RULE ONE: CRITERIA AND PROCEDURES FOR APPLICATION AND REAPPLICATION

1.1 APPLICATION AND REAPPLICATION GENERALLY

1.1.1 General Procedure

The Staff through its designated committees, ancillary services, and officers shall investigate and consider each application or reapplication for Appointment or Reappointment and each request for modifications of Staff Appointment or Clinical Privileges and shall adopt and transmit recommendations thereon to the Board.

1.1.2 Preliminary Eligibility Criteria

Only when a person can first establish that he meets each of the following preliminary eligibility criteria is he eligible to apply or reapply for Staff Appointment and/or Clinical Privileges:

1.1.2.1 that he meets the Licensure and Education, Training and Certification requirements of Sections 3.1.1 and 3.1.2 of the Staff Bylaws;

1.1.2.2 that the Clinical Privileges to be sought are not subject to an exclusive contract with a Physician or a group of Physicians not including such person;

1.1.2.3 that the Clinical Privileges to be sought are not inconsistent with the Hospital's written medical staff development plan;

1.1.2.4 that he is not ineligible to apply or reapply for Staff Appointment and/or Clinical Privileges pursuant to Rule 1.4;

1.1.2.5 that he has no other application or reapplication for Staff Appointment and/or Clinical Privileges pending or subject to further hearing, appellate review or other proceedings before the Staff or Board; and

1.1.2.6 that he has no judicial proceeding pending concerning another application or reapplication for Staff Appointment and/or Clinical Privileges at Hospital.

1.1.3 Application and Reapplication Form

Each application and reapplication shall be in writing, submitted in the form as prescribed by the Hospital and authenticated by the Applicant. When an Applicant or Practitioner requests an application form he shall be given a copy, or access to a copy of, these Bylaws, the Staff Rules, the Hospital Bylaws and summaries of other Hospital and Staff Rules relating to clinical practice in the Hospital.

1.1.4 Effect of Application or Reapplication

By applying or reapplying for Appointment or Clinical Privileges, each Applicant:

1.1.4.1 Consents to the inspection of records and documents pertinent to his licensure, specific training, experience, current competence, ability to perform the privileges requested, and health status;

1.1.4.2 Signifies his willingness to appear for interviews in regard to his application, if requested;

1.1.4.3 Agrees to be bound by the provisions of these Bylaws and the Rules of the Staff and the Hospital regardless of whether his application is approved, including, without limitation, the provisions of Bylaws Article Fourteen providing for confidentiality, immunity, release from liability, authorizations, special covenants and other matters;

1.1.4.4 Represents and warrants that all information provided by him is true, correct and complete in all material respects, and agrees to notify Hospital of any change in any of the information furnished the Hospital; and

1.1.4.5 Pledges to provide continuous care for his patients.

1.1.5 Applicant's Burden

An Applicant or Practitioner applying or reapplying for Appointment or Clinical Privileges shall have the burden of producing adequate information for a proper evaluation of his current licensure, relevant training or experience, current competence, professional judgment, demonstrated ability to perform the Clinical Privileges requested, professional ethics, physical and mental health status, emotional stability, ability to work harmoniously with others, and other qualifications and of resolving any doubts about these or other basic qualifications specified in these Bylaws and of satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate Staff or Board authorities. Failure to adequately complete the required form or to submit the form in the method as prescribed by the Hospital, the withholding of or other failure to produce requested information, the providing of false, incomplete or misleading information, or other failure of the Applicant or Practitioner to meet his burden, shall, in and of itself, constitute a basis for denial of the application or reapplication or revocation of Appointment and Clinical Privileges.

1.1.6 Denial for Hospital's Inability to Accommodate

In addition to other bases specified herein, Staff Appointment and/or particular Clinical Privileges may be denied on the basis that:

1.1.6.1 the Hospital is presently unable to provide adequate facilities, equipment, number or types of qualified support personnel, support services or patient load for the affected Applicant or Practitioner and his patients; or

1.1.6.2 there is a lack of patient care need for additional Practitioners with the affected Applicant or Practitioner's skill and training.

Such a recommendation of denial shall be considered adverse in nature, provided that application of Rule Eight in such circumstance shall be limited to the sole purpose of determining whether good cause exists for the Executive Committee's action, rather than the Applicant's or Practitioner's individual competence or qualifications.

1.1.7 Protocol For Granting Privileges For Procedures Where No Definite Criteria Exist

1.1.7.1 A Practitioner requesting Clinical Privileges to perform a procedure where no definite criteria are specified in the Staff or Departmental Rules or where there is no consensus on criteria required to grant privileges must submit in writing a request to the Practitioner's Department Chief.

1.1.7.2 Such request must contain:

1.1.7.2.1 A position paper on such procedure from the Practitioner's National governing body or society regarding the number of cases and training recommended or required;

1.1.7.2.2 A detailed listing of the Practitioner's cases involving such procedure, together with the clinical outcomes and the Practitioner's degree of involvement in each case;

1.1.7.2.3 Documentation demonstrating the Practitioner has successfully completed the training recommended or required by the Practitioner's governing body to perform such procedure;

1.1.7.2.4 The appropriate indications, contra-indications, and the risks for such procedure; and

1.1.7.2.5 A plan for the management of any complications that may arise during or from such procedure.

1.1.7.3 Once the Department Chief has determined the Practitioner has furnished the required information and meets the criteria specified above, such Chief will forward copies of the information submitted by the Practitioner, together with any other pertinent information, to the Executive Committee along with such Chief's written recommendation to the Executive Committee regarding:

1.1.7.3.1 The criteria to be applied by the Executive Committee for approval of an application for Clinical Privileges to perform such procedure;

1.1.7.3.2 The extent to which the Practitioner meets such criteria; and

1.1.7.3.3 The suitability of the Practitioner to perform such procedure.

1.1.7.4 The Executive Committee will review the information from the Department Chief above as a part of its review of the Practitioner's application for Appointment and/or Clinical Privileges and will, in due course, either approve or disapprove the application for Clinical Privileges (as outlined in Rule 1.3.4 or 1.5.6).

1.1.7.5 In a case where the Practitioner is denied privileges, the Practitioner has the right to request a hearing before members of the Staff Executive Committee under the process outlined in the Staff Bylaws.

1.1.7.6 If and when Clinical Privileges are granted for a particular procedure utilizing this format, the criteria utilized by the Executive Committee will be the precedent for any subsequent Practitioner of the same specialty applying for Clinical Privileges to perform such procedure. Subsequent Practitioners will be required to meet such criteria, until such time that more formal national criteria are developed or until Staff or Departmental Rules are adopted and approved by the Staff Executive Committee and Board setting other criteria for Clinical Privileges to perform such procedure.

1.1.7.7 Practitioners of another specialty who desire Clinical Privileges to perform such procedure must go through the procedure outlined above with the recommendations from the Practitioner's specialty's governing board or society. In such a case, because of differences in the training and experience of Practitioners in different specialties, there may well be differences in criteria such as number of cases and training recommended or required for the granting of Clinical Privileges for Practitioners of different medical specialties to perform the same procedure.

1.1.7.8 The Executive Committee may recommend approval of Clinical Privileges for a temporary period (i.e. 6 months). At the end of the temporary period, the Clinical Privilege will lapse, unless Practitioner reapplies and is approved for such privileges.

1.1.7.9 The Executive Committee may, but is not required to, condition its grant of any Clinical Privileges on intensified review by the Quality Review Committee.

1.1.7.10 Any information submitted under Rule 1.1.7.1 and 1.1.7.2 above will be presented to the Staff at the quarterly Staff meeting. At such time, the Staff Appointees will be given an opportunity to submit in writing scientific/clinical

input to the Executive Committee, supporting or objecting to the proposed criteria.

1.1.8 Protocol For Challenging Staff Or Departmental Rules Establishing Criteria For Specific Clinical Privileges

1.1.8.1 A Practitioner who wishes to propose amendment or repeal of Staff Rules that establish criteria for specific Clinical Privileges may submit in writing a request to the Practitioner's Department Chief. A Practitioner who wishes to propose amendment or repeal of Departmental Rules that establish criteria for specific Clinical Privileges may submit in writing a request to the applicable Department Chief.

1.1.8.2 Such request must contain:

1.1.8.2.1 A detailed description of the Practitioner's objections to such Rule;

1.1.8.2.2 A detailed draft of any amendment of such Rule proposed by such Practitioner; and

1.1.8.2.3 All supporting documentation the Practitioner contends supports his objections and proposed amendments to such Rule.

1.1.8.3 The Department Chief will forward copies of the information submitted by the Practitioner to the Executive Committee, along with written information to the Executive Committee regarding:

1.1.8.3.1 Whether or not the Department concurs with the Practitioner's objections;

1.1.8.3.2 Any recommendation as to whether or not the Rule should either be amended or repealed; and

1.1.8.3.3 The reasons for such recommendation.

1.1.8.4 The Executive Committee will review the information from the Department Chief.

1.1.8.5 The Executive Committee may delegate initial review of the issue to a subcommittee. However, any decision to amend or repeal such Rule, subject to Professional Staff Bylaws Sections 15.1 and 15.2, remains the responsibility of the Executive Committee.

1.1.8.6 The Executive Committee (or any subcommittee under Rule 1.1.8.5) may seek

input from the Practitioner, Staff Appointees, or other interested persons, including but not limited to inviting the Practitioner, Staff Appointees and other persons to appear before it to assist it in its review.

1.2 APPLICATION FOR INITIAL APPOINTMENT

The application form and supporting documentation, including information from the Arkansas CCVS system and the National Practitioner Data Bank, for Active and Consulting Staff categories, shall include:

1.2.1 A statement that the Applicant has received and read the Bylaws and Rules of the Staff and the Hospital and that he agrees to be bound by the terms thereof if he is granted Staff Appointment and/or Clinical Privileges, and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not the application is granted;

1.2.2 Detailed information concerning the Applicant's qualifications, including, without being limited to, information and satisfaction of the basic qualifications specified in Article Three of the Staff Bylaws;

1.2.3 Postgraduate training, including the name of each institution, degrees granted, program completed, dates attended, and names of practitioners responsible for the Applicant's performance;

1.2.4 All currently valid medical, dental and other professional licensures or certifications, and Drug Enforcement Administration registration, with the date and number of each;

1.2.5 Specialty or subspecialty board certification, recertification and eligibility;

1.2.5 Health impairments (including any alcohol or drug abuse problems), if any, affecting the Applicant's ability in terms of skill, attitude or judgment to fully perform professional and Staff duties; hospitalizations or other institution-alizations for significant health problems during the past five (5) years; any continuing health problems requiring current therapy; denials of, or ratings on, health, life or disability insurance because of health problems and names of insurers; statement from personal Physician of significant findings of last health examinations; a chest x-ray within preceding six months; a current TB test or completion of a questionnaire regarding status if previously positive;

1.2.7 Professional liability insurance coverage, and information on professional liability claims and experience (suits and settlements made, concluded and pending) during the past ten (10) years, including the names of present and past insurance carriers and consent to the release of information by the Applicant's present and past professional liability carriers;

1.2.8 If the application is for Appointment as an Allied Health Professional and the Applicant is an employee of a Physician Practitioner, the application shall include an agreement signed by such Physician Practitioner employer indemnifying and holding the Hospital harmless against all claims and losses arising out of the acts or omissions of the Applicant;

1.2.9 Specific requests stating the Staff category and Clinical Privileges for which the Applicant wishes to be considered;

1.2.10 The names of at least three persons who are not currently associated in practice with Applicant or related to him who have worked with the Applicant and directly observed his professional performance in the recent past and who can provide specific, reliable, substantive, written information based on significant personal experience as to the Applicant's clinical ability, ethical character and ability to work harmoniously with others and other qualifications for eligibility under these Bylaws. Further, at least one of such references must have had organizational responsibility for supervision of the Applicant's performance (e.g., department chief, service chief, training program director, etc.);

1.2.11 Information as to whether any of the following have ever been (whether voluntarily or involuntarily including by resignation or expiration) denied, revoked, suspended, limited, reduced, not renewed, relinquished, terminated, lost, made subject to probation, preceptorship, or monitoring requirements or have been the subject of a letter of warning, reprimand or otherwise:

1.2.11.1 staff membership status or clinical privileges at any other hospital, clinic or health care institution;

1.2.11.2 status or participation in any HMO, PPO, IPA, PHO, provider panel or managed care entity program;

1.2.11.3 status in or participation in the Medicare or Medicaid programs or any other federal or state health insurance program;

1.2.11.4 membership/fellowship in local, state or national professional organizations;

1.2.11.5 specialty board certification/eligibility;

1.2.11.6 license to practice any profession in any jurisdiction;

1.2.11.7 Drug Enforcement Administration or other controlled substances registration; or

1.2.11.8 faculty membership at any medical or other professional school.

Full details regarding any of the above shall be included as part of the application.

1.2.12 Information as to whether any formal complaints, requests for corrective action, investigations, hearings, appeals, or other processes concerning any of the following are threatened, pending or in process:

1.2.12.1 staff membership status or clinical privileges at any other hospital, clinic or health care institution;

1.2.12.2 status or participation in any HMO, PPO, IPA, PHO, provider panel or managed care entity;

1.2.12.3 status in or participation in the Medicare or Medicaid programs or any other federal or state health insurance program;

1.2.12.4 membership/fellowship in local, state or national professional organizations;

1.2.12.5 specialty board certification/eligibility;

1.2.12.6 license to practice any profession in any jurisdiction;

1.2.12.7 Drug Enforcement Administration or other controlled substances registration; or

1.2.12.8 faculty membership at any medical or other professional school.

Full details regarding any of the above shall be included as part of the application.

