ORGANIZATION AND FUNCTIONS MANUAL
OF
THE PROFESSIONAL STAFF
OF
GRANDVIEW MEDICAL CENTER

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ARTICLE 1.
ORGANIZATION OF THE PROFESSIONAL STAFF

SECTION 1.1 Staff Year

For the purpose of these Bylaws, the staff year commences on the first day of January and ends on the 31st day of December each year. All persons appointed to the Professional Staff shall pay such assessments as may be established by the Staff.

SECTION 1.2 Officers Of The Professional Staff

The officers of the Professional Staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and the Secretary/Treasurer. Officers must be Active Staff members at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. In addition, individuals holding the offices of Chief of Staff and Vice Chief of Staff must be osteopathic or medical physicians. Details as to the position requirements, accountabilities and functions of the officers of the Professional Staff are as described in the Organization and Functions Manual.

SECTION 1.3 Term

Except as otherwise provided herein, the term of office for the officers of the Professional Staff shall be two (2) years. The number of consecutive terms a person may serve as an officer shall be limited to three (3).

SECTION 1.4 The Chief of Staff

The Chief of Staff shall:

(a) act on behalf of the Staff as the chief administrative officer of the Professional Staff, in coordination and cooperation with the VPMA/CMO and the Hospital 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 Professional Staff;

(c) appoint committee Chairs and members to all standing, special and multi-disciplinary Professional Staff committees except the Medical Executive Committee;

(d) serve as ex officio member of all Professional Staff committees; and

(e) represent the views, policies, needs and grievances of the Professional Staff to the Hospital Board and to the Hospital President;

(f) at least semi-annually, formally communicate through a written report to the Professional Staff any actions taken or contemplated by the Hospital Board regarding issues affecting medical care or plans for growth.

SECTION 1.5 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, or unavailability for any other reason;

(b) be a member of the Medical Executive Committee of the Professional Staff;

(c) perform such duties as are assigned to him by the Chief of Staff; and

(d) automatically succeed the Chief of Staff during the Chief of Staff's term when the latter fails to serve for any reason.

SECTION 1.6 Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall:

(a) be a member of the Medical Executive Committee of the Professional Staff; and

(b) perform such additional or special duties as shall be assigned to him by the Chief of Staff, the Medical Executive Committee or the Hospital Board.

SECTION 1.7 Secretary/Treasurer

The Secretary/Treasurer shall:

(a) be a member of the Medical Executive Committee of the Professional Staff;

(b) keep accurate and complete minutes of all Medical Executive Committee and Professional Staff meetings;

(c) call Staff meetings on order of the Chief of Staff and record attendance;

(d) attend to all correspondence and perform such other duties as ordinarily pertain to his/her office; and

(e) collect and be custodian of Staff assessments and funds, and make disbursements authorized by the Medical Executive Committee or its designees.

SECTION 1.8 Election of Officers/Vacancies

Except for Chief of Staff and Immediate Past Chief of Staff, officers of the Professional Staff shall be elected for a term of two (2) years at the appropriate Staff meeting in October by a majority vote of those Appointees to the Staff eligible to vote, present at the meeting, at the time the vote is taken. The vote may be by written secret ballot. The election of each officer shall become effective on January 1st of the next calendar year when approved by the Hospital Board. At the end of the term of the Vice Chief of Staff, the Vice Chief of Staff shall automatically become the Chief of Staff, and the Chief of Staff shall automatically become the Immediate Past Chief of Staff. All other officers shall serve until a successor has been elected and approved by the Hospital Board.

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.

When the office of the Chief of Staff is vacated prematurely, the Vice Chief of Staff shall assume the office for the remainder of the term of office. In such an event, a new Vice Chief of Staff shall be elected by the voting Staff at the next Staff meeting to fill the unexpired term of his/her predecessor in office. If the Vice Chief of Staff is unable to succeed to this office, a special election will be held at the next Staff meeting or a special meeting called for this purpose. Nominations shall be received from the floor and the election may be conducted by secret ballot. Vacancies in the offices of Vice Chief of Staff, Secretary/Treasurer shall be filled in like manner.

SECTION 1.9 Resignation/Removal of Officers

Any officer of the Professional Staff may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified therein.

Any officer of the Professional Staff may be removed from office for conduct detrimental to the interests of the Professional Staff of the Hospital (malfeasance in office) or for failure to fulfill the duties or requisite requirements of the office. A request for the removal of any officer of the Professional Staff may be made to the Professional Staff Office in writing by the Hospital Board, the Medical Executive Committee or one-fourth (1/4) of the

Professional Staff members eligible to vote. The request for removal shall state the basis for the request and shall be signed by an appropriate member of the Hospital Board, the Medical Executive Committee or by each of the Medical Staff Services members requesting the removal. The Professional Staff Office shall deliver a copy of the request to each member of the Professional Staff, as well as to the officer. Within thirty (30) days of receiving such a request, the Professional Staff shall vote by a written ballot upon the request. No officer shall be removed from office without a vote in favor of removal by at least two-thirds (2/3rds) of those Professional Staff members eligible to vote. Any officer removed under this provision shall have access to the hearing and appeal process set forth in Article II.

ARTICLE 2.
CLINICAL DEPARTMENT, SECTION AND COMMITTEE MEETINGS

SECTION 2.1 Clinical Department and Section Meetings

Members of each Clinical Department or Section shall meet as a Clinical Department or Section at a date and time set by the Chair to review and evaluate the clinical work of the Clinical Department or Section and to discuss any other matters concerning the Clinical Department or Section. The agenda for the meeting and its general conduct shall be set by the Chair. The agenda shall generally contain business, educational and clinical, quality portions. The Chief of Staff may attend any Clinical Department or Section meetings.

SECTION 2.2 Committee Meetings

All committees shall meet as specified in these Bylaws, at a date and time set by the Chair of the committee. The agenda for the meeting and its general conduct shall be set by the Chair.

SECTION 2.3 Special Clinical Department, Section and Committee Meetings

A special meeting of any Clinical Department, Section or committee may be called by or at the request of the Chair, by the Chief of Staff, by the VPMA/CMO or by a petition signed by not less than one-fourth (1/4th) of the members of the Clinical Department, Section or committee. Written, facsimile, electronic 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 Clinical Department, Section or committee not less than seven (7) days before the time of such meeting, all as sent to the address/number provided by the Appointee as it appears on the records of the Hospital. .

The written notice of the special meeting shall be deemed delivered when deposited in the United States mail or upon confirmation of an electronic or facsimile transmission or when given orally. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting, meaning that if a member attends a meeting, s/he cannot later state any type of objection to the meeting or its actions based on not having received proper notice of the meeting.

In the event that it is necessary for a Clinical Department, Section or committee to act on a question without being able to meet, the voting members may be presented with the question, in person or by facsimile or regular or electronic mail, and their vote returned to the Chair of the Clinical Department, Section or committee by facsimile or regular or

electronic mail. Such a vote shall be binding so long as the question is voted on by the due date by a majority of the Clinical Department, Section or committee eligible to vote.

SECTION 2.4 Quorum

The presence of 51% of voting members in attendance at any regular or special Clinical Department or Section or committee meeting shall constitute a quorum for all actions.

SECTION 2.5 Minutes

Minutes of each meeting of each Clinical Department, Section and committee shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Medical Executive Committee and at the same time to the Hospital President and the VPMA/CMO, unless otherwise specified for certain committees in these Bylaws. A permanent file of the minutes of each meeting of Clinical Departments, Sections and committees shall be maintained in the office of the Hospital President or the MSS department. The MEC receives and acts on reports and recommendations from all Medical Staff committees and Clinical Department and/or Section minutes.

ARTICLE 3.
PROVISIONS COMMON TO ALL MEETINGS

SECTION 3.1 Notice and Frequency of Meetings

Except as otherwise specified, written notice of all meetings of the Professional Staff, Clinical Departments, Sections and committees shall be sent to each Appointee to the Professional Staff or member of the applicable Clinical Department, Section or committee at least seven (7) days in advance of such meetings. Such notice may be sent by mail, email, or contained in a regular newsletter. All committees, MEC, Clinical and Standing Committees will meet yearly or more frequently as determined by the Committee Chair. Notice of an urgent meeting to be held in less than seven (7) days' time must be given by telephone or electronic mail within 24 hours prior to the meeting time. If a member personally attends a meeting, s/he cannot say that s/he did not receive notice of such meeting in order that his/her attendance cannot be counted or to argue that the meeting did not have a quorum; unless such person attends a meeting for the express purpose of objecting at the beginning of the meeting, to the transaction of any business at such meeting on the basis that the meeting was not duly called or convened.

SECTION 3.2 Attendance Requirements

Each Appointee to the Active Staff and Associate Active Staff shall endeavor to attend at least twenty-five (25%) of all regular Staff meetings and fifty percent (50%) of all applicable Clinical Department, Section and committee meetings in each two-year reappointment cycle, but is expected to attend all meetings. The failure of any person required to meet the foregoing annual Staff meeting and other attendance requirements shall constitute possible probation or resignation from the Staff pending Medical Executive Committee and Hospital Board review. Reinstatement of an appointment which has been revoked because of absence from the required number of Staff meetings shall be made only upon reapplication, and all such applications shall be processed in the same manner as applications for initial appointment.

Any person appointed to the Professional Staff whose clinical work is scheduled for discussion at a regular Clinical Department, Section or committee meeting shall be so notified and shall be expected to attend the meeting. If the individual is not otherwise required to attend the meeting, the Chair of the Clinical Department, Section or 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 Special Notice, and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

The Chair of the applicable Clinical Department, Section or committee shall notify the Medical Executive Committee of the failure of an individual to attend any meeting with respect to which he was given notice that attendance was mandatory, and unless excused by the Medical 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 Medical 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 adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the Chair of his/her Clinical Department or Section, or by the Executive Committee if the Clinical Department or Section Chair 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.

Persons appointed to the Consulting and Courtesy categories of the Staff shall be expected to attend and participate in Clinical Department or Section meetings unless unavoidably prevented from doing so but shall not be required to do so as a condition of continued Staff appointment.

SECTION 3.3 Minutes

Minutes of all meetings, except as noted in the Bylaws, shall be prepared and include a record of attendance and the vote taken on each matter. Minutes are to be signed by the presiding chair or officer, forwarded to the Medical Executive Committee (or the parent committee in the case of a subcommittee), and presented to the attendees at a subsequent meeting for acceptance. Minutes shall be made available, upon request to and at the discretion of the Chief of Staff, to any Appointee who functions in an official capacity within the Hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the Hospital concerning Medical Staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

SECTION 3.4 Rules of Order

The currently revised Roberts Rules of Order shall govern all meetings.

SECTION 3.5 Voting

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. Unless otherwise specified in these Bylaws or governing manuals, voting may occur in any of the following ways as determined by the chair of the respective committee/council; the Department/Section Chair; or, for voting by the Medical Staff, as determined by the Chief of Staff:

By hand, voice or written ballot at a meeting at which a quorum is present.

By other technologically reasonable means of balloting (as determined by the Chair) at a meeting at which a quorum is present.

Without a meeting, by written, electronic or facsimile ballot provided such ballots are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

Absentee written, electronic or facsimile ballot, provided the ballots are received prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken.

Unless otherwise specified in the Bylaws or governing manuals, Practitioners may participate in and act at any meeting by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance and presence in person at the meeting.

ARTICLE 4.
COMMITTEES OF THE PROFESSIONAL STAFF

SECTION 4.1 Appointment

4.1.1 Chairs.

Appointment of all committee Chairs, unless otherwise provided for in these Bylaws, will be by the Chief of Staff. All Chairs shall be selected from among persons appointed to the Active Staff.

Such appointments must be approved by the Board.

4.1.2 Members

Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed for two (2) years by the Chief of Staff, in consultation with the VPMA/CMO or President (or designee), prior to January 1st of the appropriate year, with no limitation in 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.

The Hospital President, the VPMA/CMO and the Chief of Staff or their respective designees shall be members, ex- officio, on all committees.

SECTION 4.2 Required Committees (03.03.01 – 03.14.03)

Required committees must report to the Medical Executive Committee regularly throughout the year according to the Bylaws. Nothing in this Manual shall preclude joint meetings of Affiliate Hospitals Medical Staff committees to the extent that such meetings will assist in assuring quality patient care and effective peer review.

Required committees are:

(a) Medical Executive

(b) Utilization Review/ Quality Assessment and Performance Improvement (Includes Infection Control, Transfusion, and Surgical and Tissue Case Review)

(c) Osteopathic Practice (Utilization of Osteopathic Methods and Concepts)

(d) Peer Review

(e) Credentials

(f) Medical Records

(g) Pharmacy and Therapeutic

(h) Tumor Board

(i) Impaired Physician

SECTION 4.3 Medical Executive Committee (03.03.02)

The composition and duties of the Medical Executive Committee are as set forth in the Bylaws. As needed, the Medical Executive Committee shall select an organized Medical Staff section representative to the AMA and OSMA. In addition, the Medical Executive Committee supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical departments, sections, and units as well as conducts periodic review of Medical Staff Bylaws, Organization and Functions Manual, Credentials Policy Manual and Medical Staff policies; and makes recommendations for changes to the Medical Staff and to the Board as outlined in the Medical Staff Bylaws.

It is the responsibility of the Medical Executive Committee to initiate investigations, conduct inquiries, review and report on corrective actions, and attend to any other matters involving clinical, ethical, or professional conduct of any individual Practitioner. This responsibility may be delegated to the Quality Assessment Performance Improvement Committee or a focused professional practice quality improvement panel selected by the Chief of Staff with the intent to improve the Practitioner's performance. The panel of peers shall conduct the review following the time frames set for that focused review by the MEC.

SECTION 4.4 Utilization Review Committee/Quality Assessment and Performance Improvement ("UR/QAPI") Committee (includes Infection Control, Transfusion, and Surgical and Tissue Case Review) (03.04.02, 03.04.03)

4.4.1 Composition. The UR/QAPI Committee shall consist of not less than two or more than fifteen members of the Active Staff, which may include representatives of the Departments of Surgery, Internal Medicine, Obstetrics and Gynecology, Family Practice, Radiology and Pathology. At least two or more of the members of the Committee must be doctors of osteopathy or medicine, and no member may be financially involved in the Hospital (ownership of 5 percent or greater). Appointments to this Committee shall be for two (2) years and shall be staggered such that experienced members are always present. In addition, non-voting ex-officio members shall include the following where such positions exist: (i) Chief of Staff, (ii) VPMA/CMO, (iii) Hospital President, or his/her designees, (iv)

Quality Improvement Director, (v) Vice President of Patient Care, (vi) Quality Improvement Coordinator, (vii) Quality Improvement Tech, (viii) Chief Financial Officer, (ix) Coordinator of Quality Review/Risk Management, (x) Director of Patient Relations, (xi) Infection Control nurse, and (xii) a representative from the Department of Medical Integration, Director of Health Information and Quality Improvement Services, Vice President of Patient Care.

