for a period of no more than one year. at the end of the first year, the Medical Executive Committee, upon the written recommendations of the department to which the Practitioner has been assigned, the Credentials Committee and the Chief of Staff, may recommend to the Governing Body that the Practitioner continue on the Courtesy Staff for additional terms, not to exceed two (2) years each.

The method of supervision and review of a provisional member of the Courtesy Staff shall be delineated by the chair of the division(s) to which the Practitioner has been assigned.

### 3.4 The Honorary Medical Staff.

3.4.1 The Honorary Medical Staff shall consist of those Practitioners who are not active in the organization or who are honored by emeritus positions. These may be Practitioners who have retired from active organizational practice or who are of outstanding reputation, not necessarily residing in the community. Honorary Staff members shall be eligible to serve on standing Medical Staff committees, except the Medical Executive Committee, and the Credentials Committee, but hold no clinical privileges by virtue of their honorary membership status, are not eligible to admit patients, or to vote or hold office. They may attend Medical Staff meetings and once appointed to the Honorary Staff, they do not need to reapply.

3.4.2 This category is not intended for Practitioners who are in an active (greater than 50% of full time) practice elsewhere, but may be applied for by Practitioners upon their retirement from active practice.

### 3.5 The Associate Medical Staff.

- 3.5.1 All new applicants to the Active Medical Staff shall be appointed to the Associate Staff for a period of at least one year. At the end of the first year, the Medical Executive Committee, upon the written recommendations of the chair of the department to which the Practitioner has been assigned and the Credentials Committee may recommend to the Governing Body that the Practitioner be appointed to the Active Staff or continue the Practitioner on the Associate Staff for an additional period of one year. This appointment is subject to Governing Body approval.
- 3.5.2 The method of supervision and review of a member of the Associate Staff shall be delineated by the chair of the department to which the Practitioner has been assigned by the Chief of Staff.
- 3.5.3 Members of the Associate Staff shall:
- (1) be required to attend general Medical Staff meetings and department meetings as provided in the Article 10 of these Bylaws,
  - (2) not be eligible to vote or hold office,
  - (3) be eligible to serve on all Medical Staff committees, except the Medical Executive Committee and the Credentials Committee.
- 3.5.4 Associate Staff members must:
- (1) provide care when appropriate to unassigned patients.
  - (2) accept on-call responsibilities, as described in these Bylaws. Care must be provided regardless of the patient's payor class, race, creed, color, national origin, ancestry, religion, sexual orientation, marital status, age, newborn status, handicap or gender.
  - (3) provide emergency service care and consultations when appropriate.
  - (4) be willing to participate in quality assessment and improvement activities.
  - (5) be willing to serve on committees and attend Medical Staff, department and committee meetings as required.
- 3.5.5 Practitioners in this category are able to exercise all clinical privileges granted to them by the Governing Body.
- 3.5.6 A member of the Associate Staff who does not qualify for appointment to the Active Staff at the end of his 2nd one year term should be scheduled for a personal interview with the Credentials Committee at the time of the annual staff review to discuss the status of his continued interest in membership on the Medical Staff of the organization. The Credentials Committee, after consultation with the chair of the division/department involved, will recommend continuation on the Associate Staff for a period not to exceed three (3) months, appointment to the Active Staff, or non-reappointment to the Medical Staff. In the case of non-appointment, the Practitioner shall be entitled to the procedural rights set forth in these Bylaws.

### 3.6 The Limited Appointment Staff.

- 3.6.1 The Limited Appointment Staff category is intended for temporary or contract Practitioners. Practitioners in this category are normally hired by the organization to fulfill an otherwise unmet need. Practitioners in this category must meet all credentials requirements for the privileges they are contracted to exercise and are appointed upon the recommendation of the Credentials Committee, the Medical Executive Committee (or its designee) and the Governing Body. On-call requirements and other responsibilities are at the discretion of The Monroe Clinic.
- 3.6.2 Practitioners are appointed to this category for up to one year. Exceptions to the term of appointment may be made by the Governing Body, upon recommendation from the Medical Executive Committee. Clinical privileges are exercisable only during their period(s) of employment. Individuals in this category have no membership privileges on the Medical Staff. They have professional responsibilities attendant to exercise of their clinical privileges. In any respect that is not outlined in a contract, they are employees at will of The Monroe Clinic.

## ARTICLE 4 ALLIED HEALTH PROFESSIONALS

### 4.1 General Provisions.

- 4.1.1 Allied Health Professionals shall consist of professionally competent allied health professionals who participate in care at The Monroe Clinic. Allied Health Professionals may practice in relative independence or under the direct supervision of a supervising physician, depending on their training and the authorities outlined in this Article. Allied Health Professionals shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws and associated policies of the Medical Staff and The Monroe Clinic. Allied Health Professionals are not members of the Medical Staff and may not hold any Medical Staff office or vote at any Medical Staff meeting.
- 4.1.2 Allied Health Professionals shall be divided into two (2) categories: Independent Allied Health Professionals and Dependent Allied Health Professionals.
- 4.1.3 Each individual in these categories will present his qualifications for review by the Medical Staff in accord with the procedures as set forth in these Bylaws for the appointment of Practitioners to the Medical Staff. If approved by the Medical Staff, Governing Body may grant such individual privileges as described in this Article.
- 4.1.4 As a condition of appointment and the exercise of clinical privileges as an Allied Health Professional, each individual must meet the conditions set forth for Practitioners in Article 6 of these Bylaws.

### 4.2 Independent Allied Health Professionals.

- 4.2.1 This category of Allied Health Professionals shall consist only of the following professionals. These professionals must be credentialed regardless of their employment status with The Monroe Clinic:

- (1) Individuals with a doctorate in psychology from an accredited college or university, and licensed in the State of Wisconsin and the State of Illinois, if the individual provides services in Illinois;
  - (2) Individuals with a masters degree in speech pathology from an accredited college or university, and licensed in the State of Wisconsin and the State of Illinois if the individual provides services in Illinois;
  - (3) Nurse midwives, certified registered nurse anesthetists and other independent nurse practitioners, who are nurses registered under the laws of the State of Wisconsin (and the State of Illinois, if applicable) and engaged in independent nursing practice in the community with a collaborative agreement with one or more members of the Medical Staff;
  - (4) Individuals with a degree in orthotics and/or prosthetics from an accredited college or university, and certified by the appropriate accreditation agency.
- 4.2.2 Independent Allied Health Professionals may provide patient care services within the limits of their professional skills and abilities and their delineated privileges. The degree of participation by Independent Allied Health Professionals in patient care shall be determined according to protocols and policies recommended by the Medical Staff and approved by the Governing Body.
- 4.2.3 Applications for appointment and clinical privileges as an Independent Allied Health Professional shall be processed in accordance with the procedures set forth in Article 5 of these Bylaws. An individual applying for appointment as an Independent Allied Health Professional must be continuously sponsored by an Active, Associate or Courtesy Member of the Medical Staff who will review the adequacy of his performance on a regular basis. The physician sponsor will attest to this in writing. There can be only one physician sponsor for an Independent Allied Health Professional.
- 4.2.4 As a condition of continued privileges, such individuals may be required to attend meetings involving the clinical review of patient care in which they participated.
- 4.3 Dependent Allied Health Professionals.
- 4.3.1 This category of Allied Health Professionals shall consist of all other clinical technicians or professionals who are employees of an Active, Associate or Courtesy Staff Member or members of the Medical Staff or who are engaged by the Hospital by contract and who perform a portion of their professional responsibilities within the Hospital while under the supervision of an Active, Associate, or Courtesy Staff Member or members of the Medical Staff.
- 4.3.2 The employer of the individual who is seeking approval as a Dependent Allied Health Professional shall present a written statement of the clinical duties and responsibilities of said individual to the Credentials Committee and the Medical Executive Committee for their review and approval prior to allowing the individual to perform any professional responsibilities within the Hospital. Services provided by Dependent Allied Health Professionals should not supplant services provided by The Monroe Clinic employees. Instead, Dependent Allied Health Professionals shall serve to augment The Monroe Clinic related services normally provided by their employer(s).

- 4.3.3 The employer of the Dependent Allied Health Professional shall assume full responsibility, and be fully accountable for the conduct of the Dependent Allied Health Professional within the Hospital. The sponsoring Practitioner shall provide continuous direct supervision of the Dependent Allied Health Professional and sign a statement attesting compliance with these Bylaws describing the requirements for Dependent Allied Health Professional.
- 4.3.4 It is further the responsibility of the employer of the Dependent Allied Health Professional to acquaint the Dependent Allied Health Professional with the applicable rules and regulations of the Medical Staff and The Monroe Clinic, as well as appropriate members of the Medical Staff and The Monroe Clinic personnel with whom said individual shall have contact at The Monroe Clinic. Said employer shall furnish evidence of professional liability insurance coverage for such individuals. Such coverage shall meet the requirements established by the State of Wisconsin (and the State of Illinois, if applicable) and The Monroe Clinic.
- 4.3.5 In circumstances where the employer of the Dependent Allied Health Professional is a member of the Medical Staff, the clinical duties and responsibilities of the Dependent Allied Health Professional within The Monroe Clinic shall terminate if the Medical Staff membership of the employer is terminated for any reason or if the employer's clinical privileges are curtailed to the extent that the professional services of the Dependent Allied Health Professional within The Monroe Clinic are no longer necessary or permissible to assist the employer. When privileges are terminated under this subsection, the Dependent Allied Health Professional shall have no right to a hearing or appeal.
- 4.3.6 The qualifications, performance, and competence of non hospital employees brought into The Monroe Clinic by a member of the Medical Staff to provide care, treatment, or services are reviewed at the same frequency as individuals employed by The Monroe Clinic. This review is performed to determine their qualifications and competence are commensurate with the qualifications and competence required if the individual were to be employed by the Hospital to perform the same or similar services.

#### 4.4 Removal Procedures and Status.

- 4.4.1 Persons maintaining any of the foregoing positions are not members of the Medical Staff, and accordingly have none of the duties or prerogatives of Medical Staff members.
- 4.4.2 The Hospital retains the right, either through the administration or upon recommendation of the Medical Executive Committee, to suspend or terminate any or all of the privileges or functions of any category of Allied Health Professional, without recourse or on the part of the person in that category or others to any review and appeal procedures of these Medical Staff Bylaws.
- 4.4.3 An Allied Health Professional whose privileges are suspended, terminated, or limited shall be told the reasons for such actions and that the Allied Health Professional is entitled to a review of the action. If a review is requested, the Medical Executive Committee will schedule a time to meet with the Allied Health Professional, and give him notice of the date of the meeting. The action will be reviewed by the Medical

Executive Committee in the Allied Health Professional's presence and his employer's if applicable. The Allied Health Professional, and his employer, if applicable will have an opportunity to speak and present evidence refuting the privilege action. The Medical Executive Committee will issue a timely written decision regarding the matter which will be sent to the Allied Health Professional and, in the case of a Dependent Allied Health Professional, to his employer.

- 4.4.4 If, after review by the Medical Executive Committee, the decision regarding the Allied Health Professional's privileges continues to be adverse, the Allied Health Professional may appeal that decision within thirty (30) calendar days in writing to the Chief Executive Officer. The Chief Executive Officer will consider the matter and issue a written decision which will be sent to the Chair of the Medical Executive Committee, the Allied Health Professional and, in the case of a Dependent Allied Health Professional, to his employer. The Chief Executive Officer has the sole authority to decide the status of the Allied Health Professional's privileges and his decision will be final with regard to the matter.

## ARTICLE 5 MEDICAL STAFF APPOINTMENT/REAPPOINTMENT PROCESS

### 5.1 Application for Appointment.

- 5.1.1 All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. The completed application shall provide a full summary of the applicant's education, institutional positions held, the dates of commencement and completion of each service, date and number of state licensure, date and number of DEA registration and state registration, date and number of board certification(s), and such other information as may be relevant to the applicant's qualifications for appointment. To ensure the applicant is the same individual identified in the credentialing documents, it is required that the applicant submit a valid picture ID issued by a state or federal agency (e.g., driver's license or passport) along with the application materials. A copy of this photo is sent along with the reference requests and verification of affiliation letters, asking that The Monroe Clinic be contacted immediately if the individual pictured is not the same individual indicated.
- 5.1.2 The Chief Executive Officer, through the Credentialing Office, shall provide each applicant with a copy of the The Monroe Clinic Bylaws and Medical Staff Bylaws and Ethical and Religious Directives for Catholic Health Care Services. The applicant shall sign a statement that he has received and had an opportunity to review The Monroe Clinic Bylaws and Ethical and Religious Directives for Catholic Health Care Services of the organization and the Bylaws of the Medical Staff and agrees to be bound by their terms if granted membership or clinical privileges and to be bound by the terms of such Bylaws in all matters relating to consideration of his application without regard to whether or not he is ultimately granted membership or clinical privileges.
- 5.1.3 The application shall include the following information:
- (1) Whether any of the following has been or is currently in the process of being voluntarily or involuntarily limited, suspended, revoked, not renewed, denied,



investigated, relinquished or subjected to probationary conditions or reprimand, or whether proceedings toward any of those ends have been instituted or recommended, or whether any other disciplinary action or sanction related to the following has been received:

- (a) License to practice by any state or jurisdiction;
  - (b) DEA registration and state registration;
  - (c) Clinical privileges at any hospital or health care institution;
  - (d) Medical staff membership or other medical staff status at any hospital or health care institution;
  - (e) Specialty board certification, recertification or eligibility;
  - (f) Membership in any medical organization or professional society (local or state) that makes membership determinations based on professional qualifications, competence or conduct;
  - (g) Participation in Medicare, Medicaid or other third-party payor plan;
  - (h) Appointment to or employment in any clinical position with any employment or practice arrangement.
- (2) Whether the applicant has been denied membership on a hospital medical staff or withdrawn an application for appointment or reappointment or advancement in medical staff status, or whether such a denial has been recommended by a medical staff committee or a governing body.
  - (3) For health care facilities or entities other than The Monroe Clinic, whether the applicant's request for any specific clinical privilege(s) has been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship), or whether the applicant has withdrawn a request for any such clinical privileges, or whether such a denial or limitation has been recommended by a medical staff committee or governing body.
  - (4) Whether the applicant has been convicted of or pled guilty to a felony, misdemeanor or other offense, including a Medicare or Medicaid related offense, other than a minor traffic violation, and whether criminal charges are currently pending.
  - (5) Whether the applicant's professional liability insurance coverage has ever been denied, canceled, reduced, limited, not renewed or terminated by action of the insurance company, except for non-payment of premiums.
  - (6) Whether the applicant's professional liability insurance carrier has excluded any specific procedures from his coverage.
  - (7) Whether any professional liability suits have ever been filed against him or whether any professional liability suits have been filed against him which are presently pending.

- (8) Whether any judgments or settlements have been made against the applicant in professional liability cases.
  - (9) Whether the applicant is able to perform the essential functions of his profession, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients.
  - (10) Whether the applicant has any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the organization in obtaining any additional information required for the organization to comply with the requirements of Chapter DHS 12 of the Wisconsin Administrative Code.
  - (11) Whether the applicant has ever been excluded from any health care program funded in whole or in part by the federal government.
  - (12) Whether the applicant has ever received any sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Family Services, or any law enforcement agency or health regulatory agency of the United States or any state.
  - (13) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his ability to provide quality patient care at the organization.
- 5.1.4 The application shall identify at least three (3) peer references who have recently worked with the applicant and directly observed his professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character and ability to work with others.
- 5.1.5 The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. Failure to adequately complete the application form, withholding of requested information, providing false or misleading information, or omitting material information necessary for a full picture of the applicant's professional history shall be a basis for denial of membership on or removal from the Medical Staff. Minor omissions beyond the control of the applicant, may be corrected or fulfilling documentation substituted at the discretion of the Credentials Committee or designee. Upon receiving any information from other sources, which varies substantially from the information provided by the applicant, the Credentialing Office will notify the applicant, in writing, informing them of the variance. The Credentials Committee may interview the applicant to clarify any information or request. The applicant will be given thirty (30) days to correct or clarify, in writing, the information and return it to the Credentialing Office. The Credentialing Office will notify the applicant by phone or email that corrections were received. The applicant has

the right, upon request, to be informed of the status of his credentialing application. The credentialing office will notify an applicant of his credentialing status via phone or email. The applicant may review his credentials file, unless the information is protected under state law. A final review of the credentialing file is done by the Medical Staff Office to assure the file is complete and accurate.

- 5.1.6 The application shall be submitted to the Chief Executive Officer, through the Credentialing Office, along with other consents, authorizations and releases as may be required for the proper evaluation of the applicant's qualifications. The Credentialing Office will process applications within one hundred eighty (180) days of receipt of the completed application. After collection of the references and material deemed pertinent, the application and all supporting materials shall be transmitted to the Credentials Committee for evaluation.
- 5.1.7 By applying for appointment to the Medical Staff, each applicant thereby signifies his willingness to appear for interviews in regard to his application, authorizes the organization to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence, character, mental, physical and emotional stability, and ethical qualifications, consents to the organization's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests as well as of his moral and ethical qualifications for staff membership.
- 5.1.8 The Credentialing Office may, with the approval of the Credentials Committee chair, deny an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if it determines that the applicant does not hold a valid Wisconsin license (and/or Illinois license, if applicable) and no application is pending, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance program, is currently excluded from any health care program funded in whole or in part by the federal government, or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code, or is only requesting membership and privileges in a department that currently is subject to an exclusive contract under which the organization is contractually committed not to grant privileges to Practitioners outside of the contract group. Applicants who are administratively denied under this Section do not have a right to a fair hearing under Article 13 but may submit evidence to the Credentialing Office to refute the basis for the administrative denial.

## 5.2 Appointment Process.

- 5.2.1 After receiving a complete credentials file, the Credentials Committee shall act on the request at their next scheduled meeting and make a written report of its recommendation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine all primary source verified information as outlined in the Medical Staff Appointment and Reappointment Policy, evidence of the character, professional competence, qualifications and ethical standing of the Practitioner and shall determine through information contained in peer references and from other sources available to the committee, including an appraisal from the clinical department/division in which privileges are sought, whether the Practitioner has established and meets all of

the necessary qualifications for the category of staff membership and the clinical privileges requested by him. A department in which the Practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the Practitioner's clinical privileges and these recommendations shall be made a part of the report the Credentials Committee shall transmit to the Medical Executive Committee its recommendation that the Practitioner be either appointed to the Medical Staff, rejected for Medical Staff membership, or that the application be deferred for further consideration. If needed, the complete application shall be available to the Medical Executive Committee.

- 5.2.2 When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up in a timely manner with subsequent recommendation for appointment to the Medical Staff with specified clinical privileges or for rejection of staff membership.
- 5.2.3 When the recommendation of the Medical Executive Committee is favorable to the Practitioner, the Medical Executive Committee shall promptly forward it, together with all supporting documentation, to the Governing Body or its representative for review and action at their next scheduled meeting.
- 5.2.4 When the recommendation of the Medical Executive Committee constitutes a professional review action giving rise to hearing rights as specified in Article 13 either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the Practitioner by Special Notice and the Practitioner shall be given the opportunity to either accept the recommendation and waive procedural rights contained in Article 13 or to exercise such rights. No such adverse recommendation need be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his right to a hearing.
- 5.2.5 At its next regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act on this matter. If the Governing Body's decision constitutes a professional review action giving rise to hearing rights as specified in Article 13 in respect to either appointment or clinical privileges, and the Practitioner has not previously been afforded the opportunity to exercise or waive such hearing rights, the Chief Executive Officer shall promptly notify him of such adverse decision by Special Notice and the Practitioner shall be given the opportunity to either waive procedural rights contained in Article 13 by accepting the recommendation or to exercise such rights.
- 5.2.6 The Governing Body's decision shall be conclusive except that the Governing Body may defer final determination by referring the matter back for further consideration. Any such referral back shall state the reasons and shall set a time limit within which a subsequent recommendation to the Governing Body shall be made. At its next regular meeting after receipt of such subsequent recommendations and new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the Practitioner to the Medical Staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the Practitioner may exercise.

- 5.2.7 When the Governing Body's decision is deferred or contrary to the recommendation of the Medical Executive Committee, the Governing Body shall refer the decision back to the Medical Executive Committee for further consultation prior to a final determination.
- 5.2.8 When the Governing Body's decision is final and within ten (10) business days of such decision, it shall send notice of such decision through the Chief Executive Officer to the Chairman of the Medical Executive Committee and of the department concerned, and by Special Notice, to the Practitioner.

### 5.3 Reappointment Process.

- 5.3.1 The reappointment process will be performed at least every two (2) years, although it may be done on a staggered basis. The Chief Executive Officer, through the Credentialing Office, will provide each staff member scheduled for reappointment with a reappointment application packet at least one hundred twenty (120) days prior to expiration of the member's current appointment. Each Medical Staff member who desires reappointment shall, at least ninety (90) days prior to such expiration date, submit his completed reappointment packet to the Chief Executive Officer, through the Credentialing Office. Failure without good cause to so return the packet shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership at the expiration of the member's current term. A Practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article 13 for the sole purpose of determining the issue of good cause.
- 5.3.2 The reappointment application packet shall include all information necessary to update the information contained in the applicant's initial application for appointment, including, without limitation:
  - (1) Whether any of the following has been or is currently in the process of being voluntarily or involuntarily limited, suspended, revoked, not renewed, denied, investigated, relinquished or subjected to probationary conditions or reprimand, or whether proceedings toward any of these ends have been instituted or recommended, or whether any other disciplinary action or sanction has been received related to the following:
    - (a) License to practice by any state or jurisdiction;
    - (b) DEA registration and state registration;
    - (c) Clinical privileges at any hospital or health care institution;
    - (d) Medical staff membership or other medical staff status at any hospital or health care institution;
    - (e) Specialty board certification, recertification or eligibility;
    - (f) Membership in any medical organization or professional society (local or state) that makes membership determinations based on professional qualifications, competence or conduct;
    - (g) Participation in Medicare, Medicaid or other third-party payor plan;

- (h) Appointment to or employment in any clinical position with any employment or practice arrangement.
- (2) Whether the applicant has been denied membership on a hospital medical staff or has withdrawn an application, appointment or reappointment or advancement in medical staff status, or whether such a denial has been recommended by a medical staff committee or governing board.
- (3) Whether the applicant's request for any specific clinical privilege(s) has been denied or granted with stated limitations (aside from the ordinary and initial requirements of proctorship), whether a request for any such clinical privileges has been withdrawn, or whether such a denial or limitation has been recommended by a medical staff committee or governing board.
- (4) Whether the applicant has been convicted of a felony, misdemeanor or other offense, including a Medicare or Medicaid related offense, other than a minor traffic violation, or whether criminal charges are currently pending against the applicant.
- (5) Since the last appointment to The Monroe Clinic Medical Staff, whether any judgment or settlement has been made in a claim against the applicant in any professional liability case or any claim is pending.
- (6) Whether the applicant is able to perform the essential functions of his profession, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients.
- (7) Whether the applicant has been excluded from any health care program funded in whole or in part by the federal government.
- (8) Whether the applicant has received any sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Family Services, or any law enforcement agency or health regulatory agency of the United States or any state.
- (9) Updated information regarding any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient including a fully completed Background Information Disclosure form.
- (10) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his ability to provide quality patient care at the organization.

5.3.3 The Credentials Committee shall review and verify all pertinent information available on each Practitioner scheduled for periodic appraisal for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations in writing to the Medical Executive Committee. If needed, the complete application shall be

available to the Medical Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

- 5.3.4 Each recommendation concerning the reappointment for a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his professional ethics and conduct, physical and mental capabilities, his ability to perform the essential functions of his profession, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients, his attendance at Medical Staff meetings and participation in Medical Staff affairs, his compliance with The Monroe Clinic's corporate bylaws and these Medical Staff Bylaws, cooperation with personnel, efficient and economical use of the organization's facilities for patients, relations with other staff members, and general attitude toward patients, the organization and the public.
- 5.3.5 Reappointment will include the periodic appraisal of the professional activities of each member of the Medical Staff and of all other individuals with clinical privileges in The Monroe Clinic. A written record of all matters considered in each Practitioner's periodic reappointment appraisal will be made a part of the permanent files of The Monroe Clinic including a comparison of the Practitioner's specific information from peer review, quality assurance and improvement activities to the aggregate information for others in the Practitioner's specialty or division. When insufficient Practitioner-specific data are available, the Credentials Committee obtains and evaluates peer recommendations from other hospitals with which the Practitioner is currently affiliated. Failure to acquire such recommendations shall be a basis for denial of membership or removal from the Medical Staff.
- 5.3.6 The Medical Executive Committee shall make written recommendations to the Governing Body, through the Chief Executive Officer, concerning the reappointment, non-reappointment and/or clinical privileges of each Practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.
- 5.3.7 When the recommendation of the Medical Executive Committee constitutes a professional review action giving rise to hearing rights as specified in Article 13 either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the Practitioner by Special Notice. The Practitioner shall be given an opportunity either to exercise the procedural rights which are contained in Article 13 or to accept the recommendation. No such adverse recommendation need be forwarded to the Governing Body until after the Practitioner has exercised, or has been deemed to have waived, his right to a hearing.
- 5.3.8 If after the Medical Executive Committee has considered the report and recommendation of the Hearing Committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the Practitioner, it shall be processed in accordance with Section 5.3.6. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the Practitioner by Special Notice. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any

action thereon until after the Practitioner has exercised, or has been deemed to have waived, his right to an appellate review.

- 5.3.9 At its next regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act on this matter. If the Governing Body's decision is adverse to the Practitioner in respect to either reappointment or clinical privileges, the Chief Executive Officer shall promptly notify him of such adverse decision by Special Notice, and such adverse decision shall be held in abeyance until the Practitioner has exercised, or has been deemed to have waived, his rights under Article 13. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- 5.3.10 At its next regular meeting after all of the Practitioner's rights have been exhausted or waived, the Governing Body or its duly authorized committee shall act on the matter. The Governing Body's decision shall be conclusive except that the Governing Body may defer final determination by referring the matter back for further consideration. Any such referral back shall state the reasons, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendations and new evidence in the matter, if any, the Governing Body shall make a decision either to reappoint the Practitioner or to reject him for Medical Staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the Practitioner may exercise.
- 5.3.11 When the Governing Body's decision is deferred or contrary to the recommendation of the Medical Executive Committee, the Governing Body shall refer the decision back to the Medical Executive Committee for further consultation prior to a final determination.
- 5.3.12 When the Governing Body's decision is final and within ten (10) business days of such decision, it shall send notice through the Chief Executive Officer to the Secretary of the Medical Staff, the Chairman of the Medical Executive Committee and of the department concerned, and by Special Notice, to the Practitioner.

#### 5.4 Modification of Membership Status or Privileges.

- 5.4.1 A member of the Medical Staff may, either in connection with the reappointment process or at any other time, request modification of his staff category or clinical privileges by submitting a written application to the Medical Staff Office, subject to the limitations in Section 5.6, provided the modification requested has not previously been the subject of a final adverse action. Such application shall be processed in the same manner as provided in Section 5.3 above for reappointment.
- 5.4.2 If a member of the Medical Staff is unable to perform the essential functions of his profession, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients, the member has a duty to self-report such condition to the Chief of Staff, the Medical Director, the Chair of the department or the Chief Executive Officer. The Chief of Staff, the Medical Executive Committee, the Medical Director, the Chair of the department or the Chief Executive Officer may request the Medical Executive Committee to review



the individual's status and privileges and make recommendations as to modifications necessary to protect the safety and welfare of patients.

- 5.4.3 If any conditions which affect the ability of a member of the Medical Staff to safely exercise the clinical privileges granted them are not self-reported, it shall be the responsibility of all members of the Medical Staff to bring such conditions to the attention of the Chief of Staff, the Medical Director, the Chair of the department or the Chief Executive Officer. A review of the individual's status by the Medical Executive Committee shall follow, and the Committee may require the individual to submit any required evidence of his ability to perform the essential functions of his profession, with or without accommodations, according to accepted standards of professional performance and without posing a threat to the safety of patients, as determined by a physician acceptable to the Medical Executive Committee.
- 5.4.4 The anonymity of a member of the Medical Staff who reports the condition of a colleague will be maintained whenever possible.
- 5.4.5 If, as a result of the Practitioner's self-reporting of a condition, the Medical Executive Committee recommends modification of membership status or privileges, the affected Practitioner shall be notified in writing of the recommendation. The recommendation shall be considered a professional review action, and thus subject to hearing and review, only if the Practitioner chooses to exercise the rights available under Article 13. If the Medical Executive Committee recommends modification of membership status or privileges due to a Practitioner's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the Practitioner exercises the review rights available under Article 13.
- 5.5 Time Periods for Processing. Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications. However, any time periods specified shall not be deemed to create any right for the Practitioner to have his application processed within those periods nor create a right for a staff member to be automatically reappointed for the coming term.
- 5.6 Reapplication After Adverse Action.
  - 5.6.1 An applicant who has received a final professional review action regarding appointment or clinical privileges or both shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of one year after the date of final adverse action or until he completes training identified by the Medical Staff as a prerequisite for privileges, whichever is longer.
  - 5.6.2 Any reapplication under this Section 5.6 shall be processed as an initial application, but the applicant shall submit such additional information as the Medical Executive Committee or Governing Body may require in demonstration that the basis for the earlier professional review action no longer exists.

- 5.6.3 In order for reapplication to occur under Section 5.6.1, there must be sufficient additional information to demonstrate that the basis for the earlier adverse action no longer exists.

## ARTICLE 6 CLINICAL PRIVILEGES

### 6.1 Scope of Practice.

- 6.1.1 Every Practitioner practicing at The Monroe Clinic by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body except as provided in Sections 6.2 and 6.3.
- 6.1.2 Every initial application for Medical Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.
- 6.1.3 Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.
- 6.1.4 Applications for new or additional clinical privileges must be in writing and indicate the type of clinical privilege desired and the applicant's relevant recent education or training and experience. Such applications shall be processed in the same manner as applications for initial appointment. Prior to granting a privilege, information regarding personnel and equipment requirements, costs and other relevant issues are considered and reviewed.
- 6.1.5 Privileges granted to dentists and/or podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and/or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and/or podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

### 6.2 Temporary Privileges.

- 6.2.1 Upon verification that the applicant meets the qualifications for membership as listed in Section 2.2, and with the written concurrence of the Department/Division Chair concerned or of the Chair of the Medical Executive Committee, the Chief Executive Officer (or their designee) may grant temporary admitting and clinical privileges for a period of up to ninety (90) days with subsequent extensions of temporary privileges in

increments not to exceed ninety (90) days. Temporary privileges may be granted on a case by case basis; but in exercising such privileges the applicant shall act under the supervision of the Chair of the Department to which he is assigned.

- 6.2.2 Temporary clinical privileges may be granted by the Chief Executive Officer for an immediate and urgent patient care need or when the failure to allow the Practitioner to provide care would result in a problem meeting an important patient care need. Temporary clinical privileges may be granted to a Practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in Section 6.2.1, provided that there shall first be obtained the following: Verification of an active Wisconsin or Illinois license (dependent on where the physician will be working); verification of medical school and residency training; verification of NPDB and OIG report; Wisconsin ( and Illinois, if applicable) background check; obtain at least two (2) professional peer references to verify current competence; proof of professional liability insurance; copy of current DEA (if applicable); signed acknowledgement that the Practitioner has no health issues which would compromise or impair their ability to perform the requested privileges; signed acknowledgment that the Practitioner agrees to be bound by the terms of the organization's Medical Staff Bylaws.
- 6.2.3 Special requirements of supervision and reporting may be imposed by the Department Chair concerned on any Practitioner granted temporary privileges. Temporary privileges may be immediately terminated by the Chief Executive Officer upon notice of any failure by the Practitioner to comply with such special conditions.
- 6.2.4 No Practitioner is entitled to temporary privileges as a matter of right. The Chief Executive Officer may at any time upon the recommendation of the Chair of either the Medical Executive Committee or the Department concerned, terminate a Practitioner's temporary privileges effective as of the discharge from the Hospital of the Practitioner's patient(s) then under his care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Article 13 and the same shall be immediately effective. The appropriate Department Chair or, in his absence, the Chair of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered when feasible in selection of such substitute Practitioner. The termination, modification or denial of temporary privileges shall not entitle the Practitioner involved to the procedural rights set forth in Article 13.

### 6.3 Emergency Privileges.

- 6.3.1 In the case of emergency, any Practitioner, to the degree permitted by his license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the Practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an

“emergency” is defined as a condition which could result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to the danger.