1.2.13 Any additional information required of a Practitioner under Section 3.2.11 of the Staff Bylaws;

1.2.14 Location of offices, names and addresses of other practitioners with whom the Applicant is or was associated and inclusive dates of such association; names and locations of any other hospital, clinic or health care institution or organization where the Applicant provides or has provided clinical services with the inclusive dates of such affiliation;

1.2.15 Any current felony criminal charges pending against the Applicant and any past charges including their resolution;

1.2.16 A statement whereby the Applicant agrees that, should an adverse ruling be made with respect to his application for Staff Appointment and/or Clinical Privileges,

he will exhaust the administrative remedies afforded by the Staff Bylaws and these Rules before resorting to legal action;

1.2.17 A statement whereby the Applicant specifically agrees to the authorization, confidentiality, immunity and release provisions of these Bylaws, and the special covenants contained in Article Fourteen of the Staff Bylaws;

1.2.18 A statement whereby the Applicant agrees, if granted Clinical Privileges, to provide continuous quality care for patients;

1.2.19 A statement whereby the Applicant agrees, if granted Clinical Privileges, upon request of the Hospital or Staff, to provide appropriate and necessary emergency and non-emergency medical treatment within the scope of such Applicant's Clinical Privileges to any patient seeking such treatment, regardless of such patient's ability to pay;

1.2.20 The signature of the Applicant.

The application form and supporting documentation, including information from the Arkansas CCVS system and the National Practitioner Data Bank, for Staff categories other than Active and Consulting shall include those items listed above as deemed applicable to the category by the Medical Executive Committee and set forth in the corresponding application.

1.3 PROCESSING THE APPLICATION

1.3.1 Verification of the Information

1.3.1.1 The Applicant shall deliver a completed application form in the method as prescribed by the Hospital to the Chief Executive Officer, who shall, in timely fashion, seek to collect or verify the identification of Applicant, references, licensure, and other qualification evidence submitted.

1.3.1.2 Where the Applicant seeks temporary Clinical Privileges, the Chief Executive Officer shall verify the following prior to granting such temporary Clinical Privileges:

1.3.1.2.1 verification (which may be accomplished through a telephone call) of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, and other criteria required by medical staff bylaws;

1.3.1.2.2 that the results of the National Practitioner Data Bank query have been obtained and evaluated; and

1.3.1.2.3 that the Applicant has submitted a complete (fully filled out) application, no current or previously successful challenge of licensure or registration exist, the Applicant has not been subject to involuntary termination of medical staff membership at another organization, and the Applicant not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

1.3.1.3 The Chief Executive Officer shall promptly notify the Applicant of any problems in obtaining the information required and it shall then be the Applicant's obligation to obtain the required information.

1.3.1.4 When the collection and verification is accomplished, the Chief Executive Officer shall deem the application and supporting documentation to be complete, and shall then notify the chief of each department in which the Applicant seeks Clinical Privileges and transmit the application to the Executive Committee.

1.3.2 Staff Input

Upon receiving the completed application and supporting materials, the Executive Committee shall notify Practitioners with Active Staff Appointment of the pendency of the application. Any Practitioner may submit, in writing with full details, information relevant to the Applicant's qualifications for Appointment and Clinical Privileges. Any Practitioner who provides such a written statement may also petition, or may be requested by, the Executive Committee to appear in person before it to discuss the application.

1.3.3 Review by Chief of Staff or Designee

The Chief of Staff or his designee shall review the application and its supporting documentation and forward to the Executive Committee a written report evaluating the evidence of the Applicant's training, experience and demonstrated ability stating how the Applicant's skills are expected to contribute to the clinical and educational activities of the Staff. This report may state the chief's recommendation as to the approval or denial of, and any special limitations on, Staff Appointment, and scope of Clinical Privileges. The Chief of Staff or his designee may also, at his discretion, conduct an interview with the Applicant. If further information is desired about an Applicant or if there is insufficient clinical performance information to make a decision to grant, limit or deny the requested privilege, he may defer transmitting his report until such information has been obtained. In case of a deferral, the Chief of Staff or his designee must notify the Applicant, the Executive Committee and the Chief Executive Officer in writing of the deferral and the grounds therefor.

1.3.4 Executive Committee Action

The Executive Committee shall review the application, the supporting documentation, the reports from the Chief of Staff or his designee and other relevant information available to

it. The Executive Committee may, in its discretion, conduct an interview with the Applicant. This interview shall not constitute a hearing and none of the procedural rules provided in the Staff Bylaws or these Rules with respect to a hearing shall apply thereto. The Executive Committee shall transmit to the Board its written report and recommendations as to approval or denial of, and any special limitations on, Staff Appointment and specific Clinical Privileges. If the Executive Committee requires further information about the Applicant, it may defer transmitting its report until such information has been obtained. In case of deferral, the Executive Committee shall notify the Applicant and the Chief Executive Officer in writing of the deferral and the grounds therefor.

The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Executive Committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

1.3.5 Effect of Executive Committee Action

1.3.5.1 Favorable Recommendation: When the Executive Committee's recommendation is favorable to the Applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for consideration at the Board's next regularly scheduled meeting. For the purposes of this section "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Chief of Staff or his designee and the Executive Committee and any minority views. A "favorable recommendation" by the Executive Committee means any recommendation other than an "adverse action" as defined in Section 8.3.1 of the Staff Bylaws.

1.3.5.2 Adverse Recommendation: When the Executive Committee's recommendation is adverse to the Applicant, the Chief Executive Officer shall give prompt written notice to the Applicant by delivery either in person or by certified mail, return receipt requested. Thereafter, the provisions of Rule Eight shall apply. An "adverse recommendation" by the Executive Committee means an "adverse action" as defined in Section 8.3.1 of the Staff Bylaws.

1.3.6 Board Action

Only the Board has the power to take final action on an application for Staff Appointment or Clinical Privileges. The fact that the Executive Committee has made a favorable recommendation shall not be deemed to confer Staff Appointment or Clinical Privileges where none existed before. The Board's action following receipt of the report from the Executive Committee shall be in conformance with the following procedures:

1.3.6.1 On Favorable Executive Committee Recommendation: The Board may, in whole or in part, adopt or reject a favorable recommendation of the Executive Committee, or refer the matter back to the Executive Committee for further consideration, stating the reasons for such referral and setting a time limit in which a subsequent recommendation shall be made. If the Board's action is adverse to the Applicant as defined in Section 8.3.1 of the Staff Bylaws., the provisions of Article Eight of the Staff Bylaws and Rule Eight shall then apply.

1.3.6.2 Without Benefit of Executive Committee Recommendation: If the Board does not receive an Executive Committee recommendation within a reasonable period of time, it may, after notifying the Executive Committee and after full investigation of all previous actions and determination that further delay is not justified, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If the Board's action is adverse to the Applicant as defined in Section 8.3.1 of the Staff Bylaws, the provisions of Article Eight of the Staff Bylaws and Rule Eight shall then apply.

1.3.6.3 After Procedural Rights: In the case of an adverse Executive Committee recommendation pursuant to Rule 1.3.5.2 or an adverse first Board decision pursuant to Rule 1.3.6.1 or 1.3.6.2, the Board shall take final action in the matter after the Applicant has exhausted or waived any procedural rights as provided in Article Eight of the Staff Bylaws and Rule Eight.

1.3.7 Notice of Final Decision

Following the Board's final decision the Chief Executive Officer shall notify the Applicant and the Executive Committee. Such notice should include the Staff category to which the Applicant is appointed, the Clinical Privileges he may exercise, and any special conditions attached to his Appointment or Clinical Privileges. If approved, and no other date is specified in such approval, Applicant’s Appointment and Clinical Privileges shall begin on the first date of the month following the month in which the Board’s final decision was made.

1.3.8 Time Periods for Processing

All individuals and groups required to act on an application for Staff Appointment and Clinical Privileges should do so in a timely manner consistent with their obligations to the orderly operation of the Hospital and the best interest of patient care. Absent some mitigating factor, ordinarily each completed application should be processed within the following consecutive time periods beginning with the determination by the Chief Executive Officer that the application is complete under Rule 1.3.1:

INDIVIDUAL/GROUP	TIME
Chief of Staff or designee	60 days
Executive Committee	60 days
Board	Next Regular Meeting

These time periods are merely guidelines and are designed to assist those named in accomplishing their tasks. Consequently, they shall not be deemed to create any right for an Applicant to have his application processed within these precise periods. If the provisions of Article Eight of the Staff Bylaws and Rule Eight are activated, the time requirements provided therein shall govern the continued processing of the application.

1.4 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF DISCIPLINARY ACTION

A present or former Applicant or Practitioner shall not be eligible to apply or reapply for Staff Appointment and/or Clinical Privileges affected by a previous action for a period of at least thirty-six months who has:

1.4.1 received a final adverse decision regarding Staff Appointment or Clinical Privileges; or

1.4.2 withdrawn his application or reapplication for Staff Appointment or Clinical Privileges following an adverse recommendation by the Executive Committee or Board; or

1.4.3 received a final adverse decision resulting in suspension or termination, limitation or restriction of Staff Appointment or Clinical Privileges; or

1.4.4 resigned, surrendered, or failed to reapply for Appointment or Clinical Privileges following an automatic suspension or an adverse recommendation by the Executive Committee or Board; or

1.4.4 is the subject of an adverse action terminating the Applicant or Practitioner's employment or independent contractor relationship with such hospital; or

1.4.5 has resigned employment or terminated independent contractor relationship with such hospital while such action is pending or in lieu of such action.

Such ineligibility shall extend for a period of at least thirty-six months from the date the adverse decision became final, the date the application or request was withdrawn, or the date resignation became effective, whichever is applicable.

For the purpose of this Rule, a decision shall be considered to be adverse only if it is based

on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse for the purpose of this Rule include actions based on a failure to maintain a practice in the area (which can be cured by a move) or to pay dues (which can be cured by paying dues) or to maintain professional liability insurance (which can be cured by securing such insurance). Further, this Section shall not prohibit reapplication by a Practitioner whose Staff Appointment or Clinical Privileges have been limited or restricted from reapplying for said Appointment and Clinical Privileges upon the expiration of their normal term, subject to continuation of any applicable limitation or restriction. For the purpose of this Rule, an adverse decision shall only be considered to be final at the time of completion or waiver of: (1) all hearing, appellate review, and other proceedings conducted by the Hospital bearing on the decision and (2) all judicial proceedings bearing upon the decision.

After the thirty-six month period, the former Applicant, Practitioner or former Practitioner may submit an application for Staff Appointment and/or Clinical Privileges which shall be processed as an initial application. The former Applicant, Practitioner or former Practitioner shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the Applicant, Practitioner or former Practitioner submits satisfactory evidence to the Executive Committee that he has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions.

1.5 REAPPLICATION PROCESS

1.5.1 Reapplication Generally

Only the Board has the power to take final action on reapplication for Staff Appointment and renewal of Clinical Privileges. The fact that a Practitioner has had Staff Appointment or Clinical Privileges in the past or that the Executive Committee has made a favorable recommendation shall not be deemed to renew Staff Appointment or Clinical Privileges in the absence of action by the Board.

1.5.2 Application for Reappointment

On or before 150 days prior to the final scheduled Board meeting prior to the date of expiration of a Practitioner's term of Appointment and Clinical Privileges, the Chief Executive Officer shall give notice of such expiration date to the Practitioner by way of the electronic credentialing system.

On or before 120 days prior to the final scheduled Board meeting prior to the date of expiration of Practitioner's term of Appointment and Clinical Privileges, he shall file a reapplication with the Chief Executive Officer in the form as prescribed by the Hospital

containing, but not limited to, the following:

1.5.2.1 complete information to update the Applicant's file on the items listed in Rule 1.2.1, including information from the Arkansas CCVS system and the National Practitioner Data Bank;

1.5.2.2 documentation of continuing training and education during the preceding term of Appointment and Clinical Privileges;

1.5.2.3 a specific request for Clinical Privileges sought to be renewed or initially granted with any basis for changes;

1.5.2.4 any request for changes in Staff category or ancillary service assignments; and

1.5.2.5 Any:

1.5.2.5.1 Challenges to any licensure or registration;

1.5.2.5.2 Voluntary and involuntary relinquishment of any licensure or registration;

1.5.2.5.3 Voluntary and involuntary termination of medical staff appointment;

1.5.2.5.4 Voluntary and involuntary limitation, reduction, or loss of clinical privileges;

1.5.2.5.5 Involvement in a professional liability action, including final judgments and settlements involving a Practitioner;

1.5.2.5.6 Documentation as to applicant’s health status;

1.5.2.5.7 Relevant Practitioner-specific data compared to aggregate data if such data are available for that practitioner;

1.5.2.5.8 Morbidity and mortality data if such data are available for that Practitioner; and,

1.5.2.5.9 Peer recommendations as required for the Staff Category requested by the Practitioner.

Further, the Applicant shall submit any reasonable evidence of current health status that may be requested by the Executive Committee.

1.5.3 Failure to Reapply

Failure without good cause to reapply and provide required information shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Appointment and Clinical Privileges at the expiration of the Practitioner's current term, unless explicitly extended temporary privileges for not more than 120 days on request of the Executive Committee. The application of Article Eight of the Staff Bylaws and Rule Eight in such circumstance is limited to the sole purpose of determining the issue of good cause for failure to reapply.

1.5.4 Verification of Additional Information

The Chief Executive Officer shall verify additional information submitted by the Applicant with his reapplication and supporting documentation, and shall notify the Applicant of any information which is incomplete, inadequate or not verifiable. The Applicant shall then have the burden of furnishing complete, accurate, adequate, and verifiable information and resolving any doubts concerning such information.

The Chief Executive Officer shall assemble for the Executive Committee all relevant information regarding the Applicant's professional and collegial activities, performance and conduct in this Hospital. Such information shall include, without limitation, the Applicant's:

1.5.4.1 current licensure;

1.5.4.2 health status;

1.5.4.3 professional performance;

1.5.4.4 judgment;

1.5.4.5 current competence

1.5.4.6 clinical and/or technical skills, as indicated in part by the results of quality assessment and improvement activities;

1.5.4.7 level/amount of clinical activity (patient care contacts) at the Hospital;

1.5.4.8 maintenance of timely, accurate and complete medical records;

1.5.4.9 attendance at required Staff, ancillary service, and committee meetings;

1.5.4.10 service on Staff and Hospital committees;

1.5.4.11 compliance with all applicable Staff and Hospital Bylaws and Rules;

1.5.4.12 performance in working harmoniously with others;

1.5.4.13 previously completed or currently pending challenges to any licensure or registration (state or DEA) or the voluntary relinquishment of such licensure or registration;

1.5.4.14 appearances before any board governing professional licensure, certification or registration and whether disciplinary action was taken;

1.5.4.15 information regarding suspension, sanction, restriction or exclusion from participation in the Medicare or Medicaid Programs or any federal or state health insurance program;

1.5.4.16 previous or currently pending voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, clinic or health care institution;

1.5.4.17 detailed recommendation from the chiefs of all applicable ancillary services regarding the Clinical Privileges sought;

1.5.4.18 ability to perform the privileges requested; and

1.5.4.19 other reasonable indicators of continuing qualifications.