Reviews may not be conducted by participants in the development or execution of a patient's treatment plan or by any individual who is professionally involved in the case of a patient whose case is under review.

A physician from the Active Professional Staff shall serve as Chair and be appointed for a two (2) year term by the Chief of Staff.

4.4.2 Duties. (03.04.04)

The committee shall develop and implement a Utilization Review Plan for the Hospital to:

(a) ensure proper utilization and efficient usage of Hospital facilities, resources, and services;

(b) evaluate the quality of medical care on the basis of documented evidence;

(c) review current inpatient records;

(d) perform qualitative and quantitative analyses of medical care and report deficiencies of Staff members to the Medical Executive Committee, QAPI Committee and appropriate Clinical Departments and Sections with recommendations for correction(s);

(e) be in accordance with current federal requirements accepted by the U.S. Department of Health and Human Services; and

(f) provide for review of care and treatment of Medicare and Medicaid patients with respect to the medical necessity of admissions to the hospital appropriateness of the setting; duration of stays, medical necessity of outlier cases of extended stays and professional services furnished and the medical necessity thereof for outlier cases, including drugs and biologicals.

(g) Activities performed pursuant to the Utilization Review Plan shall be applicable to all patients regardless of source of payment. Activities are kept as peer review privileged and confidential.

The Committee also shall have a subcommittee responsible for infection control including community acquired and healthcare acquired infections in patients and healthcare workers. The Infection Control nurse and physician Infection Control officer shall be represented on this subcommittee and shall report at least quarterly to the Committee.

The Committee also shall be responsible for quality assurance and peer review functions.

The Committee shall also:

(a) establish, evaluate, implement and maintain a Quality Improvement Plan designed to measure, assess, and improve outcomes, the quality and appropriateness of selected service, and identify problems in care and performance. This clinical review shall include appropriateness of selected service/activities and management of some of the following processes:

(i) Medication therapy;

(ii) Infection control;

(iii) Surgical management;

(iv) Blood products;

(v) Medical record pertinence and timeliness;

(vi) Discharge planning;

(vii) Utilization management;

(viii) Never events promulgated from time to time by CMS;

(ix) Transfusion;

(x) Surgical and tissue case review; and

(xi) Readmission to hospital within 30 days of discharge or as otherwise tracked by CMS and/or accreditation body.

(b) review reports on quality improvement from Professional Staff Departments, Sections and committees, Hospital department managers, quality improvement personnel and quality improvement-related Hospital committees and aggregate findings to:

(i) develop plans for continuing the education of Professional Staff members;

(ii) provide annual evaluations of improvements in the clinical care provided;

(iii) utilize as information in the advancement of Professional Staff members; and

(iv) utilize as information in the process of evaluating and acting upon reappointment and reprivileging requests from Professional Staff members.

(c) report activities to the Hospital Board of Trustees through the Medical Executive Committee;

(d) review findings from Hospital Review Committee, Clinical Departments and Sections and Hospital departments and recommend action relating to quality improvement;

(e) review problems identified through the quality improvement process;

(f) disseminate committee actions to appropriate individuals, Clinical Departments, Sections, and committees;

(g) follow-up on identified problems through selective or concurrent record screening;

(h) collaboratively involve the appropriate Clinical Departments, Sections, services and disciplines, as relevant, including Allied Health Practitioners, in its design, measurement, assessment and improvement activities;

(i) collect, analyze and report data concerning the needs and expectations of patients and physicians, providers, third-party payers and others, and the degree to which these expectations have been met;

(j) perform the following infection control-related duties:

(k) develop, recommend, implement, and review at least annually and revise as necessary an Infection Control Plan for the Hospital, which includes the following:

(i) guidelines to prevent, control, identify, report and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the Hospital, encompassing all Hospital departments and patient services;

(ii) specifications for isolation procedures of all applicable Hospital departments and/or services, including orientation and instruction of all personnel regarding infection control policies, and the development of policies and procedures in each Hospital department or service relating to asepsis and infection control; and

(iii) provision for cleaning and care of all equipment including a formula for every mixture prepared in the Hospital department or service for use in the cleaning procedures. Each solution must have a proven effective spectrum of germicidal action.

(l) institute, at any time, control measures to protect patients, employees, visitors and others;

(m) evaluate and make recommendations regarding any change in chemical solutions for sterilization and other cleaning procedures;

(n) review nosocomial infections, establish techniques for discovering and reporting such infections and tracing the source of infections of patients and Hospital personnel, and establish techniques for prevention, handling and control of institutional infections;

(o) provide an orientation program for new personnel regarding Infection Control policies and establish and evaluate employee health policies;

(p) develop protocols for Infection Control studies; and

(q) respond to questions regarding techniques or policies of infection control.

(r) Concern itself with the provident and safe use of blood and blood products for transfusion, shall review the use of blood and blood products in the Hospital, shall take actions necessary to maintain high standards in transfusion practices, and shall develop policies

and procedures regarding transfusion of potentially HIV infectious blood and blood products.

(i) review transfusions of blood or blood derivatives, and make recommendations regarding the proper use of these substances.

(ii) review all transfusion reactions, and make recommendations for the improvement of blood transfusion practice and shall periodically review and recommend policies governing transfusions of blood and blood derivations, and systems for reporting blood transfusion reactions. Transfusion reactions shall be reported in the QAPI Committee program.

(iii) The committee shall provide an education program to review the blood transfusion practices, which should concern all physicians who prescribe the use of blood and blood products in transfusion therapy.

(s) Perform surgical and tissue case review

(i) review tissue samples with minimum or no pathology to determine the justification for surgical procedures performed and make appropriate recommendations to the Medical Executive Committee and the appropriate Clinical Departments and Sections;

(ii) evaluate the surgical practice within the Hospital;

(iii) advise and recommend policies for tissue maintenance and supervise the tissue records to ensure that details are recorded in the proper manner and that sufficient data is present to evaluate the care of the patient;

(iv) ensure that there is proper filing, indexing, storage and availability of tissue records; and

(v) scrutinize the relationship between preoperative and postoperative tissue final diagnosis as well as develop a protocol for review of specific types of tissue cases and refer these tissue cases to respective Hospital sections for review and education of their members.

(t) The Committee shall oversee the:

(i) quality assurance peer review functions of the Professional Staff and the Hospital;

(ii) development of guidelines for consideration of cases having bioethical implications;

(iii) development and implementation of procedures for the review of such cases;

(iv) development and/or review of institutional policies regarding care and treatment of such cases;

(v) retrospective review of cases for the evaluation of bioethical policies;

(vi) consultation with concerned parties to facilitate communication and aid conflict resolution;

(vii) education of the Hospital personnel, Allied Health Practitioners and Professional Staff on bioethical matters;

(viii) advisement and education of the Professional Staff on matters pertaining to alcohol and substance abuse;

(ix) review, investigation and intervention as appropriate of all alleged incidents of Professional Staff member impairment;

(x) implementation of appropriate referrals for impaired Professional Staff members;

(xi) follow up and monitoring of all cases of impairment as necessary; and

(xii) maintenance of confidentiality as appropriate.

(u) The Committee shall also concern itself with the provident and safe use of blood and blood products for transfusion, shall review the use of blood and blood products in the Hospital and shall take actions necessary to maintain high standards in transfusion practices. The committee shall review transfusions of blood or blood derivatives, and make recommendations regarding the proper use of these substances. It shall review transfusion reactions occurring in the Hospital, and make recommendations for the improvement of blood transfusion practice, and shall periodically review and recommend policies governing transfusions of blood and blood derivations, and

systems for reporting blood transfusion reactions. Transfusion reactions are considered adverse medical events and will be included in the quality assurance/performance improvement reports and program with the goal of identifying any issues capable of resolution and resolving same. Quality Improvements case referrals from the Blood Bank will be reviewed by the Medical Staff Departments/Sections regarding transfusion reactions as well as blood products ordered and not used. The committee shall provide an education program to review the blood transfusion practices, which should concern all physicians who prescribe the use of blood and blood products in transfusion therapy, including developing and implementing policies and procedures regarding transfusions of potentially HIV infectious blood and blood products. Quarterly Blood Bank reports shall be received by this committee. The committee shall report (with or without recommendation) to the Medical Executive Committee for its consideration and appropriate action any situation involving questions about the clinical competency, patient care and treatment with regard to use of blood and its products on the part of any individual appointed to the Professional Staff.

4.4.3 Meetings, Reports, and Recommendations. The UR/QAPI shall meet as scheduled by the Committee Chair, shall maintain a permanent written record of its findings, proceedings and actions, and shall make a report of each meeting to the Medical Executive Committee, the VPMA/CMO and the Hospital President. Summary reports shall be transmitted to the Hospital Board through the Hospital President. Interim reports shall be presented as situations indicate.

SECTION 4.5 Osteopathic Practice Committee (03.05.01)

4.5.1 Composition. The Osteopathic Practice Committee shall consist of not less than two (2) members, at least two (2) of whom are osteopathic physicians on the active staff, and which may include representatives of the Clinical Departments of Surgery, Internal Medicine, Obstetrics and Gynecology, and Family Practice. In making appointments to this committee, the Chief of Staff shall endeavor to appoint at least one osteopathic physician from each Clinical Department.

4.5.2 Purpose. The purposes of the Osteopathic Practice Committee are as follows:

(a) to promote the most effective methods for osteopathic diagnosis and treatment for comprehensive patient care;

(b) to improve the recording of osteopathic musculoskeletal findings, diagnosis, and management on patient charts;

(c) to provide for the ongoing need of continuing education in osteopathic principles and practice; and

(d) to provide a clinical environment for osteopathic diagnosis and treatment which will assure quality care in the Hospital.

4.5.3 Duties. The Committee shall: (03.05.03)

(a) make recommendations to the Medical Executive Committee, QAPI Committee and appropriate Clinical Departments and Sections to improve utilization of osteopathic principles and practice, to record osteopathic findings, describe osteopathic manipulative treatment and to apply such modalities as part of the comprehensive care received by patients;

(b) establish and record retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment; and

(c) inform osteopathic physicians of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.

(d) Meetings, Reports, and Recommendations. The Osteopathic Practice Committee shall meet at least quarterly, shall maintain a permanent written record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee, the VPMA/CMO, and the Hospital President.

SECTION 4.6 Peer Review Committee

4.6.1 Composition. The Peer Review Committee shall consist of Department and Section chairs (or their respective designee) from anesthesia, emergency medicine, internal medicine, cardiology, radiology, obstetrics and gynecology, orthopedics, pediatrics, surgery, ophthalmology, neurosurgery, otorhinolaryngology, neurology, psychiatry, and physical medicine & rehabilitation. Ex-officio members without vote shall include the VPMA/CMO, the Chief of Staff, and the Immediate Past Chief of Staff who shall serve as Chair. The Manager of Medical Staff Services shall attend each meeting in order to facilitate the work of the committee and to assist it in accomplishing its duties.

A "peer" is defined as a practitioner who has similar or more advanced education, training, experience, licensure, clinical privileges or scope of practice expertise and qualifications to those of the practitioner being reviewed. A peer may include invitees in the allied health professions for a peer review of an allied health practitioner. For all peer review performed by the medical staff, the Medical Executive Committee shall determine the degree of subject matter expertise required for a provider to be considered a peer. An individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review and will not have a conflict of interest with the individual under review. However, opinions and information may be obtained from participants that were involved in the patient's care.

4.6.2 Duties: The Peer Review Committee shall:

(a) oversee the implementation of a medical staff Peer Review Policy;

(b) review and maintain familiarity with patient care protocols and guidelines developed by national organizations;

(c) identify those variances from rules, regulations, policies, or protocols which do not require physician review but for which the practitioner involved in the case may receive an educational letter from a hospital or medical staff department;

(d) review cases referred to it as outlined in the Peer Review Policy;

(e) develop, when appropriate, performance improvement plans for practitioners;

(f) review the effectiveness of the Peer Review Policy at least every two years and recommend revisions or modifications as may be necessary; and

(g) conduct professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by health care providers; and/or conduct any other attendant hearing process initiated as a result of this Committee's recommendations or actions.

4.6.3 Meetings and Reports:

The Peer Review Committee shall meet as often as necessary to accomplish its functions and shall provide a report of its findings, actions, and recommendations to the MEC.

SECTION 4.7 Credentials Committee (03.06.01)

4.7.1 Composition.

(a) The Credentials Committee shall consist of one person from each of the following Clinical Departments: Internal Medicine, Surgery, Obstetrics and Gynecology and Family Practice, and three (3) other persons appointed by the Chief of Staff in consultation with the VPMA/CMO or President's designee, based upon the individual's maturity, objectivity, and experience on other committees. Appointments to the Credentials Committee must be approved by the Professional Staff and the Hospital Board. Service on this committee shall be considered as the primary Professional Staff obligation of each member of the committee.

(b) The Credentials Committee shall have an Allied Health Practitioner Credentials Subcommittee, which shall include Credentials Committee representatives from surgery and primary care, a member-at-large appointed by the Chief of Staff and three (3) Allied Health Practitioners selected by the Chief of Staff. Additional Allied Health Practitioners may participate on an ad hoc basis as the Allied Health Practitioner Credentials Subcommittee deems necessary and appropriate.