- 6.3.2 Critical Transport Teams in the process of moving a patient from The Monroe Clinic to a more specialized site of care are covered under this provision.
- 6.3.3 Organ Procurement Teams taking tissue or organs from a patient who has been designated as an immediate donor by The Monroe Clinic attending staff (under applicable ethical guidelines), may perform their procedures under the terms of this Section.
- 6.4 Disaster Privileges. In the event that The Monroe Clinic’s Emergency Management Plan is activated and the organization cannot meet the needs of patients in a disaster situation with current employees and Medical Staff, the Chief Executive Officer, Chief Medical Officer, Chief of Staff, or their designee(s) may grant emergency privileges to licensed or credentialed volunteers. The privileging process for Disaster Credentialing is outlined in Administrative Policy 800-059 “Disaster Credentialing.”
- 6.5 Expedited Credentialing. An Expedited Credentialing Process may be used for initial appointment and reappointment to the Medical Staff and for granting privileges when criteria for that process are met, as per the Expedited Credentialing Policy.
- 6.6 Telemedicine. All Practitioners who are responsible for a patient’s care, treatment, and services via telemedicine link are fully credentialed and privileged by The Monroe Clinic. If there is an urgent patient care need and a Practitioner can supply that service through a telemedicine link, temporary privileges may be granted per the set protocol.
  - 6.6.1 “Interpretive telemedicine” for the purposes of these Bylaws consists of providing official or unofficial readings of images, tracings, or specimens through a telemedicine link, but not engaging in interactive medicine.
  - 6.6.2 “Interactive telemedicine” for purposes of these Bylaws consists of responsibility (either total or shared) for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.
  - 6.6.3 Interpretive Telemedicine Privileges: Applicants based at distant sites whose practice at the Hospital will be limited to interpretive telemedicine only may apply for telemedicine privileges through one of the following mechanisms:
    - (1) If the applicant will be providing the interpretive telemedicine services pursuant to a written contract and the services are under the control of a Joint Commission-accredited organization, by submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (and verification of the information with either the distant site or a primary source):

- (a) Medical staff status at distant site and scope of clinical privileges currently held;
  - (b) Wisconsin licensure (Illinois licensure if applicable);
  - (c) Evidence of insurance meeting requirements for applicants for Medical Staff membership;
  - (d) Existence of any of the events or circumstances outlined in Section 2.2 of these Bylaws;
  - (e) Request for specific telemedicine privileges desired.
- (2) If the telemedicine services are being provided by contract with a Joint Commission-accredited organization, by a written contractual commitment with the distant site that it will ensure that all services provided by individuals under the contract will be provided only by Practitioners licensed to practice independently in Wisconsin (and/or Illinois if applicable):
    - (a) who are in good standing on the distant site entity's Active Medical Staff and acting within the scope of privileges granted by the distant site; and
    - (b) who are not excluded or proposed to be excluded from any federally-funded health care program; or
  - (3) By submission of the same application required of all other applicants for Medical Staff membership or clinical privileges, to be processed pursuant to the application process described in these Bylaws.
  - (4) By reliance of the Hospital on the granting of privileges at the distant site in accordance with Section 6.6.5 of these Bylaws.

6.6.4 Interactive Telemedicine Privileges: Applicants based at distant sites requesting any form of interactive telemedicine privileges may apply for privileges through one of the following mechanisms:

- (1) By submission of the same application required of all other applicants for Medical Staff membership or clinical privileges, to be processed pursuant to the application process described in these Bylaws.
- (2) If the applicant is a member of the medical staff of, or has been granted clinical privileges at, a distant site that is Joint Commission-accredited, by submission of a copy of the most recently completed application for medical staff membership or clinical privileges at the distant site, provided the applicant supplies any supplemental information required by the Hospital that is not contained on the distant site's form, with the information to be processed pursuant to the application process described in these Bylaws.
- (3) By submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (with evidence that the information has been verified by the distant Joint

Commission-accredited site), along with verification by the distant site that the applicant has been granted, at a minimum, the same privileges being requested at the Hospital as telemedicine privileges:

- (a) Medical staff status at distant site and scope of clinical privileges currently held.
  - (b) Wisconsin licensure (Illinois licensure, if applicable).
  - (c) Evidence of insurance meeting requirements for applicants for Medical Staff membership.
  - (d) Existence of any of the events or circumstances outlined in Section 2.2 of these Bylaws.
  - (e) Request for the specific telemedicine privileges desired.
- (4) By reliance of the Hospital on the granting of privileges at the distant site in accordance with Section 6.6.5 of these Bylaws.

6.6.5 In processing requests for clinical privileges, the Hospital may rely upon credentialing information obtained and verified in accord with the Joint Commission Standards by a distant site where the applicant currently holds medical staff membership or clinical privileges rather than directly obtaining primary source verification of the information supplied by the applicant.

- (1) If the telemedicine services are being provided by written agreement with a distant site telemedicine entity and the agreement ensures that the distant site telemedicine entity furnishes services that permit the Hospital to comply with all applicable conditions of participation for telemedicine services, the Hospital may rely upon the credentialing and privileging decisions made by the distant site telemedicine entity if the following provisions are met:
  - (a) The distant site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 C.F.R. §§ 482.12(a) through (a)(7) and §§ 482.22(a)(1) through (a)(2).
  - (b) The applicant is privileged at the distant-site entity hospital and the distant site entity provides a current list of the applicant's privileges.
  - (c) The applicant holds a license issued or recognized by the State of Wisconsin (and/or Illinois if applicable).
- (2) If the telemedicine services are being provided by written agreement with a distant site hospital, the Hospital may rely upon the credentialing and privileging decisions made by the distant site hospital if the following provisions are met:
  - (a) The distant site hospital is a Medicare-participating hospital.

- (b) The applicant is privileged at the distant site hospital and the distant site hospital provides a current list of the applicant's privileges.
- (c) The applicant holds a license issued or recognized by the State of Wisconsin (and the State of Illinois, if applicable).

6.6.6 Applicants for telemedicine privileges may be assigned to the Courtesy Medical Staff category or may be granted clinical privileges without Medical Staff membership and any of the rights, responsibilities and prerogatives of such membership, unless the telemedicine services are to be provided pursuant to Section 6.6.3(2), in which case the telemedicine providers shall not be individually appointed to the Medical Staff nor individually granted clinical privileges and shall have no rights or prerogatives under these Bylaws.

#### 6.7 Focused Professional Practice Evaluation.

6.7.1 A period of focused professional practice evaluation shall be implemented:

- (1) for all initially requested privileges; and
- (2) in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.

6.7.2 The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.

6.7.3 Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

#### 6.8 Ongoing Professional Practice Evaluation.

6.8.1 A process of ongoing professional practice evaluation exists to continuously review Medical Staff members' care and to identify professional practice trends that impact on quality of care and patient safety.

6.8.2 The criteria used in the ongoing professional practice evaluation may include such factors as:

- (1) The review of operative and other clinical procedures performed and their outcomes;
- (2) Patterns of blood and pharmaceutical usage;
- (3) Requests for tests and procedures;
- (4) Length of stay patterns;
- (5) Morbidity and mortality data;
- (6) Practitioner's use of consultants; and

(7) Other relevant factors as determined by the Medical Staff.

6.8.3 The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.

6.8.4 Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked. Such information will be used and disclosed to third parties only in accordance with Medical Staff policies.

## ARTICLE 7 OFFICERS

7.1 Medical Staff Officers. The Medical Staff Officers will be:

- Chief of Staff
- Vice Chief of Staff

7.2 Qualifications of Officers. Officers must be members of the Active Medical Staff, employed by The Monroe Clinic, at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers shall be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities.

7.3 Terms of Office. The term of office for Chief of Staff and Vice Chief of Staff shall be one year. The term may be renewed. At the end of the year, if either the Chief of Staff or Vice Chief of Staff is due to rotate off of the Medical Executive Committee, they are subject as any at-large member for re-election for another three (3) year term on the Medical Executive Committee. If, at the end of the year as Chief of Staff or Vice Chief of Staff, they remain on the Medical Executive Committee after the annual election, they are eligible to stand for re-election as Chief of Staff or Vice Chief of Staff by their peers on the Medical Executive Committee.

7.4 Nomination and Election of Officers. The chair of the Medical Executive Committee will be the Chief of Staff and the vice-chair of the Medical Executive Committee will be Vice-Chief of Staff. Nomination and election of these officers will follow the protocol outlined in Section 8.3.2.

7.5 Removal of Officers.

7.5.1 The Governing Body, by a resolution, may remove an officer of the Medical Staff on its own initiative upon a two-thirds majority vote of the members of the Governing Body or upon receipt of a recommendation of a two-thirds majority of the members of the Active Medical Staff eligible to vote.



- 7.5.2 Permissible basis for removal include, without limitation, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held.

7.6 Filling a Vacancy.

- 7.6.1 If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.
- 7.6.2 If there is a vacancy in the office of Vice Chief of Staff, the Medical Executive Committee shall by a simple majority vote elect a Vice Chief of Staff from its membership.

7.7 Duties of Officers.

7.7.1 Chief of Staff:

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

- (1) act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the organization,
- (2) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff,
- (3) serve as the Chair of the Medical Executive Committee,
- (4) be responsible for the enforcement of the Medical Staff Bylaws, for the implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner,
- (5) appoint committee members to all standing, special and multidisciplinary Medical Staff committees, except the Medical Executive Committee,
- (6) present the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer, as a voting Governing Body member.
- (7) receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care,
- (8) perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.

7.7.2 Vice Chief of Staff:

- (1) In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. He shall be a member

of the Medical Executive Committee. He shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

- (2) The Vice Chief of Staff shall be an ex-officio, non-voting member of the Governing Body.
- (3) The Vice Chief of Staff shall perform such additional duties as may be assigned by the Chief of Staff, the Medical Executive Committee or the Governing Body.

## ARTICLE 8 COMMITTEES

### 8.1 Designation.

- 8.1.1 Standing committees include the Medical Executive Committee and the Credentialing Committee .
- 8.1.2 Committee members, with the exception of members of the Medical Executive Committee, are appointed by the Chief of Staff.
- 8.1.3 Committees, with the exception of the Medical Executive Committee and the Credentials Committee, may be created and /or abolished at the discretion of the Medical Executive Committee to meet the needs of the Medical Staff.
- 8.1.4 Committees are a major component in the organization's program organized and operated to help improve the quality of health care in the hospital. Their activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committees relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee.

### 8.2 General Provisions of Committees.

- 8.2.1 Terms. Terms of office for the Medical Executive Committee shall be three (3) years. Terms for other committees shall be one year.
- 8.2.2 Removal of Committee Members/Chairs.

The Governing Body, by a resolution, may remove a Committee Member/ Chair on its own initiative upon a two-thirds majority vote of the members of the Governing Body or upon receipt of a recommendation of a two-thirds majority of the members of the Active Medical Staff eligible to vote.

Permissible basis for removal include, without limitation, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held.

- 8.2.3 Filling a Vacancy. Vacancies in Medical Executive Committee/Chair membership of over three (3) months duration during the Medical Staff year shall be filled by special

election. If more than one vacancy of less than three (3) months exists, they shall be filled by special election. Vacancies in committee membership/chair of committees other than the Medical Executive Committee during the Medical Staff year shall be filled by appointment from members of the Active Medical Staff, employed by The Monroe Clinic, by the Chief of Staff.

#### 8.2.4 Chair.

- (1) The Chief of Staff and Vice Chief of Staff (chair and vice chair of the Medical Executive Committee) and Chair of the Credentials Committee must be members of the Active Medical Staff, employed by The Monroe Clinic.
- (2) All committee chairpersons must be members of the Active Medical Staff and must remain members in good standing during their term as chairperson. Failure to maintain such status shall immediately create a vacancy in the position involved.

### 8.3 Medical Executive Committee.

8.3.1 Composition. The Medical Executive Committee shall be a standing committee and shall consist of five (5) members elected from the Active Medical Staff, employed by The Monroe Clinic, and three (3) division chairs. The Medical Director and the Chief Executive Officer and his designees shall be ex-officio, non-voting members. During such time as The Monroe Clinic has a contractual obligation to appoint a member of the service corporation contracted to provide radiology services to the facility to the Medical Executive Committee, an Active Medical Staff member designated by that group shall serve, ex-officio, non-voting, as a member of the Medical Executive Committee.

8.3.2 Election. Members of the Medical Executive Committee are elected via ballot from members of the Active Medical Staff who have demonstrated leadership ability and who have indicated a willingness to serve on the Medical Executive Committee.

- (1) A primary ballot is prepared, listing the names of members of the Active Medical Staff who are employed by The Monroe Clinic and who have indicated a willingness to serve on the Medical Executive Committee. The ballot is sent to all members of the Active Medical Staff. Primary ballots must be returned within seven (7) to ten (10) days.
- (2) A final ballot is prepared based on the results of the primary ballot, listing at least one, but not more than two (2) candidate(s) for each open position. The final ballot is sent to all members of the Active Medical Staff. Final ballots must be returned within seven (7) to ten (10) days.
- (3) All providers are notified via memorandum of the names of the individuals elected on the final ballot.

8.3.3 Terms. Medical Executive Committee members will serve for three (3) years. The terms shall be staggered to allow for only one or two (2) of these members to rotate off the Medical Executive Committee in any one year.

- 8.3.4 Chief of Staff/Vice Chief of Staff. Chair of the Medical Executive Committee will be the Chief of Staff. Candidates for Chief of Staff and Vice Chief of Staff will be selected from the five (5) elected members and three (3) division chairs and will be elected by the Medical Executive Committee. These officer elections will occur after each at-large election of members.

Terms of office for Chief of Staff and Vice Chief of Staff are outlined in Section 7.3.

Division Chairs are eligible to serve as Chief of Staff or Vice Chief of Staff of the Medical Executive Committee.

The Chief of Staff will be a voting member.

- 8.3.5 Duties. The duties of the Medical Executive Committee shall be to:

- (1) represent and to act on behalf of the Medical Staff in all matters of planning and evaluating medical practice issues, without requirement of subsequent approval by the Medical Staff, subject only to any limitations imposed by these Bylaws;
- (2) make recommendations on the management of the clinical practice of medicine in The Monroe Clinic. Consistent with state law provisions regarding hospital employment of physicians, The Monroe Clinic shall permit the physician employees, subject to management by the Medical Executive Committee, to exercise professional judgment without supervision or interference by The Monroe Clinic;
- (3) coordinate the activities and general policies of various Medical Staff departments;
- (4) receive and act upon committee reports, including appropriate correspondence with administrative committees (i.e., Ethics Committee) regarding clinical issues, and to make recommendations concerning them to the Chief Executive Officer and the Governing Body;
- (5) make recommendation to the Chief Executive Officer regarding the medical capital budget;
- (6) make recommendations to the Chief Executive Officer regarding clinic practice locations;
- (7) implement policies of the Medical Staff and to support the policies of the organization that affect the Medical Staff;
- (8) provide liaison between the Medical Staff and the Chief Executive Officer and the Governing Body;
- (9) keep the Medical Staff abreast of the applicable accreditation and regulatory requirements affecting the organization;

- (10) monitor quality of care and report to the Governing Body concerning the quality of care rendered to patients throughout the organization. The Medical Executive Committee will take appropriate action to assure the Governing Body that quality care is being rendered to our patients;
- (11) investigate and review the credentials of all applicants and to make recommendations to the Governing Body concerning the appropriate category of staff membership, department assignment and delineation of privileges, taking into consideration all recommendations made by the Credentials Committee;
- (12) review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and, as a result of such review, make recommendations to the Governing Body for reappointment or modification in clinical privileges, taking into consideration all recommendations made by the Credentials Committee;
- (13) take all reasonable steps to ensure professionally ethical conduct on the part of the Medical Staff;
- (14) report to each general Medical Staff meeting;
- (15) regularly review appropriateness of and compliance with the Medical Staff Bylaws, policies, and associated documents and to recommend changes and enforcement actions as may be necessary or desirable to the Medical Staff and Governing Body;
- (16) participate in and monitor the medical implications of the organizational corporate compliance program;
- (17) perform such other functions as may from time to time be delegated by the Medical Staff or Governing Body, Chief Executive Officer or their designees;
- (18) receive periodic reports from the Chief Executive Officer and the Governing Body; and
- (19) orient and provide for continuing education of department members.

8.3.6 Meetings. The Medical Executive Committee shall meet at least monthly and shall maintain a permanent record of all its proceedings and actions, which shall include the minutes of the various teams, committees and departments. Copies of the Medical Executive Committee minutes and recommendations shall be transmitted to the Chief Executive Officer and to the Governing Body.

#### 8.4 The Credentials Committee.

8.4.1 Composition. The Credentials Committee shall be a standing committee and shall consist of members of the Active Medical Staff, selected on a basis that will insure representation of the major clinical disciplines. The Chairperson of the Credentials Committee shall be appointed by the Chief of Staff. The Chief Executive Officer shall

be an ex officio, non-voting member. The Medical Director shall be an ex officio, non-voting member.

8.4.2 Duties. The duties of the Credentials Committee shall be:

- (1) to review the credentials of all applicants for staff appointment, reappointment, and clinical privileges, to investigate and interview applicants as necessary, including any investigations necessary to comply with state and federal laws, and to make a written report to the Medical Executive Committee of its findings and recommendations, including the recommendation of the Department Chair in which the candidate requests privileges;
- (2) to review periodically all relevant information available, including data collected by the relevant department quality improvement plan, regarding the competence of each staff member holding clinical privileges, including specific recommendations from the Department Chair. A written report of the Committee's findings and recommendations will be made to the Medical Executive Committee;
- (3) to review the credentials of all applicants who request to practice at The Monroe Clinic as non-clinic-employed Allied Health Professionals, to investigate and interview applicants as necessary, including any investigations necessary to comply with state and federal laws, and to make a written report to the Medical Executive Committee of its findings and recommendations, including the recommendations of the Department Chair;
- (4) to review, as questions arise, all information regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as non-clinic-employed Allied Health Professionals, and, as a result of such review, to make a written report of its findings and recommendations to the Medical Executive Committee.

8.4.3 Meetings. The Credentials Committee shall meet at least ten (10) times a year and shall maintain a permanent record of its proceedings and shall report its recommendations to the Medical Executive Committee and the Chief Executive Officer. The Chief of Staff shall periodically report the findings and recommendations of the Credentials Committee to the Governing Body.

8.4.4

ARTICLE 9 CLINICAL DIVISIONS AND DEPARTMENTS

9.1 Organization of Clinical Divisions/Departments. Divisions/Departments are a major component in the organization's program organized and operated to help improve the quality of health care in the organization. Their activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of Division/Department records and proceedings, are intended to apply to all activities of the Divisions/Departments relating to improving the quality of health care and include activities of the individual members of the Divisions/Departments as well as other individuals

designated by the Divisions/Departments to assist in carrying out the duties and responsibilities of the Division/Department.

9.1.1 The Medical Staff shall be organized into three (3) Divisions:

- Primary Care
- Consulting Services
- Surgical Services

Each Division is comprised of departments as defined in Article 14.

9.1.2 Divisions will meet as often as necessary to conduct required business and forward the minutes of the proceedings to the Medical Executive Committee.

9.2 Function of Divisions. These functions may be delegated to Departments within the Division.

9.2.1 Each Division shall assist in the development of criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges.

9.2.2 Each Division shall participate in quality of care monitoring by:

- (1) identifying quality of care indicators,
- (2) gathering and reviewing patient care information, and
- (3) recommending changes and improvements as indicated.

9.2.3 Each Division shall participate in orientation and continuing medical education for its member.

9.3 Division Chairpersons. Each Division shall have a chairperson. The Chairperson shall be a member of the Active Medical Staff, employed by The Monroe Clinic and shall be elected by a majority of the voting members of their division, with the approval of the Governing Body. The Chairperson shall be certified by an appropriate specialty board, or shall have established comparable competence through the credentialing process. The officers shall be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of hospital and Medical Staff activities.

The term of office shall be two (2) years.

9.3.1 The Division Chairperson's duties shall include the following. These duties may be delegated, by the Division Chair to Department Chairs within the Division.

- (1) Be responsible for all clinical and medical administrative activities of the Division;
- (2) Review the professional performance of the Division members;
- (3) Make recommendations to the Medical Staff regarding the criteria for and the granting of clinical privileges for members of the Division;

- (4) Make recommendations on off-site sources for needed patient care services not provided by the organization;
- (5) Be responsible for the integration of the Division into the primary functions of the organization;
- (6) Be responsible for the coordination and integration of divisional services;
- (7) Develop and implement policies and procedures that guide and support the provision of services;
- (8) Make recommendations for a sufficient number of qualified and competent persons to provide care or service;
- (9) Determines the qualifications and competence of Division personnel who are not Practitioners and who provide patient care services;
- (10) Make recommendations for space and other resources needed by the Division; and
- (11) Maintain information regarding quality assessment and improvement activities by individual members of the Division and in the aggregate by specialty.

9.3.2 The Division Chairperson serves as a member of the Medical Executive Committee.

#### 9.4 Organization of Departments.

- 9.4.1 As organization and patient care needs change and/or new specialties emerge, the Medical Staff may add or delete Departments upon approval of the Governing Body.
- 9.4.2 Department chairpersons shall be approved by the Chief of Staff and the Governing Body.
- 9.4.3 Medical Staff members will be assigned to Department(s) by the Medical Executive Committee based upon recommendations of the Department Chairs and the Credentials Committee.

#### 9.5 Function of Departments.

- 9.5.1 Each Department shall assist in the development of criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges.
- 9.5.2 Each Department shall participate in quality of care monitoring by:
  - (1) identifying quality of care indicators;
  - (2) gathering and reviewing patient care information; and
  - (3) recommending changes and improvements as indicated.
- 9.5.3 Each Department shall carry out such duties as delegated to it by the Chair of the division to which it belongs.



9.5.4 Each Department shall participate in orientation and continuing medical education for its members.

9.5.5 The Pathology Department shall conduct tissue review

9.6 Department Chairpersons. Each Department shall have a chairperson. The Chairperson shall be a member of the Active Medical Staff and shall be selected by the members of the Department. The Chairperson shall be certified by an appropriate specialty board, or shall have established comparable competence through the credentialing process. The Chairperson shall be a Practitioner with demonstrated competence in his field of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of organization and Medical Staff activities.

The term of office shall be one year.

## ARTICLE 10 MEETINGS

### 10.1 Medical Staff Meetings.

- (1) Called by: Chief of Staff.
- (2) Frequency: At least quarterly.
- (3) Quorum: Simple majority of the total membership of the Active Medical Staff.
- (4) Notices: 1) Notices of regular Medical Staff meetings will be sent to all Active Medical Staff members prior to such meeting. 2) Special meetings can be called by the Chief of Staff or upon written request of 10% of the Active Medical Staff within thirty (30) days of the Chief of Staff's receipt of this request. Notification must then be sent out not less than four (4) days nor more than thirty (30) days before the date of the meeting.
- (5) Medical Staff Attendance: Annual meeting and at least one other meeting per year. Excused absences may be granted upon advance notice.
- (6) Minutes: Taken by designee of Chairperson.
- (7) Rules of Order: Follow Roberts' Rules of Order.
- (8) Voting: Active Medical Staff.

### 10.2 Division Meetings.

- (1) Called by: Chairperson.
- (2) Frequency: As often as appropriate to conduct business, including quality review, but not less than two (2) times per year.
- (3) Quorum: Simple majority.
- (4) Notices given by: Monthly calendar. Special meetings can be called by 1/3 of division members (but not less than two (2) members), Chairperson or Chief of Staff, given at least three (3) days notice.

- (5) Attendance required: 50% of all meetings.
- (6) Minutes: Taken by designee of Chairperson. Record attendance, discussions and matters of vote. Signed by chairperson, approved by Division and submitted to the Medical Executive Committee.
- (7) Rules of Order: Follow Roberts' Rules of Order.
- (8) Voting: Active Medical Staff.

#### 10.3 Department Meetings.

- (1) Called by: Chairperson.
- (2) Frequency: As often as appropriate to conduct business, including quality review, but not less than two (2) times per year.
- (3) Quorum: Simple majority.
- (4) Notices given by: Monthly calendar. Special meetings can be called by 1/3 of department members (but not less than two (2) members) or Chairperson, given at least three (3) days notice.
- (5) Attendance required: 50% of all meetings.
- (6) Minutes: Taken by designee of Chairperson. Record attendance, discussions and matters of vote. Signed by chairperson, approved by Department and submitted to the Medical Executive Committee.
- (7) Rules of Order: Follow Roberts' Rules of Order.
- (8) Voting: Active Medical Staff.

#### 10.4 Committee Meetings.

- (1) Called by: Chairperson.
- (2) Frequency: As often as appropriate to conduct business.
- (3) Quorum: Simple majority.
- (4) Notices given by: Monthly calendar. Special meeting can be called by 1/3 of committee members (but not less than two (2) members), Chairperson or chief of staff, given at least three (3) days notice.
- (5) Attendance required: 50% of all meetings.
- (6) Minutes: Taken by designee of Chairperson. Record attendance, discussions and matters of vote. Signed by Chairperson, approved by committee and submitted to the Medical Executive Committee.
- (7) Rules of Order: Follow Roberts' Rules of Order.
- (8) Voting: Committee members.

## ARTICLE 11 IMMUNITY FROM LIABILITY

11.1 The following shall be express conditions to any individual's application or reapplication for, or exercise of, clinical privileges or Medical Staff membership at The Monroe Clinic:

11.1.1 Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made in good faith and without malice for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

11.1.2 Such privileges shall extend to members of the Medical Staff and the Governing Body, the Chief Executive Officer and any of their designated representatives and to third parties who supply information to or receive information from any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term "third parties" means both individuals and organizations who have supplied information to or received information from an authorized representative of the Hospital (including the Governing Body or the Medical Staff) and includes but is not limited to individuals, health care facilities, governmental agencies, peer review organizations and any other person or entity with relevant information.

11.1.3 There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

11.1.4 Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:

- (1) Applications for appointment or clinical privileges;
- (2) Periodic reappraisals for reappointment or clinical privileges;
- (3) Corrective action, including suspension;
- (4) Hearings and appellate reviews;
- (5) Medical care evaluations;
- (6) Utilization reviews;
- (7) Profiles and profile analysis;
- (8) Malpractice loss prevention; and
- (9) Other Hospital, departmental, or committee activities related to quality patient care and interprofessional conduct.

11.1.5 The acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

- 11.2 To reaffirm the immunity intended by this Section, each individual shall, upon request of The Monroe Clinic , execute releases acknowledging the immunity and protections set forth in this Section in favor of the individuals and organizations specified in Section 11.1.2 subject to such requirements as may be applicable under the laws of Wisconsin. Execution of such releases is not a prerequisite to the effectiveness of this Article.
- 11.3 The consents, authorizations, releases, rights, privileges and immunities required in any section of the Bylaws for the protection of The Monroe Clinic's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Article. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law.

## ARTICLE 12 CORRECTIVE ACTION

The Medical Executive Committee shall be the disciplinary body of the Medical Staff for matters involving clinical care. The disciplinary body for matters not directly involving clinical care shall be a combined Medical Staff and administrative committee, called the Medico-Administrative Committee, consisting of the Chief of Staff, the Chief Executive Officer and the Chairman of the Governing Body or his designee. Corrective action may be requested by any officer of the Medical Staff, by the chairman of any clinical division/department, by the chairman of any standing or special committee, by the Chief Executive Officer, or by the Governing Body. All requests for corrective action shall be in writing to the Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the subject of the request), and the request shall contain a detailed description of the activity or conduct upon which the request is based.

- 12.1 Grounds for Request. Conduct or activity upon which the request for corrective action may be based shall include, but not be limited to:
- (1) Conduct or activity by a Medical Staff member considered to lower the standards or aims of the Medical Staff or to adversely reflect upon the reputation of the Medical Staff or The Monroe Clinic as a whole in the community or which is disruptive to the operations of The Monroe Clinic,
  - (2) Conduct involving moral turpitude,
  - (3) Conviction of a crime,
  - (4) Unethical Practice,
  - (5) Incompetence,
  - (6) Failure to keep adequate records,
  - (7) Revocation, suspension or limitation of Practitioner's license by the appropriate licensing board or voluntarily by the Practitioner,
  - (8) Loss or limitation of Practitioner's narcotics (DEA) license,

- (9) Exercising privileges while Practitioner's professional ability is impaired, whether through illness, accident, addiction, or from any other source,
- (10) Significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the Practitioner's credentials,
- (11) Violation of these Bylaws, The Monroe Clinic's corporate bylaws, the Code of Ethics of the applicable professional association, State of Wisconsin (and/or State of Illinois, if applicable) rules or the Ethical and Religious Directives for Health Care Services as promulgated by the National Conference of Catholic Bishops
- (12) Commission of an offense that bars the Practitioner from providing services in The Monroe Clinic under Chapter DHS 12 of the Wisconsin Administrative Code, or
- (13) Failure to abide by the Corporate Compliance Program, including without limitation the Standards of Conduct and any related education and training.

## 12.2 Procedure to Determine Request.

12.2.1 Following receipt of a request for corrective action, the Chief of Staff shall determine whether or not the matter involves clinical issues. Conduct not involving clinical issues can consist of, but is not limited to, health status of the Practitioner; sexual harassment of other parties; drug, alcohol or other addictions; or criminal or other improper business conduct.

- (1) If no clinical issues are involved, the Chief of Staff shall refer the matter to the Chief Executive Officer, who shall conduct an Investigation of the matter unless he initiated the request for corrective action and has already conducted an Investigation consistent with this Section prior to filing the request. The Chief Executive Officer shall then report his findings to the Chief of Staff and the matter shall be considered by the Medico-Administrative Committee.
- (2) If the request for corrective action involves clinical issues, the Chief of Staff shall bring the matter to the Medical Executive Committee at its next scheduled meeting. If time or circumstances require prompt action, the Medical Executive Committee shall be called into a special meeting to consider the matter. The Chief of Staff or the Medical Executive Committee may elect to review the request or to appoint a special ad hoc committee to investigate the matter and report the results to the Medical Executive Committee. Such findings shall be reported to the Medical Executive Committee within thirty (30) days of receipt of the request for corrective action. The matter need not be investigated further if the request for corrective action is supported by a written report which resulted from an Investigation conducted before the request for corrective action and such Investigation was conducted consistent with this Section, including an interview with the Practitioner involved.
- (3) If the request for corrective action involves both clinical and nonclinical issues, the Medical Executive Committee shall handle all issues unless it decides to refer to the Medico-Administrative Committee. Such election to

defer may be made either before or after Investigation of the request for corrective action.

- 12.2.2 The Investigation should include an interview, if possible, with the Practitioner involved. The Practitioner shall be informed of the general nature of the charges that have been brought and that such charges may result in action entitling the Practitioner to a formal hearing.
- 12.2.3 The Practitioner shall be permitted to discuss and explain his conduct. His appearance at the interview shall not constitute a formal hearing and is considered preliminary in nature and not subject to procedural rules. A record of the interview shall be made by the Chief of Staff or his designee.
- 12.2.4 The Practitioner, at his own expense, as well as the committee conducting the Investigation and review, shall have the right of consultation with legal counsel prior to attending the interview. Due to the informal nature of the interview, legal counsel will be excluded from attending the interview except in unusual circumstance as determined by the Medical Executive Committee.
- 12.2.5 The Chief of Staff shall promptly notify the Chief Executive Officer of all requests for corrective action received and shall continue to keep the Chief Executive Officer fully informed of all action taken.
- 12.2.6 After a final decision has been made, if privileges are suspended or reduced for thirty (30) days or more, the action(s) will be reported to the appropriate state and federal organizations.

### 12.3 Medical Executive Committee Action.

- 12.3.1 Within thirty (30 ) days following receipt of the report of the Investigation of a matter involving clinical issues or a referral of a matter from the Medico-Administrative Committee, the Medical Executive Committee shall take one of the following actions:
  - (1) Issue a warning letter to the staff member,
  - (2) Issue a letter of reprimand to the staff member,
  - (3) Reject or modify the request for corrective action,
  - (4) Refer the matter to the Medico-Administrative Committee, or
  - (5) Recommend that the Governing Body:
    - (a) Require consultation,
    - (b) Impose probation for a specified term,
    - (c) Reduce privileges,
    - (d) Suspend privileges,
    - (e) Revoke privileges,

- (f) Suspend staff membership, or
- (g) Revoke staff membership.

12.3.2 Referral to the Medico-Administrative Committee shall generally occur when the Medical Executive Committee determines that nonclinical concerns outweigh any clinical concerns and that the clinical issues would not result in action by the Medical Executive Committee constituting a professional review action, as defined in Sections 13.1 and 13.1.2 of these Bylaws.

12.4 Medico-Administrative Committee Action.

12.4.1 Matters not involving clinical issues and matters referred by the Medical Executive Committee pursuant to Section 12.3.1(4) shall be handled by the Medico-Administrative Committee.

12.4.2 The Medico-Administrative Committee shall consist of the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the subject of the matter) and the Chief Executive Officer. A third individual, who shall be the Chairman of the Governing Body or his designee, shall also serve if either of the following occurs:

- (1) The Chief of Staff and the Chief Executive Officer elect to select a third person, or
- (2) The Chief of Staff and the Chief Executive Officer are unable to agree upon the disposition of the request for corrective action.

12.4.3 Within thirty (30) days following receipt of the report of the Investigation of a matter not involving clinical issues or a referral of a matter from the Medical Executive Committee, the Medico-Administrative Committee shall take one of the following actions:

- (1) Issue a warning letter to the staff member,
- (2) Issue a letter of reprimand to the staff member,
- (3) Refer the matter to the Medical Executive Committee for action or recommendation in the matter, including any action or recommendation listed in Section 12.3.
- (4) Reject or modify the request for corrective action, or
- (5) Recommend that the Governing Body:
  - (a) Impose probation for a specified term,
  - (b) Suspend privileges,
  - (c) Revoke privileges,
  - (d) Suspend staff membership, or
  - (e) Revoke staff membership.