When such collection and verification are accomplished, the Chief Executive Officer shall deem the reapplication and supporting documentation to be complete and shall then transmit the reapplication and supporting documentation to the Executive Committee.

1.5.5 Review by Chief of Staff or Designee

The Chief of Staff or his designee shall review the Applicant's file and forward to the Executive Committee a written report, including a statement as to whether or not he knows of or has observed or has been informed of any conduct which indicates a significant present or potential physical or behavioral problem affecting the Applicant's ability to perform professional and Staff duties appropriately and with recommendations for approval or denial of Appointment and specific Clinical Privileges.

1.5.6 Executive Committee Action

The Executive Committee shall review the Applicant's file, the report of the Chief of Staff or his designee, and all other relevant information available to it, and forward to the Board its written report and recommendation as to approval or denial of, and any special limitations on, Staff Appointment and specific Clinical Privileges. The Executive Committee may, in its discretion, conduct an interview with the Applicant. This interview shall not constitute a hearing, and none of the procedural rules provided in the Staff Bylaws or these Rules with respect to a hearing shall apply thereto. The Executive

Committee's review shall consider information concerning the Applicant's current licensure, relevant training and experience, current competence, professional judgment, demonstrated ability to perform the Clinical Privileges requested, professional ethics, physical and mental health status, emotional stability, ability to work harmoniously with others, clinical/technical skills, as indicated by the results of quality assessment and improvement activities and other reasonable indicators of continuing qualifications, and other qualifications.

1.5.7 Effect of Executive Committee Action

1.5.7.1 Favorable Recommendation: When the Executive Committee's recommendation is favorable to the Applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for consideration at the Board's next regularly scheduled meeting. For the purposes of this section Rule "all supporting documentation" includes the reapplication form and its accompanying information and the reports and recommendations of the Chief of Staff or his designee and the Executive Committee and any minority views. A "favorable recommendation" by the Executive Committee means any recommendation other than an "adverse action" as defined in Section 8.3.1 of the Staff Bylaws.

1.5.7.2 Adverse Recommendation: When the Executive Committee's recommendation is adverse to the Applicant, the Chief Executive Officer shall give prompt written notice to the Applicant by delivery either in person or by certified mail, return receipt requested. Thereafter the provisions of Article Eight and Rule Eight shall apply. An "adverse recommendation" by the Executive Committee means an "adverse action" as defined in Section 8.3.1 of the Staff Bylaws..

1.5.8 Board Action

Only the Board has the power to take final action on a reapplication for Staff Appointment or Clinical Privileges. The fact that the Executive Committee has made favorable recommendation shall not be deemed to confer Staff Appointment or Clinical Privileges past the expiration of the term of Appointment and Clinical Privileges. The Board's action following receipt of the report from the Executive Committee shall be in conformance with the following procedures:

1.5.8.1 On Favorable Executive Committee Recommendation: The Board may, in whole or in part, adopt or reject a favorable recommendation of the Executive Committee, or refer the matter back to the Executive Committee for further consideration, stating the reasons for such referral and setting a time limit in which a subsequent recommendation shall be made. If the Board's action is adverse to the Applicant as defined in Section 8.3.1 of the Staff Bylaws., the provisions of Article Eight of the Staff Bylaws and Rule Eight shall then apply.

1.5.8.2 Without Benefit of Executive Committee Recommendation: If the Board does not receive a Executive Committee recommendation within a reasonable period of time, it may, after notifying the Executive Committee and after full investigation of all previous actions and determination that further delay is not justified, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If the Board's action is adverse to the Applicant as defined in Section 8.3.1 of the Staff Bylaws., the provisions of Article Eight of the Staff Bylaws and Rule Eight shall then apply.

1.5.8.3 After Procedural Rights: In the case of an adverse Executive Committee recommendation pursuant to Rule 1.5.7.2 or an adverse first Board decision pursuant to Rule 1.5.8.1 or 1.5.8.2, the Board shall take final action in the matter after the Applicant has exhausted or waived any procedural rights as provided in Article Eight of the Staff Bylaws and Rule Eight.

1.5.9 Notice of Final Decision

Following the Board's final decision the Chief Executive Officer shall notify the Applicant and appropriate Hospital personnel. Such notice should include the Staff category to which the applicant is appointed, the Clinical Privileges he may exercise, and any special conditions attached to his Appointment or Clinical Privileges. If approved, and no other date is specified in such approval, Applicant's renewed term of appointment shall begin on the first day of the month following the month in which the Board's final decision was made.

1.5.10 Time Periods for Processing

All individuals and groups required to act on a reapplication should do so in a timely manner consistent with their obligations to the orderly operation of the Hospital and the best interest of patient care. Absent some mitigating factor, ordinarily each reapplication for Appointment and Clinical Privileges should be processed within the following consecutive time periods beginning with the determination by the Chief Executive Officer that the reapplication is complete under Rule 1.5.4:

INDIVIDUAL/GROUP	TIME
Chief of Staff or designee	60 days
Executive Committee	30 days
Board	Next Regular Meeting

These time periods are merely guidelines and are designed to assist those named in accomplishing their tasks. Consequently, they shall not be deemed to create any right for an Applicant to have his reapplication processed within these precise periods. If the provisions of Article Eight and Rule Eight are activated, the time requirements provided therein shall govern the continued processing of the reapplication.

1.5.11 Bases for Recommendations

Each recommendation concerning reapplication for Staff Appointment and Clinical Privileges shall be based upon documented evidence of the Applicant's demonstrated professional ability and clinical judgment in the treatment of his patients, his professional ethics, his physical and mental health status, his emotional stability, his discharge of Staff obligations, his compliance with Hospital and Staff Bylaws and Rules, his documented ability to work harmoniously with Hospital personnel and other Practitioners and with patients, and other qualifications or matters bearing on his ability and willingness to contribute to Quality Patient Care in the Hospital.

1.6 EXTENSION OF APPOINTMENT AND CLINICAL PRIVILEGES

If a reapplication has not been fully processed by the expiration date of the Practitioner's term of Appointment and Clinical Privileges, temporary privileges consistent with such Practitioner's prior Clinical Privileges shall be automatically extended for up to 120 days or until such time as the processing of the reapplication is completed, whichever time period is shorter. However, in circumstances where corrective action is being taken with respect to the Practitioner and where a preliminary recommendation to deny any part of the reapplication has been made, or when the delay in processing the reapplication is due to the Practitioner's failure to return a completed reapplication form as required, temporary privileges will be extended only on affirmative request of the Executive Committee to recommend extending temporary privileges to the Practitioner.

1.7 REQUESTS FOR MODIFICATION OF APPOINTMENT OR CLINICAL PRIVILEGES

A Practitioner may, either in connection with reapplication or at any other time, request modification of his Staff category or Clinical Privileges by submitting a written application to the Chief Executive Officer in the form as prescribed by the Board after consultation with the Executive Committee. A modification application is processed in the same manner as a reapplication.

1.8 EMERGENCY CLINICAL PRIVILEGES WHEN EMERGENCY MANAGEMENT PLAN ACTIVATED

1.8.1 During disaster(s) in which the emergency management plan has been activated, either the Chief Executive Officer (including his designee and, in their absence, the Administrator in Charge) or any Staff Officer has the option to grant emergency Clinical Privileges upon presentation of any of the following:

1.8.1.1 A current picture hospital ID card that clearly identifies professional designation;

1.8.1.2 A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

1.8.1.3 Primary source verification of the license;

1.8.1.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corp (MRC), Emergency Systems for Advanced Registration of Volunteer Health Professionals (EASR-VHP), or other recognized state or federal organizations or groups;

1.8.1.5 Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or

1.8.1.6 Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity;

1.8.2 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the Hospital. If, due to extraordinary circumstances, primary source verification cannot be completed in seventy-two (72) hours, the following will be documented:

1.8.2.1 Why primary source verification could not be performed in the time frame;

1.8.2.2 Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services;

1.8.2.3 An attempt to rectify the situation as soon as possible.

1.8.3 The Chief Executive Officer is not required to grant emergency Clinical Privileges to any individual and is expected to make such decisions on a case-by-case basis at his or her discretion.

RULE TWO: OBSERVATION REQUIREMENT

2.1 FOR INITIAL APPOINTMENTS

Except as otherwise determined by the Board, all initial Appointments to any category of the Staff and grants of Clinical Privileges will be subject to a period of observation where his performance shall be observed, either directly or through retrospective chart review, by the Chief of Staff (or his designee), to determine his eligibility for continued Appointment to the Staff category to which he was initially appointed, and for exercising the Clinical Privileges initially granted in that unit. Such Practitioner shall remain subject to observation until he has caused the following to be furnished to the Executive Committee and to the Chief Executive Officer a statement signed by the Chief or Staff or his designee that:

2.1.1 the Practitioner meets all of the qualifications, has discharged all the

responsibilities, and has not exceeded or abused the prerogatives of the Staff category to which he was appointed; and

2.1.2 the Practitioner has satisfactorily demonstrated his ability to exercise the specific Clinical Privileges initially granted to him.

2.2 FOR MODIFICATION OF APPOINTMENT STATUS OR CLINICAL PRIVILEGES

The Executive Committee may recommend to the Board that a change in Staff category of a current Practitioner or the granting of additional Clinical Privileges to a current Practitioner pursuant to Rule 1.6 be made subject to observation in accordance with procedures similar to those outlined in Rule 2.1 for Initial Appointments and Clinical Privileges.

2.3 TERM OF OBSERVATION PERIOD

An observation period for initial Appointment or for modification of Appointment status or Clinical Privileges, shall last for no more than six (6) months unless extended by the Executive Committee. If a Practitioner fails within that period to furnish the certifications required in Rule 2.1, the Executive Committee shall be notified and the Practitioner's Staff Appointment or particular Clinical Privileges shall be subject to corrective action under Rule Seven. Similarly, if a Practitioner requesting modification fails to furnish the required certification within such period, the Practitioner's change in Staff category or service, or clinical unit assignment, or additional Clinical Privileges, as applicable, shall be subject to corrective action under Rule Seven.

RULE THREE: LEAVE OF ABSENCE AND RESIGNATION

3.1 LEAVE OF ABSENCE STATUS

3.1.1 A Practitioner may obtain a voluntary leave of absence from the Staff by submitting written notice therefor to the Executive Committee and the Chief Executive Officer stating the reason for the leave of absence, the time the leave of absence is to commence, and the approximate period of time of the leave of absence which may not exceed the Practitioner’s current term of Staff Appointment, and what alternate arrangements have been made for patients and on-call responsibilities.

3.1.2 With the exception of the Practitioner’s responsibility to complete medical record documentation, the Practitioner's Clinical Privileges, prerogatives and responsibilities shall be suspended during the leave of absence.

3.1.3 A Practitioner may reapply for Staff Appointment and renewal of Clinical Privileges pursuant to Rule 1.5 during a leave of absence.

3.1.4 The Executive Committee or Board in its discretion may, but is not required to,

suspend processing of any reapplication pursuant to Rule 1.5 during a leave of absence.

3.1.5 Should a Practitioner be under investigation pursuant to Rules 7.2 or 7.4, the Executive committee in its discretion may, but is not required to, suspend its investigation during the pendency of the leave of absence. If an investigation is so suspended, it will resume upon termination of the leave of absence. However, if such investigation continues, the Practitioner is subject to all of the provisions of the Bylaws and these Rules regarding investigation, hearings and appeals.

3.2 TERMINATION OF LEAVE OF ABSENCE

3.2.1 At least thirty (30) days prior to the expiration of the leave period, or at any earlier time, the Practitioner must request termination of the leave of absence and reinstatement of his Clinical Privileges and prerogatives by submitting a written request to that effect to the Chief Executive Officer for transmittal to the Executive Committee.

3.2.2 The Practitioner shall submit any additional information requested by the Executive Committee for its consideration in reviewing the Practitioner's request. The Executive Committee may, in its discretion, require the Practitioner to appear before it to answer questions.

3.2.3 If the Executive Committee so determines, the leave of absence will terminate and the Practitioner's Clinical Privileges may be reinstated, effective as of the date specified by the Executive Committee.

3.2.4 If the Executive Committee determines that the leave of absence should not terminate and that the Practitioner's Clinical Privileges should not be reinstated, the Chief Executive Officer shall give prompt written notice to the Applicant by delivery either in person or by certified mail, return receipt requested. There-after the provisions of Article Eight shall apply.

3.2.5 Failure without good cause to request termination of the leave of absence and reinstatement as provided above shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of the Practitioner's Staff Appointment and Clinical Privileges in effect at the termination of the leave period and shall constitute a waiver of any procedural rights provided in Article Eight hereof.

3.3 RESIGNATION

Resignation of Appointment, Clinical Privileges and/or Staff office must be in writing and delivered to the Chief Executive Officer. A resignation is effective on the date specified therein or, if no date is specified, immediately upon receipt by the Chief Executive

Officer. Once delivered to the Chief Executive Officer a resignation is irrevocable.

RULE FOUR: ALLIED HEALTH PROFESSIONALS

4.1 ALLIED HEALTH PROFESSIONAL CATEGORIES GENERALLY

Qualified Allied Health Professionals (AHPs) may apply for (in the form and method as prescribed by the Hospital) and be granted Appointment as Category 1 or Category 2 AHPs and Clinical Privileges to perform specified patient care services within the Hospital. AHPs must qualify and continuously meet all other applicable requirements and obligations of this Rule.

4.2 ADDITIONAL CLASSES OR PROFESSIONALS

Additional classes of professionals may be added to Category 1 or Category 2 upon the determination by the Board, that:

4.2.1 Such class of professionals is established as one having a scientific basis;

4.2.2 The utilization of Practitioners of such class of professionals is consistent with appropriate utilization of the Hospital and its services;

4.2.3 The services to be performed by such class of professionals need to be performed in a Hospital setting or that patients frequently require such services while hospitalized;

4.2.4 Such class of professionals would provide a needed patient service that is not already adequately provided for by existing Practitioners or Hospital employees or independent contracts;

4.2.5 Adequate supervision of members of such class of professionals could be achieved by the Staff without undue burden; and

4.2.6 The presence of members of such class of professionals would not unduly complicate patient care or expose the Hospital or Staff to liability.