4.7.2 Duties. The duties of the Credentials Committee and the duties of the Allied Health Practitioners Credentials Subcommittee, with respect to matters involving Allied Health Practitioners, shall be: (03.06.02)

(a) to review the credentials of all applicants and insure that all applications are complete, to review primary source verification of information contained in the applications as performed by the CCO and MSS office and make further investigations of such information as necessary (incomplete applications shall be returned to the applicant for corrections before consideration), to interview applicants as may be necessary; to consider pertinent practitioner specific quality improvement data, and to make recommendations to the Medical Executive Committee for appointment and delineation of Clinical Privileges, including specific consideration of the recommendations from the Clinical Departments or Sections in which such applicant requests privileges or is to be assigned;

(b) to review credentials and reports on specific persons holding appointments to the Professional Staff or as Allied Health Practitioners that may be referred by the following committees: Staff

Executive, Health Information Management Services, Utilization Review, Quality Assessment and Performance Improvement and any other Professional Staff committees and by the Chief of Staff, to the extent that those reports concern the Clinical Privileges of Staff or Allied Health Practitioner Appointees and to make such recommendations as to the expansion or limitation of privileges, membership or appointment based upon that review as are provided by the Bylaws; and

(c) in any instance where a member of the Credentials Committee or Allied Health Practitioner Credentials Subcommittee has a conflict of interest in any matter involving an applicant or appointee to the staff which comes before the Credentials Committee or Allied Health Practitioner Credentials Subcommittee, respectively, that member shall not participate in the discussion or vote on the matter and shall excuse himself from the meeting during that time. In situations where it is unclear whether such a conflict of interest exists, the Chair of Credentials Committee shall make the final determination. If the Chair of the Credentials Committee is absent or in conflict, the Chief of Staff shall make the determination. The Chair of the Credentials Committee, the Chair's representative and/or such members of the committee as are deemed necessary or the Chair of the Allied Health Practitioner Credentials Subcommittee, the Chair's representative or members of that committee as deemed necessary shall be available to meet with the Medical Executive Committee on recommendations that the Credentials Committee or the Allied Health Practitioner Credentials Subcommittee shall make;

(d) in addition, the Allied Health Practitioner Credentials Subcommittee shall review the recommendations of the Clinical Departments and Sections and forward to the Credentials Committee its recommendations regarding the qualifications necessary for individuals to be granted privileges in each category of Allied Health Practitioners; and

(e) to receive, review, confirm and evaluate the information contained in the biennial applications for renewal of privileges and Professional Staff membership or Allied Health Practitioner appointment. In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or Appointee to the Staff which comes before the Credentials Committee or a member of the Allied Health Practitioner Credentials Subcommittee has a conflict of interest in any matter involving an Allied Health

Practitioner Appointee which comes before the Allied Health Practitioner Credentials Committee, that member shall not participate in the discussion or vote on the matter and shall excuse himself from the meeting during that time.

(f) The Chair of the Credentials Committee, the Chair's representative and/or such members of the committee as are deemed necessary or the Chair of the Allied Health Practitioner Credentials Subcommittee, the Chair's representative or members of that committee as deemed necessary shall be available to meet with the Medical Executive Committee on all recommendations that the Credentials Committee or the Allied Health Practitioner Credentials Subcommittee may make.

4.7.3 Meetings, Reports and Recommendations. (03.08.02)

(a) The Credentials Committee shall meet at least once annually and may meet more often as necessary to accomplish its duties, and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Medical Executive Committee, the Hospital President, the VPMA/CMO and the Hospital Board of Trustees.

(b) The Allied Health Practitioner Credentials Subcommittee shall meet at least once annually and may meet more often as necessary to accomplish its duties, and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Credentials Committee. The Credentials Committee shall review the recommendations and relevant materials and adopt or modify the recommendation, which shall be forwarded, as set forth in Section 3(a). If the Credentials Committee modifies the recommendation, it shall forward an explanation of the basis for the modification with the modified recommendation.

SECTION 4.8 Network Medical Records Committee

4.8.1 Composition. The Hospital participates in a Network Medical Records Committee with two Professional Staff members appointed by the Chief of Staff to serve the Hospital's interests and act as a liaison communicator with the Medial Staff through the MEC.

4.8.2 Duties. The duties of the Network Medical Records Committee assure that the function of medical records services are met so as to fully comply with

applicable state and federal law, regulations, rules and accrediting standards.

4.8.3 Meetings, Reports and Recommendations. The Network Medical Records Committee meets as frequently as is necessary to meet the needs of the Kettering Health Network affiliated hospitals in assessing, promoting, and evaluating the signed duties so as to fully comply with applicable state and federal law, regulations, rules and accrediting standards. Minutes of meetings are submitted to the MEC which then reports such to the Board.

SECTION 4.9 Pharmacy and Therapeutics Committee

4.9.1 Composition. The Hospital participates in a Network Medical Records Committee with two Professional Staff members appointed by the Chief of Staff to serve the Hospital's interests and act as a liaison communicator with the Medial Staff through the MEC.

4.9.2 Duties. The duties of the Network Medical Records Committee assure that the function of medical records services are met so as to fully comply with applicable state and federal law, regulations, rules and accrediting standards.

4.9.3 Meetings, Reports and Recommendations. The Network Medical Records Committee meets as frequently as is necessary to meet the needs of the Kettering Health Network affiliated hospitals in assessing, promoting, and evaluating the signed duties so as to fully comply with applicable state and federal law, regulations, rules and accrediting standards. Minutes of meetings are submitted to the MEC which then reports such to the Board.

SECTION 4.10

4.10.1 Composition. The Pharmacy and Therapeutics Committee shall consist of at least three (3) representatives of the Active Staff, Vice President of Patient Care, or designee, the Hospital President, or designee, and the chief pharmacist. The Chair of the committee shall be a physician member of the Active Professional Staff. The chief pharmacist shall be a voting member and act as secretary for the committee.

4.10.2 Duties. The duties of the Pharmacy and Therapeutics Committee shall be to examine, survey and make recommendations regarding all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use,

safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

(a) serve as an advisory group to the Professional Staff and the pharmacist on matters pertaining to the choice of available drugs;

(b) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(c) develop, review periodically and amend as appropriate a formulary or drug list for use in the Hospital;

(d) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients and which are biologically equivalent;

(e) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(f) establish standards concerning research in the use of recognized drugs; and

(g) formulate procedures for reporting adverse drug reactions and errors in administration of drugs.

4.10.3 Meetings, Reports and Recommendations.

(a) The Pharmacy and Therapeutics Committee shall meet as scheduled by the Committee Chair, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee, the VPMA/CMO, and the Hospital President.

(b) The committee shall report (with or without recommendation) at least quarterly to the Medical Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency with regard to patient drug treatment on the part of any individual appointed to the Professional Staff.

SECTION 4.11 Tumor Board Committee

4.11.1 Composition. The Tumor Board Committee shall consist of one representative of each of the Clinical Departments of Internal Medicine, Surgery, Radiology, Pathology, Obstetrics and Gynecology, Family Practice and the cancer liaison physician. In making appointments to this committee

the Chief of Staff shall seek individuals with special knowledge and skills in the area of oncology.

4.11.2 Duties. The duties of the Tumor Board shall be:

(a) to review tumor cases, including all malignant tumor cases admitted, evaluate diagnosis, suggest case management, and offer assistance to the attending physician;

(b) to review and monitor the management and care of inpatients and outpatients being treated for cancer;

(c) to provide educational programs for both professional and nonprofessional personnel in oncology and oncology practice, including the care and treatment of the physical and emotional states of the cancer patient;

(d) to review quality of care evaluation studies or other methods of audit on records of cancer patients;

(e) to make recommendations on the best diagnostic and therapeutic approaches for malignancies;

(f) to make recommendations to the Hospital on keeping records, and accumulating statistics of importance to the evaluation of tumor diagnosis and treatment;

(g) to accept and consider any responsible and practical method established by a Hospital to evaluate cases of malignancy;

(h) to require that an accurate diagnosis be made before treatment is instituted, including requiring that all malignancies be staged when applicable and noted in the patient's chart; and

(i) to report on new trends in diagnosis and therapy and make recommendations to the Professional Staff on new concepts and procedures in oncologic practice.

4.11.3 Meetings, Reports and Recommendations. The Tumor Board Committee shall meet as scheduled by the Committee Chair , shall maintain a permanent record of its findings, proceedings and actions, and shall make appropriate reports to the Medical Executive Committee and the Hospital President.

SECTION 4.12 Impaired Physicians Committee

4.12.1 Composition. The Impaired Physicians Committee shall consist of at least three (3) representatives of the Professional Staff.

4.12.2 Definition of Impairment. Deterioration in behavior and medical practice brought on by chemical dependency (including alcohol) or mental or physical illness.

4.12.3 Duties. The Impaired Physicians Committee shall:

(a) serve as an advisory and educational group to the Professional Staff on matters pertaining to alcohol and substance abuse;

(b) review, investigate and intervene as appropriate all alleged incidents of Professional Staff member impairment;

(c) implement appropriate referrals for impaired Professional Staff members;

(d) follow up and monitor all cases of impairment as necessary; and

(e) maintain confidentiality as appropriate.

4.12.4 Meetings, Reports and Recommendations. The Impaired Physicians Committee shall meet as often as necessary to fulfill its duties and shall report any recommendations as appropriate to the Medical Executive Committee, the Hospital President and the VPMA/CMO.

ARTICLE 5.
STANDING COMMITTEES

Standing committees are those committees structured as needed to perform Professional Staff functions. These committees must report as requested and are accountable to the Medical Executive Committee. Standing committees are:

1. Rules and Bylaws
2. Nominating
3. Osteopathic Medical Education Committee ("OMEC")
4. Critical Care
5. Disaster
6. Distinguished Service Award
7. Trauma

SECTION 5.1 Rules and Bylaws Committee

5.1.1 Composition. The Rules and Bylaws Committee shall consist of not less than three (3) persons appointed from the Active Staff. The VPMA/CMO shall be an ex officio member of this committee.

5.1.2 Duties. The Rules and Bylaws Committee shall review the Bylaws, Rules and Regulations of the Professional Staff no less often than every two (2) years and recommend amendments thereto to the Medical Executive Committee as necessary. In addition, the committee shall receive and consider all recommendations for changes in these Bylaws, Rules and Regulations by the Hospital Board, the Medical Executive Committee, the Clinical Departments and Sections, the Chief of Staff, the Hospital President, committees of the Professional Staff and any individual appointed to the Professional Staff.

5.1.3 Meetings, Reports and Recommendations. The Rules and Bylaws Committee shall meet as often as necessary to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Medical Executive Committee, the Hospital President, the VPMA/CMO and, when applicable, to the originator of any proposed change.

SECTION 5.2 Nominating Committee

5.2.1 Composition. The Nominating Committee shall consist of the Clinical Department Chairs of the Medical Executive Committee with the Chief of Staff as the Chair.

5.2.2 Duties. This committee shall present at the appropriate October meeting one or more nominees for the offices of Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and at least three (3) nominees for the at-large members of the Medical Executive Committee.

5.2.3 Meetings, Reports and Recommendations. The Nominating Committee shall meet as often as necessary to accomplish its purpose and provide the Secretary of the Staff with a list of its recommendations to accompany the notice of the October staff meeting.

SECTION 5.3 Osteopathic Medical Education Committee ("OMEC")

5.3.1 Composition. The Osteopathic Medical Education Committee shall consist of the Director of Medical Education ("DME"), VPMA/CMO and not less than 10 additional members, at least half of whom shall be representatives of specialty sections.

5.3.2 Duties. The OMEC shall be responsible for:

(a) assisting Department and Section Chairs, directors of residency programs, the Hospital President, DME and VPMA/CMO in matters of discipline and government of the interns and residents;

(b) assisting the DME in formulating a plan of education and quality management for all interns and medical students;

(c) coordinating educational programs among Clinical Departments and Sections;

(d) performing other duties relating to housestaff, as assigned by the Chief of Staff, the VPMA/CMO and the Hospital President; and

(e) working collaboratively with and assisting the Medical Education Department to evaluate the resources and facilities of the medical health science library on an annual basis in order to make recommendations to MEC regarding its operations, resources and technologies to assure that the professional staff has access to professional and medical knowledge-based resources, including printed and/or electronic media and other educational mediums that

are appropriate to professional, technical, educational, administrative and research needs, with availability of computer workstation facilities.

5.3.3 Meetings, Reports and Recommendations. The OMEC shall meet as scheduled by the Committee Chair, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee, the VPMA/CMO and the Hospital President.

SECTION 5.4 Critical Care Committee (Medical ICU and Surgical ICU)

5.4.1 Composition. The Critical Care Committee shall consist of not less than eight (8) members of the Professional Staff, with at least one member each from the Clinical Departments of Anesthesiology, Internal Medicine, Surgery and Family Practice. Additionally, the appropriate Directors of Nursing, the head nurse of each critical care unit, the Hospital President, or his/her designee, and the VPMA/CMO shall be ex-officio members.

5.4.2 Duties. It shall be the duty of the committee to supervise the activities of all medical and surgical intensive and critical care units and, in consultation with the VPMA/CMO, to establish those policies relating to admissions to and discharges from each unit and such other medical policies as may be necessary to ensure their proper functioning and utilization in accordance with the stated purposes of each unit.

5.4.3 Meetings, Reports and Recommendations.

(a) The Critical Care Committee shall meet as scheduled by the Committee Chair, shall maintain a permanent record of its proceedings and recommendations, and shall make a report thereof to the Medical Executive Committee, the VPMA/CMO and the Hospital President.

(b) The committee shall report (with or without recommendation) to the Medical Executive Committee for its consideration and appropriate action any situation involving questions about the clinical competency, patient care and treatment or case management, provided in these units on the part of any individual appointed to the Professional Staff.

SECTION 5.5 Disaster Committee

(a) Composition. The Disaster Committee shall consist of not less than four (4) members, including one or more Appointees to the

Professional Staff and one or more representatives of Hospital management. The Chair shall be a member of the Professional Staff.

(b) Duties. The Disaster Committee shall be responsible for the development and maintenance of methods for the protection and care of Hospital patients and others at the time of internal and external disaster or civil disorder. Specifically, it shall (1) adopt and periodically review a written plan that outlines the duties of the Professional Staff and all Hospital personnel to safeguard patients at the time of internal or external disaster or civil disorder; (2) assure that all key personnel rehearse fire drills at least monthly; (3) adopt and periodically review a written plan for the reception and care of large numbers of sick or injured persons who may come or be brought to the Hospital; (4) assure that such plan is coordinated with the inpatient and outpatient services of the Hospital as well as the police and fire departments, civil defense and the Red Cross so as to coordinate activities with local and other agency disaster programs in a manner to adequately reflect developments in the Hospital community and the anticipated role of the Hospital in the event of disasters in nearby communities; (5) that the plan is rehearsed by key personnel at least annually; and (6) develop a complete patient evacuation plan.

(c) Meetings, Reports & Recommendations. The Disaster Committee shall meet as scheduled by the Committee Chair, shall maintain a permanent record of its activities, and shall report its recommendations to the Medical Executive Committee, the Hospital President and the VPMA/CMO.

SECTION 5.6 Distinguished Service Award Committee

5.6.1 Composition.

(a) The Distinguished Service Award Committee shall consist of nine (9) members appointed for six (6) years by the Chief of the Staff. Three (3) new members will be appointed every two (2) years thereafter for a six (6) year term. Each member appointed shall be an active staff member for fifteen (15) years before he can qualify. The Chief of Staff, the VPMA/CMO, and a representative from Administration shall be members ex-officio. A member cannot be appointed for more than two (2) consecutive terms.