12.5 Effect of Committee Action.

- 12.5.1 The Executive or Medico-Administrative Committee, as appropriate, shall make a written report of its action on the request for corrective action, including the reasons for the action taken and any minority views, and shall forward the report to the Chief Executive Officer for submission to the Governing Body. If the action taken by the Executive or Medico-Administrative Committee is not a professional review action, as defined in Sections 12.1 and 12.2 of these Bylaws, the Governing Body, in its sole discretion, may conduct its own Investigation, through whatever means, and, after receipt of the report of the Investigation, impose any of the sanctions set forth in Section 12.3.1.
- 12.5.2 Any recommendation by the Medical Executive Committee or the Medico-Administrative Committee or action of the Governing Body that constitutes a professional review action, as defined in Sections 12.1 and 12.2 of these Bylaws, shall entitle the affected Practitioner to a hearing, and the Medical Executive Committee or the Medico-Administrative Committee's recommendation need not be forwarded to the Governing Body until the affected Practitioner has exercised or waived his rights to such hearing and review.
- 12.5.3 If the Medical Executive Committee or the Medico-Administrative Committee makes a recommendation to the Governing Body under either Section 12.3.1(5) or 12.4.3(5), it shall also recommend the interval status of the Practitioner during the Fair Hearing Process, if invoked.
- 12.5.4 A referral from the Medical Executive Committee to the Medico-Administrative Committee or vice versa shall not constitute a professional review action and shall not give rise to a right to hearing and review.

12.6 Suspension of Privileges.

- 12.6.1 Any of the following: the Chief of Staff, the chair of the clinical department, the division chair, the Chief Executive Officer, or the Executive Committee of either the Medical Staff or the Governing Body shall each have the authority whenever action must be taken in the best interests of patient care, to suspend all or any portion of the clinical privileges of a Medical Staff member and such suspension shall become effective immediately upon imposition.
- 12.6.2 A Medical Staff member whose suspension pursuant to this Section is for more than fourteen (14) days shall be entitled to request that an expedited hearing be held on the matter within such reasonable time period as a hearing committee may be convened, not to exceed ten (10) days after receipt by the Chief Executive Officer of a request for expedited hearing unless the Practitioner authorizes an extension in writing. Such hearing shall be held in general accord with the procedures set forth in this Article 13. Due to the expedited nature of a hearing under this Section, the procedural requirements set forth in Article 13 may be adjusted as needed to facilitate expedited review while still affording due process to the Practitioner. If an expedited hearing is held at the Practitioner's request, it shall be in lieu of, and not in addition to, any right to hearing otherwise available to the Practitioner under this Article 13.



12.6.3 The Medical Executive Committee may, upon the Practitioner's request, and as soon as feasible, afford the Practitioner an opportunity to meet with the Medical Executive Committee in special session to informally discuss the suspension, whether or not an expedited hearing is requested under Section 12.6.2. The Medical Executive Committee shall be authorized to lift, maintain or modify the suspension, except a suspension imposed by the Executive Committee of the Governing Body. If the suspension:

- (1) is lifted or modified by the Medical Executive Committee but either the Chief Executive Officer or the Chief of Staff objects in writing to such action; or
- (2) is not lifted by the Medical Executive Committee and the Practitioner requests a hearing on the professional review action, but not an expedited hearing as provided in Section 12.6.2, and also requests removal of the suspension until hearing,

the suspension shall remain in effect and the Executive Committee of the Governing Body shall be convened within four (4) days of receipt of the request for hearing. The Executive Committee of the Governing Body shall consider the written positions of the Practitioner and the Medical Executive Committee on the sole issue of maintenance of the suspension pending hearing and appellate review, as well as the recommendation of the Chief Executive Officer and the Chief of Staff. The Executive Committee of the Governing Body shall be authorized to maintain, modify or lift the suspension pending hearing and shall reduce its determination to a written finding.

12.6.4 After an expedited hearing held pursuant to Section 12.6.2, the Medical Executive Committee or the Medico-Administrative Committee, as appropriate, may recommend modification, continuance or termination of the terms of the suspension. If, as a result of such hearing, the Medical Executive Committee or the Medico-Administrative Committee does not recommend immediate termination of the suspension, the affected Practitioner shall, in accordance with Article 13, be entitled to request an appellate review by the Governing Body. The terms of the suspension as sustained or as modified by the Medical Executive Committee or the Medico-Administrative Committee shall remain in effect pending a final decision thereon by the Governing Body.

12.6.5 Immediately upon the imposition of a suspension, the Chief of Staff shall provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The patient's preference shall be obtained before an alternative Practitioner is selected. The suspended Practitioner shall confer with the alternative Practitioner to the extent necessary to safeguard the patient.

12.7 Temporary Suspension - Medical Records. A temporary suspension in the form of a withdrawal of a Practitioner's admitting or surgical privileges may be imposed after warning of overdue medical records completion as required in Article 14 of these Bylaws. The suspension shall continue until the records are complete. No such suspension of privileges shall affect the status or privileges of the Practitioner as regards patients who are at the time of the temporary suspension in the Hospital under the care of the Practitioner.

## 12.8 Automatic Suspension.

- 12.8.1 Action by the applicable licensing board revoking or suspending a Practitioner's license, or imposing probation or limitation of practice, shall automatically suspend all of the Practitioner's privileges. Such shall occur whether the action of the licensing board is unilateral or agreed to by the licensee. If a Practitioner is placed on probation or the Practitioner's practice is limited by the licensing board, the Medical Executive Committee shall promptly review the matter and submit a recommendation to the Governing Body regarding the continued Medical Staff status and clinical privileges of the Practitioner. The Medical Executive Committee shall, if concurred with by the Chief Executive Officer, be authorized to lift or modify any such automatic suspension pending final determination by the Governing Body.
- 12.8.2 A Practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by such number. Further, all the Practitioner's clinical privileges which require the ability to prescribe such medications shall be automatically suspended.
- 12.8.3 An automatic suspension of all privileges of a Practitioner shall be imposed upon notification received by the Chief Executive Officer of the conviction of a Medical Staff member of a felony. The Medical Executive Committee may, upon request of the affected Practitioner, convene to review the matter and shall submit a recommendation to the Governing Body regarding the continuation of the membership and privileges of the Practitioner.
- 12.8.4 An automatic suspension of all privileges may be imposed upon a Practitioner's failure to notify the Chief Executive Officer within five (5) days of receipt by the Practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation or the filing of charges, by a Medicare peer review organization, the Department of Health and Family Services, any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin (and/or State of Illinois, if applicable). The Medical Executive Committee shall promptly review the matter and submit a recommendation to the Governing Body regarding the continued Medical Staff status and clinical privileges of the Practitioner. The Medical Executive Committee shall, if the Chief Executive Officer concurs, be authorized to lift or modify any such automatic suspension pending final determination by the Governing Body.
- 12.8.5 Absent proof of rehabilitation review approval, an automatic suspension of all privileges of a Practitioner shall be imposed upon notification received by the Chief Executive Officer that the Practitioner:
- (1) Has been convicted of a serious crime, act or offense or has pending charges for a serious crime, act or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code,
  - (2) Has been found by a unit of government to have abused or neglected a client or misappropriated a client's property, or
  - (3) Has been determined under the Children's Code to have abused or neglected a child.

As soon as possible after an automatic suspension as described above, the Medical Executive Committee shall convene to review and consider the facts under which the individual was barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. If the Practitioner demonstrates that rehabilitation review approval covering his Medical Staff appointment and clinical privileges has been received, the Medical Executive Committee may reinstate the Practitioner after determining whether it wishes to retain the Practitioner on the Medical Staff and whether it can accommodate any restrictions imposed as a condition of rehabilitation review approval. The Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances.

12.8.6 A suspension of all privileges of a Practitioner may be imposed by the Chief Executive Officer upon notification that a Practitioner:

- (1) Is under investigation for a serious crime, act or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code,
- (2) Is being investigated by a unit of government or an entity subject to DHS 12 for abuse or neglect of a client or misappropriation of a client's property, or
- (3) Is being investigated under the Children's Code or an entity under DHS 12 for abuse or neglect of a child.

As soon as possible after suspension as described above, the Medical Executive Committee shall convene to review and consider the facts under which the individual was suspended and to determine whether or not to continue the suspension pending the outcome of the investigation, terminate the suspension subject to monitoring or other safeguards pending the outcome of the investigation, or to take such further corrective action as is appropriate under the circumstances.

12.8.7 An automatic suspension of all privileges of a Practitioner shall be imposed if the Practitioner is excluded from a federally funded health care program. If the Practitioner immediately notifies the Chief Executive Officer of any proposed or actual exclusion from any federally funded health care program as required by the Bylaws, a simultaneous request in writing by the Practitioner for a meeting with the Chief Executive Officer and the Chief of Staff, or their designees, to contest the fact of the exclusion and present relevant information will be granted. This meeting shall be held as soon as feasible but not later than five (5) business days from the date of the written request. The Chief Executive Officer and the Chief of Staff or their designees shall determine within ten (10) business days following the meeting, and after such follow up investigation as they deem appropriate, whether an exclusion has occurred, and whether the Practitioner's staff membership and privileges will be immediately terminated. The determination of the Chief Executive Officer and the Chief of Staff or their designees regarding the matter shall be final, and the Practitioner will have no further procedural rights. The Practitioner will be given Special Notice of the termination decision.

12.8.8 A member who does not immediately notify the Chief Executive Officer of any proposed or actual exclusion from any federally funded health care program as required by these Medical Staff Bylaws will have his staff membership and privileges terminated, effective immediately, at such time as the Chief Executive Officer or his designee

receives reliable information of the member's exclusion. The Practitioner shall be given Special Notice of the termination as soon as feasible

- 12.8.9 Automatic suspension may be imposed upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the Chief Executive Officer or his designee, the Credentials Committee; the Medical Executive Committee or the Governing Body. Such suspension shall be imposed only if: (1) the request for information or documentation was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his inability to comply, and (4) the Practitioner was notified in writing that failure to supply the requested information or documentation within fifteen (15) days from receipt of such notice would result in automatic suspension. Any automatic suspension imposed pursuant to this Section may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his failure to supply it.
- 12.8.10 Each Practitioner shall have the duty to notify the Chief Executive Officer of any action which may constitute a cause for automatic suspension under Sections 12.8.1 and 12.8.7. Failure to report such action will result in automatic suspension.
- 12.8.11 Automatic suspension activated pursuant to this Section shall not be a professional review action and thus not give rise to any right of hearing or appellate review, including the maintaining of any suspension instituted as a result of licensing board or DEA action.
- 12.8.12 Whenever a member's membership and privileges are terminated pursuant to an automatic suspension, the Chief of Staff will assign any patients currently under the member's care in the Hospital to the care of another appropriate Practitioner, taking the patient's wishes into account when possible.
- 12.9 Time Periods for Processing. Requests for corrective action shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in these Bylaws. The time periods specified for corrective action are to guide the acting parties in accomplishing their tasks and shall not be deemed to create any right for the Practitioner to have a suspension lifted or to have a request for corrective action dismissed within those time periods.
- 12.10 Administrative Timeout. The Medical Executive Committee may, with approval from the Chief Executive Officer and the Governing Body Chair, institute one or more administrative time outs for a Practitioner for a cumulative period not to exceed fourteen (14) calendar days in a calendar year. During an administrative time out, the Practitioner may not exercise any clinical privileges except in an emergency situation or to address an imminent delivery. An administrative time out may be instituted only under the following circumstances:
- 12.10.1 When the action that has given rise to the time out relates to one of the following policies of the Medical Staff: completion of medical records, Practitioner Behavior (or

Disruptive Practitioner) Policy, or requirements for emergency department (ED) coverage.

12.10.2 When the action(s) have been reviewed by the Medical Executive Committee and only when the Medical Executive Committee has determined that one or more of the policies have been violated.

12.10.3 When the Practitioner has received at least two (2) written warnings within the last twelve (12) months regarding the conduct in question. Such warnings must state the conduct or behavior that is questioned and specify or refer to the applicable policy and state the consequence of repeat violation of the policy.

12.10.4 When the affected Practitioner has been offered an opportunity to meet with the Medical Executive Committee prior to the imposition of the administrative time out. Failure on the part of the Practitioner to accept the Medical Executive Committee offer of a meeting will not prevent the Medical Executive Committee from issuing the administrative time out.

12.10.5 An administrative time out will take effect after the Practitioner has been given an opportunity to either arrange for his patients currently at the Hospital to be cared for by another qualified Practitioner or until he has had an opportunity to provide needed care prior to discharge. During this period, the Practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. The President of the Medical Staff or his designee will determine details of the extent to which the Practitioner may continue to be involved with hospitalized patients prior to the effective date of the administrative time out.

## ARTICLE 13 HEARINGS AND APPELLATE REVIEW

13.1 Hearing Prerequisites. The following recommendations or actions shall, if deemed a professional review action pursuant to Section 13.1.2 of these Bylaws, entitle the Practitioner affected thereby (whether presently on staff with privileges or a new applicant requesting staff membership and privileges) to a hearing:

- (1) Denial of initial staff appointment,
- (2) Denial of staff reappointment,
- (3) Suspension of staff membership,
- (4) Revocation of staff membership,
- (5) Denial of requested advancement in staff category,
- (6) Reduction in staff category,
- (7) Limitation of admitting prerogatives, except for temporary suspension due to medical record delinquency,
- (8) Denial of requested clinical privileges,
- (9) Reduction in clinical privileges,

- (10) Suspension of clinical privileges (other than suspensions pursuant to Section 12.7 or Section 12.8 hereof),
- (11) Revocation of clinical privileges,
- (12) Terms of probation or preceptorship which limit clinical privileges, or
- (13) Requirement of consultation, which limits clinical privileges.

13.1.2 When Deemed a Professional Review Action. An adverse recommendation or action listed in Section 13.1 shall be deemed a professional review action only when it:

- (1) has been recommended by the Medical Executive or Medico-Administrative Committee,
- (2) has been taken by the Governing Body contrary to a favorable recommendation by the Medical Executive Committee or the Medico-Administrative Committee under circumstances where no right to hearing existed,
- (3) is a suspension imposed pursuant to Section 12.6 of these Bylaws, or
- (4) has been taken by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Executive Committee or the Medico-Administrative Committee.

Only the actions identified in Section 13.1.2 shall constitute professional review action for the purpose of these Bylaws. Since only the Medical Executive Committee, the Medico-Administrative Committee and the Governing Body have the authority necessary to adversely affect a Practitioner's status, only activity deemed a professional review action shall entitle a Practitioner to the hearing and appellate review procedure set forth in this Article 13. All actions and recommendations made by other Medical Staff committees or officials are preliminary in nature and do not of themselves constitute professional review action.

13.1.3 Basis for Professional Review Action. In formulating any professional review action or recommendation, the acting body should conclude that:

- (1) There is a reasonable belief that the action is in furtherance of quality health care or that the action is necessary to protect the general health, safety and welfare of patients or staff,
- (2) Reasonable efforts have been taken to obtain the pertinent facts, and
- (3) A reasonable belief exists that the action is warranted by the facts.

13.1.4 Notice of Professional Review Action. A Practitioner against whom professional review action has been taken pursuant to Section 13.1.2 shall within ten (10) days be given Special Notice of such action by the Chief Executive Officer. The notice to the Practitioner shall state:

- (1) that a professional review action has been taken or is proposed to be taken against the Practitioner;
- (2) the reasons for the professional review action;
- (3) that the Practitioner has a right of hearing pursuant to this Article 13 and must request such hearing within forty-five (45) days from the date of furnishing the notice or such hearing right shall be waived; and
- (4) a summary of the hearing procedures and rights of the Practitioner, which summary can be accomplished by furnishing the Practitioner a copy of this Article 13 with the notice.

13.1.5 Request for Hearing. A Practitioner shall have forty-five (45) days following the receipt of a notice pursuant to Section 13.1.4 within which to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail so that he receives it within the forty-five (45) day time limit. If an effective date is specified for a professional review action taken pursuant to Section 13.1.2, the recommended action shall take effect as of that date unless the Practitioner submits a hearing request before that date. Receipt by the Chief Executive Officer of a request for hearing shall establish the effective date of the action and maintain the status quo of the Practitioner unless the Executive Committee of the Governing Body, with appropriate Medical Staff recommendation, imposes limitations on the privileges or membership of the Practitioner pending completion of the hearing and review process.

13.1.6 Effect of Waiver by Failure to Request a Hearing. A Practitioner who fails to request a hearing within the time and in the manner specified in Section 13.1.5 waives any right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled. Such waiver of the right to hearing shall result in the following

- (1) A professional review action taken by the Governing Body shall constitute acceptance of that action, which shall thereupon become and remain effective pending the final decision of the Governing Body.
- (2) An adverse action or recommendation of the Medical Executive Committee shall remain in effect pending the final decision of the Governing Body. At the Governing Body's next regular meeting following waiver, it shall consider the Medical Executive Committee's or the Medico-Administrative Committee's recommendation, review all the information and material considered by the Medical Executive Committee or the Medico-Administrative Committee, and consider all other relevant information received from any source. The Governing Body's action on the recommendation of the:
  - (a) Medico-Administrative Committee, whether in accord with or contrary to such recommendation, shall constitute the final decision of the Governing Body.

(b) Medical Executive Committee:

- (i) If the Governing Body's action on the matter is in accord with the Medical Executive Committee's recommendation, such action shall constitute the final decision of the Governing Body.
- (ii) If the Governing Body's action has the effect of changing the Medical Executive Committee's recommendation, the matter shall be submitted to the Joint Conference Committee as provided in these Bylaws. The Governing Body's action on the matter following receipt of the Joint Conference Committee's recommendation shall constitute its final decision.

13.1.7 The Chief Executive Officer shall promptly send the Practitioner notice informing him of each action taken pursuant to this Section 13.1.6 and shall notify the Chief of Staff and the Medical Executive Committee of each such action.

13.1.8 Notice of Date for Hearing.

- (1) Upon receipt of a timely request for hearing, the Chief Executive Officer shall either take action under Section 13.1.6(2) or deliver such request to the Chief of Staff or to the chair of the Governing Body, depending on whether the recommendation or action of the Medico-Administrative Committee, the Medical Executive Committee or the Governing Body, respectively, prompted the request for hearing.
- (2) The Chief of Staff, the Chief Executive Officer or the Chair of the Governing Body, as appropriate, shall schedule a date and arrange for a hearing.
- (3) The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of the Chief Executive Officer's receipt of the request for hearing, except as provided in Section 13.1.6(2)(b)(i).
- (4) The Chief Executive Officer shall send the Practitioner notice of the time, place and date of the hearing. Unless otherwise agreed to by the Practitioner in writing and by the Chief Executive Officer, the hearing date shall not be less than thirty (30) days from the date of the notice of such hearing.
- (5) For a Practitioner who is under suspension, which will be continued in effect at least until hearing can be held, at the Practitioner's specific request for an expedited hearing, a hearing shall be held as soon as the arrangements for it may reasonably be made. Such expedited hearing shall be held no later than ten (10) days from the date of the Chief Executive Officer's receipt of the request for expedited hearing, unless the Practitioner authorizes a longer period in the request. In such event, the Chief Executive Officer shall instead send the Practitioner notice of the date of hearing as soon as feasible after scheduling same.

13.1.9 Statement of Issues and Witnesses. The notice of hearing required by Section 13.1.8 shall be accompanied by a concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question,



if any, a preliminary list of witnesses, if any, expected to testify on behalf of the body whose action prompted the request for hearing; the other reasons or subject matter, if any forming the basis for the professional review action which is the subject of the hearing; and the names of those individuals who have been chosen to serve on the Hearing Committee. Except where an expedited hearing is requested, at least ten (10) days prior to the hearing, each party shall furnish the other party a written list of the names and addresses of the individuals that party intends to call as witnesses at the hearing. Each party shall update its witness list if and when additional witnesses are identified prior to the hearing. Neither party shall call witnesses not named at least two (2) business days in advance of the hearing except in rebuttal.

#### 13.1.10 Appointment of Hearing Committee.

- (1) By the Medical Executive Committee. A hearing occasioned by a Medical Executive Committee recommendation or action pursuant to Section 13.1.2(1) or 13.1.2(3) of these Bylaws shall be conducted by a Hearing Committee appointed by the Chief of Staff and composed of at least three (3) but no more than five (5) members of the Active or Associate Medical Staff. The Chief of Staff shall designate one of the members so appointed as chair or such role may be filled by a Hearing Officer appointed in accord with Section 13.8.2, in which case the Hearing Officer shall preside as committee chair. Voting members of the Hearing Committee shall not be Practitioners in direct economic competition with the Practitioner. For purposes of this Article 13, direct economic competition shall be defined to mean those Practitioners actively engaged in practice in the primary medical community of the Practitioner, and who practice in the same medical specialty or subspecialty. The Hearing Committee may utilize, on a consulting basis, members of the same medical specialty or subspecialty.
- (2) By the Medico-Administrative Committee. A hearing occasioned by a Medico-Administrative Committee recommendation or action pursuant to Section 13.1.2(1) or 13.1.2(3) of these Bylaws shall be conducted by the Medico-Administrative Committee or, if the affected Practitioner so requests in writing, a special committee of the Governing Body appointed by the Chair of the Governing Body. The Chair of the Governing Body shall appoint three (3) members of the Governing Body to form a Hearing Committee, which shall be chaired by the Governing Body chair or his designee. If the Medico-Administrative Committee conducts the hearing, the Chief of Staff shall serve a chair.
- (3) By the Governing Body. A hearing occasioned by professional review action of the Governing Body pursuant to Section 13.1.2(2), 13.1.2(3) or 13.1.2(4) shall be conducted by a Hearing Committee appointed by the Chair of the Governing Body and composed of five (5) persons. At least two (2) Active Medical Staff members, not in direct economic competition with the Practitioner, shall be included on this Hearing Committee, when feasible. The Chair of the Governing Body shall designate whenever feasible one of the appointees to the committee as chair of the committee or such role may be

filled by a Hearing Officer appointed pursuant to Section 13.8.2. The Hearing Committee may utilize, on a consulting basis, members of the same medical specialty or subspecialty.

13.1.11 Service on the Hearing Committee. A member of the Active or Associate Medical Staff or of the Governing Body shall not be disqualified from serving on a Hearing Committee because he has heard of the case or has knowledge of the facts involved, or what he supposes the facts to be, or has participated in the review or Investigation of the matter at issue. For hearings occasioned by the action or recommendation of the Medical Executive Committee or the Governing Body, no member of the Medical Staff or Governing Body who requests corrective action pursuant to Article 12 of these Bylaws shall serve as a voting member of the Hearing Committee. However, such individuals may appear before the committee if requested by either of the parties concerned. For a hearing occasioned by the action or recommendation of the Medico-Administrative Committee, members of that committee shall serve as voting members unless the affected Practitioner requests hearing by a special committee of the Governing Body in the request for hearing. In any event, all members of the Hearing Committee shall be required to consider and decide the case with good faith objectivity.

13.1.12 Hearing Conducted by Independent Consultant. If there are not sufficient Active or Associate Medical Staff members who are not in direct economic competition with the Practitioner to form a committee under Section 13.1.10(1), the committee may be composed of other physicians not belonging the Medical Staff or an administrative hearing officer may be designated by the Chief of Staff. Additionally, the Governing Body, or the Medical Executive Committee with the Governing Body's approval, at their sole discretion but with written consent of the affected Practitioner, may elect to contract with an independent consultant to perform the functions of the Hearing Committee as set forth in this Article 13. In such event, the composition of the Hearing Committee shall be as determined by the Governing Body in its arrangements with the independent consultant. The Governing Body may require the affected Practitioner to pay a share of the independent consultant's fees, up to one-half of the total charges.

## 13.2 Hearing Process.

13.2.1 Failure to Appear for Hearing. Failure without good cause of the Practitioner to appear in person and proceed at a hearing shall constitute voluntary abandonment of the appeal and the professional review action involved shall become final and effective immediately when approved by the Governing Body. Postponement of a hearing may be effected for good cause if mutually acceptable to the parties concerned.

13.2.2 Presiding Officer. The Chair of the Hearing Committee shall be the presiding officer of the committee and shall be the presiding officer at the hearing, unless a Hearing Officer is appointed pursuant to Section 13.8.2, in which case the Hearing Officer shall be the presiding officer at the hearing. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. Unless the presiding officer is a Hearing Officer appointed pursuant to Section 13.8.2, the presiding officer

shall also vote on any final recommendations as well as on any other matters giving rise to a vote of the Hearing Committee.

#### 13.2.3 Representation.

- (1) By a Member of the Medical Staff. The Practitioner who requested the hearing shall be entitled to be accompanied by and represented at the hearing by a member of the Active or Associate Medical Staff in good standing. The Medical Executive Committee, the Medico-Administrative Committee, or the Governing Body, depending on whose recommendation or action prompted the hearing, shall appoint at least one of its members and/or another person of its choosing to represent it at the hearing to present the facts in support of the professional review action, and to examine witnesses.
- (2) By Legal Counsel. If the affected Practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to this Article 13, his request for such hearing or appellate review must so state. Such notice must also include the name, address and phone number of the attorney. Failure to notify the Hearing Committee in accord with this Section shall permit the Committee to preclude the participation by legal counsel or to adjourn the hearing for a period not to exceed twenty (20) days. The Medical Executive Committee, the Medico-Administrative Committee or the Governing Body may also be represented by an attorney. Since these proceedings are a forum for professional evaluation and discussion, and are not judicial proceedings, legal counsel's role is primarily to attend and assist their party in the proceeding. Accordingly, the Hearing Committee and/or appellate review body retains the right to limit the role of counsel's active participation in the hearing process. Any Practitioner who incurs legal fees in his behalf shall be solely responsible for payment thereof.

#### 13.2.4 Rights of Parties. "Parties" for the purpose of this Article 13 shall be the affected Practitioner and the body whose action prompted the request for hearing. During a hearing, each of the parties shall have the right to:

- (1) Call, examine and cross-examine witnesses;
- (2) Introduce exhibits and present relevant evidence, as determined by the Chair;
- (3) Rebut any evidence;
- (4) Submit a written statement at the close of the hearing; and
- (5) Record the hearing by use of a court reporter or other mutually acceptable means of recording.

#### 13.2.5 If the Practitioner who requested the hearing does not testify in his own behalf, the Practitioner may be called by the Hearing Committee or the other party and examined as if under cross-examination.

#### 13.2.6 Record of Hearing. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be

called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record, such as a court reporter, electronic recording unit, detailed transcription, or any combination thereof. If an electronic recording unit is used, each person speaking should endeavor to identify himself each time he speaks. A Practitioner electing an alternate method under Section 13.2.4(5) shall bear the cost thereof.

13.2.7 Postponement. Requests for postponement of a hearing shall be granted by the Hearing Committee only upon a showing of good cause and only if the request is prompt. A hearing shall be postponed no more than two (2) times whether at the request of the Practitioner or the other party.

13.2.8 Participation. A majority of the Hearing Committee must be present through the hearing and deliberations. If a committee member is absent from any significant part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

13.2.9 Procedure and Evidence.

- (1) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admissible if, in the judgment of the presiding officer, it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.
- (2) The committee shall be entitled to consider any pertinent material contained on file and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff or for clinical privileges. The Hearing Committee shall be entitled to conduct independent review, research and interviews, but may utilize the products of such in its decision only if the parties are aware of such and have the opportunity to rebut any information so gathered.
- (3) The Hearing Committee may meet outside the presence of the parties to deliberate and/or establish procedures. The Hearing Committee may require that the parties submit written, detailed statements of the case to the Committee and to each other. Such statements of the case may consist of a rendering of all the facts of the case. If so, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the Hearing Committee to supply a detailed statement of the case and fails to do so, the Hearing Committee can conclude that such failure constitutes a waiver of the party's case.
- (4) If the Hearing Committee determines to require the parties to submit written statements of the case, notice to that effect shall be provided to both parties at least ten (10) days prior to the hearing date. The written statements of the

case shall be supplied both to the Committee and to the other party at least forty-eight (48) hours prior to the commencement of the hearing.

- (5) Statements from members of the Medical Staff, nursing or other staff, other professional personnel, patients or others may be distributed to the Hearing Committee and the parties in advance of or at the hearing. They shall be made a part of the record of the hearing and given such credence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statement should be available at the hearing for questioning by either party if so requested.

13.2.10 Official Notice. In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Wisconsin. Parties present at the hearing shall be informed on the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

13.2.11 Burden of Proof. The body whose professional review action occasioned the hearing shall have the initial obligation to present evidence in support of its actions. The Practitioner shall then be responsible for presenting evidence that the professional review action lacked any factual basis or that conclusions drawn from the facts are either arbitrary, unreasonable or capricious. The Practitioner who requested the hearing shall at all times, however, have the burden of proving, by clear and convincing evidence, that the professional review action lacks any factual basis or that the conclusions drawn from the facts are arbitrary, unreasonable or capricious.

13.2.12 Recess and Adjournment. The presiding officer or the Hearing Committee as a whole may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, provided such adjournment shall not extend the time within which any action is required to be taken under this Article 13, without the express consent of the parties. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may, at a time convenient to itself within the time frame previously set forth in this Article 13, conduct its subsequent deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

### 13.3 Hearing Committee Report and Further Action.

13.3.1 Hearing Committee Report. Within thirty (30) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose professional review action occasioned the hearing. The written report should include an explanation for the Hearing Committee's findings and recommendations that makes a rational

connection between the issues to be decided, the evidence presented or considered and the conclusion reached.

13.3.2 Action on Hearing Committee Report. Within thirty (30) days after receipt of the report of the Hearing Committee, the Medical Executive Committee, the Medico-Administrative Committee, or Governing Body, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. The results of that consideration shall be transmitted to the Chief Executive Officer together with the hearing record, the report of the Hearing Committee and all other documentation considered.

13.3.3 Favorable Result.

- (1) By the Governing Body. If the Governing Body's result pursuant to Section 13.3.2 is favorable to the Practitioner, such result shall become the final decision of the Governing Body and the matter shall be considered finally closed.
- (2) By the Medical Executive Committee or the Medico-Administrative Committee.
  - (a) If the Medical Executive Committee or the Medico-Administrative Committee result is favorable to the Practitioner, the Chief Executive Officer shall, within seven (7) days of his receipt thereof, forward the result, together with all supporting documentation, to the Governing Body for action.
  - (b) The Governing Body shall, within ten (10) days following its Chairman's receipt of the favorable result of the committee, take action thereon by adopting or rejecting the Medical Executive Committee's or the Medico-Administrative Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee or the Medico-Administrative Committee for further consideration. Any referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Governing Body must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Governing Body shall take final action.
  - (c) Any favorable action by the Governing Body shall become its final action and the matter will be finally closed. Any unfavorable action by the Governing Body shall be controlled by Section 13.3.4.

13.3.4 Unfavorable (Adverse) Result. If the result of the Medical Executive Committee, the Medico-Administrative Committee or the Governing Body pursuant to Sections 13.3.2 or 13.3.3 is or remains adverse to the Practitioner as set forth in Section 13.1.2, the affected Practitioner shall have the right to request an appellate review by the Governing Body as provided in 13.4. If it is the result of the Medical Executive Committee or the

Medico-Administrative Committee, the result will not be forwarded to the Governing Body for final action until the Practitioner has either waived or exercised the right to appellate review.

#### 13.3.5 Notice of Result.

- (1) The Chief Executive Officer shall promptly send a copy of the result under Section 13.3.2 to the Practitioner by Special Notice. The Practitioner shall be furnished a copy of the Hearing Committee report with such notice as well as the written decision or recommendation of the body acting on the Hearing Committee report.
- (2) If the result sent to the Practitioner is or continues to be unfavorable to the Practitioner in any of the respects listed in Section 13.1, the Special Notice shall state, in addition to the result:
  - (a) that the Practitioner has a right to request an appellate review by the Governing Body of the decision made pursuant to Section 13.3.2,
  - (b) that the Practitioner has fifteen (15) days, following mailing the notice required by this Section, to file a written request of appellate review and that failure to properly request such review shall constitute a waiver of the right to review, and
  - (c) a summary of the appellate review procedures, which summary can be accomplished by furnishing the Practitioner a copy of this Article 13 with the notice.

#### 13.4 Initiation and Prerequisites of Appellate Review.

- 13.4.1 Request for Appellate Review. A Practitioner shall have fifteen (15) days following the mailing of a. notice pursuant to Section 13.3.5 within which to file a written request for appellate review. Such request shall be delivered to the Chief Executive Officer within the time specified either in person or by certified or registered mail and may include a request for a copy of the record of the Hearing Committee and all other material that was considered in making the adverse action or result, whether favorable or unfavorable, if not previously forwarded.
- 13.4.2 Waiver of Appellate Review. A Practitioner who fails to request an appellate review within the time and in the manner specific in Section 13.4.1 waives any right to such review. A Practitioner who fails to submit a written statement required by Section 13.5.2 shall also be deemed to have waived the right to appellate review. Such waiver shall have the same force and effect as that provided in Section 13.1.5.
- 13.4.3 Notice of Date. Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Chair of the Governing Body. Within ten (10) days after receipt of such request, the Chair of the Governing Body shall schedule and arrange for an appellate review which shall be conducted not more than thirty-five (35) days from the date the Chief Executive Officer received the appellate review request. At least twenty (20) days prior to the appellate review, the Chief Executive Officer shall send the Practitioner notice of the date of the review. An

appellate review for a Practitioner who is under a suspension or revocation then in effect shall be held as soon as the arrangements for it may reasonably made, but not later than twenty (20) days from the date the Chief Executive Officer received the request for review. In such case, the Practitioner shall be afforded notice of the date of review as soon as feasible. The time for the appellate review may be extended by the Appellate Review Body for good cause. The appellate review can occur at a regular meeting of the Governing Body.

- 13.4.4 Appellate Review Committee. The Chair of the Governing Body shall determine whether the appellate review shall be conducted by the Governing Body as a whole or by an Appellate Review Committee composed of three (3) to five (5) members of the Governing Body, appointed by the Chair of the Governing Body. If a committee is appointed, the Chair of the Governing Body shall designate one of its members as chair. If a committee is appointed, members of the Governing Body who did not serve on the hearing committee shall be appointed to the Appellate Review Committee unless the size of the Governing Body makes this impracticable.