4.3 CATEGORY 1 ALLIED HEALTH PROFESSIONALS

4.3.1 Approved Classes of Professionals.
Category 1 Allied Health Professionals shall be limited to the following classes of persons:

4.3.1.1 CRNA's;

4.3.2 General Category 1 AHP Qualifications.
In order to be eligible for Appointment and Clinical Privileges to provide

specified services in the Hospital as a Category 1 AHP, in addition to the additional specific qualifications for each class of Category 1 AHPs set forth in Rule 4.3.7, the AHP must, on application and continuously thereafter:

4.3.2.1 Be an employee of:

4.3.2.1.1 a Physician or dentist Practitioner with Active of Consulting Staff Appointment; or

4.3.2.1.2 a legal entity of which a Physician or dentist Practitioner with Active or Consulting Staff Appointment is a partner, member, shareholder, officer, director, contractor or employee;

4.3.2.2 Be under the supervision and direction of such Physician or dentist Practitioner;

4.3.2.3 Submit a statement, signed by the AHP's Physician or dentist Practitioner or the AHP's employer agreeing to indemnify the Hospital against all claims and losses arising out of the acts or omissions of the AHP;

4.3.2.4 Document experience, background, training, ability physical and mental health status, and clinical results with sufficient adequacy to demonstrate that any patient treated by the AHP will receive care of a generally recognized professional level of quality and efficiency and that the AHP is qualified to provide a needed service within the Hospital;

4.3.2.5 Be determined, on the basis of documented referenced, to adhere strictly to the ethics of their respective professions as applicable, to work harmoniously with others, and to avoid conduct that suggests a lack of professional fitness;

4.3.2.6 Have freedom from, or adequate control of, any significant physical, mental or behavioral impairment, and any difficulty of oral or written communication in the English language that interferes with, or presents a substantial possibility of interfering with, the Quality of Patient Care or cooperative working relationships;

4.3.2.7 Maintain current professional insurance with a licensed and approved carrier in the amounts and of the type determined by Hospital Board for the applicable class of Category 1 AHPs;

4.3.2.8 Comply with Staff and Hospital Bylaws and Rules; and

4.3.2.9 Complete and submit the required application forms and supplementary

information.

4.3.3 Application Process.

4.3.3.1 An application for Category 1 AHP Appointment and Clinical Privileges must be requested by the AHP's Physician or dentist Practitioner.

4.3.3.2 Provided that the AHP meets the preliminary eligibility requirements of Rule 1.1.2, an application for Category 1 AHP Appointment and Clinical Privileges may be submitted to the Nursing Department, which will consider the application on the basis of these Rules and any written guidelines prepared by the Executive Committee and, if the application is determined to be complete, submit it to the Executive Committee for consideration.

4.3.3.3 Hearing and Appellate Review procedures for Category 1 AHPs regarding denial of application or reapplication are limited to those specified in Rule 4.5. A Category 1 AHP is not entitled to any hearing or appeal rights under Article Eight of the Staff Bylaws or Rules 7 or 8.

4.3.4 Reappointment.
A formal review of each Category 1 AHP will be made upon application for Reappointment and Clinical Privileges.

4.3.5 Automatic Termination.

4.3.5.1 The Appointment and Clinical Privileges of a Category 1 AHP automatically terminate if:

4.3.5.1.1 The Appointment or Clinical Privileges of the Physician or dentist Practitioner of the Category 1 AHP are suspended, terminated, denied or not renewed, whether voluntarily or involuntarily.

4.3.5.1.2 The Category 1 AHP ceases to be the employee of the Physician or dentist Practitioner or the legal entity described in Rule 4.3.2.1.2;

4.3.5.1.3 The Hospital's employment of, or contact with, the Physician or dentist Practitioner or the legal entity described in Rule 4.3.2.1.2 terminates for any reason;

4.3.5.1.4 The license or certification of the Category 1 AHP is suspended, terminated, denied or not renewed, whether voluntarily or involuntarily; or

4.3.5.1.5 The Category 1 AHP or the AHP's Physician or dentist Practitioner or legal entity employer is listed by a state or federal agency as excluded, disbarred, suspended or otherwise ineligible to participate in federal or state healthcare programs, including Medicare and Medicaid.

4.3.5.2 A Category 1 AHP whose Appointment and/or Clinical Privileges have automatically terminated as provided in this Rule 4.3.5 shall not be entitled to any hearing or appeal rights under Article Eight of the Staff Bylaws or Rules 7, 8 or 4.5 under any circumstances.

4.3.6 Sanctions and Discipline.

4.3.6.1 Any breach of the rules governing a Category 1 AHP should be reported to the Chief Executive Officer for investigation. The Chief Executive Officer will notify the AHP's Practitioner employer of any problem following the results of the investigation. Any action taken against a Category 1 AHP shall be taken through the AHP's Practitioner employer, if possible.

4.3.6.2 All disciplinary action will be reported to the Chief of Staff. Problems that may involve the quality of patient care will be appropriately investigated and administrative action taken which may include clearing the Category 1 AHP, directing that a letter of warning, reprimand, or admonition be sent, imposing terms of probation, or suspension, termination, denial or non-renewal of Appointment and/or Clinical Privileges.

4.3.6.3 Hearing and Appellate Review procedures for Category 1 AHPs regarding such disciplinary action are specified in Rule 4.5.

4.3.6.4 Nothing in these Rules or in the Staff Bylaws shall be construed to grant to Category 1 AHPs the procedural rights otherwise provided in Article Eight of the Staff Bylaws or in Rules 7 or 8 under any circumstances.

4.3.7 Qualifications and Prerogatives for Specific Classes of Category 1 AHPs. Additional qualifications and prerogatives for the approved classes of Category 1 AHPs are as follows:

4.3.7.1 *CRNA's*.

4.3.7.1.1 *Additional Qualifications*. In addition to the general qualifications listed in Rule 4.3.2, a CRNA must, on application for Appointment and Clinical Privileges and continuously thereafter:

4.3.7.1.1.1 Be a graduate from an acceptable CRNA training program that

meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs or another nationally recognized accrediting body and that has as its objective the preparation of nurses to perform as nurse anesthetists;

4.3.7.1.1.2 Be certified as a CRNA by the Council on Certification of Nurse Anesthetists, the Council on Recertification or Nurse Anesthetists, or other nationally recognized certifying body; and

4.3.7.1.1.3 Possess a current license or temporary permit issued by the State of Arkansas to practice as a CRNA.

4.3.7.1.2 *Prerogatives.* In addition to the general prerogatives listed in Rule 4.3.8, a CRNA may:

4.3.7.1.2.1 Provide anesthesia services;

4.3.7.1.2.2 Be responsible for the duties surrounding the giving of anesthesia, including but not limited to preoperative anesthesia orders, pre and post-operative visits, consultation with the operating surgeon administration of the appropriate anesthesia, and monitoring of vital signs.

4.3.7.1.2.3 Provide technical assistance for the Staff as requested within the CRNA's delineated AHP Clinical Privileges.

4.3.8 General Prerogatives of Category 1 Allied Health Professionals
The general prerogatives of a Category 1 AHP are to:

4.3.8.1 Provide specifically designated patient care services for which Clinical Privileges have been granted consistent with the limitations stated in Section 6.1 of the Staff Bylaws;

4.3.8.2 Write orders only to the extent specified in the Hospital and Staff Rules for the class of Category 1 AHP, but not beyond the scope of the AHP's license, certificate or other legal credentials;

4.3.8.3 Serve on Staff and Hospital committees where his special training and knowledge are desirable and with vote only when so specified;

4.3.8.4 Attend Staff, Hospital and service education programs and clinical meetings related to his discipline; and

4.3.8.5 Exercise such other prerogatives as the Executive Committee with the approval of the Chief Executive Officer may accord AHPs in general or a

specific category of AHPs.

4.3.9 General Requirements and Obligations Regarding Category 1 Allied Health Professionals

Each Category 1 AHP shall:

4.3.9.1 Attend an orientation session prior to the exercise of Clinical Privileges within the Hospital.

4.3.9.2 Work under the direct supervision and direction of their Physician or dentist Practitioner employer.

4.3.9.3 Provide direct or indirect patient care within the limits of their skills, the lawful scope of their practice, and the scope of Clinical Privileges.

4.3.9.4 Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services, or arrange (or alert the attending Practitioner of the need to arrange) a suitable alternative for such care and supervision.

4.3.9.5 Participate as appropriate in the quality assessment and improvement program activities and in discharging such other Staff functions as may be required from time to time.

4.3.9.6 Attend clinical meetings of the Staff when related to his discipline and meetings of the committees of which he is a member.

4.4 CATEGORY 2 ALLIED HEALTH PROFESSIONALS

4.4.1 Approved Classes of Professionals.

Category 2 Allied Health Professionals are limited to the following classes of professionals:

4.4.1.1 CRNAs;

4.4.2 General Category 2 AHP Qualifications.

In order to be eligible for Appointment and Clinical Privileges to provide specified services in the Hospital as a Category 2 AHP, in addition to the specific qualifications for each class of Category 2 AHPs set forth in this Rule 4.4, the AHP must, on application and continuously thereafter:

4.4.2.1 Have professional references from at least one individual who has served as the applicant's supervisor during his training, one medical doctor (who does not have Clinical Privileges on this Staff), and one other professional of

applicant's level or above with whom the applicant has worked;

4.4.2.2 Not be a Physician or dentist or the employee of a Physician or dentist Practitioner;

4.4.2.3 Be responsible to the Physician or dentist Practitioner on whose case he is working;

4.4.2.4 Document experience, background, training, ability, physical and mental health status, and clinical results with sufficient adequacy to demonstrate that any patient treated by the AHP will receive care of a generally recognized professional level of quality and efficiency and that the AHP is qualified to provide a needed service within the Hospital;

4.4.2.5 Be determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable, to work harmoniously with others, and to avoid conduct that suggests a lack of professional fitness;

4.4.2.6 Have freedom from, or adequate control of, any significant physical, mental or behavioral impairment, and any difficulty of oral or written communication in the English language that interferes with, or presents a substantial possibility of interfering with, the Quality of Patient Care or cooperative working relationships;

4.4.2.7 Maintain current professional liability insurance with a licensed and approved carrier in the amounts and of the type determined by Hospital Board for the applicable class of Category 2 AHPs;

4.4.2.8 Comply with Staff and Hospital Bylaws and Rules; and

4.4.2.9 Complete and submit the required application forms and supplementary information.

4.4.3 Application Process.

4.4.3.1 An application for Appointment and Clinical Privileges may be requested directly by a Category 2 AHP applicant who meets the preliminary eligibility requirements of Rule 1.1.2.

4.4.3.2 Provided that the AHP meets the preliminary eligibility requirements of Rule 1.1.2, an application for Category 2 AHP Appointment and Clinical Privileges may be submitted to the Nursing Department, which will consider the application on the basis of these Rules and any written

guidelines prepared by the Executive Committee and, if the application is determined to be complete, submit it to the Executive Committee for consideration.

4.4.3.3 Hearing and Appellate Review procedures for Category 2 AHPs regarding denial of application or reapplication are specified in Rule 4.5.

4.4.4 Reappointment.
A formal review of each Category 2 AHP will be made upon application for Reappointment for Clinical Privileges.

4.4.5 Automatic Termination.

4.4.5.1 The Appointment and Clinical Privileges of a Category 2 AHP employee will automatically terminate if:

4.4.5.1.1 The license or certification of the Category 2 AHP is suspended, terminated, denied or not renewed, whether voluntarily or involuntarily;

4.4.5.1.2 The Hospital's employment of, or contract with, the Category 2 AHP terminates for any reason; or

4.4.5.1.3 The Category 2 AHP is listed by a state or federal agency as excluded, disbarred, suspended or otherwise ineligible to participate in federal or state healthcare programs, including Medicare and Medicaid.

4.4.5.2 A Category 2 AHP whose Appointment and/or Clinical Privileges have automatically terminated as provided in this Rule 4.4.5 shall not be entitled to any hearing or appeal rights under Article Eight of the Staff Bylaws or Rules 7, 8 or 4.5 under any circumstances.

4.4.6 Sanctions and Discipline.

4.4.6.1 Any breach of the rules governing a Category 2 AHP should be reported to the Chief Executive Officer for investigation.

4.4.6.2 All disciplinary action will be reported to the Chief of Staff. Problems that may involve the quality of patient care will be appropriately investigated and administrative action taken which may include clearing the Category 2 AHP, directing that a letter of warning, reprimand, or admonition be sent, imposing terms of probation, or suspension, or revocation of Clinical Privileges.

4.4.7 Specific Qualifications and Prerogatives for Classes of Category 2 AHPs. Additional qualifications and prerogatives for the approved classes of Category 2 AHPs are as follows:

4.4.7.1 *CRNAs*.

4.4.7.1.1 *Qualifications*. In addition to the general qualifications listed in Rule 4.4.2, a CRNA must, on application for Appointment and Clinical Privileges and continuously thereafter:

4.4.7.1.1.1 Be a graduate from an acceptable CRNA training program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs or another nationally recognized accrediting body and that has as its objective the preparation of nurses to perform as nurse anesthetists;

4.4.7.1.1.2 Be certified as a CRNA by the Council on Certification of Nurse Anesthetists, the Council on Recertification or Nurse Anesthetists, or other nationally recognized certifying body; and

4.4.7.1.1.3 Possess a current license or temporary permit issued by the State of Arkansas to practice as a Certified Registered Nurse Anesthetist.

4.4.7.1.2 *Prerogatives*. In addition to the prerogatives listed in Rule 4.4.8, a CRNA may:

4.4.7.1.2.1 Provide anesthesia services for all surgical cases for which the CRNA has delineated AHP Privileges;

4.4.7.1.2.2 Be responsible for the duties surrounding the giving of anesthesia, including but not limited to preoperative anesthesia orders, pre and post-operative visits, consultation with the operating surgeon, administration of the appropriate anesthesia, and monitoring of vital signs.

4.4.7.1.2.3 Provide technical assistance for the Staff as requested within his delineated AHP privileges.

4.4.7.1.3 A CRNA shall:

4.4.7.1.3.1 Practice under the supervisory and directed care of a Practitioner with Appointment to the Active of Consulting Staff.