(b) The Distinguished Service Award Committee shall consist of at least three (3) members and no more than five (5) members from the

Section of Family Practice. The balance of the committee will consist of members from the specialty departments limited to one (1) from any one Clinical Department or Section. Prior to making appointments, it is recommended that the Chief of Staff consult with the Chair of the Distinguished Service Awards Committee.

(c) New appointments will be effective after the Distinguished Service Award scheduled official presentation, in order to maintain continuity among its membership.

5.6.2 Duties. The duties of the Distinguished Service Award Committee are:

(a) to promote appropriate recognition to osteopathic physicians and others who have made significant contributions to our staff, our profession, and community. Only those members of our staff who have contributed most to the growth and academic excellence of our institution will be considered;

(b) to elevate esprit de corps. The selection of candidates into this select group shall transcend any Clinical Department or Section affiliation and should be free of any and all prejudices;

(c) no more than two (2) inductees shall be selected to honor each year, after the initial recognition of honored charter members; and

(d) honorary membership can be granted to anyone fulfilling the criteria described, but need not be an osteopathic physician.

5.6.3 Meetings.

(a) Applications approved for the award(s) should have at least two-thirds (2/3rds) of the appointed committee members approval at a meeting designated by the Chair with the vote being final.

(b) This meeting as scheduled shall be by written notice sent to all members at least one (1) month in advance of the selection meeting.

(c) A quorum of no less than six (6) appointed members or their designated alternates including the Chair shall be present to consider this meeting as official and the vote to be valid.

(d) Alternates for those members not in attendance have to be approved by the appointed members present provided those names (alternates) have been submitted to the Chair two (2) weeks prior to

this meeting. Proxies will not be accepted. Alternates must also meet the criteria of an appointed member.

(e) No selections will be made unless the above criteria are met.

(f) If for any reason this meeting is rescheduled or continued, it will be done so only on one occasion and within two (2) weeks of the original scheduled date with all rules and requirements as set forth and written in effect with no exceptions.

5.6.4 Criteria.

(a) Must be or has been an osteopathic physician and a graduate from an approved osteopathic institution of at least twenty-five (25) years.

(b) Must be of high moral character, ethical, and of high integrity.

(c) Must have served Grandview/Southview Hospital and/or the osteopathic profession beyond the call of duty.

(d) Must have made exceptional contributions to the growth and/or to the academic excellence of his/her colleagues, Hospital and profession.

(e) Must be limited to no more than two (2) appointments a year.

(f) Honorary membership may be granted to a non-physician fulfilling the criteria as above in Items 2) through 5).

5.6.5 Inductee Selection Procedure.

(a) Applications must be submitted by April 1 of any year and a selection made by September 1 of that year.

(b) Applications submitted must be sponsored by an Active Staff member. Honorary members may be submitted by any Active Staff member or any member of the Hospital Board of Trustees of Grandview/Southview Hospital.

(c) Applications will be available for sponsoring prospective inductees and the applicant's curriculum vitae will be required.

(d) Applications submitted will be thoroughly investigated by a screening committee.

(e) The screening committee will consist of the Distinguished Service Award Committee.

(f) Applications approved for the award should have approval of at least two-thirds (2/3rds) of the committee members.

(g) The Distinguished Service Award Committee has the duty to investigate the credentials of all applications received as of April 1 and submit inductee names to the Medical Executive Committee for their information.

(h) If there are more than two (2) applicants submitted for the award, the Committee will recommend the acceptance of no more than two (2) members and recommend an active file for the remaining applicant(s) for one (1) additional year.

SECTION 5.7 Trauma Committee

5.7.1 Composition

(a) The Trauma Committee shall consist of twelve (12) members including:

(i) Chair of Section of General and Thoracic-Cardiovascular Surgery

(ii) Chair of Department of Emergency Medicine

(iii) Representative of Section of Orthopedic Surgery

(iv) Representative of Section of Neurosurgery

(v) Representative of Department of Emergency Medicine

(vi) Representative of Department of Anesthesiology

(vii) Representative of Section of General and Thoracic-Cardiovascular Surgery

(viii) Representative of Department of Internal Medicine

(ix) Chief Resident of General Surgery

(x) Chief Resident of Emergency Medicine

(xi) Chief Resident of Internal Medicine

(xii) The head nurse of the Emergency Department shall be an ex-officio member. Members shall be appointed for a term of two (2) years.

(b) The Chair shall alternate every two (2) years between the Chair of the Section of General Surgery and the Chair of the Department of Emergency Medicine.

5.7.2 Duties. Duties shall be:

(a) to make recommendations to the Professional Staff for the approval of, use of, and any changes in form or format of the established trauma protocol;

(b) to insure that trauma protocol is followed;

(c) to conduct an ongoing analysis of the quality of trauma care in all Professional Staff sections. In so doing the committee must develop mechanisms for:

(i) establishing objective criteria

(ii) taking appropriate action to correct identified problems

(iii) follow-up on action taken

(iv) reporting the findings and results to the applicable Clinical Departments or Sections, the Medical Executive Committee, and the Staff.

(d) to review all trauma deaths occurring in the Hospital;

(e) to conduct a surgical-pathological review for justification of all trauma surgery performed and to evaluate the acceptability of the procedure; and

(f) to review new equipment, changes in equipment, or supplies pertinent to trauma care.

5.7.3 Meetings, Reports, and Recommendations.

(a) The Trauma Committee shall meet as scheduled by the Committee Chair. The committee shall maintain a permanent record of their

proceedings and recommendations and shall make a report thereof to the Medical Executive Committee, the Hospital President and the VPMA/CMO.

(b) The Trauma Committee shall report to the Medical Executive Committee for its consideration and appropriate action any situations involving questions of the clinical competency, patient care, and treatment of trauma case management, or any situation involving questions of professional ethics or unacceptable conduct on the part of any individual appointed to the Professional Staff in reference to trauma care.

TRAUMA: For the purpose of these rules, trauma is defined as follows: a wound or injury whether physical or psychic.

ARTICLE 6.
CREATION OF OTHER STANDING COMMITTEES

The Medical Executive Committee may, by resolution, and upon approval of the Hospital Board, without amendment of these Bylaws, establish a committee to perform one or more Staff functions. In the same manner the Medical Executive Committee may by resolution and upon approval by the Hospital Board dissolve or rearrange committee structure, duties or composition as needed, to better perform the Professional Staff functions. Any function required to be performed by these bylaws which is not assigned to a required or standing committee shall be performed by the Medical Executive Committee or its appointed ad hoc committee.

ARTICLE 7. (03.08.01)
JOINT ADVISORY FUNCTION/JOINT CONFERENCE COUNCIL

A joint advisory function shall be the responsibility of the Joint Conference Council or such other ad hoc Board committee as is appointed to serve as an official liaison between the Medical Staff, the Board and the Hospital administration. The Joint Conference Council or other appointed committee shall have a function of keeping the Medical Staff, the Board and the Hospital administration cognizant of pertinent actions taken or contemplated by one or the other body, including but not limited to consideration of plans for growth, process communication and quality improvement, cost reduction, clinical utilization, revenue enhancement, and of issues affecting medical care that arise in the operation and affairs of the Hospital. The Joint Conference Council shall collaborate on planning, budgeting and appropriate utilization of available resources to assure that the mission of Grandview and Southview Medical Centers is accomplished, including:

- Working closely together on initiatives which make Hospital a more efficient place to practice medicine;
- Proactively addressing areas of conflict and developing solutions that are in the best interest of the overall organization;
- Working closely on Hospital's Strategic Initiatives/Key Result Areas (KRAs): Mission, Culture & People; Quality & Safety; Patient Experience; and Financial Performance;
- Reviewing and discussing new business models which might provide for a more efficient service delivery system;
- Creating a culture of teamwork among the entire Hospital workforce, including physicians, Administration, staff and volunteers; and
- Developing and implementing improved communication between Hospital and the Medical Staff.

Any committee having the joint advisory function as a responsibility shall include as members such individuals, and shall have such duties, and shall meet at such times as may be set forth in the Hospital's Code of Regulations, or as otherwise determined by the Board. The Joint Conference Council shall meet approximately every two months prior to the MEC meeting, or otherwise as frequently or infrequently as necessary. Membership on this Council shall consist of the Hospital President and Chief of Staff who shall act as co-chairs, and shall also include the President of Southview Medical Center, the Hospital Vice President of Finance and Operations, the Hospital Vice President of Clinical Services, the Director of Perioperative and Endoscopy Services, the Past Chief of Staff, the Vice Chief of Staff, the Secretary/Treasurer, Section Chairs or designees, a representative physician from each of Pathology and Anesthesiology, a physician Board representative, the Quality Medical Director, and such other members as are appointed from the Board and the Active Staff. The Council must report as requested and is

accountable to the MEC and the Medical Center Executive Council. In the event of any change in the purpose, composition, meeting, or reporting requirements related to the joint advisory function pursuant to the Hospital's Code of Regulations, such Code of Regulations shall govern and this provision will be likewise amended.

ARTICLE 8.
RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

SECTION 8.1 Admissions

8.1.1 Provisional Admitting Diagnosis: No patient shall be admitted to the Hospital until a provisional admitting diagnosis has been stated and the consent of a single admitting physician, or his/her alternate, secured. Every patient shall be under the care of a licensed Staff doctor of osteopathy or medicine with admitting privileges granted in accordance with these Bylaws. Only one active staff member may be designated as the attending physician responsible for patient care until the patient is transferred or discharged.

8.1.2 Patients: The Hospital shall accept patients suffering from all types of diseases except those whose medical needs are beyond the scope of care provided at a facility of the Hospital. Such patients presenting to a facility of the Hospital for treatment will be stabilized and transferred to another appropriate facility.

8.1.3 Protection of Other Persons: Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatever or to assure the protection of the patient from self-harm. The Hospital has the obligation of preventing hazards, and/or safeguarding all patients and personnel. Therefore, when any patient whose mental or physical condition causes him/her to be disturbing and/or unsafe to himself, other patients, and personnel of this Hospital, the patient will be transferred to a private room, at his/her own expense. This transfer will be discussed with and approved by the attending Physician. In case of disagreement, the appropriate Department/Section Chair will be contacted, and if a mutual decision with the attending Physician cannot be rendered, the Chief of Staff or his/her designee, shall be consulted and a final disposition made.

When transferred to a private room, the patient must have twenty-four (24) hour supervision, also at his/her own expense. If unable to afford the cost of special duty nursing, relatives or others, acceptable to the attending Physician and the VPMA/CMO, must remain with the patient continuously. If the above procedures are not acceptable to the Physician, patient, or his/her family, the Physician will be obligated to transfer the patient from the Hospital to an appropriate facility willing to accept the patient, or the patient and/or family may sign the patient out of the Hospital against medical

advice, unless the Physician deems the patient likely to harm himself or others.

8.1.4 Transfer of Service: Patient transfer from admitting Physician's care to another physician is arranged by agreement of current attending Physician and receiving Physician whether the transfer is requested by the patient or patient's legal surrogate or by the attending Physician.

To complete a patient transfer of service the attending Physician must order a transfer of service with appropriate documentation of reasons for transfer in the Physician progress notes as well as the receiving Physician documenting acceptance of the patient transfer in the Physician progress notes and order.

8.1.5 Assignment of Cases:

(a) Unattached patients (a patient who does not have a primary care physician (PCP), or has a PCP who does not have privileges at Hospital) shall be attended by members of the Professional Staff and shall be assigned by the Clinical Department/Section concerned in the treatment of the disease which necessitated admission.

(b) Private patients shall be attended by their own physician. In the case of the patient requiring admission who has no attending physician and does not elect or is unable to choose one, he/she shall be referred to the appropriate clinical service on-call physician.

(c) Physicians to whom unattached patients are referred have a responsibility to provide care to the patient at least once for the problem for which the patient was referred (regardless of ability to pay) and to provide continued care or provide a referral to another proper available care provider.

(d) All patients who are placed in a Hospital bed as an inpatient or observation status are required to be seen by the admitting or consulting Practitioner (who is permitted by the State and Hospital to admit patients to a Hospital) in a timely fashion with documentation of that visit in the medical record. Medicare patients must be under the care of a MD/DO. Patients transferred or admitted to an ICU shall be seen by the attending or consulting Physician within a time frame consistent with the clinical condition of the patient, usually no longer than twelve (12) hours. Patients placed in a non-ICU bed as an outpatient (ambulatory), observation status or admission, shall be seen by the admitting or consulting Practitioner within a time frame

consistent with the clinical condition of the patient, but within twenty-four (24) hours. All patients, with the exception of normal newborns or patients awaiting nursing home placement (who shall been seen at least weekly) require daily patient visits by the attending Practitioner with privileges, or his/her covering Practitioner, and these visits must be documented in the progress notes as a part of usual care. Medical student progress notes will not be a part of the medical record until they are signed by a supervising resident or Physician. To provide appropriate continuity of care for patients who are hospitalized by Practitioners other than the patient's primary care Physician, the attending is responsible to communicate, when appropriate, with the primary care Physician regarding the patient's Hospital course and the plan of care post hospitalization.

SECTION 8.2 Restraints or Seclusion

Physical or drug restraints or seclusion use for medical and post-surgical care or for emergent behavior management is limited to those situations with adequate and appropriate clinical justification (documented in the medical record) using the least-restrictive, safe and effective restraint or seclusion while protecting the patient's rights, dignity and wellbeing. Restraints or seclusion may be used following a comprehensive individual assessment according to Professional Staff approved guiding protocols by individual authenticated verbal or written orders of a Hospital credentialed licensed independent Practitioner and are time limited and renewable according to the Hospital's Restraint and Seclusion Policy, consistent with federal and State guidelines and accrediting standards. Order for seclusion or restraint are never written as a standing order or on an as-needed basis.

SECTION 8.3 Utilization

(a) The history and physical and progress notes must document the patient's clinical course in sufficient detail to provide a reasonable understanding of the patient's evolving condition, diagnoses, treatment and plan of care. In addition, the note must provide sufficient information regarding the severity of illness and/or intensity of service that requires continued use of Hospital resources.

(b) Professional Staff members are required to provide appropriate written diagnoses or clinical indications to justify diagnostic tests and therapeutic intervention performed by Hospital departments.

(c) Admissions prior to the day of surgery will be permitted if the medical condition warrants. If prior approval for elective admission is required by

the payor it must be obtained as specified by the payor prior to the admission.