### 13.5 Appellate Review Procedure.

- 13.5.1 Nature of Proceedings. The proceedings by the Appellate Review Committee shall not be a new or additional hearing, but shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that committee's report, and all subsequent results and actions. The Appellate Review Committee shall also consider the written statements, submitted pursuant to Section 13.5.2 and such other material as may be presented and accepted under Section 13.5.4 and 13.5.5.
- 13.5.2 Written Statements. The Practitioner seeking the appellate review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Appellate Review Committee through the Chief Executive Officer at least ten (10) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Executive Committee, the Medico-Administrative Committee or by the Governing Body, as the case may be; and if submitted, the Chief Executive Officer shall provide a copy thereof to the Practitioner at least five (5) days prior to the scheduled date of the appellate review. These filing deadlines do not apply to an expedited review as permitted in Section 13.4.3. In that case, the written statement shall be submitted with the request for appellate review. In any event, failure to submit the written statement by the applicable deadline shall constitute a waiver of the right to appellate review and the appellate review shall be canceled.
- 13.5.3 Presiding Officer. The Chair of the Appellate Review Committee shall be the presiding officer. He shall determine the order of the procedure during the review, make all required rulings, and maintain decorum.
- 13.5.4 Oral Statement. The Appellate Review Committee, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions directed to him by any member of the Appellate Review Committee. If a personal appearance is allowed, the Chief Executive Officer shall notify the Practitioner



by Special Notice of the date scheduled for oral arguments at least five (5) days in advance, with a copy to the body whose decision resulted in the appellate review.

- 13.5.5 Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the Appellate Review only under unusual circumstances. The Appellate Review Committee, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted. The party requesting the consideration of such matters or evidence shall explain the reasons for not presenting it earlier.
- 13.5.6 Powers. The Appellate Review Committee shall have all the powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.
- 13.5.7 Participation. A majority of the Appellate Review Committee must be present throughout the review and deliberations. If a member of the review committee is absent from any significant part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.
- 13.5.8 Recesses and Adjournment. The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.
- 13.5.9 Action Taken.
- (1) Within ten (10) days following final adjournment, the Appellate Review Committee shall submit a written report of its findings and recommendations in the matter to the Governing Body. If appellate review is conducted by the Governing Body as a whole, its conclusions shall be the Governing Body's final action unless otherwise provided in this Article 13.
  - (2) The Appellate Review Committee may recommend that the Governing Body affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee, by the Medico-Administrative Committee or by the Governing Body pursuant to Section 13.3.2 and 13.3.3(2)(b). In its discretion, the Appellate Review Committee may refer the matter back to the Hearing Committee for further review and require a recommendation to be returned to the Appellate Review Committee within twenty (20) days. Such recommendation shall be in accordance with the Appellate Review Committee's instructions. Any written report following referral shall be shared with the Practitioner. Within ten (10) days after receipt of such recommendation after referral, the Appellate Review Committee shall make its recommendations to the Governing Body to affirm, modify or reverse the professional review action of the body who occasioned the review.

13.5.10 Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

13.6 Final Decision and Action of the Governing Body.

13.6.1 Within ten (10) days after receipt of the recommendation of the Appellate Review Committee, the Governing Body shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by Special Notice and to the Chief Executive Officer and the Medical Executive Committee.

13.6.2 If the Governing Body's decision is to affirm its last adverse recommendation in the matter, if any, it shall be immediately effective and final.

13.6.3 If the Governing Body's decision is to affirm the Medical Executive Committee's or the Medico-Administrative Committee's last adverse recommendation in the matter, if any, it shall be immediately effective and final.

13.6.4 If the Governing Body's action has the effect of changing the Medical Executive Committee's last adverse recommendation, if any, the Governing Body shall refer the matter to the Joint Conference Committee as provided in Section 13.7. The Governing Body's action on the matter following receipt of the Joint Conference Committee's recommendation shall be immediately effective and final.

13.6.5 If the Governing Body's decision has the effect of changing the Medico-Administrative Committee's last adverse recommendation if any, the Governing Body's action shall be effective and final upon notice of same to the Chief Executive Officer.

13.6.6 When a final decision is made by the Governing Body, a copy of the decision will be sent by the Chief Executive Officer to the Practitioner by Special Notice and to the Medical Executive Committee.

13.7 Joint Conference Committee Review.

13.7.1 Membership. The Joint Conference Committee shall be composed of a total of six (6) members selected in the following manner: three (3) members from the Medical Executive Committee appointed by the Chief of Staff, and three (3) members from the Governing Body appointed by the Chair of the Governing Body.

13.7.2 Time Limits.

(1) Within seven (7) days following the conclusion of its consideration, the Joint Conference Committee shall submit its recommendation to the Governing Body.

(2) Within seven (7) days following receipt of a matter referred to the Joint Conference Committee by the Governing Body pursuant to the provisions of these Bylaws, the committee shall convene to consider the matter.

(3) The Governing Body's action on the matter following receipt of the Joint Conference Committee's recommendation shall be immediately effective and final.

### 13.8 General Provisions.

- 13.8.1 Number of Hearings and Reviews. Notwithstanding any other provision of these Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to professional review action.
- 13.8.2 Hearing Officer Appointment and Duties. The use of a Hearing Officer to preside at a hearing held in accord with this Article 13 is optional. The use of such Hearing Officer shall be determined by the Chief Executive Officer after consultation with the Chair of the body whose action triggered the right to hearing. A Hearing Officer may or may not be an attorney-at-law but must be experienced in conducting hearings. Such Hearing Officer shall act in an impartial manner as the presiding officer of the hearing. If requested by the Hearing Committee, the Hearing Officer may participate in its deliberations and act as its advisor, but shall not be entitled to vote.
- 13.8.3 Waiver. If at any time after receipt of Special Notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with this Article 13, he shall be deemed to have consented to such professional review action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Article 13 with respect to the matter involved.
- 13.8.4 Agreement to be Bound by Bylaws. By requesting a hearing or appellate review under this Article 13, a Practitioner agrees to be bound by the provisions of Section 11.1.3 (Indemnification from Liability) of the Medical Staff Bylaws in all matters relating.
- 13.8.5 Waiver of Time Limits. Any time limits set forth in these Bylaws may be extended or accelerated by mutual agreement of the Practitioner and the Chief Executive Officer or the Medical Executive Committee. The time periods specified in this Article 13 for action by the Medical Staff, the Governing Body and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the Fair Hearing Process or Corrective Action Procedures are not completed within the time periods specified.
- 13.8.6 Substantial Compliance. Technical or insignificant deviations from the procedures set forth in this Article 13 shall not be grounds for invalidating the action taken.

## ARTICLE 14 RULES AND REGULATION OF THE MEDICAL STAFF

### 14.1 Medical Staff.

- 14.1.1 The Medical Staff of The Monroe Clinic is dedicated to quality care of all patients regardless of race, creed, color, ancestry, religion, newborn status, disability, source of payment, gender, age, sexual orientation, marital status or national origin.
- 14.1.2 Any and all problems and concerns regarding Hospital Division personnel in which the parties directly involved are unable to resolve to their mutual satisfaction shall be referred through the Medical Staff chain of command; i.e., to the Chair of the Department, to the Chair of the Division, to the Chief of Staff, to the Medical Director, to the Chief Executive Officer. Such referrals may be accomplished by an individual physician and/or by a committee of the Medical Staff.

- 14.1.3 Members of the Medical Staff are required to attend and/or comply with legal, state and/or accreditation requirements placed on the institution.
- 14.1.4 Each member of the Medical Staff shall have the obligation to provide to the Governing Body and the appropriate Committees of the Medical Staff, necessary documentation to support his applications for Medical Staff privileges.
- 14.2 Physicians.
- 14.2.1 The attending physician shall have ultimate responsibility and authority for the medical care and treatment of each patient. The attending physician is the one who maintains primary responsibility for determining the patient's continued need for acute care and readiness for discharge even when the physician referred the patient to one or more consulting physicians for specialized treatment. The admitting physician will be considered the attending physician throughout the patient's stay unless that physician transfers responsibility for care of the patient to another physician who accepts that transfer, and so notes that transfer on the order sheet of the medical record.
- 14.2.2 Patient treatment must not conflict with the Ethical and Religious Directives for Catholic Health Care Services, which is part of this Article 14.
- 14.2.3 No member of the Medical Staff shall give to or receive from, directly or indirectly, another physician any part of the fee received from the patient for any professional service not actually rendered except when the physician has performed a portion of the professional service that forms the basis for the fee.
- 14.3 Division/Department. Each division/department shall have the prerogative to establish respective policies and procedures as long as these do not conflict with the Bylaws of the Medical Staff.
- 14.4 On Call Responsibilities.
- 14.4.1 Each department is responsible for producing an "on-call" schedule for its members. Departments exempt from providing monthly "on-call" schedules shall be determined by the Medical Executive Committee.
- 14.4.2 The department chairperson will make the call schedule available for Hospital consultations and emergency room coverage.
- 14.4.3 If a decision regarding the call arrangements cannot be reached by department members, the Division Chair will serve as consultant to arrange an equitable schedule for the department members. If the matter cannot be resolved at this level, it will be referred to the Medical Executive Committee.
- 14.4.4 Individuals are responsible for participating in "on-call" coverage as assigned by their department.
- 14.5 Patient Care.
- 14.5.1 All patient care shall be conducted in accordance with generally recognized professional standards.

- 14.5.2 Except in an emergency provisional diagnosis must be made before a patient is admitted. In emergency cases the diagnosis shall be stated as soon as possible after admission.
- 14.5.3 Standing orders may be adopted as needed by the various departments, services and physicians.
- 14.5.4 All orders for treatment shall be entered through the Hospital electronic health record. Orders dictated over the telephone shall adhere to patient safety guidelines, follow the guidelines outlined in Section 14.8 – Medical Records, and be signed by the person to whom dictated with the name of the physician clearly documented.
- 14.5.5 Periodic review of drug orders and automatic stop orders on certain drugs and therapeutics may be required by policies adopted by the Pharmacy Nutrition Therapy Committee and approved by the Medical Executive Committee. Therapeutic substitutions approved by the Medical Executive Committee upon recommendation by the Pharmacy Nutrition Therapy Committee may be made unless the attending physician's order specifically prohibits substitutions.
- 14.5.6 Except in emergencies, all patients capable of consenting or their legally authorized representatives, if available, shall consent to medical, surgical and invasive diagnostic procedures, such consent having been preceded by a thorough explanation of the risks, benefits and potential complications associated with the procedures to be undertaken by the attending physician. The foregoing shall be documented in the chart. Please refer to the Consent Policy as promulgated by the Ethics Committee.
- 14.5.7 All operations/diagnostic procedures performed shall be fully described including a description of the techniques and findings, specimens and post-op diagnosis by the attending surgeon/physician immediately following the operation/procedure, whenever possible, and always within twenty-four (24) hours. All tissues and foreign bodies, except live births and other items on the approved exempt list, removed in an operation/procedures, shall be sent to the pathologist who shall, within twenty-four (24) hours, make such examinations as he may consider necessary to arrive at a specific pathological diagnosis.
- 14.5.8 Consultation.
- (1) Compulsory Consultation.
- (a) If the quality of health care rendered by a physician or mid-level provider is challenged, a review of the situation with the attending physician may be made by any two of the following: Chairperson of any concerned department, Chairperson of any concerned Division, the Chief of Staff, Vice Chief of Staff, Medical Director, or any officer of the Medical Staff. If, after review, the health care is found to be appropriate, no further action will be pursued. If the reviewers question the care, then the reviewers may appoint an appropriate consultant for a compulsory consultation. If the attending physician fails to agree to the consultation or fails to conform to the consultant's

recommendation, the officials involved may initiate the processes outlined in Article 12 Corrective Action of these Bylaws.

- (b) When a psychologist is the attending, a physician must be responsible for the medical aspects of care.

(2) Consultation is mandatory:

- (a) When an unusually complicated situation arises where specific skills of other Practitioners are needed.
- (b) When requested by the patient's family.
- (c) If other conditions are specified by the Medical Executive Committee.

(3) Consultation is encouraged:

- (a) When the diagnosis remains obscure after appropriate diagnostic procedures.
- (b) When there is serious doubt regarding the choice of therapeutic measures.
- (c) In an instance where the patient exhibits severe psychiatric symptoms, if in the opinion of the attending physician a bona fide suicide attempt has been made by a patient, a psychiatric consultation will be requested and offered to the patient.
- (d) Whenever it seems advisable to the attending physician.

14.5.9 The Medical Staff may delegate to the nursing personnel and Allied Health Professionals employed by the organization or otherwise granted permission to perform responsibilities for certain procedures involved in the care of their patients. All patient standard care procedures shall be approved when appropriate by the Nursing Administration Committee, by the appropriate clinical departments and the Medical Executive Committee. Standard procedures so delegated shall be incorporated into the Nursing Policy and Procedure Manual and other appropriate procedure manuals.

14.5.10 Transfusions shall be given in keeping with the policies and procedures adopted by the Medical Executive Committee.

14.5.11 Medications will be administered according to the established protocol.

14.5.12 Restraints may be used in accordance with current Nursing Administration Policies.

#### 14.6 Admissions, Transfers and Discharges.

##### 14.6.1 Admissions.

- (1) Patients shall be admitted to The Monroe Clinic only by a member of the Active, Associate or Courtesy staff according to criteria established in these Medical Staff Bylaws.

- (2) Priorities for admission shall be established in keeping with policies that may be adopted from time to time by the Medical Staff or the Medical Executive Committee. These priority categories may include, but are not limited to:
  - (a) emergent
  - (b) urgent
  - (c) elective or scheduled
- (3) Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis and available identifying data have been given to the admissions office by a physician member of the Medical Staff or his representative.
- (4) Staff physicians requesting admissions of patients shall be held responsible for getting such information as they may be reasonably expected to obtain, in order to ensure the protection of other patients and personnel.

#### 14.6.2 Transfers.

- (1) When a routine or emergency care patient is transferred, arrangements shall be made by the patient's physician for positive acceptance by the receiving facility and physician, and all pertinent medical information shall accompany the patients.
- (2) Transfers between inpatient services shall not be made until the patient has been accepted by the receiving physician. A note covering the transfer must be entered in the medical record and shall indicate the responsible attending physician after transfer.
- (3) Patients who present with an unstable emergency medical condition or in active labor shall be transferred to another facility only after they are stabilized or when the required medical care cannot be provided at the Hospital and the responsible physician determines the medical benefits of transfer outweigh the risks and signs a certification of the same or if the patient requests a transfer. All patients will receive stabilizing treatment within the hospital's capacity prior to transfer to another facility.

14.6.3 Passes. Patients may be granted passes in a manner and following procedures that shall be determined by the department, Medical Executive Committee and administration.

14.6.4 Discharges. The attending physician or mid-level provider shall begin planning for discharge as soon as possible after the patient is admitted to assure that proper discharge arrangements can be made. Patients shall be discharged only upon the order of a physician, psychologist or mid-level provider (under protocol).

#### 14.6.5 Deaths.

- (1) A patient shall be pronounced dead by a physician member of the Medical Staff in accordance with State guidelines and a copy of the death certificate shall be made part of the patient's hospital record. The physician shall be

required to sign the record for the fact and time of death and for release of the body.

- (2) The attending physician or designee is responsible for immediate notification of the patient's family and prompt notification of the referring physician.
- (3) All members of the Medical Staff are expected to be actively interested in securing autopsies in all cases of unusual deaths and of medical, legal and educational interest. No autopsy will be performed without recorded consent of the legally responsible agent. Physicians seeking autopsies shall explain to the legally responsible person what constitutes a routine autopsy and the extent of the procedure. The Pathology Department shall be notified regarding exceptions in the autopsy procedure so that the intent of the person giving the consent shall be honored.
- (4) Policies with respect to the autopsies and release of bodies shall conform to Wisconsin laws.

#### 14.7 Special Care Units and Special Situations.

14.7.1 Medical Staff committees responsible for the operation of special care areas shall promulgate regulations for the care of patients in special units. These policies, procedures and regulations shall be approved by the Medical Executive Committee. These special care areas may include, but shall not necessarily be limited to: Recovery Rooms, Coronary Care Units, Intensive Care Units, Physical Therapy, Occupational Therapy, Respiratory Therapy, Cath Lab, Sleep Lab, and Emergency Room.

14.7.2 A disaster manual is the responsibility of the Disaster Committee and is reviewed by Emergency Services and the Medical Executive Committee.

#### 14.8 Medical Records.

14.8.1 The attending physician shall be responsible for the preparation of a timely, accurate, current, and complete medical record.

14.8.2 A complete medical record shall include, as applicable:

- (1) Accurate patient identification data.
- (2) Emergency care, treatment, and services provided to the patient before his arrival, if any.
- (3) Documentation and findings of assessments.
- (4) Conclusions or impressions drawn from medical History and Physical examination (see Section 14.8.3).
- (5) The diagnosis, diagnostic impression, or conditions.
- (6) The reason(s) for admission or care, treatment, and services.
- (7) The goals of the treatment and treatment plan.



- (8) Diagnostic and therapeutic orders.
- (9) All diagnostic and therapeutic procedures, tests, and results.
- (10) Progress notes made by authorized individuals.
- (11) All reassessments and plan of care revisions, when indicated.
- (12) Relevant observations.
- (13) The response to care, treatment, and services provided.
- (14) Consultation reports containing a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.
- (15) An Operative Report describing techniques and findings entered in the electronic health record or dictated immediately following surgery and signed by the surgeon.
- (16) Allergies to foods and medicines.
- (17) Every medication ordered or prescribed.
- (18) Every dose of medication administered, including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and any adverse drug reaction.
- (19) Every medication dispensed or prescribed on discharge.
- (20) All relevant diagnoses/conditions established during the course of care, treatment, and services.
- (21) Discharge Summary (see Section 14.8.7).
- (22) Autopsy findings, when an autopsy is performed.
- (23) Anatomical gift information.

#### 14.8.3 History and Physical.

- (1) Patient medical history and physical examination (i) must be completed and documented for each patient no more than thirty (30) days before and twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and (ii) when the medical history and physical examination is completed within thirty (30) days before admission or registration, be updated, including any changes in the patient's condition, and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
- (2) The history and physical examination shall be available on the medical record within twenty-four (24) hours of an unplanned admission by a member of the Medical Staff, mid-level provider or a resident or senior medical student

engaged in an approved rotation under the supervision/protocol of the attending staff.

- (3) If the History and Physical examination is recorded by a **resident** engaged in an approved rotation, the attending physician is required to countersign the record within twenty-four (24) hours indicating review and either approval of the history and physical examination or appropriate revision. The attending physician is responsible for creating an attestation note documenting key components of the history and physical and linking this note with the **resident's** history and physical or performs a stand-alone history and physical for compliance with CMS billing guidelines.
- (4) If the history and physical examination is recorded by a medical student engaged in an approved rotation, the attending physician is required to countersign immediately. In addition to countersigning the history and physical examination, the attending physician must repeat the history and physical to confirm findings and create a stand-alone history and physical for compliance with CMS billing guidelines.

#### 14.8.4 Orders.

- (1) All orders, including telephone and verbal, given by The Monroe Clinic credentialed Practitioners shall be signed within forty-eight (48) hours.
- (2) Personnel authorized to accept verbal and telephone orders include registered nurses and certified/licensed Allied Health Professionals. Such orders will be taken in a manner consistent with patient safety guidelines.
- (3) All verbal or telephone orders, regardless of where received, must be read back to the ordering Practitioner and entered in the patient medical record and shall be signed by the appropriately authorized person to whom dictated, with the name of the Practitioner and his credentials. Verbal and telephone orders shall be strictly confined to circumstances in which patient care needs required them.

#### 14.8.5 Orders for Drugs and Biologicals. All verbal and telephone orders given by The Monroe Clinic credentialed Practitioners for drugs and biologicals must be signed by the prescribing Practitioner at the earliest of the following:

- (1) The next time the prescribing Practitioner provides care to the patient, assesses the patient, or documents information in the patient's medical record;  
OR
- (2) Within forty-eight (48) hours of when the order was given.

#### 14.8.6 Progress Notes.

- (1) Physician notes and non-physician notes providing a chronological picture of the patient's progress, which are sufficient to delineate the course and the results of treatment shall be written with a minimum frequency of one progress note per day.

- (2) Progress notes that are recorded by a student or other approved medical personnel must be immediately countersigned by the attending physician, based on appropriate state/accreditation requirements for each extender category. If the progress note is recorded by a **resident** engaged in an approved rotation, the attending physician is required to countersign the record within twenty-four (24) hours indicating review and either approval of the progress note or appropriate revision. The attending physician is responsible for creating an attestation note documenting key components of the progress note and link this note with the **resident's** progress note or perform a stand-alone progress note for compliance with CMS billing guidelines. If the progress note is recorded by a medical student engaged in an approved rotation, the attending physician is required to countersign immediately. In addition to countersigning the progress note, the attending physician must repeat the history and physical to confirm findings and create a stand-alone progress note for compliance with CMS billing standards.

14.8.7 Discharge Summary. A concise Discharge Summary shall be entered electronically upon discharge and completed within fifteen (15) days, providing information to other caregivers and facilitating continuity of care and will include the following:

- (1) The reason for hospitalization.
- (2) Significant findings.
- (3) Procedures performed and care, treatment, and services provided.
- (4) The patient's condition at discharge.
- (5) Information to the patient and family, as appropriate.
- (6) In the case of normal deliveries and normal infants, a standardized summary form instead of dictation is acceptable.
- (7) On transfer of a patient to another facility, the discharge summary shall be printed prior to or upon discharge.
- (8) If the discharge summary is recorded by a **resident** engaged in an approved rotation, the attending physician is required to countersign the record indicating review and either approve the discharge summary or appropriate revision. The attending physician is responsible for creating an attestation note documenting key components of the discharge summary and linking this note with the **residents** progress note or perform a stand-alone discharge summary for compliance with CMS billing guidelines. If the discharge summary is recorded by a medical student engaged in an approved rotation, the attending physician is required to countersign immediately. In addition to countersigning the discharge summary, the attending physician must repeat the discharge exam and confirm findings and create a stand-alone discharge note for compliance with CMS billing guidelines.

14.8.8 Symbols and abbreviations in the medical record will be allowed as recommended by the Patient Safety Committee and as approved by the Medical Executive Committee.

The Organizational Abbreviations Policy is included in the Administration Policy Manual # 800-012.

14.8.9 At a minimum, the following are authenticated either by written signature or electronic signature. Electronic signature is the preferred method of authentication:

- (1) History and Physical Examination.
- (2) Orders.
- (3) Operative Report.
- (4) Consultations.
- (5) Discharge Summary.

14.8.10 Final diagnosis for all patients must be determined within thirty (30) days.

14.8.11 Record completion by the attending physician is required within fifteen (15) days of discharge. The medical record will be considered overdue after fifteen (15) days and the Practitioner will be given notice to complete the record. If the record is not completed within thirty (30) days of discharge, the Chief Medical Officer may suspend the Practitioner's admitting privileges on the thirty-first (31st) day after discharge.

14.8.12 Completion of incomplete records due to death, departure, or incapacity of a physician shall be determined by the Chief Medical Officer with the assistance of the Medical Record Department Supervisor/Director. The Chief Medical Officer will complete the Retirement of Incomplete Medical Record form, which certifies that all efforts to complete the medical record have been exhausted and there is no reasonable expectation of completion in the foreseeable future. It is therefore ordered filed in its incomplete state.

14.8.13 A charting error is corrected in the electronic medical record by the person making the error. All corrections must be made during the patient stay or within 30 days of discharge or outpatient visit.

14.8.14 Any addendum shall be denoted as such and dated as applicable to reflect when the addendum was actually entered, with references, where appropriate, to the date or dates of the chart entries to which the addendum applies.

14.9 Peer Review Process. Medical Staff Peer Review is conducted according to the guidelines in the Medical and Affiliate Staff Peer Review/ Ongoing Professional Practice Evaluation Policy and occurs within all departments at The Monroe Clinic. All peer review information is confidential and protected as are all participants in the peer review process when reviewing quality information. This includes but is not limited to: department / division chairs and members, Peer Review Committee, Credentials Committee, Medical Executive Committee minutes and members, risk management and quality management staff who attend Peer Review and other committee meetings, as well as any other involved in the care at issue. The goals of the peer review process are:

- (1) to improve the quality of care provided by the Medical Staff;

- (2) to continuously monitor the performance of the Medical and Affiliate Staff;
- (3) to identify areas for performance improvement; and
- (4) to continuously monitor significant trends by analyzing aggregated data.

## ARTICLE 15 AMENDMENT AND ADOPTION

15.1 Dues. There are no dues required of the Medical Staff.

### 15.2 Amendments.

15.2.1 Medical Staff Responsibility. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, with a major review approximately every three (3) years, so as to have bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing, effective professional review.

15.2.2 Methodology. Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

- (1) These Bylaws may be amended after submission of the proposed amendment by the Medical Executive Committee or by a petition signed by 25% of the members of the Active Medical Staff at any regular or special meeting of the Medical Staff. An amendment proposed by the Medical Staff may be referred to the Bylaws Committee or the Medical Executive Committee, which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. The vote will be taken at the next full staff meeting or may be mailed to voting members of the Medical Staff for approval by written or secure electronic ballot. To be adopted, an amendment shall require a two-thirds vote of the Active Medical Staff. The Medical Executive Committee shall determine whether to submit the proposed amendments for approval by mail or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail shall be subject to approval by two-thirds of the members of the Active Staff by submitting written or secure electronic ballots. Written or secure electronic ballots shall be prepared and validated in such manner as the Medical Executive Committee shall determine. An affirmative vote will be counted by returning the ballot marked "yes" or by not returning the ballot. Amendments so made shall be effective when approved by the Governing Body. In the event of a conflict between members of the Medical Staff and the Medical Executive Committee regarding the adoption of any bylaw, or any amendment thereto, the Conflict Resolution process set forth in Section 15.4 shall be followed.
- (2) The amendment shall be presented to the Governing Body at its next meeting. The amendment is not final until it receives an affirmative vote of the majority of the Governing Body.

- (3) Neither the Medical Staff nor the Governing Body may adopt a bylaw amendment by unilateral action. Unilateral action by the Governing Body for these purposes would be the adoption of a proposed amendment without notice to the Medical Executive Committee and Medical Staff and further without providing a reasonable time for response and recommendation.

### 15.3 Policies.

15.3.1 The Medical Staff may from time to time create policies which define the manner in which the Medical Staff and its committees, services and departments carry out the duties assigned to each group. The purpose of policies will be to insure successive committee and leadership groups carry out their duties in a consistent manner. Policies will be drafted by the Medical Staff committee, service or department that will be governed by that policy and forwarded to the Medical Executive Committee for its review. Before any policy can be implemented, the Medical Executive Committee must review it to ensure it complies with the guidelines for policy development and purpose as outlined in these Bylaws. Any policy adopted by the Medical Executive Committee and approved by the Governing Body shall be promptly communicated to the Medical Staff.

15.3.2 Once the Medical Executive Committee determines the policy complies with these Bylaws, the originating department, service or committee shall implement that policy. Should any member(s) of the Medical Staff subsequently conclude that policy improperly infringes on the duties and responsibilities of a Practitioner, that Practitioner may submit his objections to the policy to the Medical Executive Committee staff in writing. The Medical Executive Committee shall then seek to identify an appropriate solution to the concern raised by the Practitioner. If the Medical Executive Committee is unable to identify a solution acceptable to all parties, or, if the policy was formulated and implemented by the Medical Executive Committee itself, that concern shall be forwarded to the full Medical Staff at its next quarterly meeting for review and discussion. The Medical Staff may, by a two-thirds vote of the members of the Active Medical Staff present at a duly convened meeting of the Medical Staff, vote to revoke a policy. The Medical Executive Committee shall then return such policy to the originating department, service or committee with a written explanation of what must be changed in the policy before the committee will again consider the policy, or, if the Medical Executive Committee was the origin of the policy, must seek to modify the policy to satisfy the concerns raised by the full Medical Staff.

15.4 Conflict Resolution. In the event of a conflict between members of the Medical Staff and the Medical Executive Committee regarding the adoption of any bylaw, policy or any amendment thereto, the matters shall be submitted to a joint meeting of equal members of the Medical Staff and the Medical Executive Committee for review and recommendation to the Governing Body. If resolution cannot be made through this process, both groups shall submit their position to the Governing Body for final decision. Such amendments shall be effective when approved as decided by the Governing Body. In the event the Medical Staff proposes an amendment that is not approved by the Medical Executive Committee, the same process for resolving conflict between the Medical Staff and the Medical Executive Committee shall be followed.

- 15.5 Adoption. These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, Credentialing Manual and Fair Hearing Plan and shall become effective when approved by the Governing Body of The Monroe Clinic.

Adopted by the Active Medical Staff of The Monroe Clinic

December 20, 2011

Date

\_\_\_\_\_  
Amy Simantel, MD  
Chief of Staff

Approved by the Governing Body of The Monroe Clinic

December 19, 2011

Date

\_\_\_\_\_  
Anthony Rogerson, MD  
Secretary of the Governing Body

Revised: June 2005; June 2009, December 2011  
KS/08/04

**ST. CLARE HOSPITAL AND HEALTH SERVICES**

**MEDICAL STAFF BYLAWS**

**(2011)**



## **PREAMBLE**

WHEREAS, SSM Health Care of Wisconsin, Inc. owning and operating St. Clare Hospital and Health Services, Baraboo, Wisconsin, is a non-profit corporation organized under the laws of the State of Missouri with the purpose of providing patient care, education and research; and (6/00)

WHEREAS, the hospital Board of Directors wishes to delegate to the clinical services, to the committees of the Medical Staff, and specifically to certain officers of the staff, and members of those committees, duties and responsibilities for monitoring the quality of medical care in the hospital, refining quality assurance mechanisms and reporting thereon concerning each applicant's appointment or reappointment to the Medical Staff of the hospital and the clinical privileges such applicant shall enjoy in the hospital;

THEREFORE, to discharge these duties and responsibilities to the hospital in an orderly fashion the physicians, podiatrists and dentists practicing in St. Clare Hospital and Health Services shall function and act in accordance with the following bylaws and procedures which have been approved by the Board of Directors. The hospital management shall cooperate with and assist the appointees to the Medical Staff in the accomplishment of this responsibility to the hospital.

For the purpose of these bylaws, whenever the term "Medical Staff" appears, it shall be interpreted to include all physicians, podiatrists and dentists who are given privileges to treat patients in St. Clare Hospital and Health Services.

Whenever the term "Board" or "Governing Body" appears, it shall be interpreted to refer to the Board of Directors of SSM Health Care of Wisconsin, Inc. owning and operating St. Clare Hospital and Health Services which has the overall responsibility for the conduct of the affairs of the hospital including those of the Medical Staff by virtue of the authority vested in it by law and charter and by its bylaws. (6/00)

Whenever the term "Executive Committee" appears, it shall be interpreted to mean the Executive Committee of the Medical Staff unless it is specifically written otherwise.

Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.

## **ARTICLE I. PURPOSE**

The purposes of the single organized Medical Staff of St. Clare Hospital and Health Services acting through its duly appointed and functioning clinical services and committees and in accordance with these bylaws shall be: (approved 5/27/03 Medical Staff; board approval 8/03)

1. To discharge those duties and responsibilities delegated to it by the Board, to monitor the quality of medical care in the hospital and to make recommendations thereon to the Board so that all patients admitted to or treated at any one of the facilities, departments or services of the hospital shall receive an appropriate quality of care;
2. To discharge those duties and responsibilities delegated to it by the Board; to make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff to the hospital; to recommend to the Board the clinical privileges such applicant or appointee shall have in the hospital and to review and evaluate on a continuing basis such clinical privileges as have been given; and to recommend to the Board any appropriate action that may be necessary in connection with any appointee to the Medical Staff; to the end that there shall be a high level of professional performance by all persons authorized to practice in the hospital;
3. To provide oversight for the performance of individuals with clinical privileges. (approved 5/27/03 Medical Staff; board approval 8/03)

4. To cooperate with and participate in the hospital's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) process in accordance with, respectively, the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy.
5. To establish procedures whereby issues concerning the hospital Medical Staff and the hospital management or Board may be discussed both within the Medical Staff and with the Board and the management of the hospital;
6. To establish specific rules and regulations to govern actions and professional responsibilities to the Medical Staff;
7. To recommend amendments to and ensure compliance with the Bylaws, Rules and Regulations, Fair Hearing Plan, Credentials Policy and Procedure Manual, and other appropriate Hospital policies and procedures.
8. To provide an appropriate educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized from time to time by the Board; and
9. To cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and postgraduate education.
10. To prepare and complete all medical and other required records within the timelines established in the medical records completion policy or other Hospital or Medical Staff policies and procedures, which for medical records shall be no longer than thirty (30) days following discharge or outpatient care. Failure to complete charts within the designated period shall result in automatic suspension, in accordance with these Bylaws and Credentials Policy and Procedure Manual.

## **ARTICLE II. CATEGORIES OF THE MEDICAL STAFF**

To be appointed to the Medical Staff, the applicant must meet the eligibility and qualification requirements outlined in the Medical Staff Bylaws and the Credentials Policy and Procedure Manual.