4.4.8 General Prerogatives of Category 2 Allied Health Professionals.

The general prerogatives of a Category 2 AHP are to:

4.4.8.1 Provide specifically designated patient care services for which Clinical Privileges have been granted consistent with the limitations stated in Section 6.1 of the Staff Bylaws;

4.4.8.2 Write orders only to the extent specified in the Hospital and Staff Rules for the class of Category 2 AHP, but not beyond the scope of the AHP's license, certificate or other legal credentials;

4.4.8.3 Serve on Staff and Hospital committees where his special training and knowledge are desirable and with vote only when so specified;

4.4.8.4 Attend Staff, Hospital and service education programs and clinical meetings related to his discipline; and

4.4.8.5 Exercise such other prerogatives as the Executive Committee with the approval of the Chief Executive Officer may accord AHPs in general or a specific category of AHPs.

4.4.9 General Requirements and Obligations Regarding Category 2 Allied Health Professionals:
Each Category 2 AHP shall:

4.4.9.1 Attend an orientation session prior to the exercise of Clinical Privileges within the Hospital;

4.4.9.2 Work in coordination with the Physician Practitioner who admitted the patient;

4.4.9.3 Provide direct or indirect patient care within the limits of their skills, the lawful scope of their practice, and the scope of Clinical Privileges;

4.4.9.4 Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services, or arrange (or alert the attending Practitioner of the need to arrange) a suitable alternative for such care and supervision;

4.4.9.5 Participate as appropriate in the quality assessment and improvement program activities and in discharging such other Staff functions as may be required from time to time; and,

4.4.9.6 Attend clinical meetings of the Staff when related to his discipline and meetings of the committees of which he is a member.

4.5 PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

Applicants for Appointment or Clinical Privileges as an AHP and AHP Practitioners are not entitled to the procedural rights provided in Articles Seven and Eight of the Staff Bylaws and Rules Seven and Eight. However, an AHP shall have the right to challenge any action that would constitute grounds for a hearing under Section 8.3.1 of the Staff Bylaws, by filing a written grievance with the chief of the Chief of Staff, within 15 days of such action. Upon receipt of such a grievance, the Chief of Staff shall initiate a careful investigation and afford the affected AHP an opportunity for a hearing before an *ad hoc* committee appointed by the Chief of Staff. This hearing shall not constitute the same type of "hearing," as is established by Article Eight of the Staff Bylaws and Rule Eight and need not be conducted according to the procedural rules applicable with respect to such hearings; rather, this hearing will be conducted solely pursuant to the procedures set out in this Rule 4.5. Before the hearing, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the hearing, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. A report of the findings and recommendations shall be made by the *ad hoc* committee to the AHP and the Executive Committee. Within ten (10) days of receipt of the report, the AHP may appeal the findings and recommendations by submitting to the Executive Committee a written statement detailing the factual and procedural matters with which the AHP disagrees. This appeal shall not constitute the same type of "appeal" as is otherwise established by Article Eight of the Staff Bylaws and Rule Eight and need not be conducted according to the procedures applicable with respect to such appeals; rather, this appeal will be conducted solely pursuant to the procedures set out in this Rule 4.5. The Executive Committee shall consider the report and the AHP's written statement, if any, and act thereon. The action of the Executive Committee shall be final, subject to approval by the Governing Body.

RULE FIVE: DUTIES OF OFFICERS

5.1 CHIEF OF STAFF

The Chief of Staff shall:

5.1.1 act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern with the Hospital;

5.1.2 call, preside at, and be responsible for the agenda of all meetings of the Staff;

5.1.3 serve on the Executive Committee as chairman;

5.1.4 serve as an ex officio member of all other Staff committees without vote;

5.1.5 be responsible for the enforcement of Staff Bylaws and Rules, for implementation of sanctions where these are indicated, and for the Staff's

compliance with the procedural safeguards in all stages of the Staff's credentialing process and in all instances where corrective action has been requested against a Practitioner;

5.1.6 review and enforce compliance with standards of ethical conduct and professional demeanor among Practitioners in their relations with each other, the Board, Hospital administration, other professional and support Staff, and the community the Hospital serves;

5.1.7 appoint all Staff committees except the Executive Committee and except as otherwise provided in these Bylaws;

5.1.8 communicate and represent the views, policies, needs and grievances of the Staff to the Board and to the Chief Executive Officer;

5.1.9 receive and interpret the policies of the Board to the Staff and report to the Board on all matters concerning the Staff including the maintenance of Quality Patient Care;

5.1.10 be responsible for the educational activities of the Staff;

5.1.11 be the spokesman for the Staff in its external professional and public relations;

5.1.12 impose sanctions as specified in Article Seven of the Staff Bylaws and Rule Seven;

5.1.13 authenticate minutes, resolutions and other Staff documents;

5.1.14 be responsible for the functioning of the clinical organization of the Hospital and keep or cause to be kept a careful supervision over the clinical work in the Hospital;

5.1.15 be a member of the Joint Conference Committee;

5.1.16 as a representative of the Staff, regularly attend Board meetings; and

5.1.17 meet and collaborate with the Chief Executive Officer on a regular basis to:

5.1.17.1 coordinate the regular meeting agendas of Staff meetings and Executive Committee meetings;

5.1.17.2 review the clinical organization and requirements prescribed within the Staff Bylaws and develop appropriate actions;

5.1.17.3 communicate the views of the Staff and plan corresponding initiatives; and

5.1.17.4 strengthen working relationships among and between the Staff and Hospital departments.

5.2 VICE CHIEF OF STAFF

In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all of the duties and have the authority of the Chief of Staff. He shall be a member of the Executive Committee of the Staff. He shall automatically succeed the Chief of Staff should the latter fail to serve for any reason.

5.3 IMMEDIATE PAST CHIEF OF STAFF AND CHIEF ELECT

The Chief-Elect and Immediate Past Chief of Staff shall serve on the Executive Committee of the Staff. The Chief of Staff will give the Chief-Elect such responsibilities as might prepare him to become Chief of Staff the following year. The Immediate Past Chief of Staff shall have such additional duties as directed by the Chief of Staff.

5.4 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Executive Committee. He shall keep or cause to be kept accurate and complete minutes of all Staff meetings, authenticate minutes, resolutions and other Staff documents, be accountable for all funds entrusted to him, and perform such other duties as ordinarily pertain to this office

RULE SIX:ADDITIONAL STANDING STAFF COMMITTEES

6.1 COMMITTEE FUNCTIONS IN GENERAL

6.1.1 Reports

Written reports of conclusions, recommendations, actions taken, the results of actions, and attendance are maintained.

6.1.1.1 The Home Health Advisory Board, the Infection Control Committee, Grievance Committee, Obstetrics, Surgical Care, Trauma Advisory, ICU/CCU, Emergency Department and Environment of Care (Clinical Safety Issues) Committees shall report to the Patient Care Committee;

6.1.1.2 The Patient Care Committee shall report to the Medical Executive Committee and the Quality Steering Committee;

6.1.1.3 The Medical Executive Committee shall report to the Medical Staff and the Hospital Board;

6.1.1.4 The Quality Steering Committee, the Patient Care Committee and any other committee shall report to Administration;

6.1.1.5 Administration shall report to the Hospital Board.

6.1.2 Quality Review Functions
Organized committees (and their subcommittees) of the Staff are considered to be engaging in the review and evaluation of the quality of medical and hospital care.

6.1.3 Changes in Committee Function
The Executive Committee may change the function, composition, or duties of Staff committees, following subsequent approval by the Board.

6.2 ADDITIONAL COMMITTEES AND FUNCTIONS

6.2.1 Patient Care Committee

6.2.1.1 Composition
The Patient Care Committee shall consist of four active Medical Staff appointees appointed by the Chief of Staff, the Chief Executive Officer, Quality Manager, Director of Nursing and representatives from Infection Control, Environment of Care, Grievance Medical Records, Pharmacy & Therapeutics, Blood Utilization, Organ & Tissue/Mortality/Denials, Case Management, Home Health, Obstetrics, Emergency Department, ICU/CCU, Surgical Care, Trauma Advisory and Physician Peer Review Committees.

6.2.1.2 Duties
The committee shall be responsible for:

6.2.1.2.1 the Medical Record Review Function described in Rule 6.2.2;

6.2.1.2.2 the Blood Usage Review Function described in Rule 6.2.3;

6.2.1.2.3 the Drug Usage Evaluation Function described in Rule 6.2.4;

6.2.1.2.4 the Infection Control Function described in Rule 6.2.5;

6.2.1.2.5 the Utilization Review Function described in Rule 6.2.6;

6.2.1.2.6 the Quality Assessment and Improvement Function as described in Rule 6.2.7;

6.2.1.2.7 the Risk Management Function as described in Rule 6.2.8;

6.2.1.2.8 the Surgical and Other Invasive Procedures Review Function as described in Rule 6.2.9;

6.2.1.2.9 monitoring and evaluating issues relative to the general improvement of Staff performance and patient safety;

6.2.1.2.10 monitoring and evaluating issues relative to the intensive care unit;

6.2.1.2.11 representing the Staff through cooperation with the nursing department and other Hospital departments in matters relating to its functions.

In performing its duties and functions, this committee and any subcommittee thereof, acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care.

6.2.1.3 Meetings

The committee shall meet monthly or more often as necessary and shall maintain a permanent record of its proceedings and actions.

6.2.2 Medical Record Review Function

The Patient Care Committee reviews medical records for completeness of information, and takes action to improve the quality and timeliness of documentation that impacts patient care. The medical record review function:

6.2.2.1 is performed on an ongoing basis by the committee, with input from the nursing department, the medical record department, administration, and other departmental representatives as appropriate;

6.2.2.2 includes a representative sample of records in the review process;

6.2.2.3 addresses the presence, timeliness, legibility, and authentication of medical records data and information as appropriate to the Hospital's needs; and

6.2.2.4 focuses its review on information available at the point of care.

The committee recommends the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes. In performing the medical record review function, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care. Written reports of conclusions, recommendations, actions taken, and the results of actions taken are maintained, and reported at least quarterly through channels established by the Staff.

6.2.3 Blood Usage Review Function

The Patient Care Committee performs blood usage review at least quarterly. Blood usage

review includes:

6.2.3.1 the review of the use of blood and blood components in the Hospital, including when blood or blood components are:

6.2.3.1.1 administered when not indicated;

6.2.3.1.2 not administered when indicated; or

6.2.3.1.3 administered incorrectly.

6.2.3.2 review of all blood use processes performed in the Hospital, such as:

6.2.3.2.1 ordering;

6.2.3.2.2 distributing, handling and dispensing; and

6.2.3.2.3 monitoring blood and blood component effects on patients.

6.2.3.3 the intensive evaluation of all confirmed transfusion reactions.

Screening criteria may be used to identify single cases or patterns of cases that require more intensive evaluation. Screening criteria are predetermined and may apply to either one specific category of blood or blood components or to several categories of blood or blood components. When screening or intensively evaluating any category of blood or blood components, an adequate number of cases is included. In performing the blood usage review function, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care. Written reports of conclusions, recommendations, actions taken, and the results of actions taken are maintained and reported at least quarterly through channels established by the Staff.

6.2.4 Drug Usage Evaluation Function

The Patient Care Committee performs drug usage evaluation at least quarterly as a criteria-based, ongoing, planned and systematic process designed to continuously improve the appropriate and effective use of drugs. The drug usage evaluation function:

6.2.4.1 includes the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use;

6.2.4.2 consists of ongoing monitoring and evaluation of selected drugs that are chosen for one or more of the following reasons:

6.2.4.2.1 the drug is one of the most frequently prescribed drugs;

6.2.4.2.2 the drug is known or suspected to present a significant risk to patients;

6.2.4.2.3 use of the drug is known or suspected to be problem prone; or

6.2.4.2.4 the drug is a critical component of the care provided for a specific diagnosis, condition, or procedure.

6.2.4.3 provides for a process for monitoring and evaluating the use of drugs:

6.2.4.3.1 is performed by the committee in cooperation with, as required, the pharmacy department, the nursing department, administration and others;

6.2.4.3.2 is based upon the use of objective criteria that reflect current knowledge, clinical experience, and relevant literature; and

6.2.4.3.3 may include the use of screening mechanisms to identify, for more intensive evaluation, problems in or opportunities to improve the use of a specific drug or category of drugs.

In performing the drug usage evaluation function the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care. Written reports of conclusions, recommendations, actions taken, and the results of actions taken are maintained and reported at least quarterly through channels established by the Staff at least quarterly.

6.2.5 Infection Control Function

The Patient Care Committee reviews at least the following in assessing the effectiveness of the Hospital infection control program every two months:

6.2.5.1 Infections within the Hospital, particularly with regard to their proper management and their epidemic potential. A determination should be made as to whether an infection is nosocomial and, if so, what action the committee recommends be taken to minimize other such occurrences. Review may be directed to surveillance data, when available, looking particularly for unusual epidemics, clusters of infections, infections due to unusual pathogens, or any occurrence of nosocomial infection that exceeds the usual baseline levels.

6.2.5.2 Any cultures of personnel or the environment required by the Hospital, the Staff, or federal, state, or local agencies or regulations. Except for federal, state, or local requirements, such sampling activities shall be originated, supervised, reviewed, and acted on by the committee. In addition, the sampling should ordinarily be reserved for specific situations when the

outcome can be expected to have a potential beneficial effect on standards of care, or to support change in maintenance practices, personnel practices, or equipment. Occasionally, routine sampling may be used as a quality control mechanism or as an education or training exercise, as, for example, in demonstrating to patient care personnel the reduction of microbial contamination by hand washing, or to housekeeping personnel a reduction in surface bacteria after the use of instituted cleaning practices.

6.2.5.3 The results of any antimicrobial susceptibility/resistance trend studies.

6.2.5.4 Proposals and protocols for all special infection control studies to be conducted throughout the Hospital, and any subsequent findings.

6.2.5.5 Medical records reflecting the presence of infections that were not reported in the final diagnosis. This requires the cooperation of the medical record department and the use of preestablished criteria.

6.2.5.6 Pertinent related findings from other Hospital units.

In performing the infection control function, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care. The committee shall report its findings and recommendations to the Staff through the Executive Committee, to the Chief Executive Officer, and to the director of the nursing department. Written minutes of all meetings shall be maintained and made available to these personnel, as appropriate. The pertinent findings of the infection control function shall be made part of the Hospital's continuing education program and the orientation program for new employees.

The committee, through its chairman, shall have the power and authority to institute any appropriate control measures or studies where there is reasonably considered to be a danger to any patient or personnel.