(d) If approval for performance of any procedures is required by the third party payor, such approval must be obtained prior to performance of that procedure.

(e) Periodic review of the appropriateness of patient care may be made by the staff of the Quality Improvement Committee. Deviations will be referred to the Utilization Review Committee for initial review, and if appropriate to the applicable Professional Staff Chair or the Chief of Staff, or their designee for evaluation and recommendation, if any.

SECTION 8.4 Orders

8.4.1 Admission Orders: All inpatients must have orders upon admission provided by an Appointee in good standing with admitting privileges granted in accordance with the Bylaws, or by an eligible House Staff physician. Non-Appointees shall not have authority to admit or co-admit patients to the Hospital, except to the extent provided by Ohio law, Medicare Conditions of Participation, standards of the applicable accrediting body such as the Healthcare Facilities Accreditation Program, other applicable law and regulations, and the Bylaws and its governing documents.

8.4.2 Written/Verbal Orders. All orders (including orders for diagnostic procedures, treatment, medication, biologicals, progress notes, patient assessments, history and physicals, etc.) must be legible, complete, dated, timed and authenticated within 48 hours in written or electronic form by the prescribing physician or other licensed practitioner who is authorized to write orders by State law and Hospital policy, and who is responsible for the care of the patient even if the order did not originate with such practitioner. Verbal orders (including telephoned orders) shall be used infrequently and limited to those situations in which it is impossible or impractical to write the order or enter it into the computer, and shall not be accepted or carried out unless dictated to credentialed personnel within the scope of their licensure consistent with federal and State law. All verbal orders received by telephone must be read back to the ordering practitioner for verification of accuracy. Verbal orders shall be reviewed for accuracy and authenticated promptly (but not later than 48 hours post discharge) by the responsible Physician or another licensed practitioner who is responsible for the care of the patient and is authorized to write orders by Hospital policy in accordance with State law. Authentication of verbal orders may be written, electronic or faxed and must include the time the verbal order was received, and the date and names of the qualified individuals who gave, received, recorded and

implemented the orders. Orders may be accepted via email or two-way pager services if sent through a Hospital approved site, or another secure site, and the ordering Practitioner is clearly identified; and orders so received via such means shall be transcribed into the medical record and dated, timed and authenticated as described above. Verbal orders for restraints and code status must be reviewed and authenticated within 24 hours following the time the order was given.

8.4.3 Preprinted Orders. A "preprinted order" is a patient-specific, definitive set of drug treatment directives to be administered to an individual patient who has been first been examined by a Practitioner authorized to prescribe and for whom such Practitioner has determined that the drug therapy is appropriate and safe when used pursuant to the conditions set forth in the preprinted order. A Department Chair or the Medical Director of a special care unit (in consultation with other appropriate representatives of the Medical Staff and appropriate representatives of Patient Care Services and/or other applicable Hospital departments) may formulate preprinted orders for any Department or Section or other clinical unit, subject to approvals as relevant. All preprinted orders should be individualized for each patient as clinically appropriate, and must be dated, timed and authenticated promptly in the patient's medical records by the ordering Practitioner or by another Practitioner responsible for the care of the patient and who is acting in accordance with State law, his/her professional scope of practice, Hospital policies and these Medical Staff's Bylaws, Rules and Regulations. All Hospital units have direct computerized Practitioner order entry (CPOE). Clinical Pathways, Department Order Sets, Doctors Personal Order Sets and Care Plans Order Sets have replaced traditional preprinted orders within the CPOE environment. During times that computer order entry is unavailable, orders shall be entered legibly, completely, clearly, signed, dated and timed on the Hospital's standard blank Physician Order Form. Order sets may be included in the CPOE system by submitting requests to the CPOE committee that is responsible for reviewing and implementing the addition, confirmation, or change of order sets in the electronic environment with the review, advise and approval of the relevant inpatient care committee, Hospital nursing and pharmacy leadership, and the Medical Executive Committee acting on behalf of the Medical Staff. Order sets within CPOE shall be reviewed by the foregoing committees and leadership within 12 to 24 months of the previous approval dates (and affirmed as being consistent with then current, nationally recognized and evidence-based guidelines), and submitted to the Medical Executive Committee for re-approval.

8.4.4 Stop-Orders. Stop-orders shall be applied to certain specified categories of drugs, and nursing service or pharmacy will notify attending physicians when such stop-orders have been applied.

8.4.5 Unusual Orders. When a nurse receives an order for a medication in unusual circumstances, or in dosage beyond that usually prescribed, or in excess of that listed in reference books or package inserts, he/she may verify the order with the Hospital pharmacist. If the Hospital pharmacist concurs with the Physician's order, then the dosage ordered should be given. If the Hospital pharmacist considers the order wrong in dosage, the attending Physician is notified of this opinion by the pharmacist. If the attending Physician does not change the order, then the nurse shall consult with the appropriate Professional Staff Chair who will then consult with the attending Physician, and a joint decision will be rendered. If necessary, the Chief of Staff shall be consulted and a final disposition made. If the nurse is unwilling to carry out the order for personal-professional-legal reasons, he/she shall refer the order to the appropriate Director of Nursing whereupon the order shall be carried out.

8.4.6 Order for Drugs. Unless otherwise specified in these Rules and Regulations, all orders for drugs must be patient-specific with well-defined parameters for administration, and authorized by the prescribing practitioner prior to implementation. The parameters to be used in prescribing drugs include: (1) description of the intended recipients, (2) drug name and strength, (3) specific instructions of how to administer the drug, (4) dosage, (5) frequency, and (6) a signature of the authorized prescribing practitioner.

SECTION 8.5 Records

8.5.1 Content, Review And Evaluation

8.5.1.1 Content: A medical record must be maintained for every individual evaluated or treated in the Hospital, both inpatient and outpatient. In general, a medical record must contain contemporaneously documented information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services. A complete inpatient medical record shall include identification data; complaints; history of present illness; relevant patient/family social-developmental history; relevant historical review of systems, relevant physical findings and examination; an osteopathic musculoskeletal examination of a patient (unless contraindicated) whose admitting Physician is an osteopathic physician; identification of problems and

needs; provisional admitting diagnosis; medication history and current medications including intended purpose; allergies; medical or surgical treatment; operative report; pathological findings; progress notes, including reassessments; multidisciplinary notes and flow sheets; medication administration records; special reports such as consultations, clinical laboratory, x-ray and others; complications; Hospital acquired infections; unfavorable reactions to drugs and anesthesia; final diagnosis; and a discharge summary, including a discharge diagnosis. Autopsy reports must be included in those cases in which an autopsy is performed. Physical examinations will include relevant body systems as indicated by the patient's medical histories including chief complaint; present illness; past, social and family history; and review of systems. Newborn care initial assessments, intervention and reassessments are defined as approved by the Medical Staff in relevant clinical departments, including the Department of Obstetrics and Gynecology. Routine screening preventative physical examinations such as breast exams, pelvic exams, rectal exams, neurologic exams and fundoscopic eye exams are encouraged but not required for a completed medical record, unless indicated by the patient's history. Symbols and abbreviations may be used only when such have been approved by the Medical Executive Committee. An official current record of approved symbols and abbreviations will be kept on file in the Health Information Management Department. Medical records must be completed within 21 days following discharge. No medical record shall be stored until it is complete except by instruction of the VPMA or other qualified designee as designated by the President/CEO upon consultation with the Chief of Staff. EPIC is the current integrated EMR software used by the Hospital that provides an accessible electronic backup for digital records.

8.5.1.2 Non-Medical Comments. Criticism, impertinent and inappropriate comments or language, or personal attacks against Staff members, Hospital personnel or the Hospital and its policies shall not appear in the medical record. Any questionable violation of this rule shall be referred to a committee consisting of the officers of the Professional Staff and the VPMA for interpretation, judgment, and action. If warranted, this committee shall refer the incident to the Staff Executive Committee for review and recommendation.

8.5.1.3 History and Physical. Each patient admitted for inpatient care shall have a complete medical history and physical examination (H&P) performed and documented no more than 30 days before or 24 hours

after admission (but prior to any surgery or procedure requiring anesthesia) by the attending Physician or other qualified licensed individual who has been granted such privileges by the Hospital in accordance with State law. Dentists, podiatrists and psychologists are responsible for the part of their patient's H&P that relates to their respective specialty. An H&P performed within thirty (30) days prior to admission must be updated and documented within 24 hours after admission (but prior to any surgery or procedure requiring anesthesia). The update should include a physical assessment after admission to update any components of the medical status that may have changed since the H&P was completed, and should address any areas where more current data is needed, and shall be attached to the H&P. If the Practitioner finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the Practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P and conduct and document in the medical record a new H&P within 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia. The H&P records, including update assessments and notes, are the responsibility of the attending Physician, and if they are written by a member of the housestaff or other licensed professional who requires a co-signature under Hospital Policy in accordance with State law, they shall be verified, signed, timed, and dated by the attending Physician in addition to being signed, timed, and dated by the individual preparing the record. The H&P requires review and a co-signature in all circumstances prior to the surgery or procedure when not completed by an MD/DO, and in all circumstances when not completed by an MD/DO. In the event that the H&P have been completed by a remote practitioner who has not been granted privileges at this Hospital, then such H&P must be reviewed and updated by a licensed Practitioner who is credentialed and privileged by the Hospital's Medical Staff to perform an H&P. An osteopathic musculoskeletal examination is required if the H&P is performed by osteopathic physicians unless such physician documents the reasons such is contraindicated.

8.5.1.4 Outpatient H&Ps or Notes Related to Type of Anesthesia. Outpatients undergoing surgery or procedures which require moderate conscious sedation or anesthesia also require an H&P to be performed and documented prior to such surgery/procedure, with the exception of cases using only local anesthesia without any pre-operative medication, and except in the case of emergencies. In cases which use only local anesthesia, an H&P is not required, but

a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary. Other pertinent positive findings, such as drug allergies and serious pre-existing disease entities should also be noted. For obstetric patients where the office prenatal record is forwarded to the labor and delivery department, an update at the time of admission shall serve in lieu of a full H&P.

8.5.1.5 Pre-Operative/Pre-procedure Record. Emergencies excepted, patients shall not be taken to the operating room/or procedure room unless the medical record contains a signed and witnessed consent form conforming to Hospital policy, preoperative/or procedure attestation statement and/or anesthesia/or conscious sedation attestation statement, plan of care for the surgery/procedure and anesthesia, a current H&P, and a pre-anesthesia evaluation completed and documented within 48 hours prior to a surgery/procedure using general, regional or monitored anesthesia by a licensed and qualified individual who is privileged to administer anesthesia under Hospital Policy and State law who wishes to institute them within the timeframe established by Staff policy and used only when a printed copy of such orders is affixed or otherwise electronically attached to the patient's record and each page of a preprinted order is signed, dated and timed by the ordering Physician. The pre-anesthesia evaluation shall include a notation of anesthesia risk, a history of anesthesia, drug allergies, potential anesthesia problems, and the patient's condition prior to induction of anesthesia. In emergency conditions, an acceptable H&P for preoperative purposes may be limited to major significant conditions requiring immediate surgery. Operating/procedure time may be forfeited on the authority of the operating/procedure room committee as outlined in the operating/procedure room policy, when the starting of the operation/procedure is delayed for more than fifteen (15) minutes.

8.5.1.6 Pre-Operative Attestation Informed Consent. To assist the patient in providing informed consent, the privileged Professional Staff individual performing surgery or procedures shall provide a plan of care for the patient including informing the patient and/or appropriate legal surrogates regarding the need for, benefits, alternative options, risks and potential complications associated with the surgery procedure.

To assist the patient in providing informed consent, the Professional Staff member responsible for managing the patient's care, treatment and services (or qualified designee) shall inform the patient and/or appropriate legal representative(s) regarding the need for, benefits, alternative options, risks, and potential complications associated with the proposed treatment, care and services, including those as related to any blood transfusion when blood or blood components may be needed associated with an operative procedure, as applicable.

To assist the patient in providing informed consent, the Practitioner or CRNA privileged to provide anesthesia or conscious sedation shall provide an anesthesia or conscious sedation plan of care, including informing the patient and/or appropriate legal representative(s) of the need for, benefits, alternative options, risks, and potential complications associated with anesthesia or conscious sedation prior to administration of pre-operative medication. A pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services. An intra-operative anesthesia record shall be maintained.

Plans of care for surgery or procedures, anesthesia/conscious sedation and blood use, including the need for, benefits, alternative options, risk, and potential complications shall be attested to, dated and timed by the Physician in the medical record, either on the consent form, history and physical, anesthesia record and/or in the Physician progress notes except in an emergency situation where informed consent cannot be given. A properly executed Informed Consent Form must be in the patient's chart prior to any procedure (except in emergencies) in accordance with the Hospital's Informed Consent Policy. Informed consents must include not only the name of the primary Practitioner performing the procedure, but also the names of practitioners performing significant surgical tasks such as opening, closing, harvesting grafts, dissecting or removing or altering tissue, implanting devices, etc. The Informed Consent Form must include the time it is signed by the patient or the patient's legal representative.

8.5.1.7 Surgical Record. All operations or procedures performed in the Hospital shall be described in full through immediate dictation, handwritten report, or electronic entry in accordance with current Hospital policy and practice, and shall include the following:

(i) the name and Hospital identification number of the patient

(ii) the date/time of surgery

(iii) the name(s) of the licensed independent practitioner(s) who performed the procedure and who administered anesthesia and his or her assistant(s) (even when performing those tasks under supervision)

(iv) the name of the procedure, techniques used and patient position

(v) findings of the procedure (including complications, if any)

(vi) a description of the procedure/techniques (including the type of drugs and anesthesia administered, the dosage, route and time)

(vii) name and amounts of fluids

(viii) any estimated blood loss

(ix) any specimens/tissues removed or altered

(x) pre-operative diagnosis

(xi) the postoperative diagnosis

(xii) description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include prosthetic devices, grafts, tissues, transplants, or devices implanted, if any

(xiii) complications, adverse reactions, or problems occurring during surgery or anesthesia, as well as treatments rendered with patient response

When a hard copy of the operative report is not placed in the medical record immediately after surgery or the procedure, a progress note of the operation or procedure is entered immediately. All tissues and foreign material surgically removed, unless specifically excluded by the Staff Executive Committee, shall be sent to the Hospital pathologist who shall make such examination as he/she shall consider necessary to arrive at a pathological diagnosis and he/she

shall issue a signed report which shall become a permanent part of the patient's record.