All appointments to the Medical Staff shall be made by the Board, upon recommendation from the Executive Committee, and shall be to one of the following categories of the staff. As provided in the Credentials Policy and Procedure Manual, all initial appointments to the Medical Staff and all initial clinical privileges, unless otherwise provided by the Board, shall be provisional for a period of (12) months from the date of the appointment, or longer if recommended by the Executive Committee and approved by the Board. The Executive Committee may also recommend, and the Board may approve, an additional twelve (12)-month period of provisional appointment and privileges. Appointments to the Medical Staff after the initial provisional appointment(s) shall be for a period of two (2) years, unless a shorter period of time is prescribed in the notice of reappointment. During the provisional period of appointment, appointees shall be subject to the same qualifications, prerogatives, and responsibilities of the Medical Staff category to which the individual is appointed, except as otherwise limited in these Bylaws.

### **PART A: ACTIVE STAFF**

## **Section 1. Qualifications**

- (a) The Active Staff shall consist of Medical Doctors (M.D.), Doctors of Osteopathy (D.O.), Doctors of Oral Surgery (D.O.S.), Doctors of Podiatric Medicine (D.P.M.), Doctors of Dental Surgery (D.D.S.), and Doctors of Dental Medicine (D.M.D.), each of whom:
  - (1) Meets the eligibility criteria and qualifications for appointment and reappointment outlined in the Credentials Policy and Procedure Manual and accepts the responsibilities of Active Staff membership.
  - (2) Regularly admits patients to, or is otherwise involved in the care of patients in the hospital.
- (b) To be eligible for reappointment to the Active Staff, he/she must have been involved in the treatment of patients at the hospital during his/her previous term of appointment. (Exception would be ER Physicians and the Medical Directors of Pathology and Radiology.)

## **Section 2. Prerogatives**

- (a) M.D.s and D.O.s appointed to the active staff shall be eligible to admit patients.
- (b) Persons appointed to the Active Staff are eligible for privileges in all clinical services for which they are qualified. Requested privileges will be considered according to the requirements outlined in the Credentials Policy and Procedure Manual. The term of appointment shall be for a period of two (2) years; (3/98; 1/05)
- (c) Persons appointed to the Active Staff shall be entitled to vote, to hold office and to serve on Medical Staff committees, and as chairpersons of such committees, and shall be required to attend Medical Staff and committee meetings;

## **Section 3. Responsibilities**

- (a) Each Active Staff appointee must abide by the Medical Staff Bylaws, Rules and Regulations, the Disruptive Physician Policy, the Physician Availability Policy, and all medical staff and hospital policies and rules.
- (b) Each Active Staff appointee must participate in the hospital's emergency on-call schedule relevant to their specialty. The office and residence of each Active Staff appointee must be located within a geographic proximity to the hospital such that the appointee is able to travel from his or her office or residence and arrive at the hospital within thirty (30) minutes of a call request, in accordance with the Medical Staff Rules and Regulations. (The requirement in this Section 3(b) does not apply to ER physicians and the Medical Directors of Pathology and Radiology; other exceptions may be made by the Board upon recommendations of the Executive Committee); (3/98)
- (d) Active Staff must assume reasonable service, teaching, continuing medical education, Medical Staff committee and hospital responsibilities each year. Failure to fulfill such responsibilities in any year shall cause the Medical Staff appointment of the individual to lapse at the end of that year. In such a situation, the individual must reapply and

his/her appointment shall be made only if he/she satisfies the Executive Committee and the Board that he/she is willing to discharge the above responsibilities;

- (e) Each Active Staff appointee must assume and carry out responsibility within his/her area of professional competence for the daily care and supervision of each patient in the hospital for whom he/she is providing services, or arrange for a suitable alternative appointee to the Active Staff to provide such care and supervision during his/her absence or unavailability;
- (f) Persons appointed to the Active Staff shall complete all necessary medical records of their patients in an accurate, timely, and legible manner in accordance with the Hospital Bylaws, Rules and Regulations, hospital policy and as otherwise required by law.
- (g) Appointees to the Active Staff must participate in peer review and performance improvement processes, and participate in and cooperate with the hospital's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with, respectively, the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy.
- (h) Appointees to the Active Staff shall accept consultations when requested.
- (i) Each new appointee to the Active Staff shall complete training on the hospital's electronic medical record software (e.g., Epic software) prior to providing patient care at the hospital, unless there is an urgent care need. In the event of an urgent patient care need, training will be provided as soon as practicable after the urgent patient care is rendered. Failure to complete any required electronic medical record software training may result in automatic suspension of Medical Staff membership and clinical privileges.
- (j) The term "reasonable service, teaching, Medical Staff committee and hospital responsibilities" as used in subsection (d) above shall be defined as follows:
  - (1) Each person appointed to the Active Staff shall contribute service hours to the hospital each year either in the delivery of care to the indigent or unassigned patients, in education, committee membership or in a combination of the three; (3/98)
  - (2) Service on Medical Staff or Board committees shall count as service hours; (3/98)
  - (3) Service as Chief of Staff, Vice Chief of Staff, or Secretary/Treasurer of the Medical Staff or as chairperson of a Clinical Service Committee shall constitute full compliance with the service requirement for that year; and
  - (4) The Executive Committee may authorize a specific exception to this requirement in any year for any person appointed to the Active Staff who is deemed to be contributing sufficient service to the hospital to satisfy this requirement.

## **PART B: COURTESY STAFF**

### **Section 1. Qualifications**

- (a) The Courtesy Staff shall consist of M.D.s and D.O.s who meet the eligibility criteria and qualifications for staff appointment and reappointment outlined in the Credentials Policy and Procedure Manual and who either:
  - (1) Admit no more than 25 patients to the hospital on an inpatient basis per year (if this number is exceeded, the appointee shall immediately be elevated to Active Staff, upon recommendation by the Executive Committee, provided the member also meets the qualifications for Active Staff); or
  - (2) Are unable to fulfill the requirements for Active Medical Staff membership because their office or residence is located at a distance from the hospital such that they are not able to travel from their office or residence and arrive at the hospital within thirty (30) minutes of a call request, in accordance with the Physician Availability Policy and Medical Staff Rules and Regulations.
- (b) A Courtesy Staff appointee must be an appointee of another Joint Commission accredited Hospital's Medical Staff.

## **Section 2. Prerogatives**

- (a) Appointees to the Courtesy Staff shall be eligible to admit patients, subject to the limitations outlined in Section 1.
- (b) Persons appointed to the Courtesy Staff may, but are not required to, serve on staff committees without vote; may not vote on medical staff matters, and may not hold office. They are encouraged to attend staff and committee meetings. (3/98)
- (c) Courtesy Staff may only perform those acts which fall within the clinical privileges specifically approved for them by the Board.

## **Section 3. Responsibilities**

- (a) Each Courtesy Staff appointee must abide by the Medical Staff Bylaws, Rules and Regulations, the Disruptive Physician Policy, the Physician Availability Policy, and all medical staff and hospital policies and rules.
- (b) Persons appointed to the Courtesy Staff shall complete all necessary medical records of their patients in an accurate, timely, and legible manner in accordance with the Hospital Bylaws, Rules and Regulations, hospital policy and as otherwise required by law.
- (c) Persons appointed to the Courtesy Staff shall retain responsibility within the area of professional competence for the continuous care and supervision of each patient in the hospital for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision.
- (d) Persons appointed to the Courtesy Staff must cooperate with the peer review and performance improvement processes, and participate in and cooperate with the hospital's obligation to conduct Ongoing Professional Practice Evaluation (OPPE) and Focused

Professional Practice Evaluation (FPPE) in accordance with, respectively, the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy.

- (e) Each new appointee to the Courtesy Staff shall complete training on the hospital's electronic medical record software (e.g., Epic software) prior to providing patient care at the hospital, unless there is an urgent care need. In the event of an urgent patient care need, training will be provided as soon as practicable after the urgent patient care is rendered. Failure to complete any required electronic medical record software training may result in automatic suspension of Medical Staff membership and clinical privileges.

## **PART C: AFFILIATE STAFF**

### **Section 1. Qualifications**

- (a) The Affiliate Staff shall consist of M.D.s, D.O.s, D.O.S.s, D.P.M.s, D.D.S.s, and D.M.D.s, provided that they meet the eligibility criteria and qualifications for staff appointment outlined in the Credentials Policy and Procedure Manual, and that they are appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients and the provision of Clinical Services. Affiliate staff may be Fellows of the American College of Surgeons, Fellows of the American College of Physicians, Diplomats of the American Boards, or others whom the Executive Committee may consider worthy of recommending for appointment to this category of the staff.
- (b) M.D. and D.O. appointees to the Affiliate Staff must be an appointee of another Joint Commission accredited Hospital.

### **Section 2. Prerogatives**

- (a) Affiliate Staff appointees may perform only those acts that fall within the clinical privileges specifically approved for them by the Board. The clinical privileges approved for Affiliate Staff appointees shall be limited to those privileges necessary for providing consultation in the diagnosis and treatment of patients and the provision of Clinical Services.
- (b) Appointment to the Affiliate Staff does not entitle the appointee to admit patients, to vote or to hold staff offices, but such appointee may serve on Medical Staff committees and is encouraged to attend staff meetings.

### **Section 3. Responsibilities**

- (a) Each member of the Affiliate Staff shall abide by the Medical Staff Bylaws, Rules and Regulations, the Disruptive Physician Policy, and by all medical staff and hospital policies and rules.
- (b) Each member of the Affiliate Staff shall provide quality data and other information as may be requested to assist in appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, and information from managed care organizations in which the individual participates).

- (c) Appointees to this category may be required to participate in and cooperate with the hospital's obligation to conduct Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy.
- (d) Each new appointee to the Affiliate Staff shall complete training on the hospital's electronic medical record software (e.g., Epic software) prior to providing patient care at the hospital, unless there is an urgent care need. In the event of an urgent patient care need, training will be provided as soon as practicable after the urgent patient care is rendered. Failure to complete any required electronic medical record software training may result in automatic suspension of Medical Staff membership and clinical privileges.

## **PART D: HONORARY MEDICAL STAFF**

### **Section 1. Qualifications**

- (a) The Honorary Medical Staff shall consist of physicians who are not active in the hospital. These may be either physicians who have retired from active hospital practice or non-appointees to the Medical Staff who are of outstanding reputation, not necessarily residing in the community.

### **Section 2. Prerogatives:**

- (a) Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office or to serve on standing Medical Staff committees, but may be appointed to special committees.

### **Section 3. Responsibilities:**

- (a) Each member of the Honorary Staff shall abide by the Medical Staff Bylaws, Rules and Regulations, the Disruptive Physician Policy, and by all medical staff and hospital policies and rules.

## **PART E: ALLIED HEALTH PROFESSIONALS (AHP)**

### **Section 1. Definitions**

Non-physician health professionals who wish to provide treatment to patients at St. Clare Hospital and Health Services may apply for clinical privileges as Independent or Dependent Allied Health Professionals. These persons shall not be considered members of the Medical Staff. Independent Allied Health Professionals are non-physicians permitted by law and St. Clare Hospital and Health Services to provide patient care services without direct supervision, within the scope of their Wisconsin licenses and in accordance with individually granted clinical privileges. Those professionals permitted to apply for privileges as Independent Allied Health Professionals are listed in Appendix A to the Credentials Policy and Procedure Manual. Certified Registered Nurse Anesthetists are permitted to perform updated history and physicals per privilege list.

Dependent Allied Health Professionals are non-physicians permitted by law and St. Clare Hospital and Health Services to provide patient care services under the supervision of a physician, within the scope of their Wisconsin licenses and in accordance with individually granted privileges. Those professionals permitted to apply for privileges as Dependent Allied Health Professionals are listed in Appendix A to the Credentials Policy and Procedure Manual. (9/97; 4/02; 1/05).

Registered Nurses, Licensed Practical Nurses, and Surgical Assistants are not Allied Health Professionals. Applications from Registered Nurses, Licensed Practical Nurses, and Surgical Assistants shall be processed by the Human Resources Department in accordance with Human Resources Policies in the Employee Manual.

## **Section 2. Admissions**

Each patient's general medical condition and care shall be the ultimate responsibility of a qualified medical physician or osteopathic member of the Medical Staff. Allied Health Professionals may treat patients in conjunction with a member of the Medical Staff but may not independently admit patients. Only Active and Courtesy Medical Staff members may admit or discharge patients.

## **Section 3. Application**

All Allied Health Professionals are required to complete an application that will be reviewed and approved by the Chair of the service assigned, the Executive Committee, and the Board in conformance with the Medical Staff Bylaws, Rules and Regulations, and the Credentials Policy and Procedure Manual. If the Allied Health Professional applicant is also licensed as a registered nurse, the application should also be reviewed and approved by the Director of Nursing. As set forth in the Credentials Policy and Procedure Manual, the application must, at a minimum, include evidence of sufficient education, training, experience, licensure/certification, three letters of recommendation and insurance coverage commensurate with the privileges being requested. (9/97)

## **Section 4. Privileges**

All Allied Health Professionals will be credentialed and granted clinical privileges following the same process as set forth in the Credentials Policy and Procedure Manual for Medical Staff members.

Consistent with the requirements outlined in the Credentials Policy and Procedure Manual, Independent and Dependent Allied Health Professionals shall be granted delineated clinical privileges by the Board after review and approval of the clinical service chairperson and the Executive Committee. (9/97) In the event of a disaster, see Credentials Policy and Procedure Manual, Article II, Part E, Emergency Clinical Privileges. (8/03)

Allied Health Professionals may only perform those acts which fall within the clinical privileges specifically approved by the Executive Committee and Board. Allied Health Professionals are entitled to a fair hearing and appellate review as set out in Article VII of the Medical Staff Bylaws and the Fair Hearing Plan. (8/03, 4/06)

Allied Health Professionals must participate in and cooperate with the hospital's obligation to conduct Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with, respectively, the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy.



Allied Health Professionals shall complete training on the hospital's electronic medical record software (e.g., Epic software) prior to providing patient care at the hospital, unless there is an urgent care need. In the event of an urgent patient care need, training will be provided as soon as practicable after the urgent patient care is rendered. Failure to complete any required electronic medical record software training may result in automatic suspension of clinical privileges.

## **PART F: HOUSE STAFF**

### **Section 1. Qualifications**

The house staff shall be graduates of approved schools of medicine, osteopathy or dentistry who are in training at the University of Wisconsin or other accredited residency training programs. Members of the house staff may or may not be licensed, as required by Wisconsin Law.

### **Section 2. Limitations and Prerogatives**

House staff do not possess individual membership in the Medical Staff, are not eligible to vote or hold office in the Medical Staff organization, but may have representation on the Medical Staff committees. House Staff shall be supervised and evaluated as outlined in the Hospital Rules and Regulations and Hospital policy.

### **Section 3. Responsibilities**

Each member of the House Staff shall abide by the Medical Staff Bylaws, Rules and Regulations and hospital policies and procedures.

House Staff shall complete training on the hospital's electronic medical record software (e.g., Epic software) during initial orientation and prior to providing patient care at the hospital, unless there is an urgent care need. In the event of an urgent patient care need, training will be provided as soon as practicable after the urgent patient care is rendered.

## **ARTICLE III. ORGANIZATION OF THE MEDICAL STAFF**

### **PART A: GENERAL**

#### **Section 1. Medical Staff Year:**

For the purpose of these bylaws the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year. All persons appointed to the Medical Staff shall pay annual staff dues as established by the Medical Staff.

### **PART B: OFFICERS OF THE MEDICAL STAFF**

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and the Secretary/Treasurer. The immediate past Chief of Staff shall also be an officer of the Medical Staff but is not subject to the nomination and election provisions outlined below (in the case of a vacancy in the office of the immediate past Chief of Staff, the Executive Committee shall select a replacement for the remainder of the term).

Officers must be appointees to the Active Medical Staff at the time of nomination and election and must continue as appointees during their term of office. Appointees with provisional appointment to the Medical Staff shall be ineligible for election as officers. Failure to maintain such status shall immediately create a vacancy in the office involved.

**Section 1. The Chief of Staff:**

The Chief of Staff shall:

- (a) act on behalf of the Board as the chief medical officer of the hospital, in coordination and cooperation with the President in matters of mutual concern involving the hospital;
- (b) call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;
- (c) appoint committee chairpersons and members to all standing, special and multidisciplinary Medical Staff committees except the Executive Committee;
- (d) serve as the chairperson of the Executive Committee, with vote;
- (e) serve as an ex officio member of all other Medical Staff committees, without vote;
- (f) represent the staff recommendations, views, policies, needs and grievances of the Medical Staff to the Board and to the President; (approved 5/27/03 Medical Staff; board approval 8/03)
- (g) receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;
- (h) be the spokesperson for the Medical Staff, in its external professional and public relations;
- (i) be responsible for meeting the Medical Staff requirements for accreditation of the various educational programs of the Medical Staff working with the Service Committee Chairpersons. He/she shall report the accreditation status to the Executive Committee, the Medical Staff and the Board;
- (j) be the coordinator of the research and educational activities on the Medical Staff, student, house staff and postgraduate levels and provide information, where appropriate, to the sponsoring universities or institutions about the quality of care, treatment, and services and educational needs of the students, house staff and postgraduate levels;
- (k) enforce the Bylaws and Rules and Regulations of the Medical Staff;
- (l) be responsible for the organization and oversight of the conduct of the Medical Staff;
- (m) ensure, along with the Executive Committee and other appropriate committees, that hospital-wide safety functions are performed;

- (n) be responsible, along with the hospital President, for the overall quality of patient care and the professional standards of the Medical Staff and ensure:
  - (1) A quality assurance program is implemented and effective for all patient care related services;
  - (2) The program findings are incorporated into a well-defined method of assessing staff performance in relation to patient care; and
  - (3) The program findings, actions, and results are reported to the Board as necessary.

## **Section 2. Vice Chief of Staff:**

The Vice Chief of Staff shall:

- (a) assume all the duties and have the authority of the Chief of Staff in the event of the Chief of Staff's temporary inability to perform due to illness, absence from the community or unavailability for any other reason. Should both officers be unavailable, the authority and duties of the Chief of Staff will be temporarily assumed by the Secretary/Treasurer of the Medical Staff, Chairperson of the Service Committees of Medicine, Obstetrics, Surgery, or Emergency/Ambulatory Care in that order of succession;
- (b) be a member of the Executive Committee of the Medical Staff; automatically succeed the Chief of Staff when the latter fails to serve for any reason;
- (c) perform such duties as assigned to him/her by the Chief of Staff.

In the event that the office of the Chief of Staff shall for any reason become vacant prior to the completion of a Medical Staff year, the Vice Chief of Staff shall succeed to the office of Chief of Staff for the balance of the unexpired term. In that event, the office of Vice Chief of Staff shall be filled by a special election to be held at the first regular meeting of the staff, following the succession of the Vice Chief of Staff to the office of Chief of Staff. Time served in filling an unexpired term of office in the manner herein described shall not be considered in computing the term of office permitted by Section 5(c) of this Article.

## **Section 3. Secretary/Treasurer:**

The Secretary/Treasurer shall oversee:

- (a) accurate and complete minutes of all staff and Executive Committee meetings or delegate this duty to appropriate hospital personnel;
- (b) collection and custody of staff dues and funds, and make disbursements authorized by the Executive Committee or its designee;
- (c) calling meetings on order of the Chief of Staff; accounting for funds where necessary, attending to all correspondence and such other duties as pertain to this office.

In case of vacancy in the office of Secretary/Treasurer, the Executive Committee shall select a replacement for the remainder of the calendar year.

## **Section 4. Nominations:**

- (a) Nominations for officers of the staff will be made at a staff meeting at least two (2) months prior to the annual meeting. Individuals so nominated will be contacted after the meeting in order to ascertain whether they wish to stand for election.
- (b) By Petition: Nominations may also be made by petition signed by at least twenty-five percent (25%) of the Medical Staff members eligible to vote and filed with the Medical Staff Office at least three (3) weeks prior to the general Medical Staff meeting in October. As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the staff.

#### **Section 5. Election of Officers:**

- (a) Officers of the Medical Staff shall be elected at every other general Medical Staff meeting in October by a majority vote of those appointees to the Medical Staff eligible to vote and present at the meeting at the time the vote is taken. The vote shall be by secret ballot. The election of each officer shall become effective as soon as approved by the Board but no sooner than January 1 of the following year. Each officer shall then serve until his/her successor has been elected and his/her election approved by the Board.
- (b) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.
- (c) All officers may be re-elected, but the Chief of Staff and Vice Chief of Staff may not hold their respective offices for more than four (4) consecutive years.
- (d) Vacancies in office during the Medical Staff year, except for the Chief of Staff and Vice Chief of Staff, shall be filled by the Executive Committee from appointees to the Active Staff.

#### **Section 6. Removal of Officers:**

An officer may be removed by majority vote of the Executive Committee, subject to approval by the Board, for:

- (a) failure to fulfill the duties of the officer's position;
- (b) failure to comply with the Bylaws or Rules and Regulations; or
- (c) conduct that is detrimental to the interests of the hospital and/its Medical Staff.

Officers shall be automatically removed from office upon the verification of such officer's revocation or suspension of license to practice medicine, dentistry, or podiatry, and there shall be no right of appeal or hearing with such action. Officers shall also be automatically removed from office upon loss or suspension of medical staff appointment, unless an exception is granted by the Executive Committee. Removed officers will also be removed from any subsequent office linked to that office.

#### **PART C: MEETINGS OF THE MEDICAL STAFF**

**Section 1. October General Medical Staff Meeting:**

The voting staff of the hospital at the regular member meetings shall receive the report of the Nominating Committee. At that time additional nominations may be received from the floor. The voting staff shall elect the officers for the ensuing year.

**Section 2. Staff Meetings:**

The Medical Staff shall meet ten (10) times per year, on dates set at the beginning of the year by the Chief of Staff, for the purpose of conducting the general Medical Staff business and to review and evaluate clinical services and other committee reports, including any findings identified through the quality assurance program, and to act on any other matters placed on the agenda by the Chief of Staff. (12/00)

**Section 3. Special Staff Meetings:**

Special meetings of the Medical Staff may be called at any time by the Board, the President, the Chief of Staff, a majority of the Executive Committee of the Medical Staff or a petition signed by not less than one-fourth (1/4) of the voting staff. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the Chief of Staff by mail. Such a vote shall be binding as long as the question is voted on by a majority of the staff eligible to vote.

**Section 4. Notice of Special Meetings:**

A written notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be mailed to each appointee eligible to vote not less than seven (7) days before the date of such meeting, or shall be posted in the hospital as required in these bylaws. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to each appointee at his/her address as it appears on the records of the hospital, or when posted in the hospital so long as the posting occurs not less than seven (7) days prior to the date of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

When, in the opinion of the Chief of Staff, or, if the Chief of Staff is absent from the hospital or otherwise unavailable, the Vice Chief of Staff, it is necessary to convene a special meeting of the staff at such a time or for such a purpose as would not permit compliance with the notice requirements hereinabove set forth, the Chief of Staff or Vice Chief of Staff may convene such a special meeting, provided that a reasonably substantial effort is made to give actual notice of the meeting to appointees eligible to vote therein, and provided further that at the time of the meeting or reasonably contemporaneous therewith, a majority of said appointees execute a written waiver of the formal notice requirement with respect to said special meeting.

**Section 5. Quorum:**

The presence of one-third (1/3) of the persons eligible to vote, but no less than two (2) , shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any action to be taken. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

**Section 6. Agenda:**

The agenda at any monthly Medical Staff meeting shall be, at the discretion of the Chief of Staff:

- (a) Call to order
- (b) Acceptance of the minutes of the last regular and of all intervening special meetings
- (c) Report of the Executive Committee
  - Committee reports
  - Issues/Action

- Information
- (d) Other business
- (e) Next meeting date
- (f) Adjournment

All important actions of the Executive Committee shall be included in the Executive Committee's report to the Medical Staff. Any person eligible to vote, by proper motion and majority vote, may require reconsideration of any such action by the Executive Committee at its next meeting. Such reconsideration could result in the change or withdrawal of any such action that has not been approved by the Board or carried into effect.

## **PART D: PROVISIONS COMMON TO ALL MEETINGS**

### **Section 1. Posting Notice of Meetings:**

Notice of all meetings of the Medical Staff and of Clinical Service Committees and other committees shall be posted on the Medical Staff bulletin board one week in advance of such meetings. For all meetings, except special meetings of the voting Medical Staff, such posting shall be deemed to constitute actual notice to the persons concerned if it occurs seven (7) days prior to the meeting.

### **Section 2. Attendance Requirements:**

- (a) Each appointee to the Active Staff shall be required to attend at least fifty percent (50%) of all regular Medical Staff meetings and applicable committee meetings in each year but is expected to attend all meetings. Any person who is compelled to be absent from any meeting shall promptly submit to the Chief of Staff, in writing, the reason for such absence if the individual desires to receive credit for attendance at that meeting. Credit shall then be granted at the discretion of the Executive Committee. The failure of any person required to do so to meet the foregoing annual staff meeting and other attendance requirements shall constitute grounds for action leading to revocation of Medical Staff appointment. Reinstatement of an appointment which has been revoked because of absence from the required number of staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for initial appointment. (3/98)(12/00)
- (b) Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular committee meeting may be required to attend such meeting. If such individual is not otherwise required to attend the meeting, the chairperson of the committee shall give him/her advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by certified mail, return receipt requested and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.
- (c) The chairperson of the applicable committee shall notify the Executive Committee of the failure of an individual to attend any meeting with respect to which he/she was notified that attendance was mandatory and, unless excused by the Executive Committee upon showing of good cause, such failure shall result in an automatic suspension of all or such portion of the individual's admitting privileges as the Executive Committee may direct and such suspension shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement supported by an

adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the chairperson of the committee, or by the Executive Committee if the chairperson is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

- (d) Persons appointed to the Affiliate and Courtesy categories of the Medical Staff shall be expected to attend and participate in committee meetings when requested to do so, unless unavoidably prevented from doing so, but shall not be required to do so as a condition of continued staff appointment.

### **Section 3. Rules of Order:**

Wherever they do not conflict with these bylaws, the currently revised Robert's Rules of Order shall govern all meetings.

### **Section 4. Voting:**

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

### **Section 5. Minutes:**

Minutes of each meeting of the Medical Staff shall be prepared by the Secretary/Treasurer or his or her designee and shall include a record of the attendance of members, the general business conducted, the recommendations made, and of the votes on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Executive Committee and at the same time to the President. Copies of such minutes shall be approved by the attendees at the subsequent meeting, and be available to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained in the Administration Office at the hospital.

## **ARTICLE IV. ORGANIZATION OF CLINICAL SERVICES**

### **PART A: CLINICAL SERVICES**

#### **Section 1. Organization of Clinical Services:**

There shall be clinical services of medicine, surgery, obstetrics/newborn/pediatric, emergency/ambulatory care and pharmacy & therapeutics. Each service shall have a committee consistent with requirements for the clinical service committees outlined in this Article IV and Article V, and shall be headed by a clinical service committee chairperson.

The Executive Committee shall periodically review the organization of the clinical services and clinical service committees and may make recommendations to the Board regarding creating new or consolidating existing clinical services (and corresponding committees) for better organizational efficiency and improved patient care. Any re-organization of clinical services shall be final and effective when approved by the Board.

#### **Section 2. Qualifications, Selections and Tenure of Clinical Service Committee Chairpersons:**

- (a) Each clinical service committee chairperson shall be an appointee to the Active Staff and a member of his/her clinical service, and shall be qualified by training, experience and demonstrated ability for the position, established by certification by an appropriate

specialty board or through comparable competence established through the credentialing process. Chairpersons may be reappointed. Appointees with provisional appointment to the Medical Staff shall be ineligible for appointment as a clinical service committee chairperson.

- (b) Each chairperson shall be appointed by the Chief of Staff subject to the approval of the Executive Committee and Board, and serve for a two (2) year term. Chairpersons shall be limited to two (2) consecutive terms, but may serve again after at least one (1) term of non-service. In the event of a vacancy, the Chief of Staff shall appoint a replacement for the affected clinical service for the remainder of the term.
- (c) Removal of a chairperson during his/her term of office may be initiated by a two-third (2/3) majority vote of all Active Staff members, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and the Board.
- (d) Chairpersons shall be automatically removed from office upon the verification of such Chairperson's revocation or suspension of license to practice medicine, dentistry, or podiatry, and there shall be no right of appeal or hearing with such action. Chairpersons shall also be automatically removed from office upon loss or suspension of medical staff appointment, unless an exception is granted by the Executive Committee.

This section does not apply to the Chairpersons of the Executive Committee, the Ethics Committee, the Continuing Medical Education/Library Committee, or the Physician and Licensed Independent Practitioners Health Committee. The person elected as Chief of Staff shall also serve as Chairperson of the Executive Committee. Chairpersons of the Ethics Committee, the Continuing Medical Education/Library Committee, and the Physician and Independent Practitioners Health Committee are appointed as provided in Article V, Part A, section 1.

### **Section 3. Function of Clinical Service Committee Chairperson:**

Each clinical service committee chairperson shall:

- (a) be accountable for all professional, administrative, and clinically related activities;
- (b) give guidance on the overall medical policies of the hospital and make specific recommendations and suggestions regarding his/her own clinical service in order to assure quality care;
- (c) maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her clinical service, including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE), in accordance with, respectively, the Focused Physician Performance Evaluation Policy and the Ongoing Physician Performance Reports Policy, and report regularly to the Executive Committee;
- (d) appoint one (1) member from his/her clinical service, who may be him/herself, to conduct the initial phase of patient care review in conjunction with the Quality Assurance activities of the committee;



- (e) be responsible for enforcement of the hospital bylaws and of the Medical Staff bylaws, rules and regulations within his/her clinical service and assist in formulating special rules and policies for the clinical service;
- (f) be responsible for implementation within his/her clinical service of actions taken by the Executive Committee of the Medical Staff;
- (g) evaluate and transmit to the Executive Committee recommendations concerning the staff classification, the appointment/reappointment, and the delineation of clinical privileges for all practitioners in his/her clinical service;
- (h) be responsible for the teaching, education and research program in his/her service;
- (i) participate in every phase of administration of his/her clinical service through cooperation with the nursing service and the hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;
- (j) assist in the preparation of such annual reports pertaining to his/her clinical service as may be required by the Executive Committee, the President or the Board;
- (k) assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the clinical service or the hospital;
- (l) assist with the integration of the service into the primary functions of the hospital and assist with the coordination and integration within the service and with other clinical services;
- (m) conduct continuous assessment and improvement of the quality of care, treatment, and services provided by the clinical service and assist in maintaining the quality of medical records within the service;
- (n) oversee the orientation and continuing education of all persons in his/her clinical service;
- (o) recommend space and other resources needed by his/her service;
- (p) make recommendations for a sufficient number of qualified and competent persons to provide care or service;
- (q) assist in the coordination of care, treatment, and services among the hospital's different programs, services, sites or departments;
- (r) represent the service in a medical advisory capacity to the hospital's administrative staff and Board;
- (s) recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the service; and
- (t) assist in the determination of the qualifications and competence of clinical service personnel who are not licensed independent practitioners (including but not limited to Allied Health Professionals) and who provide patient care, treatment and services.

#### **Section 4. Functions of Services:**

- (a) Each clinical service shall recommend its criteria, consistent with the policies of the Medical Staff and of the Board, for the granting of clinical privileges in the clinical service.
- (b) Each clinical service shall have a member who is responsible for the quality assurance activities of the service committee.

This representative shall participate in a retrospective review of the completed records of discharged patients, and other pertinent sources of medical information relating to patient care, for the purpose of selecting cases for presentation at staff meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assess the delivery of high quality care.

- (c) Such reviews shall include a consideration of all deaths, of patients with infections, complications, diagnosis and treatment of patients in the hospital with unsolved clinical problems, proper utilization of hospital facilities and services and of other significant patient care matters. The review of surgical matters shall also include a comprehensive tissue review for justification of all surgery performed, whether tissue was removed or not, for acceptability of the procedure chosen, and for agreement or disagreement between the preoperative and pathological diagnosis.

#### **Section 5. Assignment to Clinical Services:**

The Executive Committee shall, after consideration of the recommendations of the clinical services, recommend initial service assignments for all Medical Staff appointees and for all other approved practitioners with Medical Staff privileges.

### **ARTICLE V. COMMITTEES OF THE MEDICAL STAFF**

#### **PART A: APPOINTMENT**

##### **Section 1. Chairpersons of Committees:**

- (a) Chairpersons of Clinical Service Committees: Chairpersons of clinical service committees shall be appointed as provided in Article IV, Part A, section 2.
- (b) Chairpersons of Non-Clinical Service Committees: Chairpersons of the Ethics Committee, the Continuing Medical Education/Library Committee, and the Physician and Licensed Independent Practitioners Health Committee will be appointed by the Chief of Staff. Chairpersons shall be selected from among persons appointed to the Active Staff.
- (c) Chairperson of the Executive Committee: The Chairperson of the Executive Committee shall be the Chief of Staff.