6.2.6 Utilization Review Function

6.2.6.1 Utilization Review Studies: The Patient Care Committee conducts utilization review studies designed to evaluate the appropriateness of admission to the Hospital and the clinical necessity of continued stay in the Hospital, discharge practices, use of medical and Hospital services and all related factors which may contribute to the effective utilization of Hospital and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the Hospital's services affects the quality of patient care provided at the Hospital, shall study patterns of care and obtain criteria relating to average or normal (usual) lengths of stay by specific disease categories, and shall evaluate

systems of utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital. The committee may communicate the results of its studies and other pertinent data through appropriate Staff mechanisms and shall make recommendations for the optimum utilization of Hospital resources and facilities commensurate with quality of patient care and safety.

6.2.6.2 Utilization Review Plan: The committee formulates a written utilization review plan for the Hospital. Such plan, as approved by the Staff and Board, must be in effect at all times and must include all of the following elements:

6.2.6.2.1 the organization and composition of the committee or sub-committee which will be responsible for the utilization review function;

6.2.6.2.2 frequency of meetings;

6.2.6.2.3 the types of records to be kept;

6.2.6.2.4 the method to be used in selecting cases on a sample or other basis;

6.2.6.2.5 the definition of what constitutes the period of extended duration;

6.2.6.2.6 the relationship of the utilization review plan to claims administration by a third party;

6.2.6.2.7 arrangements for committee reports and their dissemination;

6.2.6.2.8 responsibilities of the Hospital's administrative Staff in support of utilization review.

6.2.6.3 Extended Duration Evaluations: The committee evaluates the medical necessity for continued Hospital services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

6.2.6.3.1 No physician shall have review responsibility for any extended stay cases in which he was professionally involved.

6.2.6.3.2 All decisions that further inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out-of-hospital facilities and services.

6.2.6.3.3 Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending physician shall be given great weight.

6.2.6.3.4 All decisions that further inpatient stay is not medically necessary shall be given by written notice to the Executive Committee, to the chief of the appropriate service, to the Chief Executive Officer and to the attending physician, for such action, if any, as may be warranted.

6.2.6.4 In performing all utilization review functions, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care.

6.2.7 Quality Assessment and Improvement Function

The Patient Care Committee is responsible for the overall coordination of the Hospital's quality assessment and improvement program and shall fulfill the responsibilities and duties as delineated throughout the Hospital's quality assessment and improvement plan. In performing the quality assessment and improvement function, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care.

6.2.8 Risk Management Function

The Executive Committee coordinates the Staff's active participation in the following risk management activities related to the clinical aspects of patient care and safety:

6.2.8.1 the identification of general areas of potential risk in the clinical aspects of patient care and safety;

6.2.8.2 the development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluation of these cases;

6.2.8.3 the correction of problems in the clinical aspects of patient care and safety identified by risk management activities; and

6.2.8.4 the design of programs to reduce risk in the clinical aspects of patient care and safety.

In performing the risk management function, the committee and any subcommittee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care.

6.2.9 Review of Surgical and Other Invasive Procedures

The Patient Care Committee is responsible for the review of surgical and other invasive procedures, which is conducted on an ongoing basis. The purpose of such review is to continuously improve the selection (appropriateness) and performance (effectiveness) of surgical and other invasive procedures. Categories of procedures are reviewed through the use of screening criteria to identify single cases or patterns of cases that require more intensive evaluation, and/or through intensive evaluation of a single case or group of cases. In identifying categories of procedures for review, priority is given to those categories that are performed in high volume, and/or are of high risk to patients, and/or are suspected or known to be problem prone. Screening criteria are predetermined and may apply to either one specific category of procedure or to several categories of procedures. When the review of specimens is removed during a surgical or other invasive procedure identifies a major discrepancy, or a pattern of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, intensive evaluation is performed. When screening or intensively evaluating any category of procedure, an adequate number of cases is included. The combined use of screening mechanisms and intensive evaluation encompasses most categories of surgical and other invasive procedures performed in the hospital. All categories of procedures have been identified as involving major discrepancies or a pattern of discrepancies and are encompassed by the review (except, for example, a high-volume procedure that is neither high risk nor problem prone). Relevant results from the review of surgical and other invasive procedures are used primarily to study and improve processes involved in the selection and performance of these procedures. Written reports of conclusions, recommendations, actions taken and the results of actions taken are maintained and reported monthly to the committee.

6.2.10 Pharmacy and Therapeutics Committee

The Patient Care Committee reviews drug therapy practice and drug utilization within the Hospital at least quarterly. The committee performs this function with input from the Hospital pharmacy, administration, the nursing department and other services or individuals as required. The pharmacy and therapeutics committee functions include:

6.2.10.1 the development or approval of policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;

6.2.10.2 the definition and review of all significant untoward drug reactions;

6.2.10.3 the development and maintenance of a formulary or drug list; and

6.2.10.4 the evaluation and, when no other such mechanism exists, the approval of protocols concerned with the use of investigational or experimental drugs.

In performing its functions, the committee and any sub-committee thereof acts as an organized committee of the Staff engaging in the review and evaluation of the quality of medical or hospital care. Written reports of conclusions, recommendations, actions

taken, and the results of actions taken are maintained.

RULE SEVEN: CORRECTIVE ACTION

7.1 PURPOSE

The purpose of Article Seven of the Staff Bylaws and this Rule Seven is to provide for action whenever there are grounds to suspect that a Practitioner has engaged in, made or exhibited acts, statements, demeanor or personal or professional conduct, either within or outside the Hospital, which is, or is reasonably likely to be:

7.1.1 detrimental to patients' safety or the delivery of appropriate patient care in the Hospital;

7.1.2 lower than the standards and aims of the Staff or the qualifications, obligations or responsibilities of Practitioners;

7.1.3 disruptive to the operations of the Hospital; or

7.1.4 contrary to or in disregard of these Staff Bylaws, Staff Rules or Hospital Rules.

7.2 SUMMARY SUSPENSION

7.2.1 Summary Suspension Generally

The Staff Executive Committee and the Board shall each have the authority to summarily suspend the Clinical Privileges of a Practitioner whenever such action must be taken immediately to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient, employee or other person present in the Hospital. The Practitioner shall be promptly notified of the summary suspension. Such summary suspension shall become effective immediately upon imposition. Since instances may occur where convening the entire committee may be impractical, and in the interest of time and immediate action, the authority of the Staff Executive Committee is hereby delegated to any one of the following individuals: the Chief of Staff, the chairman of any Staff committee and the Chief Executive Officer. If any such individual summarily suspends the Clinical Privileges of a Practitioner pursuant to such delegation, then such summary suspension shall be ratified by the Staff Executive Committee within ten (10) days of the date of such summary suspension.

7.2.2 Provision for Patient Care

Immediately upon the imposition of summary suspension, the Chief of Staff shall have the authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Practitioner.

7.2.3 The Investigation

The Executive Committee shall investigate the summary suspension as soon as is reasonably practical following the summary suspension. As a part of its investigation, the Executive Committee may, in its discretion, afford the affected Practitioner an opportunity for an interview. At such interview he shall be informed of the general nature of the cause for the summary suspension, provided relevant information relating to the investigation, whether inculpatory or exculpatory, and shall be invited to discuss, explain or refute said causes. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing and appeal shall apply thereto. A record of such interview shall be made by the committee and included with its report to the Chief Executive Officer. The Executive Committee may name such non-voting, advisory members to assist in its investigation as it deems necessary. As a part of its investigation, the Executive Committee may require that the affected Practitioner submit to an examination to determine the Practitioner's current health status, if such is an issue in the investigation.

7.2.4 Further Corrective Action

In addition to investigating the summary suspension, the Executive Committee may, upon notice to the Practitioner, broaden the issues under investigation beyond those in the summary suspension, and may base its report, wholly or in part, upon issues not necessarily encompassed by the summary suspension.

7.2.5 Report of Executive Committee

As soon as is reasonably practical, but no later than 14 days after the date of summary. suspension, the Executive Committee shall report to the Chief Executive Officer the results of its investigation and shall take one or more of the following actions with regard to the summary suspension:

7.2.5.1 make a finding clearing the Practitioner of the charges against him;

7.2.5.2 direct that the summary suspension be terminated;

7.2.5.3 direct that the summary suspension be continued pending further proceedings under Article Eight of the Staff Bylaws and Rule Eight;

7.2.5.4 issue a warning, a letter of admonition or a letter of reprimand to the Practitioner;

7.2.5.5 impose terms of probation or requirements of prior or concurrent consultation or direct supervision;

7.2.5.6 make a finding that there is sufficient evidence to warrant, and a recommendation of, suspension, reduction, limitation or termination of Staff Appointment and/or Clinical Privileges;

7.2.5.7 direct that a part or all of the Practitioner's Clinical Privileges be suspended pending further proceedings under Article Eight.

The report of the Executive Committee to the Chief Executive Officer shall be accompanied by a written statement of the facts and reasons supporting the action of the committee. Any minority views shall also be reduced to writing, referencing facts and reasons supporting such minority views, and transmitted to the Chief Executive Officer with the majority report. The Practitioner shall be furnished a copy of the report.

7.2.6 Deferral

If additional time is needed to complete the investigative process, the Executive Committee may defer action on the matter but only upon the written consent of the affected Practitioner. A subsequent recommendation for one or more of the actions provided above must be made within the time specified in the consent, and if no time is specified, then within 30 days of the deferral.

7.2.7 Report to the Board

The Chief Executive Officer shall promptly forward the Executive Committee's report to the Board in situations where the committee's action involves clearing the Practitioner, issuing a letter of warning or letter of admonition or reprimand, or imposing terms of probation, consultation or supervision. The foregoing actions do not entitle the Practitioner to hearing and appeal rights under Article Eight of the Staff Bylaws or Rule Eight. The Board may affirm or modify the action of the committee, or may take action involving suspension, reduction or revocation of Staff Appointment and/or Clinical Privileges subject to any applicable hearing and appellate review pursuant to Article Eight of the Staff Bylaws and Rule Eight.

7.2.8 Adverse Action

When the recommendation of the Executive Committee or Board involves a continuation of summary suspension or other actions deemed adverse under Rule 8.1.2, the provisions of Article Eight of the Staff Bylaws and Rule Eight shall apply, provided however, the action of the Executive Committee or Board shall remain in full force unless and until modified by the hearing committee or the Board on appellate review.

7.2.9 Re-evaluation of Probation

In the event that the action of the Executive Committee is to impose terms of probation, the committee shall re-evaluate its action and the performance of the Practitioner under the terms of the probation within a time prescribed by it, but in no event longer than six months from its initial action, and shall take such further action including extending the period of probation, as is then appropriate.

7.2.10 Expiration of Terms

In the event that the Executive Committee members' terms expire during an investigation of a summary suspension, or during a period of probation imposed on a Practitioner by it,

said members shall continue to participate and act in such uncompleted matters with all power and duties theretofore existing in said members.

7.3 AUTOMATIC SUSPENSION

7.3.1 Failure to Complete Medical Records

A temporary suspension in the form of withdrawal of a Practitioner's admitting privileges, effective until the medical records are completed, shall be imposed automatically after warning of deficiency for failure to complete medical records within the time prescribed in the Staff Rules. Repeated violations may also subject the Practitioner to further corrective action pursuant to Rule 7.4.

7.3.2 Loss of License

Expiration of a license or action by an appropriate licensing agency revoking or suspending or restricting the Practitioner's license shall result in the automatic suspension of all the Practitioner's Clinical Privileges consistent with the action of the licensed agency. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's license by the appropriate licensing agency and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Executive Committee. Should the Executive Committee decline to remove or revoke the automatic suspension, then the provisions of Article Eight of the Staff Bylaws and Rule Eight shall apply.

7.3.3 Failure to Maintain Professional Liability Insurance

Failure to maintain required professional liability insurance shall result in the automatic suspension of all the Practitioner's Clinical Privileges. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's professional liability insurance (including not only current coverage but also continuous coverage for all claims arising out of acts which occur from the date the Practitioner was originally granted Staff Appointment and Clinical Privileges) and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Executive Committee. Should the Executive Committee decline to remove or revoke the automatic suspension, then the provisions of Article Eight of the Staff Bylaws and Rule Eight shall apply.

7.3.4 Loss of DEA Number

Whenever a Practitioner's DEA or other controlled substances number is revoked, suspended, or restricted, the Practitioner's privilege to prescribe medications covered by this number is automatically suspended. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon the reinstatement of the Practitioner's DEA or other controlled substances number and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Executive Committee. Should the Executive Committee decline to remove or revoke the automatic suspension, then the provisions of Article Eight

of the Staff Bylaws and Rule Eight shall apply.

7.3.5 Exclusion from Medicare or Medicaid Programs

Whenever a Practitioner is excluded from the Medicare or Medicaid Programs, all of the Practitioner's Clinical Privileges are automatically suspended. Unless the Practitioner's term of Appointment has expired in the meanwhile, upon reinstatement to the Medicare and Medicaid Programs and written request from the Practitioner to do so, the question of removal of the automatic suspension of the Practitioner's Clinical Privileges shall be considered by the Executive Committee. Should the Executive Committee decline to remove or revoke the automatic suspension, then the provisions of Article Eight of the Staff Bylaws and Rule Eight shall apply.

7.4 REVOCATION OF APPOINTMENT AND SUSPENSION OR REVOCATION OF CLINICAL PRIVILEGES

7.4.1 Request for Corrective Action

Whenever there is reason to believe that the activities or professional conduct of any Practitioner warrant corrective action, such corrective action may be requested by any officer of the Staff, by the chairman of any standing committee of the Staff, by the Chief Executive Officer, or by the Board. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. The Practitioner shall be furnished promptly with a copy of the request for corrective action.

7.4.2 Investigation by Executive Committee

After receipt of a request for corrective action, the Executive Committee shall investigate the request for corrective action.

7.4.3 Suspension or Restriction of Clinical Privileges During Investigation

The Executive Committee, upon notice to the Practitioner, may suspend or restrict all or part of a Practitioner's Clinical Privileges for a period of not longer than fourteen (14) days during which an investigation is being conducted to determine the necessity or appropriateness of corrective action. Such suspension or termination does not trigger the hearing and appeal procedures described in Article Eight of the Staff Bylaws and Rule Eight. The Practitioner shall be given the opportunity to discuss the suspension or restriction with the Executive Committee within fourteen (14) days following such suspension or restriction. If an attorney participates in such discussion on behalf of the Executive Committee, then the Practitioner shall be permitted to have his attorney participate in the discussion to the same extent. Such discussion, in the sole discretion of the Executive Committee, may be treated as the interview described in Section 7.4.4 or as preliminary to such interview.