8.5.1.8 Post-Anesthesia Evaluation. Moderate and conscious sedation excepted, within 48 hours after surgery or a procedure requiring anesthesia services (according to individual patient factors), a post-anesthesia evaluation must be completed and documented by a licensed individual who is qualified to administer anesthesia under State law and Hospital policy evidencing procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care. The evaluation is required any time general, regional or monitored anesthesia has been administered to the patient. At a minimum, the post-anesthesia evaluation shall include monitoring/assessment of: respiratory function (including respiratory rate, airway patency and oxygen saturation); cardiovascular function (including pulse rate and blood pressure); mental status; temperature; pain; nausea and vomiting; and postoperative hydration. Depending on the surgery/procedure, additional or differing types of monitoring and assessment may be necessary. The calculation of the 48-hour time frame begins at the point the patient is moved into the designated recovery area.

8.5.1.9 Discharge Summary:

(i) Patients shall be discharged or transferred only on the order of the attending MD/DO or other qualified Practitioner with admitting privileges or other qualified healthcare personnel to whom the MD/DO has delegated the writing of the discharge summary (to the extent recognized under State law and regulations and Hospital and Medical Staff policy). To facilitate continuity of care, a discharge summary containing at a minimum the reasons for and outcome of the hospitalization; the case disposition, including significant findings; procedures performed and treatments rendered; the resolution of the admitting diagnosis and chief complaint; course of the facility stay; interventions and results; consultations; complications and their management; difficulties in establishing the diagnosis and treatment plan; the patient's final diagnosis and condition at discharge; and instructions to the patient and/or appropriate legal representative(s) regarding follow-up care and pain management will be included in a completed medical record. The discharge summary must be completed within the time

frame specified by law and accrediting standards (currently, within seven days of discharge), with any pending tests/diagnostics so noted. For normal newborns, uncomplicated deliveries, or patients whose admitted Hospital stay is less than forty-eight (48) hours with uncomplicated care, a discharge progress note, which includes the outcome of hospitalization, the patient's condition at discharge/disposition of the case, discharge instructions, and provisions for follow up care, may be substituted for a discharge summary. A discharge progress note may also be used to satisfy the discharge summary requirements for the initial hospitalization when a patient is transferred to another KHN facility. For patients with outpatient surgery or procedures and observation stay patients, a progress note is required. The attending Physician will be responsible for the discharge summary. In the event of death, in addition to the discharge summary, there shall be a final progress note covering end of life decisions, if any, pronouncement of death, potential harvesting of organs/tissues, a determination of the death not meeting criteria to be considered a coroner's case, and the disposition of the body.

(ii) The discharge summary is to include the future care of the patient, including nutrition, medication, activity, referrals, pain management, and other appointments as appropriate.

(iii) The attending Physician shall be primarily responsible for completion of the medical record including the discharge summary, which entries must all be authenticated, dated and timed. If the discharge summary is written by other than the responsible Physician, the Physician responsible for the patient must co-authenticate and date the discharge summary to verify its content.

8.5.1.10 Completion of Records - Requirements

(i) History and physical, discharge summary, consultation and operative/procedure notes, orders, requisitions for tests and diagnostic reports shall be authenticated with a handwritten or electronic signature. Rubber stamp signatures are not acceptable for authentication.

(ii) Charts must be complete within twenty-one (21) days of discharge. Charts are complete only after dictated reports are

authenticated; merely dictating before the deadline is not sufficient.

(iii) The elective and emergency admitting privileges of a person holding a current Professional Staff appointment shall be automatically suspended upon written notification sent by registered mail for failure to complete medical records within thirty (30) days of discharge; provided that the VPMA or Chief of Staff, or their designee may excuse them if their medical records remain incomplete beyond the twenty-one (21) day period because of extenuating circumstances. Extenuating circumstances shall include, but not be limited to, illness, system or electronic failure.

(iv) Suspension of admitting privileges does not in any way affect physicians' responsibilities for patients already under their care in the Hospital.

(v) Any physician whose admitting privileges have been suspended because of incomplete or delinquent records, or portions thereof, may in the event of unusual or extenuating circumstances obtain authority to admit a specific patient from The VPMA or the Chief of Staff, or their designee. The physician so authorized to approve a specific admission shall personally notify the admissions office of his/her decision prior to the admission of the patient.

(vi) A physician who has received two (2) temporary suspension letters during any one calendar year and who again has become delinquent will receive a suspension of privileges letter sent by registered mail from the Chief of Staff or the VPMA. Privileges will automatically be suspended and the Physician will have to present himself/herself before the Staff Executive Committee at its next regularly scheduled meeting. When a physician's privileges are suspended, he/she will be unable to admit patients to the Hospital or schedule surgery until the Staff Executive Committee lifts the suspension. Suspension of admitting privileges under this subsection does not in any way affect physicians' responsibilities for patients already under their care in the Hospital. On an emergency basis the VPMA (or President or designee) may temporarily restore the suspended physician's privileges.

8.5.1.11 Ownership. All records, including original medical images, are the property of the Hospital. Copies of the medical record may be removed from the Hospital's jurisdiction and safekeeping only in accordance with patient authorization, a court order/subpoena signed by a judge, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending Practitioner, whether the patient is being attended by the same Practitioner or another.

8.5.1.12 Access to Medical Records. Access to all medical records of all patients shall be afforded to Staff physicians in good standing for bona fide study and research (with appropriate IRB overview and authority), consistent with preserving of confidentiality of personal health information concerning individual patients in compliance with State and federal law. Upon approval of the Hospital President, in accordance with Hospital policy, former members of the Professional Staff may be permitted access to information from the medical records of their patients covering all periods in which they attended such patients in the Hospital. Review of medical records is limited to Hospital professionals who are responsible for providing care to the patient, or as assigned to that patient such as a student. Also, for peer review and utilization review functions, Practitioners may review any chart assigned for review. Physicians on the Professional Staff who have the permission of the attending Physician and patient or patient's legal representative may review that patient's medical record. Physicians not on the Professional Staff, in the presence of the attending Physician or his/her physician designee, and with permission of patient or patient's legal representative, may review that patient's medical record of a currently hospitalized patient.

SECTION 8.6 Medical Consultation (03.01.23)

8.6.1 General. The responsibility for patient care rests with the attending Physician who is responsible for requesting medical consultations and documenting the indication for the consult. Medical consultation is recommended when there is a reasonable doubt as to the diagnosis and/or treatment. The patient's medical record shall include the reason the medical consultation was sought and provide sufficient information as is readily available to facilitate the consultation.

8.6.2 Response Time. Professional Staff members are expected to respond to requests for medical consultations in a timely fashion that meets patient care demands and the need for appropriate utilization of services. The Professional Staff member requesting medical consultation will be

responsible to provide appropriate clinical information and "time-to-respond" expectations on the order sheet. Guidelines for "time-to-respond" expectations are as follows:

8.6.2.1 Emergency Medical Consultations. The least amount of time as required by accrediting standards or State law, but not more than 30-60 minutes (e.g., immediate threat to life, limb or body organ). For the purpose of this section, an "emergency" medical condition is a condition manifesting itself by acute symptoms of sufficient severity which one could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

8.6.2.2 Urgent Medical Consultations. 4 hours (impending threat to life, limb or body organ).

8.6.2.3 Routine Medical Consultations. 24 hours.

Physician to physician contact is the preferred way of initiating these medical consultations, but is required for emergent and urgent consultations.

8.6.3 Required Consultations. Medical consultation with other members of the Active Staff, Active Affiliate Staff, Associate Active Staff, and the Consulting Staff shall be sought as appropriate. Medical consultation is required when the patient needs care which is beyond the attending Physician's scope of Professional Staff approved privileges. Except in emergencies, consultations are required on critically ill patients, patients who are poor surgical risks and those having diagnoses that are difficult or obscure. Consultation with a Practitioner in the Department of Obstetrics and Gynecology is required when a known pregnant woman is admitted to other than the Departments of Family Medicine or Obstetrics and Gynecology. A preoperative consultation with such Department Practitioner is also required when an inpatient or outpatient operative or other interventional procedure requiring moderate or deep sedation or anesthesia is planned for a known pregnant woman. This consultation should be requested at the time of surgical scheduling. In cases of financial hardship, consultation shall be furnished free of charge by the member of the Active Staff whenever such consultations are required solely to comply with rules, regulations, ordinances, or statutes. All records must document the results of all consultative evaluations and appropriate findings by clinical and other staff involved in the care of the patient.

8.6.4 Undesirable or Unnecessary Consultations. Notwithstanding the foregoing subsections, if circumstances are such as to render medical consultation undesirable or unnecessary, then medical consultation shall not be performed and the reasons thereof shall be communicated to the requesting Physician and shall be entered in the progress notes of the clinical record.

8.6.5 Substance Abuse Consultation. Hospital patients with substance abuse medical problems requiring medical consultation may be referred to a Professional Staff member with substance abuse privileges or referred to an external community based substance abuse service.

8.6.6 Second Opinions: If the attending Physician and the consultant disagree on the management of a patient, then a second medical consultation shall be ordered.

8.6.7 Categories of Consultant's Involvement: The attending Physician shall document the expectations of the consultation.

8.6.7.1 Consultation only which leaves management to the attending Physician and prohibits consultants from writing orders on the chart.

8.6.7.2 Consultation and management of a specific entity or procedure in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending Physician.

8.6.7.3 Participation in management which permits the attending Physician and the named physician to write orders, however, overall chart responsibility remains with the attending Physician.

8.6.7.4 Consultation and management where the consultant assumes full responsibility for writing orders and management of the patient and the admitting Physician may no longer write orders.

8.6.7.5 Management is transferred to another named physician in which case patient care responsibilities in the Hospital are transferred to the named physician and the admitting Physician may no longer write orders.

8.6.8 Consultant's Report: A satisfactory consultation includes examination of the patient, review of the chart, and a written report of the findings and recommendations signed, dated, and timed by the consultant which is made a part of the record. Pre-surgical consultation reports, at least in brief form, shall be recorded prior to the operation.

8.6.9 Urgent Consultation: In circumstances of grave urgency or when consultation is required by rules of the Hospital, the VPMA, Hospital President and/or designee shall at all times have the right to call in a consultant after conference with the Chief of Staff or an available member of the Medical Executive Committee.

8.6.10 Specifics:

8.6.10.1 Sterilization for Patients of Majority Age (18)

May be performed at the request of the patient with a signed consent. When possible, the signed consent of the spouse is desirable but not required. No medical consultation is required.

8.6.10.2 For Mentally Incompetent Patients and/or Minors

For mentally incompetent patients and/or minors, a sterilization procedure shall be performed only upon court order signed by a judge.

8.6.10.3 Therapeutic Abortions

(i) Any Practitioner wanting to perform a therapeutic abortion at the Hospital must follow the KHN Organization-Wide Policy regarding "Induced Pregnancy Termination" which establishes guidelines and parameters for abortions that are in compliance with State law, established medical science, and the religious heritage of the Seventh-Day Adventist Church. Ohio law does not require any hospital or any person to participate in an abortion, and hospitals and persons refusing to participate are free from liability. Any Practitioner who objects to abortion based upon moral or religious grounds may not be compelled to participate in such a procedure, nor can his/her refusal to participate be grounds for disciplinary action. Written informed consents and the procedure and performance of any therapeutic abortion at the Hospital shall be in compliance with current State law and the above-referenced Hospital Policy.

(ii) When a patient is admitted in a condition of abortion, she or her legal representative shall sign a statement certifying that neither any employee of the Hospital nor the attending Physician was directly or indirectly responsible for its production. Cases of suspected criminal abortion shall be

reported to the VPMA (or other designee as appointed by the President/CEO) and the coroner.

8.6.10.4 Reporting Suspected Abuse/Neglect

The Medical Staff shall comply with legal requirements to identify and report to the appropriate State agency and/or authority any known or suspected child abuse or neglect; or known or suspected abuse, neglect or exploitation of elderly patients (60 years or older).

SECTION 8.7 Discharge

Patients shall be discharged only on order of the attending Physician or designated alternate. To the extent possible, at the time of discharge, the attending Physician (or designee) shall take appropriate action to resolve all active orders, see that the record is complete, state the final diagnosis and authenticate the record. A concise discharge summary must be completed within 7 days of patient discharge for continuity of care. All tests/diagnostics pending at the time of discharge may be noted as such in the discharge summary. As new results are obtained relating to the inpatient stay, the record may be amended by the discharging Practitioner.

SECTION 8.8 Rape Examinations

Rape examination is a formal legal collection of evidence when the allegation of sexual assault has occurred. Emergency Department Physicians and nurses are specifically trained in this procedure. Patients presenting to the Emergency Department from the outpatient environment or the inpatient setting with a request for rape examination will be evaluated, evidence collected and medical treatment offered as dictated in the ED Policy Manual, as such manual may be amended from time to time. If a Sexual Assault Nurse Examiner ("SANE") professional is available, the evidence collection and exam may be deferred to that person. Medical treatment of injury or infection is addressed by the ED Physician or may be assumed by the patient's private Physician in attendance at the time of the evaluation.

SECTION 8.9 Basic Rules For The Use Of Hospital Facilities

The exercise of Privileges are contingent upon the Practitioner's abiding by the Medical Staff Bylaws, and other related Manuals, all applicable policies, and compliance with accreditation and regulatory requirements. Failure to do so may subject the Practitioner to corrective action in accordance with the process set forth in the Medical Staff Bylaws and other related Manuals.

(a) A physician to be in charge of an area (director) shall be recommended by the Hospital President in consultation with the Chief of Staff, and report to the appropriate vice president.

(b) The director (with committee approval and in conjunction with Hospital administration) shall establish the necessary rules for scheduling and use of the facility.

(c) Each physician requesting privileges or any current physician who may desire to perform these procedures shall demonstrate to the director his/her knowledge of the use of the Hospital equipment and his/her understanding of the use of the facility. In the event that the director is not satisfied with applicant's knowledge and skills, he/she shall report these findings to the Chief of Staff and defer the use of the facility.

(d) All privileges will be given on the understanding that failure to abide by the basic rules for the scheduling and use of the room or complications beyond those normally expected shall be cause for the loss of privileges. The physician director shall call these matters to the attention of the Chief of Staff who shall take such action as he/she feels necessary, including immediate suspension, if appropriate. The Staff Executive Committee will consider the action of the Chief of Staff at its next meeting and make recommendations in the established routine.