##### **Section 2. Members:**

- (a) Except as otherwise provided in these bylaws, members of each committee shall be appointed every two (2) years by the Chief of Staff, not more than ten (10) days after the end of the Medical Staff year, with no limitation on the number of terms they may serve. All appointed members may be removed and vacancies filled by the Chief of Staff at his/her discretion.
  - (b) Active Staff members shall be members of Medical Staff committees in relation to the requirements for membership as defined in Article II, Categories of the Medical Staff, Part A and Part B. Committee membership requirements: (3/98)
    - (1) Medical Staff Officers shall meet their committee membership requirement through membership on the Executive Committee. (3/98)
    - (2) All other Active Staff members shall state their preferences for membership and be appointed by the Chief of Staff as follows: (3/98)
      - ((a)) Membership on one (1) of the following four (4) clinical committees which meet monthly: Medical, Surgical, Obstetrics/Pediatrics/Newborn, Pharmacy & Therapeutics; (3/98, 8/03) OR
      - ((b)) Membership on any two (2) of the following: a committee which meets less than ten (10) times per year (Emergency/Ambulatory Care, CME/Library, Ethics) or membership or advisor in one of the following hospital areas (Performance Improvement, HBOC, Rehab, Clinical PATHWAYS®, Patient Education/Dietary). (3/98)
- If the required number of committee members is not met for each of the five (5) clinical committees (Medical, Surgical, Obstetrics/Pediatrics/Newborn, Emergency/Ambulatory Care, and Pharmacy & Therapeutics), the Chief of Staff may make assignments to achieve minimums. (3/98)
- (c) The President and the Chief of Staff, or their respective designees, shall be members, ex officio without vote, of all committees.
  - (d) Voting members of committees will be the Active Staff members of that committee. (12/98)

## **PART B: PROVISIONS COMMON TO CLINICAL SERVICE COMMITTEE MEETINGS**

### **Section 1. Special Clinical Service Committee Meetings:**

In addition to the clinical service committee meeting requirements outlined for each committee in Article V of these bylaws, special meetings of the clinical service committees may be called as follows:

- (a) A special meeting of any clinical service committee may be called by or at the request of the chairperson, by the Chief of Staff, or by a petition signed by not less than one-fourth (1/4) of the members of the Clinical Service Committee. Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each member of the committee not less than seven (7) days before the time of such meeting or posted in the hospital as required by these bylaws. If mailed, the notice of the mailing shall be deemed delivered when deposited in the United States mail ad-

dressed to the member's address as it appears on the records of the hospital. The attendance and participation without objection as to notice of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

When, in the opinion of the Chief of Staff, or, if the Chief of Staff is absent from the hospital or otherwise unavailable, the chairperson of the Clinical Service Committee, it is necessary to convene a special meeting of the Clinical Service Committee at such time or for such a purpose as would not permit compliance with the notice requirements hereinabove set forth, the chairperson may convene such a special meeting, provided that a reasonably substantial effort is made to give actual notice of the meeting to appointees eligible to vote therein, and provided further that at the time of the meeting or reasonably contemporaneous therewith, a majority of said appointees execute a written waiver of the formal notice requirement with respect to said special meeting.

- (b) In the event that it is necessary for a clinical service committee to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the chairperson of the clinical service committee. Such a vote shall be binding as long as the question is voted on by a majority of the clinical service committee or service eligible to vote.

This section does not apply to meetings of the Executive Committee, the Ethics Committee, the Continuing Medical Education/Library Committee, and the Physician and Licensed Independent Practitioners Health Committee.

### **Section 2. Quorum:**

For clinical service committee meetings, the presence of one-third (1/3) of the total membership of the committee eligible to vote, but no less than two (2), at any regular or special meeting shall constitute a quorum for all actions. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting. This section does not apply to meetings of the Executive Committee, the Ethics Committee, the Continuing Medical Education/Library Committee, and the Physician and Licensed Independent Practitioners Health Committee.

### **Section 3. Minutes:**

Minutes of each meeting of each clinical service committee shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Executive Committee and at the same time to the President unless otherwise specified for certain clinical service committees in Article V. Each clinical service committee shall maintain a permanent file of the minutes of each of its meetings. This section does not apply to meetings of the Executive Committee, the Ethics Committee, the Continuing Medical Education/Library Committee, and the Physician and Licensed Independent Practitioners Health Committee.

## **PART C: EXECUTIVE COMMITTEE**

### **Section 1. Composition:**

- (a) The Executive Committee shall consist of the officers of the Medical Staff (including the immediate past Chief of Staff) and the Clinical Service Committee Chairpersons. All will be voting members.

- (b) The President or designee must attend the Executive Committee meetings but without vote. The nurse executive or designee and members of the Board may attend meetings of the Executive Committee and participate in the discussions, but without vote.
- (c) In the event that a closed session of the Executive Committee is required to discuss a sensitive issue, the Chief of Staff shall involve only the officers of the Medical Staff, except in circumstances where the Chief of Staff determines that the Executive Committee as a whole shall participate in the closed session.

## **Section 2. Removal:**

Executive Committee members may be removed from their positions as follows:

- (a) Members of the Executive Committee who are also officers of the Medical Staff (including the immediate past Chief of Staff) shall be removed if removed from office pursuant to Article III, Part B, Section 6 of these Bylaws. Vacancies on the Executive Committee created by such removal shall be filled in accordance with Article III, Part B.
- (b) Members of the Executive Committee who are Clinical Service Committee Chairpersons shall be removed from the Executive Committee if removed as Chairperson pursuant to Article IV, Part A, Section 2 of these Bylaws. Vacancies on the Executive Committee created by such removal shall be filled by appointment in accordance with Article IV, Part A, Section 2 of these Bylaws.

There shall be no right of appeal or hearing in regard to the removal from the Executive Committee.

## **Section 3. Duties:**

The Medical Staff delegates to the Executive Committee the authority to perform the following duties. Further delegation or removal of delegated authority is accomplished following the procedures outlined in Article XII of these Bylaws. The duties of the Executive Committee are:

- (a) to discharge the Medical Staff's accountability to the Board for the medical care rendered to patients in the hospital;
- (b) to implement and coordinate the activities and general policies of the medical staff including creation of additional committees where indicated;
- (c) to recommend action to the President on matters of a medico-administrative and hospital management nature;
- (d) to ensure that the Medical Staff is kept abreast of all forms of accreditation and informed of the accreditation status of the hospital;
- (e) to review and document performance improvement results and recommendations and forward to the staff and to review information related to the hospital's Ongoing Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE), in accordance with, respectively, the Ongoing Physician Performance Reports Policy and the Focused Physician Performance Evaluation Policy;
- (f) to serve as the Credentials Committee for the hospital.

- (g) to receive and act upon reports regarding clinical issues that impact patient care, from medical staff committees and assigned performance improvement teams and to make recommendations concerning the staff to the President and the Board regarding matters such as:
  - (1) the medical staff's structure;
  - (2) the mechanism used to review credentials and to delineate individual clinical privileges;
  - (3) recommendations of individuals for medical staff appointment and reappointment;
  - (4) recommendations for delineated clinical privileges for each eligible individual;
  - (5) the participation of the medical staff in organization performance improvement activities;
  - (6) the mechanism by which medical staff membership and/or privileges may be terminated, suspended, reduced, or restricted;
  - (7) the mechanism and indications for automatic suspension and precautionary suspension of a practitioner's medical staff membership or privileges; and
  - (8) the mechanism for fair-hearing procedures.
- (h) to take all reasonable steps to ensure professionally ethical conduct and the enforcement of hospital and Medical Staff rules in the best interest of patient care and of the hospital on the part of all persons who hold appointment to the Medical Staff, and to make recommendations to the Board on actions described in the Fair Hearing Plan;
- (i) to review the bylaws, the rules and regulations of the Medical Staff, the Credentials Policy and Procedure Manual, and the Fair Hearing Plan every two (2) years and recommend amendments thereto to the Medical Staff. In addition, the Executive Committee may receive and consider all recommendations for changes made by the Board, the Chief of Staff, the President, the committees of the Medical Staff and any individual appointed to the Medical Staff;
- (j) to adopt and amend the Rules and Regulations, Credentials Policy and Procedure Manual, Fair Hearing Plan, and Related Policies, consistent with Article XII of these Bylaws
- (k) to present at the October general Medical Staff meeting one or more nominees for the offices of Chief of Staff, Vice-Chief of Staff and Secretary-Treasurer. Nominees must be licensed, Active Medical Staff members and must receive a simple majority of votes of those present to be elected to office;
- (l) to represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters arising between meetings of the Medical Staff, subject only to any limitations imposed by these bylaws;
- (m) to act on behalf of the Medical Staff as liaison to the Hospital President and the Board of Directors, subject to such limitations as may be imposed by these Bylaws;
- (n) to document all recommendations, conclusions and actions, and to communicate same to the Medical Staff; and
- (o) to review and approve the Clinical Resource Management Plan at least every two (2) years; following Executive Committee approval, the Board shall also approve the Plan.

Conflicts between the Executive Committee and the Medical Staff shall be handled in accordance with the Medical Staff conflict management policy.

In any instance where a member of the Executive Committee has a conflict of interest in any matter involving another appointee to the staff which comes before the Executive Committee, or in any instance where a member of the Executive Committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter and shall absent himself/herself from the meeting during that time, although he/she may be asked and answer any questions concerning the matter before leaving.

The chairperson of the Executive Committee or designee shall be available to meet with the Board or a Board sub-committee to provide information on Executive Committee recommendations.

### **Section 3. Quorum**

A quorum for committee meetings shall consist of four of the members of Executive Committee who are entitled to vote.

### **Section 4. Meetings, Reports and Recommendations:**

The Executive Committee shall meet monthly or as often as necessary to transact pending business. The Secretary/ Treasurer shall oversee the maintenance of minutes of each meeting, which shall include a record of the attendance of members, of the recommendations made, and of the votes on each matter. The Secretary/ Treasurer will maintain reports of all meetings, which reports shall include the minutes of the various committees of the staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the President routinely as prepared. Important actions of the Executive Committee shall be reported to the staff and shall be transmitted through the President to the Board.

The Chief of Staff may declare a closed session meeting of the Executive Committee to discuss sensitive issues. Chairpersons of the Clinical Service Committees shall not be present at these closed session meetings.

## **PART D: MEDICAL COMMITTEE**

### **Section 1. Composition:**

The Medical Committee shall consist of at least four (4) members of the Active Medical Staff. Representatives of Nursing, Laboratory, Pharmacy, Radiology and Administration shall be ex officio members without vote. (3/98; 1/05)

### **Section 2. Duties:**

The committee shall be responsible for the areas of medicine, intensive care, respiratory therapy, laboratory/blood use, drug utilization and radiology. The committee shall be responsible to:

- (a) ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, though are not limited to, those within the:
  - (1) medical assessment and treatment of patients;
  - (2) use of medications;
  - (3) use of blood and blood components;
  - (4) use of ICU, respiratory therapy, laboratory and radiology services;

- (5) use of nutrition services and care;
  - (6) efficiency (the relationship between the outcomes [results of care] and the resources used to deliver patient care) of clinical practice patterns; and
  - (7) significant departures from established patterns of clinical practice;
  - (8) education of patients and families;
  - (9) coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and accurate, timely, and legible completion of patients' medical records.
  - (10) sentinel event data (1/05)
  - (11) patient safety data (1/05)
  - (12) Clinical Resource Management data.
- (b) ensure that when the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges;
- (c) conduct peer review related to the areas of medicine, intensive care, respiratory therapy, laboratory/blood use, drug utilization and radiology. The Committee delegates to the Performance Improvement Department the authority to receive cases and determine whether review by this Committee is appropriate and to delegate the initial review to a licensed independent practitioner; (6/05)
- (d) ensure that the findings, conclusions, recommendations and actions taken to improve organization performance are communicated to appropriate medical staff members, and where appropriate, the Executive Committee and the Board;
- (e) participate in quality assurance activities and performance improvement;
- (f) make recommendations to the Executive Committee for individuals for medical staff membership and recommendations for delineated clinical privileges for each eligible individual;
- (g) the chairperson or his/her designee shall serve as the intensive care unit medical advisor; (12/01)
- (i) serve, together with the Surgical Committee and Infection Control Coordinator, as the infection control committee and carry out surveillance and investigation of infections in the hospital and implement measures designed to reduce these infections, including the annual review of infection control policies, procedures, systems, and techniques.

### **Section 3. Meetings, Reports and Recommendations:**

The Medical Committee shall meet ten (10) times per year or as often as necessary to conduct pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the Medical Committee shall maintain a permanent record of its findings, proceedings and recommendations. The Medical Committee shall make a quarterly report to the Executive Committee and the President. (3/98)

## **PART E: SURGICAL COMMITTEE**

### **Section 1. Composition:**



The Surgical Committee shall consist of at least four (4) members of the Active Medical Staff, a representative from Nursing, Laboratory, Anesthesia, Administration, and the Infection Control Coordinator or designee. Representatives from nursing, Laboratory, Anesthesia, Administration, and the Infection Control Coordinator or designee shall be ex officio members without vote. (3/98; 1/05)

## **Section 2. Duties:**

The committee shall be responsible for the areas of surgery, anesthesia, pathology and infection control review. The committee is responsible to:

- (a) ensure that when the performance of a process is dependent primarily on the activities of one (1) or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, though are not limited to, those within the:
  - (1) assessment and treatment of surgical patients;
  - (2) use of medications;
  - (3) use of pathology services;
  - (4) use of operative and other procedures;
  - (5) use of anesthesia care;
  - (6) use of special treatment procedures;
  - (7) infection control process;
  - (8) efficiency (the relationship between the outcomes [results of care] and the resources used to deliver patient care) of clinical practice patterns; and
  - (9) significant departures from established patterns of clinical practice;
  - (10) education of patients and families;
  - (11) coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and
  - (13) accurate, timely, and legible completion of patients' medical records.
  - (14) sentinel event data (1/05)
  - (15) patient safety data (1/05)
  - (16) Clinical Resource Management data.
- (b) serve, together with the Medical Committee and the Infection Control Coordinator, as the infection control committee and carry out surveillance and investigation of infections in the hospital and implement measures designed to reduce these infections, including the annual review of infection control policies, procedures, systems, and techniques;
- (c) ensure that when the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges;
- (d) conduct peer review related to the areas of medicine, intensive care, respiratory therapy, laboratory/blood use, drug utilization and radiology. The Committee delegates to the Performance Improvement Department, the authority to receive cases and determine whether review by this Committee is appropriate and to delegate the initial review to a licensed independent practitioner; (6/05)
- (e) participate in quality assurance activities and performance improvement;

- (f) ensure that the findings, conclusions, recommendations and actions taken to improve organization performance are communicated to appropriate medical staff members, and where appropriate, the Executive Committee and the Board; and
- (g) make recommendations to the Executive Committee for individuals for medical staff membership and recommendations for delineated clinical privileges for each eligible individual.

### **Section 3. Meetings, Reports and Recommendations:**

The Surgery Committee shall meet ten (10) times per year or as often as necessary to conduct pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the Surgical Committee shall maintain a permanent record of its findings, proceedings and recommendations. The Surgical Committee shall make a report to the Executive Committee and the President. (3/98)

## **PART F: OBSTETRICS, NEWBORN AND PEDIATRIC COMMITTEE**

### **Section 1. Composition:**

The Obstetrics, Newborn and Pediatric Committee shall consist of at least four (4) members of the Active Medical Staff and representatives of Nursing and Administration. Representatives of Nursing and Administration shall be ex officio members without vote. (3/98; 1/05)

### **Section 2. Duties:**

The committee shall be responsible for the areas of obstetrics, newborn and pediatrics. The committee shall be responsible to:

- (a) ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, though are not limited to, those within the:
  - (1) assessment and treatment of obstetric, newborn and pediatric patients;
  - (2) use of medications;
  - (3) efficiency (the relationship between the outcomes [results of care] and the resources used to deliver patient care) of clinical practice patterns; and
  - (4) significant departures from established patterns of clinical practice;
  - (5) education of patients and families;
  - (6) coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and
  - (7) accurate, timely, and legible completion of patients' medical records.
  - (8) sentinel event data (1/05)
  - (9) patient safety data (1/05)
  - (10) Clinical Resource Management data.
- (b) ensure that when the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges;
- (c) conduct peer review related to the areas of medicine, intensive care, respiratory therapy, laboratory/blood use, drug utilization and radiology. The Committee delegates to the Perfor-

mance Improvement Department the authority to receive cases and determine whether review by this Committee is appropriate and to delegate the initial review to a licensed independent practitioner; (6/05)

- (d) participate in quality assurance activities and performance improvement;
- (e) ensure that the findings, conclusions, recommendations and actions taken to improve organization performance are communicated to appropriate medical staff members and where appropriate, the Executive Committee and the Board; and
- (f) make recommendations to the Executive Committee for individuals for medical staff membership and recommendations for delineated clinical privileges for each eligible individual.

### **Section 3. Meetings, Reports and Recommendations:**

The Obstetrics, Newborn and Pediatric Committee shall meet ten (10) times per year or as often as necessary to conduct pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the Obstetrics, Newborn and Pediatric Committee shall maintain a permanent record of its findings, proceedings and recommendations. The Obstetrics, Newborn and Pediatric Committee shall make a quarterly report to the Executive Committee and the President. (3/98)

## **PART G: EMERGENCY/AMBULATORY CARE COMMITTEE**

### **Section 1. Composition:**

The Emergency/Ambulatory Care Committee shall consist of at least four (4) members of the Active Staff and a member each from Nursing Service and Administration. Representatives of Nursing and Administration shall be ex officio members without vote. (3/98; 1/05)

### **Section 2. Duties:**

The Emergency/Ambulatory Care Committee shall be the areas of emergency, ambulatory and rehabilitation services. The committee shall be responsible to:

- (a) ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, though are not limited to, those within the:
  - (1) assessment and treatment of emergency and ambulatory patients;
  - (2) use of medications;
  - (3) use of rehabilitation services;
  - (4) efficiency (the relationship between the outcomes [results of care] and the resources used to deliver patient care) of clinical practice patterns; and
  - (5) significant departures from established patterns of clinical practice;
  - (6) education of patients and families;
  - (7) coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and
  - (8) accurate, timely, and legible completion of patients' medical records
  - (9) sentinel event data (1/05)
  - (10) patient safety data (1/05)
  - (11) Clinical Resource Management data.

- (b) ensure that when the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges;
- (c) conduct peer review related to the areas of medicine, intensive care, respiratory therapy, laboratory/blood use, drug utilization and radiology. The Committee delegates to the Performance Improvement Department the authority to receive cases and determine whether review by this Committee is appropriate and to delegate the initial review to a licensed independent practitioner; (6/05)
- (d) review emergency services and medical records for appropriateness of patient care on at least a quarterly basis;
- (e) participate in quality assurance activities and performance improvement;
- (f) ensure that the findings, conclusions, recommendations and actions taken to improve organization performance are communicated to appropriate medical staff members and where appropriate, the Executive Committee and the Board; and
- (g) make recommendations to the Executive Committee for individuals for medical staff membership and recommendations for delineated clinical privileges for each eligible individual.

### **Section 3. Meetings, Reports and Recommendations:**

The Emergency/Ambulatory Care Committee shall meet six (6) times per year or as often as necessary to conduct pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the Emergency/Ambulatory Care Committee shall make a permanent record of its findings, proceedings and actions. The Emergency/Ambulatory Care Committee shall make a report thereof to the Executive Committee and the President.

## **PART H: ETHICS COMMITTEE**

### **Section 1. Composition:**

The Ethics Committee shall consist of members of the Medical Staff and a member each from Administration, Nursing Service and Pastoral Care. The Ethics Committee responsibilities include:

### **Section 2. Duties:**

- (a) addressing specific ethical dilemmas that arise in the course of providing patient care;
- (b) providing consultation services regarding patient care related ethics issues; and
- (c) providing training and continuing education to medical staff and other hospital workforce on topics related to medical ethics.

### **Section 3. Meetings, Reports and Recommendations:**

The Ethics Committee shall meet regularly, shall maintain minutes of the meetings in accordance with Article V, Part B, section 3, and shall make a permanent record of its findings, proceedings and actions. The Ethics Committee shall make a report thereof to the Executive Committee and to the President.

## **PART I: CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE**

### **Section 1. Composition:**

The Continuing Medical Education/Library Committee shall consist of members of the Medical Staff, Allied Health Staff, Administration, Performance Improvement Department and the coordinator of the CME Committee.

### **Section 2. Duties:**

The duties of the Continuing Medical Education/Library Committee, under the co-sponsorship of St. Mary's Continuing Medical Education program, in organizing and implementing continuing medical education programs and supervising the hospital's professional library services, shall be:

- (a) to develop and plan, or participate in, programs of continuing medical education and inservices that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsible to evaluation findings;
- (b) to analyze, on a continuing basis, the hospital's and staff's needs for professional library services;
- (c) to act upon continuing medical education recommendations from the Executive Committee and from other committees responsible for patient care;
- (d) to maintain a permanent record of education and library activities; and
- (e) to cooperate where appropriate, with universities and other institutions in Medical Staff continuing education.

### **Section 3. Meetings, Reports and Recommendations:**

The Continuing Medical Education/Library Committee shall meet as often as necessary to conduct current business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the committee shall maintain a permanent record of its findings, proceedings and actions. The Continuing Medical Education/Library Committee shall make a report thereof to the Executive Committee and the President.

## **PART J: PHYSICIAN AND LICENSED INDEPENDENT PRACTITIONERS HEALTH COMMITTEE (1/05)**

### **Section 1. Composition:**

The Physician and Licensed Independent Practitioners Health Committee shall consist of at least three (3) members of the Active Medical Staff. The committee shall include members whose expertise or personal experience may be beneficial to the committee. One such member shall be designated as the "secretary" for this committee. (1/05)

### **Section 2. Duties:**

The duty of the Physician and Licensed Independent Practitioners Health Committee is to follow the Corporate Physician Impaired Policy and the Disruptive Physician entity policy. (1/05)

- (a) to develop and revise as necessary, in consultation with the President, a protocol under which the committee can efficiently and effectively operate to achieve the committee's stated purpose in responding to self referrals or referrals made by others regarding physician and/or licensed independent practitioner impairment. (1/05)
- (b) to coordinate activities concerning personal health and related issues for the Medical Staff and Licensed Independent Practitioners;
- (c) to review information regarding specific incidents relating to practitioner health as they arise;
- (d) to conduct personal conferences with practitioners relating to their health issues as appropriate;
- (e) to arrange medical consultation for practitioners as appropriate;
- (f) to assist with referral for care, treatment, monitoring and follow-up for practitioners as appropriate;
- (g) to summarily report to the Executive Committee and President at least annually, with additional reports as contemplated below;
- (h) to provide education. (8/03)

### **Section 3. Meetings, Reports and Recommendations:**

The Physician and Licensed Independent Practitioner Health Committee shall meet as often as necessary to transact pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the secretary will maintain reports of all meetings, which reports shall include the minutes of the various committees and services of the staff. Copies of all minutes, reports and recommendations of the committee shall be transmitted to the Executive Committee and the President routinely as prepared. The President shall report any important actions of this committee to the Board. Confidentiality will be maintained except as required by law, ethical obligations or when health or safety of a patient is threatened. (1/05)

## **PART K: PHARMACY & THERAPEUTICS COMMITTEE (1/05)**

### **Section 1. Composition:**

The Pharmacy & Therapeutics Committee shall consist of the physician (chairperson), pharmacist (secretary), representatives from pertinent medical staff and hospital entities including but not limited to: administration, nursing, pharmacy, infection control, performance improvement and nutrition. Committee members should be appointed by a governing unit or authorized official.

### **Section 2. Duties:**

The duties of the Pharmacy & Therapeutics committee shall be:

- (a) To serve in an evaluative, educational and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications.

- (b) To develop, maintain and enforce a formulary of medications accepted for use in the organization, and provide for its constant revision. The selection of items to be included in the formulary should be based on objective evaluation of their relative therapeutic merits, safety and cost. The committee should minimize duplication of the same basic medication type, medication entity, or medication product.
- (c) To establish programs, policies and procedures that ensure safe and effective medication therapy including, but not limited to, selection, distribution, handling, use, prescribing, preparing, dispensing, administering and monitoring.
- (d) To establish programs and procedures that ensure cost-effective medication therapy and fiscal responsibility relating to medication use.
- (e) To establish or plan suitable educational programs for the organization's professional staff on matters related to medication use.
- (f) To participate in quality assurance activities related to distribution, administration and use of medications.
- (g) To monitor and evaluate adverse drug events and make appropriate recommendations.
- (h) To initiate or direct medication use evaluation programs and studies (efficacy, safety, cost efficiency), review the results of such activities and make appropriate recommendations to optimize medication use.
- (i) To disseminate information on its actions and approved recommendations to all organization health care staff.
- (j) To review Clinical Resource Management data.

### **Section 3: Meetings, Reports and Recommendations;**

The Pharmacy & Therapeutics Committee shall meet ten (10) times per year or as often as necessary to conduct pending business. In addition to maintaining minutes in Accordance with Article V, Part B, section 3, the Pharmacy & Therapeutics Committee shall maintain a permanent record of its findings, proceedings and recommendations. The Pharmacy & Therapeutics Committee shall make a report to the Executive Committee and the President. (1/05)

## **PART L: CREATION OF SPECIAL COMMITTEES**

The Executive Committee of the Medical Staff may, by resolution, establish special committees to perform one or more staff functions. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee. In the same manner the Executive Committee may dissolve or rearrange special committee structure, duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these bylaws which is not assigned to a standing or special committee shall be performed by the Executive Committee of the Medical Staff.

## **ARTICLE VI. APPOINTMENT/REAPPOINTMENT TO THE MEDICAL STAFF**

### **PART A: QUALIFICATIONS FOR APPOINTMENT/REAPPOINTMENT**

Appointment and reappointment to the Medical Staff of St. Clare Hospital and Health Services is a privilege which shall be extended only to professionally competent persons who meet the threshold eligibility criteria and qualifications outlined in these bylaws and the Credentials Policy and Procedure Manual, and

who continuously meet the qualifications, standards and requirements set forth in these bylaws and in the Credentials Policy and Procedure Manual, the substantive provisions of which are incorporated herein by reference. All persons practicing medicine, dentistry and podiatry in St. Clare Hospital and Health Services, unless excepted by specific provisions of these bylaws and associated manual, must first have been appointed to the Medical Staff.

## **PART B: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES**

Applications for appointment to the Medical Staff shall be in writing and shall be submitted on forms prescribed by the Board after consultation with the Executive Committee. These forms shall be obtained from the President or his/her designee. The application shall require detailed information concerning the applicant's professional qualifications as outlined in the Credentials Policy and Procedure Manual. Except for those categories of the Medical Staff for which members are not granted clinical privileges, each application for appointment to the Medical Staff shall contain a request for specific clinical privileges. The process related to initial appointment and the granting of clinical privileges is set forth in the Credentials Policy and Procedure Manual.

## **PART C: REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES**

Applications for reappointment to the Medical Staff shall be in writing and shall be submitted on forms prescribed by the Board after consultation with the Executive Committee. These forms will be distributed by the President or his/her designee. Appointees who fail to provide the information necessary for reappointment within the prescribed time frame will have their appointment lapse and will be required to re-apply for appointment and privileges. Such a lapse in appointment will not trigger the right to hearing and appeal rights as outlined in the Fair Hearing Plan. Except for those categories of the Medical Staff for which members are not granted clinical privileges, each application for reappointment to the Medical Staff shall contain a request for renewal of specific clinical privileges. The process related to reappointment and the renewal of clinical privileges is set forth in the Credentials Policy and Procedure Manual.

# **ARTICLE VII. DISCIPLINARY ACTIONS**

## **PART A: AUTOMATIC RELINQUISHMENT/SUSPENSION**

In the instances outlined in the Credentials Policy and Procedure Manual, and as otherwise indicated in these Bylaws, a practitioner's privileges and/or Medical Staff membership will be considered automatically suspended, relinquished, terminated or limited as described therein, and the action shall be final without a right to hearing or appeal. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the Executive Committee determines it is not applicable. The process related to automatic relinquishment and suspension is set forth in the Credentials Policy and Procedure Manual.

## **PART B: PRECAUTIONARY SUSPENSION**

The Chief of the Medical Staff, the chairperson of a clinical service, the President of the Hospital or, in his/her absence, his/her designee, or the President of the Board shall have the authority to suspend or restrict all or any portion of a practitioner's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may inter-



ferre with the orderly operation of the hospital. The process related to the imposition of a precautionary suspension is set forth in the Credentials Policy and Procedure Manual.

### **PART C: CORRECTIVE ACTION**

The Executive Committee may recommend corrective action against any individual holding a current Medical Staff appointment or clinical privileges whenever it has reason to question any of the criteria outlined in Article III, Part C of the Credentials Policy and Procedure Manual. The process related to the imposition of corrective action, including recommendations for termination or suspension of Medical Staff membership, and/or termination, suspension, or reduction of clinical privileges is set forth in the Credentials Policy and Procedure Manual.

### **PART D: FAIR HEARING AND APPELLATE REVIEW**

- (a) An applicant or individual holding appointment to the Medical Staff or clinical privileges (including Allied Health Professionals) may request a formal hearing whenever an adverse recommendation or action is made by the Executive Committee or Board that would entitle the individual to request a hearing under the Fair Hearing Plan. When a proper request for a hearing is received, the President shall deliver it to the Chief of Staff, who shall promptly schedule a hearing. Practitioners shall be entitled to receive notice when they are entitled to a fair hearing in accordance with the Fair Hearing Plan. A hearing relating to an adverse recommendation of the Executive Committee or the Board shall be conducted by a hearing committee or a hearing officer appointed by the President of the Hospital in accordance with the Fair Hearing Plan. The fair hearing process is set forth in the Fair Hearing Plan.
- (b) Practitioners shall be entitled to request an appellate review for the grounds specified in the Fair Hearing Plan. As soon as practicable after receiving a request for appellate review, the Board shall schedule and arrange for the review. The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee. The appellate review process is set forth in the Fair Hearing Plan.

## **ARTICLE VIII. CONFLICTS OF INTEREST**

When performing a function outlined in these bylaws or the Credentials Policy and Procedure Manual, a Medical Staff member who has or reasonably could be perceived as having a conflict of interest shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the Chief of Staff or applicable clinical service chairperson by any other member with knowledge of it.

The fact that a clinical service chairperson, or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

The fact that a Medical Staff member, including a Medical Staff leader, chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of an actual conflict.

#### **ARTICLE IX. EXCLUSIVE CONTRACTS**

From time to time, the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts shall obtain and maintain medical staff appointment and clinical privileges at the Hospital, in accordance with the terms of these Bylaws and the Credentials Policy and Procedure Manual.

To the extent that any such contract confers the exclusive right to perform specified services at the Hospital on the other party to the contract, no other person may exercise clinical privileges to perform the specified services while the contract is in effect.

If any such exclusive contract would have the effect of preventing an existing medical staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of these Bylaws, the Credentials Policy and Procedure Manual, and the Fair Hearing Plan. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

A physician who performs services pursuant to an exclusive contract with the Hospital agrees that his medical staff appointment and clinical privileges are incident to and coterminous with the existence of the exclusive contract, unless waived by the President of the hospital. The physician's medical staff appointment and clinical privileges automatically terminate, without a hearing or appeal, when the exclusive contract expires or terminates and/or upon the physician's termination or removal from the group with which the hospital entered into the exclusive contract.

In the event of any conflict between this Article and the terms of any contract, the Executive Committee shall determine whether the bylaws or the contract shall control, except that nothing contained in any separate contract renders a staff member immune from the coverage of the Procedure for Corrective Action contemplated in these bylaws nor from any other disciplinary sanction.

#### **ARTICLE X. REQUIREMENTS FOR PERFORMING HISTORIES AND PHYSICAL EXAMINATIONS**

A complete history and physical examination shall be completed and documented in the medical record no more than thirty (30) days before or twenty-four (24) hours after admission of a patient (and prior to surgery or procedure requiring anesthesia services). A full history and physical examination shall include, at a minimum, those elements of the history and physical examination immediately pertinent to the chief complaint or presenting problem; the history of the present illness; relevant past medical, surgical, social, and family history; medications and allergies; vital signs, pain assessment, and review of systems; physical examination; any laboratory results or other pertinent reports; impression/ assessment; treatment plan; and any additional elements of the history and physical examination necessary for safe and effective treatment of the patient.

A physical and history (and updates thereof) may be performed by physicians or other qualified licensed individuals, including but not limited to Certified Registered Nurse Anesthetists, who are authorized by the State of Wisconsin to perform histories and physical examinations and who are privileged to perform histories and physical examinations by St. Clare Hospital and Health Services. Dentists and podiatrists are responsible for the portion of the history and physical relating to dentistry and podiatry.

If a complete history and physical examination are completed within thirty (30) days prior to the admission and a durable legible (or electronic) copy of such history and examination is in the patient's hospital medical record, an updated history and physical examination of the patient, including any changes, must be completed and documented in the medical record within twenty-four (24) hours after admission (and prior to surgery or procedure requiring anesthesia services). Such update shall include a reference to the previous history and physical examination and, as necessary, provision of required information that is otherwise absent or incomplete; a description of the patient's condition and course of care since the history and physical examination was performed; and, regardless of whether any changes or updated information are necessary, the signature of the physician or other qualified licensed individual, time, and date on any document with updated or revised information as an attestation that it is current. The previous history and physical examination may be completed by a physician who is not credentialed or privileged by St. Clare Hospital and Health Services, as long as the required update is performed by a physician or other qualified licensed individual, including but not limited to a Certified Registered Nurse Anesthetist, who is authorized and privileged to do so by St. Clare Hospital and Health Services.

If a history and physical examination and an update, if applicable, are not properly recorded before the time scheduled for surgery or procedure requiring anesthesia, the surgery or procedure shall be delayed until the history and physical is obtained unless the attending physician (surgeon) states in writing in the patient's medical record that such delay would cause a hazard to the patient.

Patients registered for ambulatory or other outpatient surgeries and procedures requiring anesthesia services shall have a history and physical examination. Such histories and physical examinations or updates thereof shall meet the requirements of an inpatient history and physical examination and shall be recorded in the medical record within the same timeframes.