7.4.4 The Investigation

As a part of its investigation, the Executive Committee may, in its discretion, afford the

affected Practitioner an opportunity for an interview. At such interview he shall be informed of the general nature of the request for corrective action, provided relevant information relating to the investigation whether inculpatory or exculpatory, and invited to discuss, explain or refute the issues presented by the request for corrective action or as otherwise determined by the Executive Committee. If an attorney participates in an interview on behalf of the Executive Committee, then the Practitioner shall be permitted to have his attorney participate. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing and appeal shall apply thereto. A record of such interview shall be made by the committee and included with its report to the Chief Executive Officer. The Executive Committee may name such non-voting, advisory members to assist in its investigation as it deems necessary. As a part of its investigation, the Executive Committee may require that the affected Practitioner submit to an examination to determine the Practitioner's current health status, if such is an issue in the investigation.

7.4.5 Report of the Executive Committee

As soon as is reasonably practical, but no later than 60 days after the date of the request for corrective action, the Executive Committee shall report to the Chief Executive Officer the results of its investigation and shall take one or more of the following actions with regard to the request for corrective action:

7.4.5.1 make a finding clearing the Practitioner of the charges against him;

7.4.5.2 issue a warning, a letter of admonition or a letter of reprimand to the Practitioner;

7.4.5.3 impose terms of probation or requirements of prior or concurrent consultation or direct supervision;

7.4.5.4 make a finding that there is sufficient evidence to warrant, and a recommendation of, suspension, reduction, limitation or termination of Staff Appointment and/or Clinical Privileges;

7.4.5.5 direct that a part or all of the Practitioner's Clinical Privileges be suspended pending further proceedings under Article Eight of the Staff Bylaws and Rule Eight.

The report of the Executive Committee to the Chief Executive Officer shall be accompanied by a written statement of the facts and reasons supporting the action of the committee. Any minority views shall also be reduced to writing, facts and reasons supporting such minority views, and transmitted to the Chief Executive Officer with the majority report. The Practitioner shall be furnished a copy of the report.

7.4.6 Deferral

If additional time is needed to complete the investigative process, the Executive Committee may defer action for up to an additional 60 days.

7.4.7 Report to the Board

The Chief Executive Officer shall promptly forward the Executive Committee's report to the Board in situations where its action involves clearing the Practitioner, issuing a letter of warning or letter of admonition or reprimand, or imposing terms of probation, consultation or supervision. The foregoing actions are in full force and effect unless and until modified by the Board and do not entitle the Practitioner to hearing and appeal rights under Article Eight of the Staff Bylaws and Rule Eight. The Board may affirm or modify the action of the Executive Committee, or may take action involving suspension, reduction or revocation of Staff Appointment and/or Clinical Privileges subject to any applicable hearing and appellate review pursuant to Article Eight of the Staff Bylaws and Rule Eight.

7.4.8 Adverse Action

When the recommendation of the Executive Committee or Board involves actions deemed adverse under Rule 8.1.2, the provisions of Article Eight of the Staff Bylaws and Rule Eight shall apply, provided however, that any action of the Executive Committee or Board shall remain in full force unless and until modified by the hearing committee or the Board on appellate review.

7.4.9 Re-evaluation of Probation

In the event that the action of the Executive Committee is to impose terms of probation, the committee shall re-evaluate its action and the performance of the Practitioner under the terms of the probation within a time prescribed by it, but in no event longer than six months from its initial action, and shall take such further action including extending the period of probation, as is then appropriate.

7.4.10 Expiration of Terms

In the event that the Executive Committee members' terms expire during an investigation or during a period of probation imposed on a Practitioner by it, said members shall continue to participate and act in such uncompleted matters with all power and duties theretofore existing in said members.

7.5 IMPAIRED PRACTITIONERS

7.5.1 Physical and Mental Examinations

In order to promote the quality and safety of patient care in the Hospital, whenever the physical and/or mental health status of a Practitioner or Applicant is called into question, the Executive Committee, in its sole discretion and without triggering any rights under Article Eight of the Staff Bylaws and Rule Eight, may require such person to undergo a mental and/or physical health assessment by a Physician or at a facility selected by the committee and under such circumstances (including direct reporting back to the committee or its designee) as the committee may establish. Failure or refusal of the affected

Practitioner to cooperate with the assessment may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the chairman of the committee and shall at a minimum address:

7.5.1.1 whether the Practitioner or Applicant has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;

7.5.1.2 whether such ability is compromised by reason of illness, the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and

7.5.1.3 whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner or Applicant's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

On the basis of the report and any further investigation, the Executive Committee may take further corrective action as appropriate, subject to the provisions of Articles Seven and Eight of the Staff Bylaws and Rule 8.

7.5.2 Specific Drug and Alcohol Screening

Since instances may occur where drug or alcohol screening may be necessary or appropriate and where convening the entire committee may be impractical, and in the interest of time and immediate action, the authority of the Staff Executive Committee to require immediate drug or alcohol screening is hereby delegated to any one of the following individuals: the Chief of Staff, the chairman of any Staff committee, and the Chief Executive Officer. If any such individual requires a Practitioner to submit to an immediate drug or alcohol screening pursuant to such delegation, then such action shall be ratified by the Staff Executive Committee within ten (10) days of the date of such action.

Failure or refusal of the affected Practitioner to cooperate with the required screening may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the chairman of the Executive Committee will investigate the matter and address:

7.5.2.1 the necessity and appropriateness of the requirement of the drug or alcohol screening;

7.5.2.2 the results of such screening;

7.5.2.3 whether the Practitioner or Applicant has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges

granted him;

7.5.2.4 whether such ability is compromised by reason of the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and

7.5.2.5 whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner or Applicant's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

On the basis of the screening and any further investigation, the Executive Committee may take further corrective action as appropriate, subject to the provisions of Articles Seven and Eight of the Staff Bylaws and Rule 8.

7.5.3 Random Drug and Alcohol Screening

The Executive Committee may authorize a program for random drug and alcohol screening of all Practitioners. Failure or refusal of any Practitioner to cooperate with the required screening may constitute grounds for denial of an application or reapplication or for corrective action. Any positive screen results shall be reported to the chairman of any Staff committee and the Chief Executive Officer.

The Executive Committee will investigate the matter and address:

7.5.3.1 the results of such screening;

7.5.3.2 whether the Practitioner has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;

7.5.3.3 whether such ability is compromised by reason of the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and

7.5.3.4 whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

On the basis of the screening and any further investigation, the Executive Committee may take further corrective action as appropriate, subject to the provisions of Articles Seven and Eight and Rule 8.

7.6 INFORMAL ACTION

In certain circumstances where no summary suspension has been invoked pursuant to Rule 7.2 and the Executive Committee has not received a request pursuant to Rule 7.4.1 and the

nature of an issue is such that it may appropriately be resolved through informal, person-to-person contact, the Executive Committee may exercise its powers regarding review and evaluation of the quality of medical and hospital care through such informal means. Recognizing that such informal, person-to person action may be more effective if performed by a person rather than a committee, the Executive Committee delegates its power to take informal action in such instances to any one of the following individuals: the Chief of Staff, the chief of any department, the Vice-President of Clinical Affairs or the Chief Executive Officer. Such action shall not entitle an affected Applicant or Practitioner to any hearing, appellate review or other rights under these Professional Staff Rules.

RULE EIGHT: HEARING AND APPELLATE REVIEW PROCEDURES

8.1 RIGHT TO HEARING AND APPELLATE REVIEW

8.1.1 Right to Hearing Generally

Except as provided in Rule 8.14, when any Applicant or Practitioner receives notice of any final adverse action under circumstances as defined in Rules 8.1.2 and 8.1.3, he shall be entitled, upon timely and proper request, to the hearing and other procedures provided for in this Rule.

8.1.2 Adverse Actions

The following recommendations or actions, if deemed final under Rule 8.1.3 below, shall entitle the Practitioner to the rights provided for in this Rule Eight:

8.1.2.1 denial of initial Staff Appointment,

8.1.2.2 denial of reapplication for Staff Appointment,

8.1.2.3 revocation of Staff Appointment,

8.1.2.4 denial of requested Clinical Privileges,

8.1.2.5 reduction, revocation or suspension of Clinical Privileges other than as provided in Rule 8.1.4.3, 8.1.4.4 or 8.1.4.5,

8.1.2.6 summary suspension of Clinical Privileges, and

8.1.2.7 denial of reinstatement after Leave of Absence.

8.1.3 Final Action

A recommendation or action listed in Rule 8.1.2 above is final only when it has been:

8.1.3.1 recommended by the Executive Committee pursuant to Rule 1.3.4, 1.5.6, 7.2.5,

7.4.5, or

8.1.3.2 has been taken by the Board under circumstances where no prior right to request a hearing existed.

8.1.4 Actions Not Deemed Adverse

None of the following actions shall entitle an affected Applicant or Practitioner to any hearing, appellate review or other rights under this Rule Eight:

8.1.4.1 the issuance of a warning, a letter of admonition, or a letter of reprimand;

8.1.4.2 the imposition of terms of probation, preceptorship, monitoring, or pre or post case consultation requirements;

8.1.4.3 the termination of any temporary Clinical Privileges;

8.1.4.4 automatic suspensions pursuant to Rule 7.3;

8.1.4.5 a suspension or restriction of Clinical Privileges for a period of not longer than 14 days during which an investigation is being conducted to determine the need for professional review action;

8.1.4.6 change or denial of a change in Staff category;

8.1.4.7 other situations which are specifically covered in the Staff Bylaws or these Rules which specifically exclude hearing and appeal rights.

8.1.5 Extension of Right to Hearing and Appellate Review

The Chief Executive Officer may, in his sole discretion, extend the Applicant's or Practitioner's right to the hearing and other procedures provided for in this Rule to recommendations or actions not specifically set forth in Rule 8.1.2 and 8.1.3 or excluded in Rule 8.1.4.

8.2 NOTICE OF ADVERSE ACTION

The Chief Executive Officer shall be responsible for giving prompt written notice of adverse action described in Rule 8.1.2 and 8.1.3 by delivery to the affected Applicant or Practitioner either in person or by certified mail, return receipt requested. This notice shall:

8.2.1 advise the Applicant or Practitioner of the action and of his right to request a hearing pursuant to the provisions of these Bylaws;

8.2.2 specify that the Applicant or Practitioner has thirty days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the

conditions of Rule 8.3;

8.2.3 state that the failure to request a hearing within the time period and in the proper manner shall constitute a waiver of rights to any hearing or appellate review on the matter which is the subject of the notice;

8.2.4 state that the Board is not bound by the adverse action that the Applicant or Practitioner accepts by virtue of his waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances;

8.2.5 state the grounds upon which the adverse recommendations or actions are based;

8.2.6 state that upon receipt of his hearing request, the Applicant or Practitioner will be notified of the date, time and place of the hearing;

8.2.7 provide a summary of the Applicant's or Practitioner's rights at the hearing.

8.3 REQUEST FOR HEARING

The Applicant or Practitioner shall have thirty days after receiving a notice under Rule 8.2 to file a written request for a hearing. The request must be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested. In addition to requesting a hearing, such request must respond, point by point, to each finding or ground relied upon by the Executive Committee in support of its action or recommendation. This response must clearly detail all reasons that, from the affected Applicant's or Practitioner's point of view, each finding or ground of the Executive Committee and the action or recommendation itself, is in error.

8.4 WAIVER

8.4.1 Failure to Request Hearing

Failure of an Applicant or Practitioner to request a hearing within the time and in the manner specified in Rule 8.3 above shall be deemed to be a waiver of his right to any hearing or appellate review to which he might otherwise have been entitled.

8.4.2 Incomplete Request

In the event the affected Applicant's or Practitioner's request is incomplete, the Chief Executive Officer shall so notify him. Failure to furnish a complete request within five days after notice from the Chief Executive Officer shall be deemed to be a waiver of the Applicant's or Practitioner's right to any hearing or appellate review to which he otherwise may have been entitled, notwithstanding the earlier incomplete request.

8.4.3 Effect of Waiver

Any waiver shall apply only to the matters which were the bases for the adverse action triggering the Rule 8.2 notice. Upon waiver, the adverse action taken against the

Applicant or Practitioner shall remain in effect pending the Board's final action in the matter. The Board is not bound by the previous adverse action that the Applicant or Practitioner has accepted by virtue of his waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances. The Chief Executive Officer shall promptly notify the affected Applicant or Practitioner of his status and of the final action of the Board.

8.5 HEARING PREREQUISITES

8.5.1 Notice of Time and Place of Hearing

Within 10 days after receipt of a request for hearing from an Applicant or Practitioner entitled to the same, the Chief Executive Officer shall schedule and arrange for a hearing and shall notify the Applicant or Practitioner of the time, place and date of the hearing by written notice delivered either in person or by certified mail, return receipt requested. Ordinarily, the hearing date shall not be less than 30 days from the date of the notice of the hearing by the Chief Executive Officer; provided, however, that the Applicant or Practitioner may request an earlier hearing date and, in such case, the hearing shall be held as soon as arrangements therefor may reasonably be made. Further, the hearing date shall not be more than 180 days from the date of the notice of the hearing by the Chief Executive Officer; provided, however, that if the Applicant or Practitioner requests a delay of the hearing date beyond such date, the Chief Executive Officer, in his sole discretion, may extend such date.

8.5.2 Statement of Issues

The notice of hearing shall contain a concise statement of the factual bases for the adverse action, a list by number of the specific or representative patient records in question, a list of witnesses (if any) expected to testify at the hearing and/or the other reasons or subject matter forming the basis for the adverse action or recommendation which is to be the subject of the hearing.

8.5.3 Composition of Hearing Committee

8.5.3.1 A hearing occasioned by an adverse action taken by the Executive Committee shall, subject to Rule 8.5.4, be conducted by a hearing committee comprised of the members of the Executive Committee. The Chief of Staff shall serve as the chairman of the hearing committee or designate another member of the Staff Executive Committee to serve as chairman of the hearing committee. If the Chief of Staff is disqualified, or otherwise prevented from serving on the hearing committee, the Vice-Chief will serve as chairman of the hearing committee, or designate another member of the Executive Committee to so serve.

8.5.3.1.1 Prior involvement of an Executive Committee member in formulation of the adverse action which occasioned the hearing shall not bar his

participation as a hearing committee member.