SECTION 8.10 Autopsy (03.02.01)

(a) The attending Physician should attempt to obtain permission for an autopsy in hospitalized cases where it is felt to be medically indicated or to satisfy family concerns, and in all cases of unusual deaths and of medical/legal and educational interest (after determining whether the death is reportable to the Coroner and falls under the Coroner's jurisdiction (see Section 12 of these Rules and Regulations regarding "Pronouncement of Death"). Examples of deaths with medical/legal implication may include the following:

(i) dead on arrival to the emergency room or dying in the emergency room, without previous diagnosis or before definitive diagnosis could be made;

(ii) trauma – internal;

(iii) any case where there is medical/legal necessity;

(iv) maternal deaths;

(v) cause of death not related to treatment;

(vi) occult hemorrhage;

(vii) pneumonia – no microbiological diagnosis;

(viii) systemic infection – no microbiologic diagnosis;

(ix) sudden infant death;

(x) pediatric deaths; and

(xi) perinatal deaths.

This Hospital does not perform autopsies on site, and any required autopsies must be contracted to another hospital. Certain cases fall under the jurisdiction of the coroner including: 1) deaths within twenty-four (24) hours of anesthesia, 2) deaths within twenty-four (24) hours of admission to the Hospital, and 3) deaths under unusual circumstances (Also see enhanced list at Section 12 herein regarding "Pronouncement of Death"). If there is any question whether or not the case falls within the coroner's jurisdiction, the coroner's office should be contacted for an opinion.

(b) No autopsy shall be performed without consent of the legally authorized individual. Generally, such permission should be in writing. However, consent may be obtained by recorded and witnessed telephone authorization. Autopsies performed by the coroner do not require any type of authorization, written or otherwise. Documentation of the request for autopsy and response should be documented in the progress notes.

(c) The Department of Pathology reserves the right to determine which infectious or presumptively infectious cases will have autopsies performed.

(d) When an autopsy is performed, the preliminary impression of the cause of death should be recorded in the medical record within three (3) days of receipt of results, with the final report to be completed and included in the medical record within sixty (60) days, except for valid delays due to forensic considerations. In the event the final diagnosis is not in accord with the final autopsy report, disagreement or correction of the final diagnosis shall be added to the progress report.

SECTION 8.11 Guidelines For Determining Brain Death In Adults

8.11.1 Definition of Death: An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or

irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards, a determination that death has occurred is made by a Physician by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred. (ORC 2108.40)

(a) Cardiorespiratory: Irreversible cessation of cardiac, circulatory, and respiratory function in the absence of artificial means of cardiopulmonary support.

(b) Brain Death: Irreversible cessation of all functions of the entire brain (cerebral hemispheres and brain stem) in the presence of artificial means of cardiopulmonary support.

(c) Determination of whole brain death in patient with ventilator support and continuing cardiac function: 3 cardinal findings (must be present):

(d) Absence of cortical function: Deep coma and unresponsiveness: no motor response to the most intensely painful stimuli in all extremities (nailbed and supraorbital pressure). Peripheral nervous system activity and spinal cord reflexes may persist after death.

(e) Absence of brainstem reflexes

(i) Pupils

a) No pupillary response to bright light in either eye

b) Size: midposition (4 mm) to dilated (9 mm)

(ii) Ocular movement

a) No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)

b) No oculovestibular reflex – no deviation of the eyes upon irrigation in each ear with 50 ml of ice water (allow 1 minute of observation after injection and at least 5 minutes between testing on each side) after patency of the external canal is confirmed.

(iii) Facial sensation and facial motor response

a) No corneal reflex to touch with a throat swab

b) No jaw reflex

c) No grimacing or facial muscle movement to deep pressure on nailbed, supraorbital ridge, or temporo-mandibular joint

(iv) Pharyngeal and tracheal reflexes

a) No response after stimulation of the posterior pharynx with tongue blade

b) No cough response to bronchial suctioning (catheter advanced to the level of carina followed by one or two suctioning passes).

(e) Apnea-testing performed as follows:

(i) Prerequisites

a) Core temperature >36.5° C or 97° F

b) Systolic blood pressure >90 mm Hg

c) Euvolemia. Option: positive fluid balance in the previous 6 hours

d) Normal PCO2 Option: arterial PCO2 >40 mm Hg (check just before ventilator stopped)

e) Normal PO2 Option: preoxygenation to obtain arterial PO2 >200 mm Hg

f) Connect a pulse oximeter and disconnect the ventilator.

g) Deliver 100% O2, 6 1/min via E.T., into the trachea. Option: place a cannula at the level of the carina.

h) Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).

i) Measure arterial PO2, PCO2, and pH after approximately 8 minutes and reconnect the ventilator.

(ii) If respiratory movements are absent and arterial PCO2 is >60 mm Hg (option: 20 mm Hg increase in PCO2 over a baseline normal PCO2), the apnea test result is positive (i.e., it supports the diagnosis of brain death).

(iii) If respiratory movements are observed, the apnea test results is negative (i.e., it does not support the clinical diagnosis of brain death) and the test should be repeated.

(iv) Connect the ventilator if, during testing, the systolic blood pressure become >90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If PCO2 is >60 mm Hg or PCO2 increase is >20 mm Hg over baseline normal PCO2, the apnea test result is positive (it supports the clinical diagnosis of brain death); if PCO2 is <60 mm Hg or PCO2 increase is <20 mm Hg over baseline normal PCO2, the result is indeterminate, and an additional confirmatory test can be considered.

(f) Irreversibility Determination

(i) Cause of coma is established clinically or by neuro-imaging and is sufficient to account for the irreversible loss of brain function.

(ii) The possibility of recovery is excluded:

a) No drug toxicity: no sedative, no anesthetic, or no neuromuscular blocking agents; no poisoning.

b) No hypothermia below 32.2° C (90°)

c) No shock

d) No severe electrolyte, acid-base or endocrine disturbances.

(iii) Persistent cessation of all brain function for a period of at least 12 hours.

(g) Confirmatory laboratory tests which may be used:

(i) Repeat clinical examination in 6 hours.

(ii) EEG: One EEG recording showing electrocerebral silence done in accordance with the standards of the American EEG Society Guidelines at least 12 hours after persistence of the clinical criteria outlined above.

(iii) Conventional 4 vessel angiography: no intracerebral filling at carotid bifurcation or circle of Willis (external carotid circulation is patent).

(iv) Somatosensory evoked potentials of median nerve: absent N20-P23.

(v) Brain stem auditory evoked potentials: absent except for wave.

(vi) Isotope angiography with Tc-99m HMPAO: no brain uptake.

(vii) Transcranial doppler ultrasonography: very high vascular resistance associated with increased intracranial pressure, produces early small systolic peaks without diastolic flow or reverberating flow.

(h) Medical record documentation:

(i) Etiology and irreversibility of condition

(ii) Absence of brain stem reflexes

(iii) Absence of motor responses to pain

(iv) Absence of respiration with apnea test

(v) Confirmatory test justification and results

(vi) Repeat neurologic exam 6 hours after first diagnosis of brain death.

SECTION 8.12 Pronouncement Of Death

Only licensed Physicians or individuals holding a current training certificate issued under ORC 4731.291 may pronounce a patient dead. Temporary certificate holders are not

qualified to pronounce death. The Physician need not personally examine the body. A resident, nurse, physician assistant or other competent observer as defined by Ohio law (OAC 4731-14(D)) may report findings on the telephone and the Physician makes the death pronouncement. The Physician pronouncing the patient is responsible for completing the Death/Autopsy form on all deaths. The death certificate must be signed by the attending, fully-licensed Physician or coroner within 48 hours after death. The following deaths require reporting to the Office of the Coroner: accidental deaths - falls, blunt force or mechanical injury, cuttings/stabbings, explosions, firearms, asphyxiation, vehicular accidents, weather-related deaths, actual or suspected drug overdose, burns, electrocutions, stillborn or newborn infant death with a recent or past trauma involving the mother that may have precipitated the death or had a detrimental effect to the newborn; homicides (by any known or suspected means); suicides (by any known or suspected means); sudden deaths; deaths under unknown circumstances; occupational deaths; confinement deaths (jail or custody); therapeutic deaths: anesthesia induction or post-anesthesia; during or following diagnostic or therapeutic procedures, due to administration of drug, vaccine or other substance; deaths involving allegations of "medical malpractice"; abortion-related death; delayed death (past traffic or industrial accidents with debilitating injuries, hip fractures in the elderly resulting in a downward medical condition following the injury, etc.); death about which there is doubt/question suspicion; any unattended death at home or in a public or outdoor place. Only the coroner can legally sign the death certificate of a person who has died as a direct or indirect result of any reportable cause.

SECTION 8.13 Access To Personal File

All Medical Staff peer review records (including those of Allied Health Professionals) are confidential, including but not limited to the credentialing files and anything used in the credentialing process, committees, Departments/Sections, and Medical Staff meeting minutes, reports and discussions and deliberations concerning this information. Such information shall be disclosed only to those persons and only for the purposes listed in policies concerning the confidentiality and sharing of Medical Staff/AHP peer review records. Confidentiality must be maintained for subsequent use of the information, and is the responsibility of the person requesting the information and anyone receiving the information.

SECTION 8.14 Conduct

Unprofessional and unethical conduct and the violation of these Rules and Regulations, or those of the Hospital shall constitute cause for summary suspension of privileges in this Hospital.

SECTION 8.15 Disruptive Physician Three-Step Policy

8.15.1 Policy Statement:

This policy emphasizes the need for all individuals working in the Hospital to treat others with respect, courtesy and dignity and to conduct themselves in a professional and cooperative manner. This policy is intended to address conduct which does not meet that standard. In dealing with incidents of inappropriate conduct, the protection of patients, employees, Physicians, and others in the Hospital, and the orderly operation of the Hospital are paramount concerns. This policy applies to members of the Medical Staff and to Allied Health Professionals.

For purposes of this policy, "inappropriate conduct" includes, but is not limited to those behaviors which create a hostile work environment and is regularly upsetting to Hospital staff, other physicians, visitors and patients. Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats as well as passive activities, such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, phone calls or pages; condescending language or voice intonation; and impatience with questions.

Employees who engage in inappropriate conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Members of the Medical Staff and Allied Health Professional Staff (defined as "practitioners" for purposes of this policy) who engage in inappropriate conduct will be dealt with in accordance with this policy. Conduct that may constitute sexual harassment shall be addressed pursuant to the Hospital's Sexual Harassment Policy.

In the event of any apparent or actual conflict between this policy and the Bylaws, Rules, Regulations or other governing documents or policies of the Hospital or Medical Staff, the provisions of this policy shall control.

This policy outlines collegial steps (i.e., several warnings and meetings with a practitioner) that can be taken in an attempt to resolve complaints dealing with the subject matter of this policy. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this policy precludes immediate referral to the Medical Executive Committee (or the Board) or the elimination of any particular step in the policy in dealing with complaints regarding the subject matter of this policy.

Retaliation against any person reporting an incidence of inappropriate conduct will be grounds for immediate exclusion from all Hospital facilities.

8.15.2 Procedure:

(a) Nurses and other Hospital employees who observe, or are subjected to inappropriate conduct by a practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the VPMA, Chief of Staff, or the President (or designee). Any Physician who observes such behavior shall notify the President, Chief of Staff or VPMA directly. Upon learning of the occurrence of an incident of inappropriate conduct, the aforenamed recipient shall request that the individual who reported the incident document it in writing. In the alternative, such recipient shall document the incident as reported, including:

(i) the date and time of the questionable behavior;

(ii) a factual description of the questionable behavior;

(iii) the name of any patient or patient's family member who witnessed the incident;

(iv) the circumstances which precipitated the incident;

(v) the names of other witnesses to the incident;

(vi) consequences, if any, of the inappropriate conduct as it relates to the patient care, personnel, or Hospital operations; and

(vii) any action taken to intervene in, or remedy, the incident.

(b) Supervisors shall forward a documented report to the President (or designee) or VPMA, who shall immediately notify the President. The President, VPMA and/or Chief of Staff shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident. After a determination that an incident of inappropriate conduct has occurred, the President, VPMA and/or Chief of Staff shall proceed as set forth below in the 3-step policy.

SECTION 8.16 Disruptive Physician Three-Step Policy:

(a) On the first alleged offense regarding a Physician's disruptive behavior as outlined in the Hospital Bylaws, the VPMA or President (or the President's designee) and Chief of Staff will be informed of the allegations. A conference will occur between the VPMA or President (or the President's designee) and the Chief of Staff at which time a decision will be made as to whether: (a) the case warrants investigation, or (b) the case should be dismissed. Should both individuals agree the allegation merits investigation, the VPMA or President (or the President's designee) shall obtain from the parties directly involved a written synopsis of the disruptive behavior to substantiate the claim outlining when, where, and under what circumstances this event occurred. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the physician involved will be requested to attend a meeting held by the VPMA or President (or the President's designee), Chief of Staff, and Department Chairman at which point these allegations will be brought to the Physician's attention. Upon conclusion of this meeting the VPMA, or President (or the President's designee) Chief of Staff, Department Chairman and the Physician involved will decide if a 28-day observation period to include a follow-up meeting with the VPMA or President (or the President's designee) and Chief of Staff to monitor and discuss the Physician's behavior, and a formal letter outlining the offense should be placed in their administrative file. The matter can then be considered resolved upon satisfactory completion of the observation period. If the Physician involved feels this resolution to be unsatisfactory, this individual can request a hearing at the next Medical Executive Committee meeting and present the case where the Medical Executive Committee will be the final determining body. Should the Medical Executive Committee, at that point, feel that the problem warrants a 28-day observation period and a formal letter placed in their file, this will be undertaken. If the Medical Executive Committee determines it is undeserving, no action will be taken and the matter will be considered resolved.

(b) Should a second disruptive offense occur by the same Physician during a three-year period, the VPMA or President (or the President's designee) and Chief of Staff will be informed of the allegations. A written synopsis shall again be obtained from the parties directly involved with the disruptive behavior. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the Physician involved will be requested to attend a meeting held by the VPMA or President (or the President's designee), Chief of Staff, and Department Chairman at which point these allegations will be brought to the Physician's attention. Upon conclusion of this meeting

the VPMA or President (or the President's designee), Chief of Staff, Department Chairman and the Physician involved will decide if a 28-day observation period to include a follow-up meeting with the VPMA or President (or the President's designee) and Chief of Staff to monitor and discuss the Physician's behavior, and a second formal letter outlining the offense should be placed in their administrative file. If the Physician involved feels this resolution to be unsatisfactory, this individual can request a hearing at the next Medical Executive Committee meeting and present the case where the Medical Executive Committee will be the final determining body. Should the Medical Executive Committee feel that the problem warrants a 28-day observation period and a second formal letter placed in their file, this will be undertaken. If the Medical Executive Committee determines it is undeserving, no action will be taken and the matter will be considered resolved.