Any physician having a pattern of not having histories and physical examinations completed and documented within twenty-four (24) hours after admission or registration (in the case of outpatient surgeries and procedures) shall be referred to the appropriate service committee which shall forward a report with or without a recommendation for disciplinary action to the Executive Committee of the Medical Staff.

## **ARTICLE XI. IMMUNITY**

All applicants to the Medical Staff, all appointees to the Medical Staff, and anyone having or seeking privileges to practice his/her profession in the hospital shall be subject to the release and immunity provisions outlined in Article II, Part A, Section 4 of the Credentials Policy and Procedure Manual.

## **ARTICLE XII. AMENDMENTS TO THE BYLAWS, RULES AND REGULATIONS, CREDENTIALS POLICY AND PROCEDURE MANUAL, FAIR HEARING PLAN, AND RELATED POLICIES**

### **PART A: BYLAWS**

#### **Section 1. Adoption:**

The Bylaws shall be adopted by a majority of the voting Medical Staff and approved by the Board. Once adopted, the Bylaws shall be amended as provided in Part A, Section 2 of this Article. The Bylaws shall be equally binding on the Board and the Medical Staff. In the event of a conflict between the Bylaws of the Medical Staff and the Rules and Regulations of the Medical Staff or between the Bylaws of the Medical Staff and the policies of the Medical Staff, the Bylaws shall control.

## **Section 2. Amendments:**

The voting Medical Staff or the Executive Committee may initiate proposed amendments to the Bylaws. The Medical Staff may propose such amendments directly to the Board.

Proposed Bylaws amendments, whether initiated by the Executive Committee or by the Medical Staff, must be approved by a majority of the votes cast by voting Medical Staff members, provided that a quorum has voted. Such amendments shall be effective only upon approval by the Board. Neither the Medical Staff nor the Board may unilaterally amend the Bylaws.

## **Section 3. Review:**

These Bylaws shall be formally reviewed by the Executive Committee every two years.

# **PART B: RULES AND REGULATIONS**

## **Section 1. Scope:**

The Rules and Regulations are created to implement more specifically the general principles of conduct found in these Bylaws. Rules and Regulations shall set standards of practice that are to be required of Medical Staff members of the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. The Rules and Regulations will provide a framework within which the Medical Staff can act with a reasonable degree of freedom and confidence.

## **Section 2. Adoption/Amendment by the Executive Committee:**

The voting Medical Staff delegates to the Executive Committee the authority to adopt and amend such Rules and Regulations as it deems necessary, provided that notification has been given to the Medical Staff at least twenty-one (21) days prior to any submission to the Board. Any such adoption or amendment to the Rules and Regulations shall be made by a majority of the Executive Committee, subject to approval by the Board. This delegation of authority to the Executive Committee shall not prevent the voting Medical Staff from making proposals directly to the Board in accordance with Part B, Section 3 of this Article.

## **Section 3. Adoption/Amendment by the Medical Staff:**

Rules and Regulations of the Medical Staff may be adopted or amended by a majority of the votes cast by voting Medical Staff members, provided that a quorum has voted. The Medical Staff may make any proposed adoption or amendment directly to the Board, provided that it first communicates the proposed adoption or amendment to the Executive Committee at least twenty-one (21) days prior to any submission to the Board. Any proposed adoption or amendment shall be effective only upon approval by the Board.

#### **Section 4. Urgent Amendments:**

In the event that the Hospital receives a written notice, demand or other similar communication from a governmental or similar entity, or if the Hospital becomes aware that it needs to amend the Rules and Regulations in order to comply with any law, regulation, or accreditation standard, by way of delegation from the voting Medical Staff, the Executive Committee shall adopt, and the Board may provisionally approve without any prior notice to the Medical Staff, an amendment to Rules and Regulations. In such cases, the Medical Staff will be immediately notified by the Executive Committee. Communication of such changes may be made via email or by posting in the Medical Staff Office. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the voting Medical Staff and the Executive Committee regarding the provisional amendment, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the voting Medical Staff shall initiate the conflict resolution process set forth in the applicable policy. If necessary, a revised amendment may be submitted to the Board.

### **PART C: CREDENTIALS POLICY AND PROCEDURE MANUAL, FAIR HEARING PLAN, AND OTHER RELATED POLICIES**

#### **Section 1. Scope:**

The Credentials Policy and Procedure Manual addresses the qualifications for appointment, the process for granting initial appointment, clinical privileges (Medical Staff members, Allied Health Professionals, and telemedicine), temporary privileges, expedited credentialing, reappointment, renewal of privileges, corrective action, immunity, suspension of privileges (including precautionary and automatic suspension), and leave of absence.

The Fair Hearing Plan addresses adverse actions, notice requirements, and the process for hearings and appeals.

In addition to the Credentials Policy and Procedure Manual and the Fair Hearing Plan, additional Medical Staff policies and procedures may be developed to provide the associated details related to various sections of these Bylaws. For purposes of this Article, such policies and procedures shall be referred to as "Related Policies."

#### **Section 2. Adoption/Amendment by the Executive Committee:**

The voting Medical Staff delegates to the Executive Committee the authority to adopt and amend the Credentials Policy and Procedure Manual, the Fair Hearing Plan, and Related Policies as it deems necessary. Adoption and amendment of such documents may be made by a majority of the Executive Committee. Any such adoption or amendment shall be effective only upon approval by the Board. This delegation of authority to the Executive Committee shall not prevent the voting Medical Staff from making proposals directly to the Board in accordance with Part C, Section 3.

All amendments to the Credentials Policy and Procedure Manual, the Fair Hearing Plan, and the Related Policies initiated by the Executive Committee shall be reported to the Medical Staff at the next regularly scheduled Medical Staff Meeting, or sooner if necessary. A description of any changes made to these documents shall be made available for inspection by any practitioner.

#### **Section 3. Adoption/Amendment by the Medical Staff:**

The voting Medical Staff may adopt and amend the Credentials Policy and Procedure Manual, the Fair Hearing Plan, and the Related Policies by a majority of the votes cast by voting Medical Staff members, provided that a quorum has voted, and provided that notification was given to the Executive Committee at least twenty-one (21) days prior to any submission to the Board. Any such adoption or amendment shall be effective only upon approval by the Board.

#### **PART D: CONFLICT RESOLUTION**

In the event of a conflict between the Medical Staff and the Executive Committee in regard to a proposal to adopt or amend the Rules and Regulations, the Fair Hearing Plan, the Credentials Policy and Procedure Manual, or other Related Policy, the conflict resolution process set forth in the applicable policy shall be initiated.

ADOPTED

by the St. Clare Hospital and Health Services Medical Staff on \_\_\_\_\_

\_\_\_\_\_  
[Insert Name]

Chief of Staff, Medical Staff

ADOPTED

by the SSM Health Care of Wisconsin, Inc. Board of Directors on: \_\_\_\_\_

\_\_\_\_\_  
Sr. Mary Jean Ryan, FSM

Chairperson, Board of Directors

\_\_\_\_\_  
Gerald Lefert

Interim CEO, SSM Health Care of Wisconsin

\_\_\_\_\_  
Sandy Anderson

President, St. Clare Hospital & Health Services

**MEDICAL STAFF RULES AND REGULATIONS**

**ST. CLARE HOSPITAL AND HEALTH SERVICES  
BARABOO, WISCONSIN**

**(2011)**

## **ST. CLARE HOSPITAL AND HEALTH SERVICES MEDICAL STAFF RULES AND REGULATIONS**

Individuals who accept appointment to the medical staff and all other practitioners who obtain clinical privileges at St. Clare Hospital and Health Services agree to abide by the Medical Staff Rules and Regulations.

1. Except in an emergency, a patient shall not be admitted to the hospital until a provisional diagnosis of the patient is provided. In case of emergency the provisional diagnosis shall be provided as soon after admission as is reasonably possible.
2. A person may be admitted to the hospital only on the recommendation of a physician. To assure the safety of the patient and other persons in the hospital, physicians admitting patients shall provide such information as may reasonably be obtained and shall request such actions as are reasonable and necessary from the hospital. Information to be provided and clearly documented in the medical record shall include, as relevant, any known risks to the patient or dangers relating to the patient (including the potential for self-harm or harm to others). The physician shall take all other reasonable steps to prevent such harm from occurring.
3. Each patient shall have an attending physician who is a member of the Medical Staff and who has staff privileges appropriate for attending the patient. Each patient shall be assigned to the clinical service concerned with the treatment of the condition of the patient. In the event that a patient requires admission and has no attending physician, the patient shall be assigned to a member of the Active Medical Staff who is on duty at the time of admission.

Attending physicians or their designee in their respective call group are required to see each hospitalized medical, surgical, and obstetrical patient daily, and shall document the daily visits in the chart, in accordance with these Rules and Regulations. (3/06)

4. Absent extraordinary circumstances, an on-call physician shall arrive at the hospital within thirty (30) minutes of an urgent call request, as is consistent with the responsibilities of appointees to the Active Medical Staff in the Medical Staff Bylaws. For non-urgent calls, the on-call physician shall arrive at the hospital within sixty (60) minutes of the call request, unless the requesting clinician specifies a different timeframe.
5. Each member of the Medical Staff who does not reside within thirty (30) minutes of the hospital shall designate a member of the Active Medical Staff who resides within thirty (30) minutes of the hospital, who shall agree to be responsible to attend the non-resident physician's patients as medically necessary. If a resident physician is not available, the President or designee may call upon any member of the Active Medical Staff.
6. The Medical Staff has a process for supervision of residents and such supervision is defined in the resident's scope of practice. (4/02) Staff physicians are required to either co-sign a daily progress note or write their own note. (12/02) Patient procedures or assistance in procedures require direct supervision by a staff physician.

Medical Students. All patient orders and progress notes written by medical students must be countersigned by the attending physician or other appropriately designated member of the



Medical Staff or resident prior to the execution of said order. Approval of said orders by the attending physician or other appropriately designated member of the Medical Staff or licensed resident may be done by telephone communication in accordance with the rules covering telephone orders. (9/97) (12/02)

PG-1 Residents. Any patient orders, progress notes, and any other medical record entries prepared by physicians at the PG-1 level of training must be countersigned within twenty-four (24) hours by a Rural Resident Training Track Faculty physician for either patient care procedures or the administration of drugs. (9/97)

PG-2 and PG-3 Residents. Histories and physicals can be gathered and a counter signature is required by staff physician. Discharge summaries, and operative reports prepared by physicians at the PG-2 and PG-3 level of training must also be countersigned by a Rural Resident Training Track Faculty physician. Orders can be written and there is no requirement for a countersignature, as long as the attending physician documents participation in the patient's care by co-signing the daily progress note or writing their own note. (4/02) (12/02)

7. Order sets shall be approved by the appropriate clinical service committee. Approved order sets shall then be forwarded to the Medical Executive Committee for review and approval, and then forwarded to the general Medical Staff for information purposes. Order sets may be changed only upon approval by the appropriate clinical service committee through the Electronic Health Record order set review process. Order sets shall be in legible writing or in the Electronic Health Record and shall be electronically dated, timed, and authenticated by the attending physician. All order sets shall be reviewed annually by the appropriate clinical service committee. Standing orders, as-needed orders, or order sets for restraint or seclusion shall not be used.
8. All orders for diagnosis, treatment, and medication shall be in writing and shall be issued by a physician, except as permitted by the privileges and scope of practice of other practitioners. All orders shall be dated, timed, and authenticated by the ordering practitioner. Verbal and telephone orders are permitted if the following requirements are met:
  - a. Verbal and telephone orders (including prescription orders) shall be strictly confined to circumstances in which patient care needs require them. All orders may be dictated to a Registered Nurse, and orders pertaining to their professional disciplines may be dictated to a Pharmacist, Respiratory Therapist, Physical Therapist, Occupational Therapist, Clinical Dietitian, Radiology Technologist, or Laboratory Technician or Technologist respectively.
  - b. The complete verbal or telephone order shall be written down or entered into the computer, including the name of the ordering practitioner, and must be electronically dated, timed and signed by the individual receiving the order. The complete order shall then be read back to the ordering practitioner, who shall confirm the information. Verbal and telephone orders shall be authenticated (signed, timed, and dated) within forty-eight (48) hours of receipt by the ordering practitioner or another practitioner privileged to do so who has knowledge of the patient's hospital course, medical plan of care, condition, and current status. The authenticating practitioner is then professionally and legally responsible starting at the time of signing for the treatments and medications prescribed

under the orders, as well as the diagnostics on which the orders are based. (5/99) (6/00)  
(2/07)

9. Critical test results that are reported verbally or by telephone shall be written down or entered into the computer, including the name of the ordering practitioner, and must be dated, timed and signed by the individual receiving the test result. The complete test result shall then be read back to the individual who communicated the test results, who shall confirm the information.
10. All orders and reports issued by Allied Health Professionals shall be countersigned by a physician, except where the Allied Health Professional has privileges to issue such order or report.
11. Certified Registered Nurse Anesthetists (CRNAs) may be granted prescriptive authority if they are also certified as an advanced practice nurse prescriber in the State of Wisconsin. (9/97)  
CRNAs are permitted to perform histories and physicals and any updates thereto if they have been granted privileges to do so in accordance with the requirements outlined in the Medical Staff Bylaws.
12. In the event of a situation where it is necessary to protect a patient from harm to self or others by the use of restraint or seclusion, the restraint or seclusion shall be used only in compliance with current Joint Commission, regulatory requirements, and hospital policies and procedures.
13. Medications used shall be those listed in the United States Pharmacopeia, National Formulary, New and Non-Official Drugs, and/or the Physician's Desk Reference, and in the formulary of St. Clare Hospital, with the exception of drugs for bona fide clinical investigation. Exceptions to this rule shall be justified by the Pharmacy & Therapeutics Committee. (1/05)
14. Medications shall be administered only upon the order of a member of the Medical Staff, an authorized member of the House Staff, or other individual who has been granted clinical privileges to write such orders. (6/00)
15. All medications shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with laws and governmental rules and regulations governing such acts and in accordance with the approved Medical Staff Rules and Regulations.
16. Automatic Stop Orders on Medications:
  - a. All medication orders shall be automatically cancelled when a patient undergoes surgery.
  - b. Once weekly, the patient's entire medication profile will be reviewed so that the physician may determine whether the medications' administration is to be continued or altered.
17. Cautionary measures for the safe admixture of parenteral products shall be developed. Whenever medications are added to intravenous solutions, a distinctive supplementary label shall be affixed to the container. The label shall indicate the patient's name and location; the name and amount of the medications added; the name of the basic parenteral solution; the date and time of the addition; the date, time, and rate of administration; the name or identifying code of the individual

who prepared the admixture; supplemental instructions; and the expiration date of the compounded solution.

18. Medications to be administered shall be verified with the prescribing practitioner's orders and properly prepared for administration. The patient shall be identified prior to medication administration, and each dose of medication administered shall be recorded properly in the patient's medical record.
19. Adverse drug events, including medication errors and adverse drug reactions, shall be reported immediately to the attending physician and, if different, to the practitioner who ordered the medication. An entry of the medication administered and/or the medication reaction shall be properly recorded in the patient's medical record. Medication errors and adverse drug reactions also shall be reported to the hospital quality assurance program. It is suggested that any unexpected or significant adverse reactions should be reported promptly to the Food and Drug Administration and the manufacturer.
20. Medications brought into the hospital by patients shall not be administered unless the medications have been identified and there is a written order from the responsible practitioner to administer the drugs. If the drugs are not to be used during the patient's hospitalization, they shall be packaged and sealed, and either given to the patient's family or stored and returned to the patient at the time of discharge, provided such action is approved by the responsible practitioner.
21. Self-administration of medications by patients shall be permitted on a specific written order by the authorized prescribing practitioner and in accordance with established hospital policy. The prescribing practitioner shall determine that the patient is competent at medication administration, and the patient or family involved in self-administration shall be educated about medication name, type, and reason for use; how to administer the medication, including process, time, frequency, route, and dose; anticipated actions and potential side effects of the medication administered; and monitoring the effects of the medication.
22. Investigational medications shall be properly labeled and stored, and shall be used only under the direct supervision of the authorized principle investigator and consistent with Board Policy relating to investigational drugs and procedures. Such medications should be administered in accordance with an approved protocol that includes requirements for a patient's appropriate informed consent. On approval of the principle investigator, registered nurses may administer these medications after they have been given, and have demonstrated an understanding of, basic pharmacologic information about the medications. When required, a research consent form meeting the requirements of state and federal law shall document the patient's consent and shall be kept in the medical record or research file.
23. Orders involving abbreviations and chemical symbols should be carried out only if the abbreviations/symbols appear on an explanatory legend approved by the Medical Staff, which shall be updated every two (2) years. In the interest of minimizing errors, the use of abbreviations is discouraged, and the use of a trailing zero should be avoided. Each practitioner who prescribes medication must clearly state the administration times or the time interval between doses. The use of "prn" and "on call" with medication orders should be qualified.

24. Medications prescribed for ambulatory care patient use in continuity with hospital care shall be released to patients upon discharge only after they are labeled for such use under the supervision of the pharmacist and only on written order of the authorized prescribing practitioner. Each drug released to a patient on discharge should be recorded in the medical record.
25. Individual medications should be administered as soon as possible after the dose has been prepared, particularly medications prepared for parenteral administration, and, to the maximum extent possible, by the individual who prepared the dose, except where unit dose drug distribution systems are used.
26. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. The record shall contain the following:
  - a. identification data, when not obtainable the reason shall be entered in the record;
  - b. medical history of patient, a concise statement of complaints, including the chief complaint, and the date of onset and duration of each, relevant past personal, family and social histories; present illness; (approved 5/27/03 Medical Staff; board approval 8/03)
  - c. a statement about the results of the physical examination, including positive and negative findings resulting from an inventory of systems;
  - d. plan of action;
  - e. special reports such as operative, consultants, clinical laboratory, x-ray, tissue, autopsy, and all others;
  - f. provisional diagnosis;
  - g. medical and surgical treatment, including diagnostic and therapeutic orders;
  - h. reports of procedures, tests and results;
  - i. pathological diagnosis and findings;
  - j. daily progress notes written by the attending physician or designee;
  - k. clinical observations, including results of therapy;
  - l. properly executed informed consent forms (if consent is not available the reason shall be entered in the record);
  - m. discharge summary or transfer summary, which shall be dated, timed, and signed by the attending physician and shall include history of present illness and reason for hospitalization, hospital course, final diagnosis, significant findings, procedures performed, results of diagnostic and therapeutic procedures, condition of patient on discharge, provisions for follow-up care, and any specific instructions given to the patient or family; (7/97)

- n. documentation of complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia;
- o. anatomical gift information promptly and prominently set out in the record, including the name and title of the person making the request, name and relation to the patient of the individual receiving the request, and if a determination is made that no request is made, the basis for that determination;
- p. autopsy findings when an autopsy is performed;
- q. a list of known allergies;
- r. final diagnosis; and
- s. for patients receiving emergency services, the medical record shall also contain the following information: information concerning the time of the patient's arrival, means of arrival and by whom transported; pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital; time of physician notification; time of treatments, including administration of medications, time of patient discharge or transfer from the service, and any other information required by EMTALA and hospital policies.

In accordance with the Wisconsin Administrative Code DHS § 124.14(3)(a)(14), a discharge summary is required for all medical records, including the following patient types: inpatient, emergency, observation, hospice, day surgery, and short stay inpatient accounts.

All entries in the medical record must be signed by the responsible physician or other person making an entry and must include that person's title. All entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Authentication of medical record entries may include written signatures, initials, computer key, or other code.  
(7/97)

- 27. Current medical records and those for discharged patients shall be completed promptly. Medical records for discharged patients shall be completed within thirty (30) days following discharge.  
(7/97) (2/02)

If a provider is delinquent on the completion of medical records, notification will be given to the provider, indicating that timely completion is needed. If the provider fails to complete the records following such notification, the elective admitting privileges, which exclude emergencies and obstetrical cases, of a person holding a current Medical Staff appointment shall be automatically suspended for failure to complete medical records in accordance with Article III, Part E, Section 1 of the Credentials Policy and Procedure Manual. Exceptions to this rule may be granted by the Executive Committee of the Medical Staff for extenuating circumstances.

An automatic suspension of admitting privileges due to a failure to complete medical records is not considered to be an adverse action and the affected practitioner is not entitled to any procedural rights or hearing for such relinquishment. (7/97) (2/02)

28. All medical records are the property of the hospital. No original medical record shall leave the safe keeping and jurisdiction of the hospital except upon express permission of the President or designee upon court order, subpoena or statute, in which case prior notice shall be given to the President or designee.
29. Written authorization of the patient is required for the release of medical information to persons not otherwise authorized by law to receive the information.
30. An admission Complete Blood Count, urinalysis, and other appropriate laboratory tests performed in a laboratory other than St. Clare Hospital may be used in lieu of such tests being performed at the St. Clare Hospital laboratory if the admitting physician or consulting physician so elects and if the following conditions are met:
  - a. That the laboratory performing the Complete Blood Count, urinalysis, and/or other appropriate laboratory test is certified to perform such test under DHS Chapter 165 of the Wisconsin Administrative Code and meets the Joint Commission requirements for a hospital-affiliated Laboratory;
  - b. That the test shall have been performed in a reasonable period of time appropriate to the particular case and in no instance should be performed more than 30 days before the time of admission; and
  - c. That an original or facsimile of a timed and dated report stating that the above test(s) have been performed be provided in the medical orders for admission.

The report should be available at the time the patient is admitted to the hospital. If no outside report is available, the hospital laboratory shall perform the required tests and the results of these tests will be permanently charted.

31. All laboratory reports shall be dated, timed, and signed by the technologist.
32. Authenticated laboratory reports shall be filed in the patient's medical record. The laboratory will have access to laboratory reports through the electronic health record.
33. A complete history and physical shall be completed and documented for each admitted patient in accordance with the requirements outlined in Article X of the Medical Staff Bylaws. Patients registered for ambulatory or other outpatient surgeries and procedures requiring anesthesia services shall also have a history and physical examination in accordance with the requirements outlined in Article X of the Medical Staff Bylaws.
34. Except in emergencies, a surgical operation shall be performed only with the written informed consent of the patient or the patient's legal representative.

35. Anesthesia services must be provided consistent with hospital policies and procedures, state and federal law, and relevant Joint Commission standards. Within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services, regardless of inpatient or outpatient status, a pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia and shall include pertinent information relative to the choice of anesthesia and the procedure anticipated. The evaluation shall also include the patient's previous drug and allergy history, anesthesia risk, other anesthetic experiences, any potential anesthetic problems, and the patient's condition prior to induction of anesthesia.
36. An intraoperative anesthesia record shall also be completed and documented. The intraoperative anesthesia record shall include at least the following:
- a. Name and hospital identification number of the patient;
  - b. Name of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
  - c. Name, dosage, route and time of administration of drugs and anesthesia agents;
  - d. IV fluids;
  - e. Blood or blood products, if applicable;
  - f. Oxygen flow rate;
  - g. Continuous recordings of patient status noting blood pressure, heart and respiration rate; and
  - h. Any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
37. Within forty-eight (48) hours after surgery or a procedure requiring anesthesia services, a postanesthesia evaluation shall be completed and documented. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.
38. All operations shall be fully described by the operating surgeon and his medical record report shall be made before leaving the surgical area. The report shall include at least: name and hospital identification number of the patient; date and times of the surgery; name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision); pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications, if any; a description of techniques, findings, and tissues removed or altered; surgeons' or practitioners' name(s) and a description of the specific significant surgical tasks (e.g., opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) that were conducted by practitioners other than the primary surgeon/practitioner; and

prosthetic devices, grafts, tissues, transplants, or devices implanted, if any. The operating surgeon shall sign, date, and time the report.

All infections of clean surgical cases shall be recorded and reported to the administrative staff and infection control committee.

39. The surgeon shall be in the operating room and prepared to commence surgery at the time scheduled.
40. Specimens removed during surgical procedures shall ordinarily be sent to the pathologist for evaluation. Such specimens shall be labeled, and identified as to patient and source in the operating room at the time of removal. Such specimens shall be accompanied by pertinent clinical information and, to the degree known, the pre-operative diagnosis. The pathologist shall issue a written report for the medical record and the physician requesting the examination shall be notified of its results.

Exceptions for pathological review of surgically removed specimens will be as follows:

- Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
  - Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
  - Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
  - Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
  - Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;
  - Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics; and
  - Teeth, provided the number, including fragments is recorded in the medical record.
41. Except in emergency situations, consultation with a member of the Affiliate or Active Medical Staff shall be required on all critically ill patients where, in the judgment of the attending physician: (9/97)
    - a. The patient is not a good risk for operation or treatment;
    - b. The diagnosis is obscure;



- c. There is doubt as to the best therapeutic measure to be utilized;
- d. In all cases of suspect criminal action; and
- e. In all other cases as determined by individual clinical services.

A satisfactory consultation includes examination of the patient and the record, and all other standards as promulgated by individual clinical services. A written opinion signed, dated, and timed by the consultant must be included in the medical record when operative procedures are involved. The consultation note, except in an emergency, shall be recorded prior to the operation.

The recommendation of consultants shall not justify a violation of the Catholic Healthcare Ethics, Catechism of the Catholic Church.

- 42. Dentists, podiatrists, or other non-physician health professionals shall comply with the Rules and Regulations of the Medical Staff.
- 43. Patients shall be discharged only on written or verbal order of the attending physician. Whenever a patient wishes to leave against medical advice, an Against Medical Advice Consent shall be procured from the patient, when possible.
- 44. When a patient comes to the hospital seeking emergency treatment, the hospital shall provide an appropriate medical screening examination to determine whether the patient has an emergency medical condition in accordance with EMTALA and hospital policies. The patient must be screened by a physician or other qualified medical personnel (QMP), which includes nurse practitioners and physician assistants with appropriate training. Certified Nurse Midwives are also considered QMPs for purposes of MSEs related to labor. Patients who are having contractions must be screened by a physician, Certified Nurse Midwife, or other QMP acting within his or her scope of practice and privileges, to determine and certify whether the patient is in false labor. (6/00) (4/02)
- 45. Physicians shall adhere to the Autopsy Policy MSA-951-019-001. No autopsy shall be performed without written consent of a relative or person legally authorized to give consent for autopsy. Further, no autopsy may be performed without the written authorization of the county coroner in the case of deaths that meet the criteria for medical examiner or coroner review. (approved 5/27/03 Medical Staff; board approval 8/03) Autopsy reports shall be distributed to the attending physician.
- 46. In general (and to the extent permitted by law), orders not to resuscitate, to forego or withdraw life-sustaining treatment, will be considered appropriate when either a) there is irreversible, irreparable illness where death is imminent, b) the quality of residual life does not warrant extraordinary care, or c) other factors make these efforts inappropriate. The order should be based upon consultation with the patient (or surrogate decision-maker) and the patient's family as appropriate. This policy will respect the patient's autonomy and respect the rights of the patient and the patient's designated representative to make treatment decisions. The development of these orders will include consideration of the advance directives prepared by the patient. The order is cancelled at discharge, or anytime the patient (or proxy for incompetent patient) chooses.

In the event of a cardiopulmonary arrest, the order "DNR" means Do Not Resuscitate. The absence of a DNR order means to "Resuscitate" (or "full code"). Oral orders may be given but must be reduced to writing and authenticated within forty-eight (48) hours as are other oral orders. "Resuscitate" (or "full code") means basic life support and advanced cardiac life support. Absence of the DNR order means full resuscitation until the attending physician or designee is able to respond, unless there is some clear and convincing reason to do otherwise. The preferred progress note indicates the diagnosis and prognosis, the alternative forms of treatment (if available) and their estimated material risks and benefits, and the affirmation of the patient or proxy. "Partial DNR" orders should be minimized because of the potential for ambiguity.

47. The Medical Staff shall follow the Peer Review Reference Manual as adopted by MSEC. (1/05)
48. The hospital shall maintain hospital disaster plans pursuant to which there shall be Medical Staff disaster assignments. During drills or in the actual event, the most recent disaster plan shall be followed.
49. Members of the Medical Staff and all other practitioners with clinical privileges shall comply with all required computer software training (e.g., Epic training), in accordance with the requirements outlined in the Medical Staff Bylaws and Credentials Policy and Procedure Manual. Failure to comply with training requirements may result in an automatic suspension of privileges as outlined in the Credentials Policy and Procedure Manual.
50. Annual dues for the Medical Staff shall be set at the October general Medical Staff meeting. If the Medical Staff does not convene an October meeting, the Chief of Staff may designate another meeting at which the Medical Staff shall set annual dues.
51. No patient may be denied appropriate care, treatment, or services because of the patient's race, creed, color, national origin, ancestry, religion, sexual orientation, marital status, age, newborn status, handicap, or source of payment.
52. The current edition of Robert's Rules of Order shall govern the procedure for Medical Staff meetings unless they conflict with the Medical Staff Bylaws, Rules and Regulations, Fair Hearing Plan, Credentials Policy and Procedure Manual, or any other hospital or medical staff policy, all of which shall take precedence.
53. The Medical Staff Rules and Regulations shall only be adopted or amended in accordance with Article XII of the Medical Staff Bylaws.

These Medical Staff Rules and Regulations are hereby ADOPTED by the Medical Staff.

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Mary Ellen Sabourin, MD  
Chief of Staff of the Medical Staff  
St. Clare Hospital and Health Services

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Date

These Medical Staff Rules and Regulations are hereby ADOPTED by the Board of Directors of SSM Health Care of Wisconsin, Inc.

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Sr. Mary Jean Ryan, FSM  
Chairperson, Board of Directors

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Date

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Gerald Lefert  
Interim CEO, SSM Health Care of Wisconsin

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Date

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Sandy Anderson  
President, St. Clare Hospital & Health Services

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Date

Effective Date: 6/2012

Last Reviewed:

Last Revision Date: 03/2012

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### **PURPOSE**

To define a process for the supervision of medical students and residents by a licensed independent practitioner with appropriate clinical privileges.

### **POLICY**

The management of each patient's care, treatment and services, including patients under the care of participants in medical education and residency programs, is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

All medical students and residents must abide by the medical staff's bylaws, rules & regulations, policies and procedures, as well as those of the organization.

### **PROCEDURE**

All medical students and residents will be under the supervision of a licensed independent practitioner who is a member of Divine Savior's Medical Staff. The supervising licensed independent practitioner is ultimately responsible for the care, treatment and services provided by the medical student or resident. Those activities exercised by a medical student or resident cannot exceed those privileges currently held by the supervising licensed independent practitioner.

Medical and residency training involves allowing, and requiring, residents to participate in patient with care with increasing degrees of independence. Although all care provided by medical students and residents is supervised and is the ultimate responsibility of the supervising physician, the proximity and timing of supervision, as well as the specific tasks delegated to the medical student or resident depend on a number of factors, including:

- The level of training (i.e. year of medical school or resident) of the resident.
- The skill and experience of the resident with the particular care situation.
- The familiarity of the supervising physician with the resident's abilities.
- The acuity of the situation and the degree of risk to the patient.

In addition, medical students, residents and supervising licensed independent practitioner are guided by:

- The agreement with the medical school or residency program.
- The medical student or resident job description.
- Goals and objectives of the specific rotation curriculum.
- Medical student or resident responsibilities and expectations.

Procedural skills may be taught; however, as medical students and residents are not formally privileged for independent practice of medicine, members of the medical staff must provide supervision for each delegated procedure.

All documentation in a patient medical record (H&P, Progress Notes, Discharge Summary, etc.) made by a medical student or resident must be reviewed and countersigned by the supervising licensed independent practitioner. Under direct supervision, only residents holding a Wisconsin license to practice medicine and surgery may write patient care orders. Patient care orders do not require a co-signature by the supervising licensed independent practitioner.

The Physician and Clinical Services Department will effectively communicate to the Medical Staff through the Executive and Credentials Committee and Governing Body regarding the safety and quality of patient care, treatment and the services provided by, and the related education and supervisor needs of, medical students and residents.

Policy  
01992

## Supervision of Resident Physicians

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### Abstract/Purpose:

To specify the mechanisms by which house staff are supervised by members of the Medical Staff.

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### POLICY

This policy is intended to guide the activities of admitting/attending physicians, family medicine residents, nursing staff, and medical records personnel in insuring that in-hospital patient care activities in which Family Medicine Residents participate is appropriately supervised and documented during the course of their several rotations based in the hospital. This supervision should begin with the residents' initial contact with the attending physician and the patient, continue through the daily contact the Resident has with the patient, and with the attending physician, and be completed when all the documentation of the hospital stay is collected for the permanent medical record.

### Exceptions

- I. Residents must consider new requests for their participation inpatient care in light of their current and expected patient care responsibilities and have the option of declining additional patient care responsibilities if they would jeopardize current patient care.
- II. Residents may write patient care orders as delegated by the admitting/ attending physician, but no member of the Medical Staff can be prohibited from writing orders on patients cared for in part by Residents.
- III. Members of the Medical Staff participate voluntarily in the residency teaching program. Members who choose not to participate in the program are not subject to denial or limitation of hospital privileges.

### Background

- I. Family Medicine residents provide care to patients hospitalized at St. Elizabeth Hospital in a variety of teaching service and preceptorship rotations, with supervision provided by privileged attending physicians. Residency training involves allowing (and requiring) residents to participate in patient care with increasing degrees of independence. Although all of resident care is supervised and the attending physician is ultimately responsible for care of the patient, the proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:
  - A. the level of training (i.e. year in residency) of the resident,
  - B. the skill and experience of the resident with the particular care situation,
  - C. the familiarity of the supervising physician with the resident's abilities,
  - D. the acuity of the situation and the degree of risk to the patient.
- II. In addition, residents and supervising attending physicians are guided by:
  - A. This policy,
  - B. The "Resident Job Description" (Below),
  - C. Goals and objectives of specific rotation curriculum (Residency Curriculum Summary), and
  - D. Resident responsibilities and expectations provided in the Resident's Employment Information Manual.

### PROCEDURE

- I. Residents are expected to interact with patients in St. Elizabeth Hospital with the permission, and under the direction of admitting/attending physicians (hospitalists, family physicians, specialists, or Residency Program faculty family physicians) who delegate to Residents some defined portion of that medical care responsibility. Medical care begins with admission of the patient, continues through the daily progress of the hospitalization, and concludes with discharge of that patient from the hospital with completion of the permanent medical record on that patient. Residents will also:
  - A. be familiar with the AHS Medical Staff Bylaws
  - B. support the mission, vision and values of the Hospital;
  - C. conform their hospital practice to the ethical code of their respective professions, and to the Ethical & Religious Directives for Catholic Health Care Services;
  - D. work compatibly with peers and hospital staff;
  - E. upon request, provide evidence of freedom from physical and mental illness which would impair the fulfillment of responsibilities of Medical Staff membership and, when requested, shall authorize access to any and all medical records or treatment information concerning his/her health status;
  - F. provide quality clinical services to patients of their choosing, or who are assigned to them in order to fulfill the hospital's goals or obligations; and

- G. Residents will not deny their clinical services to hospital patients on the basis of race, creed, color, religion, national origin, ancestry, marital status, gender, sexual orientation, disability, age, newborn status, or source of payment for services.
- II. Specific Resident responsibilities are addressed in the Resident Job Description (below). Key, specific responsibilities of the supervising attending physician and of the resident are:
- A. An evaluation of the appropriateness of each patients' admission to the teaching service will be made by a member of the Medical Staff (prior to, or concurrent with the initial involvement of a Resident in the care of each patient).
  - B. The admitting/attending physician contacts the Resident to determine, if the Resident can accept an additional patient and, if so, to give important background information on the medical condition of the patient.
  - C. The admitting/attending physician shall evaluate the patient in person and be in a position to confirm the findings of the Resident and discuss the care plan in the following time table: as soon as possible for an unstable and deteriorating patient; within one hour for a patient in the Intensive Care Unit; or within a time period appropriate for the needs of a stable medical patient admitted to a general hospital bed, but not to exceed 8 hours. Supervising physicians must receive all pertinent information about the patient per discussion with the admitting resident in order to determine the acuity of need for on-site supervisory assessment.
  - D. The ultimate responsibility for the care provided to patients lies with the attending physician, regardless if the resident is involved in the care of the patient. As such the supervising admitting/attending physician confirms the subjective and objective findings of the Resident, reviews the differential diagnosis and discusses patient care management with the Resident at least daily.
  - E. For an obstetrical admission, after consulting the prenatal record available on the labor floor, and after examining the patient, the Resident will contact the admitting/attending physician with obstetric privileges to describe findings and discuss the plan of care. All acute or high-risk patients shall be evaluated as soon as possible by the attending physician.
  - F. At least on a daily basis (more often as the needs of the individual patient may dictate), the Resident and the admitting/attending physician will review progress of the patient, make the necessary modification in the care plan, plan family conferences as needed, and agree on the type and scope of documentation for the medical record.
  - G. All orders written by the unlicensed physicians, i.e., First Year Residents, must be co-signed by the admitting/attending physician.
  - H. When either a medical patient or an obstetrical patient develops a condition that the Resident feels is potentially dangerous for that patient, the Resident will contact the admitting/attending physician and report these developments. The Resident may identify the need for that physician to see the patient at an agreed upon time to assist in the evaluation and treatment of such a patient.
  - I. As the level of skill and knowledge increases for individual Residents, admitting/attending physicians may delegate increasing levels of responsibility and allow increasing level of participation in patient care, including the performance of procedures.
  - J. As with patient care in general, procedural skills may be taught to the Residents by admitting/attending physicians. Because Residents are not formally, at any point in their training, privileged for independent practice of medicine, including the performance of procedures, members of the Medical Staff must provide supervision for each procedure they delegate to a Resident.
  - K. At the time of discharge, the admitting/attending physician may delegate some of the discharge planning to the Resident, and should review any discharge documents generated by the Resident and must sign any attestation statements required.
  - L. The admitting/attending physician should insure the completeness of the medical record by offering suggestions to the Resident or by making additional comments in the progress notes. The principal documents of each hospital stay which are prepared by the Residents - the history and physical and the discharge summary, for example, must be reviewed for completeness by the admitting/attending physician, and pertinent suggestions should be offered to the Resident about either form, content, or both. These documents are to be countersigned by the admitting/attending physician or his or her coverage. The admitting/attending physician remains responsible for the completeness and accuracy of the medical record generated by the Resident.
  - M. When patients of the Fox Valley Family Medicine Residency are hospitalized, residency faculty, in their capacity as members of the Medical Staff, have ultimate responsibility for the care of these patients, functioning as the admitting/attending physician described above. When specialist physicians are involved as the admitting physician for these patients, or assume primary management of these patient's care during the hospitalization, they may elect to consult the Family Physician Faculty to assist them in medical or psychosocial management of that patient.
  - N. First year residents (PGY-1) may not evaluate, care for or interact with patients without direct supervision immediately available. This requires a supervising physician (PGY-2 resident or beyond or attending physician) to be physically present on the premises and available to assist the PGY-1 resident whenever that resident is involved in patient care.
  - O. PGY-2 and above resident must be able to get assistance and supervision from an attending physician at all times, but it can be in the form of telephone support or off-site assistance as long as that physician can come to the hospital in a reasonable amount of time to assure safe and appropriate care is provided.
  - P. Supervising physicians must be attentive to signs of resident fatigue as it pertains to patient safety, and should excuse the residents from patient care when they are fatigued or impaired to a degree that safe patient care is compromised. (Refer Resident Programs Policy Manual)

## Overview

Family Medicine residents provide care to patients hospitalized at St. Elizabeth Hospital in a variety of teaching service and preceptor rotations, with supervision provided by privileged attending physicians. Residents function in accordance with responsibilities and expectations described in the Resident Employment Information Manual and in this Resident Job Description.

Required hospital-based teaching services at St. Elizabeth Hospital include the Pediatrics Teaching Service, the Obstetrics Teaching Service, the Emergency Medicine rotation and the first year Surgery Preceptorship rotation. In addition, residents provide patient care in the hospital setting as part of a number of elective rotations and preceptorships, when their preceptors are providing care in the hospital. Residents also provide care to their own private panel of UW Health Fox Valley Family Medicine patients when hospitalized, with program faculty providing supervision. All resident patient care is supervised by attending physicians with hospital privileges. Guidelines for supervising attending physicians are provided in the above policy. As the level of skill and knowledge increases for individual residents, supervising attending physicians may delegate increasing levels of responsibility and allow residents increasing levels of participation in patient care, as delineated in above policy.

Patient care provided by residents and supervising attendings is assessed by the same quality review mechanisms already in place to evaluate the quality of patient care in the hospital. The residency program director supervises an evaluation program, designed to assess community and program faculty supervision of residents. At least annually residents complete evaluations of each supervising attending's performance as a teacher and supervisor. Problems with inadequate supervision are discussed with individual attendings with specific plans outlined for remediation. This formal evaluation is augmented by periodic discussions with residents, especially those on the teaching service, regarding adequacy of supervision. Formal, written evaluations of resident rotation performance occurs monthly by supervising attending physicians, and comprehensive evaluations are conducted by the residency program faculty twice yearly.

Brief descriptions of teaching services and preceptor rotations, and specific resident job descriptions are delineated herein. Details of each teaching rotation, including descriptions of the rotation, curriculum goals and objectives, and expectations of residents, can be found in the New innovations and are available from the Residency program office upon request.

## General Responsibilities of Residents

Patient services a resident may provide, under the supervision of attending physicians according to this policy include:

- I. Initial and ongoing assessment of patient's medical, physical, and psychosocial status
- II. Perform history and physical
- III. Develop assessment and treatment plan
- IV. Perform rounds
- V. Record progress notes
- VI. Order tests, examinations, medications, and therapies
- VII. Arrange for discharge and after care
- VIII. Write / dictate admission notes, progress notes, procedure notes, and discharge summaries
- IX. Provide patient education and counseling covering health status, test results, disease processes, and discharge planning
- X. Perform procedures
- XI. Assist in surgery

\*Note: All resident care is supervised and the attending physician is ultimately responsible for care of the patient. The proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:

- I. the level of training (i.e. year in residency) of the resident,
- II. the skill and experience of the resident with the particular care situation,
- III. the familiarity of the supervising physician with the resident's abilities, and
- IV. the acuity of the situation and the degree of risk to the patient.

## Teaching Services (Obstetrics / Pediatrics / Emergency Medicine) - St. Elizabeth Hospital

### Pediatrics

The overall purpose of the Pediatrics Teaching Service is to provide resident physicians with in-hospital clinical opportunities to develop the knowledge, skills, and attitudes necessary to care for infants and children with medical problems severe enough to require hospitalization. The rotation is structured to maximize the resident's ability to develop independent decision-making skills while still providing adequate supervision and role-modeling by attending family physicians, internists and medicine subspecialists.

The Pediatrics Teaching Service rotation encompasses two months of the first year and one month of the second year of residency training. Presently, the teaching service is located on the 3rd floor pediatrics unit of the hospital. Two first year

residents and one second year resident are on the rotation each month. Residents admit and care for patients under the supervision of attending physicians, usually pediatricians or family physicians. Second year residents have some senior teaching and organizing responsibilities.

## **Obstetrics**

The overall purpose of the Obstetrics Teaching Service is to provide residents with clinical opportunities to acquire the knowledge, skills, and attitude to safely and skillfully provide family practice obstetrical care for women in labor.

Specific areas of focus, include the following opportunities (with supervision of privileged attending physicians):

- I. Assessment and management of labor
- II. Normal cephalic delivery, including vacuum extraction
- III. Management of typical and atypical 3rd stage of labor
- IV. Performance of episiotomy and repair, including 3rd and 4th degree perineal repair
- V. Performance of pudendal anesthesia
- VI. Performance and interpretation of fetal heart monitoring
- VII. Management of selective induction of labor
- VIII. Diagnosis and management of third-trimester and obstetric complications, including premature and/or prolonged rupture of membranes, arrested labor, pre-term labor, post-partum hemorrhage, breech presentation, placenta previa and abruptia, preeclampsia and eclampsia, and endometritis
- IX. Post-partum care
- X. Surgical assistance at cesarean section

## **Emergency Medicine**

The overall purpose of the Emergency Medicine rotation is to provide residents with a foundation of clinical experiences caring for persons of all ages presenting to the emergency room for evaluation and care of urgent and emergency problems, including accidents and injuries. Second year residents are assigned for a one-month rotation in the St. Elizabeth Hospital Emergency Room setting, under the direct supervision of a Board Certified Emergency Room physician, who also sees the patient concurrent with, or after the resident has evaluated the patient.

## **Supervision**

Residents' care of patients on these teaching services (above) is supervised by privileged attending physicians, pediatricians, obstetricians and family physicians, and Emergency Medicine specialists, depending on the specialty of care provided. Residents are accountable to attending physicians who have the ultimate professional, ethical, and legal responsibility for care of the patient.

## **Summary of Resident Responsibilities**

- I. Admission assessment and management of patients requiring hospital care, including specific duties:
  - A. Initial communication with attending physician regarding patient and attending's concerns and expectations
  - B. Performance of a comprehensive admission history and physical examination
  - C. Documentation of admission history and physical exam (brief written note and comprehensive dictation), including assessment and plan
  - D. Formulation of a comprehensive assessment and management plan, with input and supervision of the attending physician, including writing orders for nursing care, diagnostic studies, monitoring, and medications and treatment
  - E. With regard to women in labor, the resident's role (with supervision of the attending physicians,) includes assessing and admitting (if appropriate) women presenting to the labor and delivery suite, in various stages of labor. This includes evaluation of the patient and discussion with the attending physician regarding work-up and labor or problem management.
  - F. Daily routine management of the patient's care, as discussed at least daily with the responsible attending physician. This includes daily assessment, review of chart and results of diagnostics, writing orders, documenting with daily progress note and other notations as change of condition dictates.
  - G. Evaluation and management of Pediatric Teaching Service or Obstetrics Service patient with acute changes of condition requiring urgent attention, if attending is not available or requests initial resident assistance in management while attending physician is en route to the hospital.
  - H. Participation or independent performance of procedures, with direct supervision, such as intubation, suprapubic bladder puncture, circumcisions or lumbar punctures (pediatrics), or labor procedures, such as delivery with and without operative interventions.
  - I. Some procedures, such as cervical checks on obstetrical patients, and nasogastric intubation, placement of indwelling Foley catheters, intravenous access, and venipuncture may be performed independently once the supervising, attending or program faculty has determined the resident to be proficient in these procedures.
  - J. Residents and attendings will be jointly responsible for ensuring appropriate explanation and acquisition of informed consent, as well as for detailed documentation.
  - K. Residents are ACLS and NRP certified and prepared to perform emergency life-saving care when needed and



should do so without delay when attending physicians are not immediately available. Frequent practice-codes are conducted in hospital settings to ensure resident and team readiness and to periodically evaluate performance.

- L. Responsibility for coordination of discharge management, after receiving approval of the attending physician. Includes:
  - 1. Performing a pertinent discharge exam
  - 2. Arranging for discharge medications, follow-up visit, studies and plans, providing orders for home health services, coordinating with the hospital discharge planner
  - 3. Discussion of medications and treatments and follow-up precautions with the patient
  - 4. Discharge dictations are the responsibility of the resident, unless otherwise arranged with the attending physician. These should be dictated at the time of discharge, or prior to if the summary needs to accompany the patient to another care setting such as a nursing home or another hospital. A brief discharge summary note should be written on the chart to provide information otherwise not available until the discharge summary has been transcribed. Contents of a brief note should include: discharge diagnoses, medications and treatments, and follow-up plans.
- M. Other, specific on-call hospital responsibilities: Code Blue and Rapid Response Team Assessments: resident carrying the code beeper responds to all codes and runs code until a senior attending physician (primary physician, hospitalist, responding hospitalist, ER physician or internist, cardiologist) arrives, and preferably until code completion with attending supervision. Attending codes takes precedence over other responsibilities unless resident is currently involved in emergency/critical care for a patient and the code situation is covered by another physician. Advanced planning is important in such cases, i.e., if code beeper resident is involved in unstable admission, he/she should ask a colleague to temporarily carry the code beeper.
- N. Other: Residents on the obstetrics service may be called when staff are having difficulties with intravenous access, for placement/ confirmation of naso-gastric tubes and urinary catheters.
- O. Further details of expectations and responsibilities on the medicine service can be found in the Family Medicine Residency Curriculum.

## Preceptorship Rotations Overview

The Family Medicine Residency curriculum involves a number of required and elective preceptorship rotations, which, to varying degrees, require residents' participation in providing care in the hospital setting. It is beyond the scope of this job description to delineate specific resident responsibilities for each of these rotations. A listing of the types of electives and a general overview of responsibilities is contained herein, with the entire curriculum available in New Innovations are available from the residency program office upon request.

In general, preceptorship rotations involve the traditional one-to-one relationship between a resident physician and community attending role model/teacher. The degree of time spent in the care of hospitalized patients varies depending on the specialty, with more teaching occurring in the hospital in the surgical and procedural-oriented specialties such as surgery, orthopedics, and cardiology.

As with other hospital patient care provided by residents, supervision is required by the privileged attending physician, in this case the rotation preceptor, in accordance with the guidelines of this policy. Responsibilities of the residents in the hospital are similar to those outlined elsewhere in this job description.

Available required and elective rotations include, but are not limited to:

- I. Family Medicine Preceptorship
- II. Internal Medicine Preceptorship
- III. Medicine Subspecialty Electives
- IV. Rheumatology
- V. Cardiology
- VI. Pulmonary Medicine
- VII. Infectious Disease
- VIII. Gastroenterology
- IX. Hematology/oncology
- X. Endocrinology
- XI. Neurology
- XII. Additional obstetrics/perinatology
- XIII. Neonatology
- XIV. Surgery
- XV. ENT
- XVI. Ophthalmology
- XVII. Urology
- XVIII. Orthopedics
- XIX. Ambulatory
- XX. Pediatrics
- XXI. Occupational Medicine
- XXII. Additional Emergency Medicine
- XXIII. UW Health Fox Valley Family Practice Admissions

Further information on these rotations are available in the New Innovations Residency Management Suite.

During all three years of training, family medicine residents provide care for their own health center patients when hospitalized. Residency faculty, as privileged attendings, supervise residents in accordance with this policy, assuming ultimate responsibility for care. Resident responsibilities are similar to those outlined elsewhere in this job description.

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**Regulatory Body: TJC**

MS.04.01.01, HR.01.02.07, MS.03.01.01

**JC Functional Category**

- Medical Staff (Structural Category)

**Policy Discipline**

- Medical Staff

**Policy Entity**

- AHS (Corporate)

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**Approval Information**

- Professional Activities Committee (PAC), Barbara Shand, MD, Chairman, approved July 15, 2012. Approved at PAC March 14, 2012.

**Policy Subject Matter Expert**

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**AHS Values**

- Service
- Integrity
- Teamwork

**Find this article at:**

<http://intranet.affinityhealth.org/object/supervisionofresidentphysicians.html>

☐ Check the box to include the list of links referenced in the article.

Policy  
02535

## Supervision of Resident Physicians - Affinity Medical Group

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### Abstract/Purpose:

To specify the mechanism by which residents are supervised by members of the Affinity Medical Group medical staff.

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### Statement of Policy

This policy is intended to guide the activities of the Affinity Medical Group physicians, residents and nursing staff in insuring that patient care activities in which the residents participate are appropriately supervised and documented during the course of their preceptorship\* in the clinic. This supervision should begin with the resident's initial contact with the physician and the patient, continue through the preceptor time period and end with the completion of documentation in the medical record as indicated by the supervision physician.

### Exception

Members of the medical staff participate voluntarily in the residency preceptor program.

### Background

Residents provide care to patients of Affinity Medical Group in a variety of teaching service and preceptorship rotations, with supervision provided by the physicians. Residency training involves allowing (and requiring) residents to participate in patient care with increasing degree of independence. Although all of the resident care is supervised and the physician is ultimately responsible for care of the patient, the proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:

- A. level of training (i.e. year in residency) of the resident,
- B. the skill and experience of the resident with the particular care situation,
- C. the familiarity of the supervising physician with the resident's abilities, and
- D. the degree of risk to the patient.

### Procedure

Residents are expected to interact with patients in Affinity Medical Group with the permission, and under the direction of the supervising physician who delegate to residents some defined portion of that medical care responsibility. Medical care is any service or procedure rendered in the office setting including the completion of the medical record of the patient.

Residents will also:

- A. be familiar with the Medical Staff Governing Documents (Bylaws),
- B. support the mission, vision and values of Affinity Health System,
- C. conform their office practice to the ethical code of their respective professions, and to the Ethical & Religious Directives for Catholic Health Care Services,
- D. work compatibly with peers and clinic staff,
- E. upon request, provide evidence of freedom from physical and mental illness which would impair the fulfillment of responsibilities of the medical staff membership and when requested, shall authorize access to any and all medical records or treatment information concerning his/her health status,
- F. provide quality clinical services to patients in order to fulfill the clinic's goals and obligations,
- G. comply with OSHA and all state and federal health guidelines and,
- H. residents will not deny their clinical services to clinic patients on the basis of race, creed, color, religion, national origin, ancestry, marital status, gender, sexual orientation, disability, age, newborn status or source of payment for services.

Specific responsibilities of the supervising physician and the resident:

- A. An evaluation of the appropriateness of each patients' care plan will be made by the supervising physician (prior to, or concurrent with the initial involvement of a resident) in the care of each patient.

- B. The supervising physician will evaluate the patient and be in a position to confirm the findings of the resident and discuss the care plan.
- C. The supervising physician confirms the subjective and objective findings of the resident, reviews the differential diagnosis and discusses patient care management with the resident.
- D. All orders written by the unlicensed physician (i.e. first year residents) must be co-signed by the supervising physician.
- E. As the level of skill and knowledge increases for individual residents, the supervising physician may delegate increasing levels of responsibility and allow increasing level of participation in patient care, including the performance of procedures.
- F. As with patient care in general, procedural skills may be taught to the residents by the supervising physician. Because residents are not formally, at any point in their training, privileged for independent practice of medicine, including the performance of procedures, members of the Medical Staff must provide supervision for each procedure they delegate to a resident.
- G. The supervising physician should insure the completeness of the medical record by offering suggestions to the resident or by making addition comments in the clinic note. These documents are to be countersigned by the supervising physician. The supervising physician remains responsible for the completeness and accuracy of the medical record generated by the resident.

**\*Definition of Preceptorship Rotation:**

In general, preceptorship rotations involve the traditional one-to-one relationship between a resident and community role model/teacher. The degree of time spent in the care of office visits and hospitalized patients varies depending on the specialty, with more teaching occurring in the hospital in the surgical and procedural-oriented specialties such as surgery, orthopedics and cardiology. As with other clinic visit and hospital patient care provided by the resident, supervision is required by the privileged attending, supervising physician, or in this case the rotation preceptor.

**Regulatory Body: TJC**  
MS.2.30

<b>IC Functional Category</b>	
• Medical Staff (Structural Category)	
<b>Policy Discipline</b>	
• Medical Staff	
• CMO Clinic	
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<b>Policy Subject Matter Expert</b>	
• Lisa Allen	
• allenl@fhsfhsd.net	
<b>AMS Values</b>	
• Service	
• Integrity	

**Find this article at:**

[http://intranet.affinityhealth.org/object/IO\\_8383.html](http://intranet.affinityhealth.org/object/IO_8383.html)

☐ Check the box to include the list of links referenced in the article.

# Policy Regarding Supervision of Learners

Mad River Family Practice

The Ohio State University Rural Program

Revised August 16, 2008

## General considerations

A faculty physician supervises all learners at Mary Rutan Hospital, at all levels of training from medical student through senior resident. In an apprenticeship-style, directly supervised residency program such as the Ohio State University Rural Program, the closeness of supervision becomes more “arms length” as the faculty physicians become comfortable with a resident’s or student’s abilities. Regardless of stage of training, however, program faculty directly responsible for the supervision of patient care services provided by resident physicians must be as available to participate in that care as they would be if learners were not involved at all.<sup>1</sup>

The Graduate Medical Education Committee (GMEC) of Mary Rutan Hospital is responsible for medical staff oversight of all medical education activities within the institution and as such receives at least annual reports of such activities from the appropriate supervising faculty. The OSU Rural Program is also accredited by the ACGME and is reviewed every one to five years. In this review the program is required to demonstrate appropriate methods for evaluating the competence of its learners. The Ohio State University Medical Center, as the “sponsoring institution” for the program under the ACGME, through its Graduate Medical Education Committee, is also responsible for oversight, and conducts periodic internal program reviews.

For all billable procedures and for all procedures in the hospital requiring credentialing by the medical staff, a faculty physician with privileges for that procedure shall provide immediate (physically present) supervision for the key portion of the procedure, and shall document the same. It is expected that, like any other medical staff member in an emergency, the resident physician shall act with good judgment commensurate with his/her previously documented skills in proceeding with any life-saving procedure in the absence of a faculty physician.

The learner’s performance is evaluated by the supervising faculty physician immediately following a supervised procedure, using the following scale, and is documented on the resident’s PDA:

- |   |                              |
|---|------------------------------|
| 1 | Needs close supervision      |
| 2 | Needs some supervision       |
| 3 | Satisfactory performance     |
| 4 | Able to perform unsupervised |

A level “4” evaluation does not entitle the resident to unsupervised performance of a procedure, but rather documents progressive learning and competence, and provides a basis for recommending unrestricted privileges upon graduation from the residency program.

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<sup>1</sup> AAMC Policy Guidance on Graduate Medical Education, October 2001

Procedures performed by the resident or student while on rotations with faculty other than residency faculty shall be supervised by the volunteer faculty who is billing for the procedure. For residents, a list of core procedural competencies is included in the curriculum for each rotation, and these procedural competencies are addressed in the evaluation by the Rotation Coordinator at the end of the month or end of the rotation. These procedural competencies are included in a summative report for each resident's quarterly evaluation and for each year of graduate training, and provide a basis for recommending unrestricted privileges upon graduation from the residency program.

The Program Director for the OSU Rural Program shall report periodically, but no less than annually, to the Graduate Medical Education Committee (GMEC) of Mary Rutan Hospital regarding the performance of family practice resident physicians practicing in this institution. In addition, the Program Director shall report any change in resident status leading to probation or dismissal from the program to the Medical Director of the hospital as well as the Graduate Medical Education office at The Ohio State University Medical Center. The Medical Director will determine whether any additional GMEC action is needed prior to the next regularly scheduled meeting. If action is needed prior to that time, the GMEC will convene at his/her direction.

## Summary of Responsibilities

### General expectations of learners and faculty

- The attending faculty physician (Most often listed as the “private physician” in the hospital record) has the ultimate responsibility for all medical decisions regarding patients under his/her care.
- The attending faculty physician is responsible for providing oversight and supervision of all care provided by trainees.
- Resident physicians, regardless of level of training, must be supervised for all procedures for which the Medical Staff grants privileges.
- Medical students require a faculty co-signature for all entries into the medical record, and any orders written must be co-signed or verified through a verbal order by the responsible faculty physician before implementation. Resident physicians, by virtue of holding a training license in the State of Ohio do not require a co-signature.
- Faculty physicians are expected to behave in a professional manner at all times in regard to learner supervision and are expected to encourage each trainee to seek guidance at any time the trainee feels it would be beneficial to the care of the patient.

### Attending faculty responsibilities

- Develop a plan for the medical management of each patient, in conjunction with resident physicians and consultants
- Ensure implementation of the plan and its documentation in the medical record.
- Ensure that trainees to whom care is delegated have the requisite training, experience, and competence for carrying out these duties.

### Conditions requiring notification of attending faculty physician by a resident physician:

1. Admission to the hospital
2. Transfer of the patient to the Intensive Care Unit
3. Need for intubation or ventilatory support
4. Cardiac arrest or significant change in hemodynamic status
5. Development of significant neurological changes
6. Development of major wound complications
7. Medication or other therapeutic errors requiring clinical intervention
8. Any significant clinical problem that will require an invasive procedure or operation

Questions of oversight and supervision from either learners or faculty shall be directed to any one or more of the following: Dr. Randall Longenecker, Rural Program Director; Dr. Grant Varian, Medical Director and chair, GMEC; or Becky Nicholl RN, VP for Risk Management.



## **Specific Circumstances**

### **Routine and Emergent Family Practice Admissions**

Resident physicians may approve admission from the Emergency Department. However, the resident is obligated to personally evaluate the patient within the hour and establish the urgency of their presenting condition. In the event the patient's condition is unstable, the admitting resident shall immediately call the FP faculty on call. In the event the patient's condition is stable, the resident physician shall notify the faculty physician when the initial impression and plan are formulated, preferably within two hours of admission to an inpatient bed. After discussing the case with the resident, the FP faculty physician shall, based upon the clinical presentation and urgency of the problem, decide whether to come in immediately or wait to see the patient until morning rounds. If the resident asks for help from the FP faculty physician, he/she shall immediately come in to the hospital. All patients are seen independently by the faculty for the initial and all subsequent hospital visits at least daily and these visits are documented accordingly as a "faculty note" in the medical record.

### **Family Practice Inpatient Care**

All patients of Mad River Family Practice admitted to the hospital are assigned a resident as the "Managing Physician" (the physician the nurses call first with a problem) and a faculty member as the "Private Physician" (the physician maintained in the hospital information system as the continuing and responsible physician). Family Practice inpatient care includes all medical, surgical, pediatric, obstetrical, and newborn patients of the practice.

The faculty physician identified as the "Private Physician" or his/her designee (e.g. the faculty physician on call or the faculty physician providing obstetrical care) shall ensure proper supervision and teaching of medical students and residents in the hospital setting. He/she shall daily discuss each assigned hospitalized patient with the residents to ensure they receive proper supervision and teaching, and shall, on occasion, make bedside teaching rounds together with the residents.

Morning Report provides a daily forum for sharing information about individual patients among program faculty and learners, ensures appropriate patient assignment and continuity of care across providers, and presents opportunity for case-based teaching.

Resident physicians are expected to write or give verbal orders for hospitalized patients. These orders are reviewed daily by the supervising faculty physician, and do not require a co-signature for implementation.

### **Family Practice Clinic – Mad River Family Practice**

There shall always be adequate faculty supervision available in the FP clinic, with a minimum of 1 teaching (precepting) physician for every 4 residents in the clinic. The precepting physician will be scheduled and identified, and, in the presence of more than one learner, shall have no other concurrent and conflicting responsibilities. As the teaching physician, he/she must review the charts of every (100%) patient seen by the residents, preferably before releasing the patient from the office, and certainly prior to submitting and signing the

appropriate superbill. Patients not meeting the “Primary Care Exception” must be seen by the teaching physician and documentation provided in accord with the Teaching Physician regulations that are available in the “Precepting Manual” in the preceptor’s office.

### **Family Practice After-hours Call**

A faculty physician is on call every night and weekend for patients of Mad River Family Practice as well as patients of Oakhill Medical Associates. After the initial 6 months of training and verification by the Program Director of sufficient competence to do so, the resident, when assigned to “first call,” is responsible for fielding calls from patients of Mad River Family Practice. Whenever the resident physician physically sees a patient on call, as an inpatient, as an outpatient or through the Emergency Department, or approves an admission to the hospital, he/she must, within a reasonable period of time but within no more than one hour of seeing the patient, contact the faculty physician and discuss the case with him/her.

### **Family Practice Obstetrical and Newborn Care**

Care provided for Mad River Family Practice patients by a resident on labor and delivery, ante-partum and post-partum, will always be supervised directly or indirectly by the FP faculty. Faculty physicians on call for obstetrics shall be physically available within 15 minutes of the hospital at all times. Faculty physicians will supervise all births in person. As a minimum, all newborn records will have a FP faculty note within 24 hours of birth. In addition, the resident will discuss the condition of the newborn daily with the FP attending. Faculty physicians supervise all circumcisions.

### **Community Rotations**

Supervision of resident physicians in community settings other than a physician’s office is the responsibility of the Rotation Coordinator(s).

## **Special supervision considerations by level of training**

Medical students are supervised on site by faculty physicians and primarily function in an observer or information-gathering role. When a medical student participates in a procedure, it is always under the supervision of a credentialed physician and with the informed consent of the patient.

First year resident physicians (PGY1) also require the ready availability of residency faculty supervision at all times, since, in our hospital, upper level resident physicians are not as available as they might be in other larger institutions with programs in graduate medical education. For the purposes of our institution, ready availability shall mean physically present on site within the hospital, or, for patients other than obstetrical patients, easily available by phone and able to be physically present within 30 minutes.<sup>2</sup> An emergency department physician is present at all times within the hospital and these physicians are volunteer faculty of the residency program. Only in a dire and life-threatening emergency will they need to provide this supervision (e.g. a “Code Blue” for cardiopulmonary arrest).

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<sup>2</sup> AAMC Policy Guidance on Graduate Medical Education, October 2001

During at least the first 6 months of residency training, PGY1 residents taking call shall be closely supervised by core residency faculty. The residency faculty on call with them shall field all hospital calls first, accepting admissions to the hospital and relaying messages to the resident, functioning as a “chief resident” in a larger residency program. Residency faculty physicians shall evaluate new admissions to the hospital by a first year resident physician in the first 6 months of residency within six (6) hours of admission to an inpatient bed, or earlier if dictated by the urgency of the patient’s presenting condition or the necessity of a procedure.

Upper level resident physicians (PGY1 generally after the first 6 months, and PGY2 & 3), through demonstrated competence and eventually promotion to the second year of postgraduate training, require less immediate supervision. However, a faculty member must be physically present for all procedures for which medical staff credentialing is required (as noted under “General Considerations” above). Admissions to the hospital by upper level residents shall be physically seen and evaluated by the faculty physician within 24 hours of admission to an inpatient bed.

**In summary, supervision of learners by level of training follows these general rules:**

**Medical Student**

- Functions as observer
- Participates only in information gathering and assistance with procedures
- Requires a co-signature for entries in the medical record

**PGY1 Resident physician (1<sup>st</sup> 6 months of training)**

- Functions at the direction of supervising faculty, who takes “first call”
- Performs procedures under direct supervision of a credentialed medical staff physician
- Does not require co-signature for entries in the medical record, but shall consult with supervising faculty before giving phone advice or before writing or giving a verbal order

**PGY1 Resident physician (after 1<sup>st</sup> 6 months of training and verification by Program Director through assignment to “first call”)**

- Takes “first call,” functioning under the immediate supervision of faculty
- Performs procedures under direct supervision of a credentialed medical staff physician
- Does not require co-signature for entries in the medical record, but shall daily review with supervising faculty phone calls as well as written and verbal orders

#### PGY2 & 3 Resident physician

- Functions semi-independently, but still under at least daily supervision by faculty
- Performs procedures under direct supervision of a credentialed medical staff physician

#### **Residency Faculty Coverage**

In the event that residency faculty are unable to provide the degree of supervision required above (e.g. illness or temporary duties requiring their presence elsewhere), it is the responsibility of that faculty member (or the Program Director or acting designee) to arrange for another medical staff physician to provide the appropriate level of supervision.