(c) Should a third disruptive offense by the same Physician during a three-year period be brought to the attention of the VPMA and/or the Chief of Staff, the Physician involved will be asked to report directly to the next Medical Executive Committee meeting for a presentation of the facts from the written synopsis of all three events with the Physician involved relating his/her account of the events. A decision will then be made by the Medical Executive Committee as to whether: (a) any action is warranted, or (b) if the action warranted should be educational in nature, involve counseling, or result in suspension of privileges. If the Physician involved successfully completes any program as outlined by the Medical Executive Committee per the Chairman, the matter will be considered resolved. If the Physician does not complete such program to the satisfaction of the Medical Executive Committee per the Chairman, a continuation of education, counseling and/or suspension can proceed. Lastly, it should be noted that at the end of three years, if there has been no action or complaints regarding the Physician, the administrative file of such Physician is to be purged.

SECTION 8.17 Referral to the Board

The Medical Staff Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including any hearing or appeal, shall then be conducted under the direction of the Board.

SECTION 8.18 Exclusion from Hospital Facilities

When, despite prior warning, the practitioner continues to engage in inappropriate conduct, the practitioner may be excluded from the Hospital's facilities pending the formal investigation process pursuant to the Medical Staff Bylaws and any related hearing and appeal that may result. Such exclusion is not a suspension of clinical privileges, even

though the effect is the same. Rather, the action is taken to protect patients, employees, physicians and others on the Hospital's premises from inappropriate conduct and to emphasize to the practitioner the most serious nature of the problem created by such conduct. Before any such exclusion, the practitioner shall be notified of the event or events precipitating the exclusion and shall be given an opportunity to respond in writing and to demonstrate that acceptable standards of conduct have not been violated. However, to ensure that there is not inappropriate delay in addressing the concerns, the practitioner must submit any response within three (3) days of being notified.

SECTION 8.19 Legal Counsel

In order to effectuate the objectives of this policy, and except as otherwise may be determined by the Chief of Staff and the President, legal counsel shall not attend any of the meetings described above.

SECTION 8.20 Medical Staff Disaster Assignments

In the event of a disaster, Physicians should report to the command post at the Hospital. The Physician in charge, according to the Hospital's disaster plan, will make appropriate assignments. In case of a major disaster involving multiple hospitals, the Physician should report, as assigned, to the command post of a hospital at which he/she has privileges.

SECTION 8.21 Professional Liability Action

Each individual with clinical privileges at the Hospital will notify the Medical Staff Services Office within thirty (30) days of a final settlement or judgment of a professional liability action. It is recommended that individuals with clinical privileges notify the risk management office of the Hospital if they are aware that a professional liability action involving the Hospital has been filed or is likely to be filed.

SECTION 8.22 Residents, Interns And Medical Students

Residents, interns and medical students will be supervised for all clinical activities by a Physician with privileges at the Hospital, according to Hospital policies (including the Hospital's Housestaff Policy Manual) and applicable State law.

SECTION 8.23 Contracted Sources Of Physician Care

The Medical Executive Committee, in cooperation with the QAPI Committee, will review contracted arrangements that provide patient care by independent contract physicians or physician groups. All Practitioners who will be providing patient care, treatment and services shall have appropriate Privileges. Written agreements will specify that the contracted organization will ensure that all contracted services provided by the

Practitioners will be within the scope of their privilege, will be provided in a timely manner, and will include the expectation that consistent performance of patient care processes must be provided according to appropriate accreditation and regulatory standards.

SECTION 8.24 House Staff

House Staff Fellow Physicians (MD or DO) who are members of a Hospital or affiliated postdoctoral education program approved by the ACGME or AOA, will be supervised for all clinical activities by a Physician with Privileges at the Hospital, according to Hospital policies, including the Hospital's House Staff Policy Manual. Hospital affiliated House Staff educational program policies regarding supervision must be consistent with the Hospital's House Staff Policy Manual. House Staff with an unrestricted State Medical Board of Ohio license may provide direct inpatient and/or outpatient medical care within the scope of their licensure with appropriate supervision.

The supervising Physician is responsible for fostering an environment in which House Staff members under their supervision acquire the requisite skill and training to practice within a specialty. Concurrently, the supervising Physician has the responsibility for assuring that there is no difference or adverse variation in the quality of care provided when a House Staff member treats a patient.

The supervising Physician's name will be documented on all patients' medical records whose care is provided as a part of a post-graduate training program. Delegated clinical responsibilities are defined in the House Staff Policy Manual for all levels of post-graduate training and are based on a system of graded authority which includes direct observation and knowledge of the House Staff member's education, experience, skills and abilities.

Documentation in the medical record by a House Staff member and supervising Physician is confirmation that supervision has taken place. When House Staff members episodically see patients which are not assigned to a teaching panel, the patient's attending Physician, after being notified by the House Staff member, assumes the responsibility for supervision.

The supervising Physician will countersign the following documents: the history and physical, the discharge summary, the operative/ high risk procedure report, and the consultation report. The supervising Physician will also be responsible for completing the medical record in a timely manner in situations where the House Staff member may not complete his/her responsibilities in regard to the medical record.

The Graduate Medical Education Committee ("GMEC") must communicate to the Medical Executive Committee and the Hospital Board of Directors about the safety and quality of patient care provided by, and the related educational and supervisory needs of, its professional graduate education program participants.

SECTION 8.25 Use Of Investigational/Experimental Drugs Or Devices

8.25.1.1 General: Physician must obtain Institutional Review Board ("IRB") approval prior to using any investigational/experimental drugs or devices for research studies or emergency use. Investigational/experimental drugs or devices are defined as any non-FDA approved drug/device or a drug/device used in a research study. IRB approval is for protection of patient's rights and does not imply credentials beyond those approved by the medical staff. Investigational procedures may need to be processed through the usual credentialing process. The granting of Professional Staff privileges for new procedures that are necessary to use these investigational/experimental devices will follow the process set forth in Article II of the Professional Staff Bylaws. Research involving human subjects shall be conducted in a manner that preserves subject rights (including the right to privacy) and informed consent shall be obtained and documented in the medical record as required by applicable federal, State and Hospital requirements. Such research shall be initially approved by the Hospital's IRB and thereafter be under its continued review. Where such research involves the investigational use of drugs, such shall be reviewed by the Pharmacy and Therapeutics Committee. The Physician who uses or requests the use of a medical device or system is responsible for assuring compliance with this rule, including the requirement to obtain the informed consent of the subject. Devices and systems used for diagnostic testing done in vitro shall be approved by the Department of Pathology prior to initiation or implementation.

8.25.1.2 Ongoing Research Studies: To obtain approval of investigational/experimental drugs or devices for use in an ongoing research study, submit a protocol and consent form in the normal method to the IRB Office for approval at the next scheduled IRB meeting. Investigational procedures may need to be processed through the usual credentialing process as well.

8.25.1.3 Emergency Use: Emergency use is defined as the use of an investigational/experimental drug or device on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval for its use. A written request, usually in letter form, that includes the risks, benefits, and informed consent, signed by the requesting physician, stating the life-threatening situation or one-

time need and, the absence of standard acceptable treatment, is submitted to the IRB Office. The IRB Chair or designee will review the request and approve or disapprove its use. In accordance with FDA Regulation 21 CFR 50.23 and CFR 56.104, the protocol and consent form are reviewed and approved by the IRB Committee within five (5) working days of initial approval. The standard guidelines for obtaining informed consent apply. When the IRB receives a request from a physician for an emergency use of an investigational/experimental drug or device, the IRB must examine each case to assure itself and the institution that the emergency use was justified.

8.25.1.4 Other: Patients currently on research protocols from the Hospital or other institutions who are admitted, must follow Pharmacy Department Policy covering investigational drug procedures.

SECTION 8.26 Cancer Staging

All newly diagnosed cancers will be staged by the managing physician (defined as the treating physician, usually the surgeon, medical oncologist, or radiation oncologist) using the American Joint Committee on Cancer-TNM-staging format. The staging format will be entered on a form adopted by the Tumor Board Committee and the completion of the staging will be required to complete the medical record on the patient. Cases that cannot be staged will be so indicated on the staging form with a reason why it cannot be staged. In addition, each case of cancer shall be reported (within six months of date of diagnosis and/or first contact with the Hospital) to the Ohio Department of Health in a manner required by the then-current Ohio Cancer Incidence Surveillance System (OCISS) Reporting Source Procedural Manual

SECTION 8.27 Osteopathic Musculoskeletal Examination For Osteopathic Physicians

Documentation of the osteopathic musculoskeletal examination of the hospitalized patient may be accomplished by either use of a standardized form or a narrative report, both of which include those elements considered essential to the application of osteopathic principals and practice in order for the Physician to understand the total health status and function in the diagnosis and treatment of a hospitalized patient.

SECTION 8.28 Emergency Department On-Call Physicians.

Appointees of the Medical Staff have an obligation to work with the Hospital administration to provide coverage of emergency medical conditions arising within or presenting to the Hospital as required by law. The Emergency On-Call list is developed by Medical Staff Services in conjunction with Hospital administration and is available on the Hospital

Intranet. Providers may be on-call at multiple network hospitals as long as there are plans to provide alternate coverage should more than one facility require emergent services at one time.

The Emergency On-Call list is intended to provide urgent and emergent consultation to patients either seeking care in the ED or within the Hospital and its affiliated units.

If there are discrepancies, administrative, or reimbursement concerns, it is the responsibility of the currently listed on-call Practitioner to see to the emergent needs of the patient first and deal with the non-clinical issues secondarily. If an on-call Practitioner is unavailable for duty on the day that they are specified for call, it is their responsibility to find and report to the Medical Staff Office and/or the Emergency Department, a suitable on-call replacement Practitioner.

On-call Practitioners must respond to emergency requests for evaluation in a timely fashion and provide stabilization and/or emergent definitive treatment as requested by the consulting Physician without regard to insurance status or payment capability. Emergency patients referred to the provider in the outpatient setting will also receive initial stabilizing care without regard to immediate payment capability.

If stabilization and/or definitive treatment of the patient's medical condition are not available within the current capabilities of the Hospital, the patient may be transferred to an appropriate facility upon certification by the Physician that the medical benefits of the transfer outweigh the risks and that the transfer is in the best interest of the patient. An on-call Practitioner may not request that a patient be transferred to a second hospital for the Practitioner's convenience. In the circumstance where needed services do exist at this Hospital, a patient or legal representative may still request a transfer to another hospital. Transfer may occur only when that other hospital has verified availability of services and an accepting physician has been established. This process must be clearly documented in the medical record and on the appropriate COBRA Transfer form.

SECTION 8.29 Patient Care Protocols

"Protocols" and "Standing Orders" have the same definition in Ohio. A protocol may only be used in three situations: (i) a true emergency, or (ii) for biologicals, or (iii) vaccines administered to individuals for the purpose of preventing diseases. For all other situations, Patient care protocols may be developed through collaborative efforts involving physicians, patient care services and/or other hospital departments. The Pharmacy and Therapeutics Committee must approve and review annually any protocol referencing medication. After review and approval of protocols by the Medical Executive Committee, such may be utilized in patient care on the order of a qualified practitioner. Approved protocols shall be reviewed and approved by the Medical Executive Committee within 12 to 24 months of previous approval.

SECTION 8.30 Electronic Clinical Information System - Electronic Medical Records and Other Clinical Documentation (EMR)

The electronic clinical information system(s) is essential to the continuous quality improvement program of this Hospital. The Hospital will grant security access to its electronic clinical information system(s) only to practitioners who demonstrate proficiency in the use of such system(s).

All practitioners who seek privileges for patient care activities at the time of initial Hospital appointment are required to demonstrate proficiency in the use of the Hospital's EMR system(s) (currently a competency rate of 80 percent or higher on the Epic examination, and proficiency in Departmental EMR systems as applicable and as determined by the Chair of the Department/Section) and/or complete training sessions on the use of the Hospital's EMR system to enable the practitioner to use the system for electronic medical record entry and other applicable clinical documentation that is available from time to time (or as may be used in Departments or Sections), and must provide appropriate documentation of successful completion of such training to Medical Staff Services prior to the initiation of any clinical activities.

All practitioners who provide ongoing patient care activities are expected to obtain and maintain current competencies in the use of the Hospital's then-current EMR system applications as required to utilize the EMR for computerized order entry and all other applicable clinical documentation.

For practitioners who do not successfully demonstrate proficiency in the use of the Hospital's EMR system, additional training will be available to assure a reasonable opportunity to achieve sufficient competency levels.

Non-compliance with these requirements can result in suspension of patient care activities, including elective admissions, outpatient care activities, and non-emergency surgical cases. Hospital privileges will be reinstated upon documentation that the practitioner has agreed to utilize the EMR for all applicable patient care activities, including an agreed-upon plan to complete (and proof of successful completion) any necessary remedial training within a specified time period.

Enforcement of these requirements is the joint responsibility of the Chief of Staff and the Vice President of Medical Affairs/Chief Medical Officer.

ARTICLE 9.
ADOPTION, AMENDMENT, OR REPEAL

This Organization and Functions Manual may be adopted, amended, or repealed, in whole or in party, as provided in the Medical Staff Bylaws.

CERTIFICATION OF ADOPTION AND APPROVAL

Originally adopted by the Medical Executive Committee on November 23, 1999
Revisions adopted by the Medical Executive Committee on October 19, 2010
Re-adopted by the Medical Executive Committee on November 6, 2012
Manual adopted by the Medical Executive Committee on August 20, 2013
Re-adopted by the Medical Executive Committee on November 15, 2016.
Re-adopted by the Medical Executive Committee on June 20, 2017.
Revisions adopted by the Medical Executive Committee on November 20, 2018.
Revisions adopted by the Medical Executive Committee on March 19, 2019.

Eric Nordin D.O.
Chief of Staff

Originally approved by the Board of Directors on December 8, 1999 and included in Bylaws, after receipt of a recommendation by the Medical Executive Committee. Revisions approved by the Board of Directors on November 9, 2010, after receipt of recommendations by the Medical Executive Committee. Re-adopted by the Board of Directors on November 6, 2012 after receipt of a recommendation by the Medical Executive Committee. Separated from the Bylaws proper and integrated and incorporated thereto as a governing manual thereof on August 19, 2014.

Re-adopted by the Board of Directors on November 15, 2016 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Directors on June 23, 2017 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Directors on March 30, 2018 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Directors on November 28, 2018 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Directors on March 28, 2019 after receipt of a recommendation by the Medical Executive Committee.

Rebecca Lewis RN, MSN
Hospital President