8.5.3.1.2 The hearing committee shall exclude as members persons who are in direct economic competition with the affected Applicant or Practitioner. Such exclusion may initially be effected by the determination of the Chief Executive Officer or the hearing committee member himself.

8.5.3.1.3 The affected Applicant or Practitioner shall be notified of the names of the hearing committee members and may object to any hearing committee member on the basis of such member being in direct economic competition with him or on the basis of lack of impartiality. The chairman of the hearing committee shall rule on any such objection except when the objection is to the chairman himself, in which case the objection shall be ruled on the first of such individuals who is not the subject of an objection: a hearing officer, if one is utilized under Section 8.6.2.3, the Chief of Staff, and the Vice-Chief. Failure of the affected Applicant or Practitioner to so object as to any hearing committee member shall be deemed a waiver of his right to do so.

8.5.3.1.4 If one or more members are excluded from the hearing committee, the Chief Executive Officer shall, in his discretion, determine whether a sufficient number of hearing committee members remain to conduct the hearing. If this determination is in the negative, the Chief Executive Officer may, in his discretion, name additional hearing committee members or may name an arbitrator to serve as the trier of fact at the hearing. Such additional hearing committee members or arbitrator need not have Staff Appointment or Clinical Privileges at the Hospital. However, an arbitrator must be independent and may not be an employee of the Hospital or be from a firm that regularly represents the Hospital or the affected Applicant or Practitioner. The affected Applicant or Practitioner shall be notified of the names of any additional hearing committee members or arbitrator and may object to any additional committee member or an arbitrator on the basis of such additional member or arbitrator being in direct economic competition with him, the lack of impartiality, or, in the case of an arbitrator, the lack of independence. The chairman of the hearing committee shall rule on any such objection. Failure of the affected Applicant or Practitioner to so object as to any additional hearing committee member or arbitrator shall be deemed a waiver of his right to do so. If one or more members are excluded from the hearing committee or if an objection to the arbitrator is upheld, the process set forth in this Section 8.5.3.5 will be repeated.

8.5.3.2 A hearing occasioned by an adverse action of the Board under circumstances where the Applicant or Practitioner had no previous right to request a hearing

shall be conducted by a hearing committee appointed by the Chairman of the Board and composed of not less than three persons. The Chairman of the Board may also name any replacement or substitute committee members, any non-voting, advisory members to assist the hearing committee, and the chairman of the hearing committee. The Vice-Chairman of the Board will rule on any objection to the Chairman of the Board serving as chairman of the hearing committee.

8.5.3.2.1 The affected Applicant or Practitioner shall be notified of the names of the hearing committee members and may object to any hearing committee member on the basis of such member being in direct economic competition with him or on the basis of lack of impartiality. The chairman of the hearing committee shall rule on any such objection. Failure of the affected Applicant or Practitioner to so object as to any hearing committee member shall be deemed a waiver of his right to do so.

8.5.4 Authority of Hearing Committee

The hearing committee shall have the authority to:

8.5.4.1 Conduct a hearing, consider and receive evidence, and deliberate and reach a determination in the form of a final recommendation;

8.5.4.2 Request that other Practitioners or outside experts examine questions within their respective specialties or questions where a dispute exists between the position of the affected Practitioner and the adversary representative, and report to the hearing committee their opinions and the basis for those opinions;

8.5.4.3 Direct the attendance and participation of witnesses, and the submission and introduction of documentary evidence, whether or not proffered by the adversary representative or the affected Applicant or Practitioner;

8.5.4.4 Determine the weight to be accorded to evidence which is admitted; and

8.5.4.5 Take such other actions as will facilitate its business.

8.6 HEARING PROCEDURE

8.6.1 Personal Presence

The personal presence of the Applicant or Practitioner is required. An Applicant or Practitioner who fails without good cause to appear and proceed at the hearing shall be deemed to waive his rights in the same manner and with the same consequences as provided in Rule 8.4.1 and 8.4.3.

8.6.2 Presiding Officer

Except as provided in Section 8.6.3, the chairman of the hearing committee shall serve as the presiding officer over the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum. The presiding officer shall have the authority to:

8.6.2.1 Establish the time, place, manner, and procedure for conducting the hearing, consistent with these Bylaws;

8.6.2.2 Clarify and narrow the issues;

8.6.2.3 Hold a preliminary meeting with the parties for the purpose of clarifying issues, establishing procedures, or otherwise aiding the committee;

8.6.2.4 Rule on the admissibility of evidence;

8.6.2.5 Perform other tasks specified in the Bylaws and Rules; and

8.6.2.6 Otherwise preside over the hearing.

8.6.3 In lieu of the chairman of the hearing committee serving as the presiding officer, the Chief Executive Officer may appoint a hearing officer to serve as the presiding officer over the hearing. If a hearing officer is utilized, he may be an attorney at law. However, the hearing officer must be independent and may not be an employee of the Hospital or be from a firm that regularly represents the Hospital or the affected Applicant or Practitioner. The affected Applicant or Practitioner shall be notified of the name of any hearing officer and may object to the hearing officer on the basis of lack of impartiality or lack of independence. The chairman of the hearing committee shall rule on any such objection. Failure of the affected Applicant or Practitioner to so object as to the hearing officer shall be deemed a waiver of his right to do so. If an objection to the hearing officer is upheld, the process set forth in this Section 8.6.3 will be repeated.

8.6.4 Committee Members

Members of the hearing committee are actively encouraged to take a participatory role in the proceedings, to question witnesses, to call upon witnesses for information within their possession, to direct the submission of additional evidence and documentation, to question the adversary representative and the affected Applicant or Practitioner, and to see that the record contains all information which the committee considers necessary in order to reach a decision.

8.6.5 Representation of the Adverse Recommendation

If the action which prompted the hearing was taken by a committee of the Staff, it shall appoint one or more of its members or Practitioners to represent it at the hearing. If the action which promoted the hearing was taken by the Board, it shall appoint one or more of

its members to represent it at the hearing. Such adversary representatives shall have the obligation to present the facts in support of the adverse action, to examine witnesses, and to otherwise participate fully in the hearing.

8.6.6 Representation of the Practitioner
The affected Applicant or Practitioner is entitled to be represented by an attorney or other person of his choice.

8.6.7 Utilization of Attorneys
While both the affected Applicant or Practitioner and the adversary representative are entitled to utilize an attorney at law to make statements, introduce evidence, examine witnesses, or otherwise serve as an advocate at the hearing, it is with the understanding that the hearings provided for in these Bylaws are for the purpose of resolving, on an intra professional basis, matters bearing on professional competency and conduct and are not a judicial forum. If attorneys are utilized by either the Applicant or Practitioner or adversary representative, they should strive to facilitate, and not hinder, the hearing process in order that a prompt and fair decision may be made by the hearing committee. Accordingly, the presiding officer and the hearing committee retain the right to limit the role of attorneys as participants in the proceedings.

8.6.8 Clarification of Issues

8.6.8.1 Outline of Case. At least fifteen (15) days prior to the scheduled date of a hearing, the affected Applicant or Practitioner and the adversary representative shall each submit an outline and written documentation to the Chief Executive Officer for transmittal to the committee and to the other party setting forth, so far as is then reasonably known:

8.6.8.1.1 Issues which each party proposes to raise at the hearing.

8.6.8.1.2 Witnesses whom each party proposes to call at the hearing and the subject or subjects on which such witnesses will testify.

8.6.8.1.3 All written or documentary evidence that each party anticipates introducing as evidence at the hearing.

8.6.8.1.4 A short summary of what the party expects to demonstrate at the hearing in support of its position.

8.6.8.1.5 The specific result or results requested from the hearing committee.

8.6.8.2 Pre-hearing Conference. Prior to the scheduled commencement of the hearing, the presiding officer shall meet with the parties for the purpose of conducting a pre-hearing conference to discuss possible stipulations of facts,

amendments to the grounds for action or the issues in dispute, and changes in the witness or evidence list of each party. Any further procedures established for the conduct of the hearing shall be explained at such time.

8.6.9 Issues

Once a hearing has been requested, the hearing committee shall not be bound by the statement of issues from Rule 8.5.2 or 8.6.8. Instead, the committee may, upon advising the parties, broaden the issues under examination and may base its decision, wholly or in part, upon the resolution of issues not originally considered or listed.

8.6.10 Rights of Parties

During a hearing, each party may:

8.6.10.1 call and examine witnesses,

8.6.10.2 introduce exhibits,

8.6.10.3 cross-examine any witness on any matter relevant to the issues,

8.6.10.4 impeach any witness,

8.6.10.5 rebut any evidence,

8.6.10.6 request that the record of the hearing be made by use of a court reporter or electronic recording unit pursuant to the provisions of Rule 8.6.15 hereof; and

8.6.10.7 submit a written statement at the close of the hearing.

8.6.11 Procedure and Evidence

The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the existence of any common law or statutory rule which might make the evidence inadmissible over objection in civil or criminal actions. However, evidence related to the professional performance or behavior of another Practitioner and evidence of actions taken, or not taken, regarding the professional performance or behavior of another Practitioner is not relevant and is not admissible. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and such memoranda become part of the hearing record. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents.

8.6.12 Order of Procedure

The basic order of procedure for the hearing shall be as follows:

8.6.12.1 First, the adversary representative shall present the facts in support of the adverse action, whether through testimony, written evidence or otherwise.

8.6.12.2 Immediately following conclusion of the adversary representative's presentation (and any cross-examination by the affected Applicant or Practitioner), the affected Applicant or Practitioner shall testify in response to the facts and issues raised by the adversary representative, and shall be subject to cross-examination by the adversary representative. If the affected Applicant or Practitioner does not testify in his own behalf, he may be called at this time and examined as if under cross-examination.

8.6.12.3 Upon conclusion of the affected Applicant or Practitioner's testimony, the affected Applicant or Practitioner may then call such other witnesses to testify as to matters which are relevant to the issues before the hearing committee.

8.6.12.4 Upon conclusion of the affected Applicant or Practitioner's presentation (and any cross-examination by the adversary representative), the adversary representative may introduce rebuttal evidence.

8.6.12.5 At any time during the procedure the hearing committee members may question witnesses.

8.6.13 Official Notice

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of this state. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the hearing committee. The committee is also entitled to consider all other information that can be considered under these Bylaws in connection with credentials matters. The hearing committee is also entitled to consider all other information that can be considered under the Bylaws and Rules in connection with credentials matters.

8.6.14 Burden of Proof

When a hearing relates to Rule 8.1.2.1, 8.1.2.2, 8.1.2.4 or 8.1.2.7, the Applicant or Practitioner shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that such basis (or the action based thereon) is either arbitrary, unreasonable or capricious. When a hearing relates to Rule 8.1.2.3, 8.1.2.5, or 8.1.2.6, the adversary representative shall have the initial obligation to present evidence in support of the adverse action, but the Applicant or Practitioner thereafter is responsible for supporting (by a preponderance of the evidence) his challenge

that the adverse action lacks any substantial factual basis, or that such basis (or the action based thereon) is either arbitrary, unreasonable, or capricious.

8.6.15 Hearing Record

A record of the hearing must be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may be later called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceeding.

The affected Applicant or Practitioner shall be entitled to a copy of the record upon request accompanied with payment for one-half (½) of the charges associated with the preparation of the hearing record.

8.6.16 Postponement

Postponement of a hearing shall be granted only by the hearing committee, in its sole discretion, upon a showing of good cause therefor.

8.6.17 Presence of Committee Members and Vote

A majority of the hearing committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing, he may not participate in the final hearing committee vote until he certifies that he has reviewed the portion of the hearing record covering the portion of the hearing which took place during his absence. No committee member may vote by proxy. The Chief Executive Officer is entitled to and shall be present during all proceedings, deliberations and vote of the hearing committee as the duly authorized representative of the Board.

8.6.18 Recesses and Adjournment

The hearing committee may recess and reconvene the hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

8.6.19 Proposed Findings

The hearing committee may direct the parties to submit proposed findings, referencing the hearing record, prior to conducting its deliberations. The presiding officer shall set the schedule for the submission of such proposed findings to the hearing committee.

8.7 HEARING COMMITTEE REPORT AND FURTHER ACTION

8.7.1 Hearing Committee Report

The hearing committee shall make a written report of its findings and shall affirm, modify, or reject the original adverse action. Such report shall include a statement of the basis for

the action of the hearing committee. Such action by the hearing committee shall remain in full force and effect unless and until modified by the Board in the appellate review process, or otherwise as provided in these Bylaws. The hearing committee report, along with the hearing record and all other documentation considered, shall be forwarded to the Board.

8.7.2 Notice

The Chief Executive Officer shall be responsible for giving the affected Applicant or Practitioner prompt notice of the hearing committee's action either by certified mail, return receipt requested, or personal delivery. This notice shall:

8.7.2.1 include a copy of the hearing committee report;

8.7.2.2 advise the affected Applicant or Practitioner of his right to request appellate review under Rule 8.8 and of the waiver provisions of Rule 8.8.2; and

8.7.2.3 be copied to the Chief of Staff, and to the Board.

8.7.3 Effect of Report

8.7.3.1 Appellate Review From Action of Hearing Committee Composed Under Rule 8.5.3.1: Action by a hearing committee composed under Rule 8.5.3.1 involving any of the adverse actions described in Rule 8.1.2 shall entitle the affected Applicant or Practitioner to appellate review under Rules 8.8 and 8.9 hereof. Any action of such hearing committee involving an adverse action described in Rule 8.1.2 shall remain in effect unless and until modified by the Board in the appellate review process or otherwise as provided in these Bylaws.

8.7.3.2 Report to Board From Other Action of Hearing Committee Composed Under Rule 8.5.3.1: Action by a hearing committee composed under Rule 8.5.3.1 involving actions other than specified in Rule 8.1.2, shall not entitle the affected Applicant or Practitioner to appellate review under Rules 8.8 and 8.9 hereof. The hearing committee report shall be forwarded to the Board for final action. The Board may affirm, reject or modify the action of the hearing committee and itself take any action, whether more or less severe than the action of the hearing committee, it deems warranted by the circumstances. In the event such action by the Board results in an action specified in Rule 8.1.2 hereof, the affected Applicant or Practitioner shall then be entitled to appellate review under Rules 8.8 and 8.9 hereof.

8.7.3.3 Report to Board From Action of Hearing Committee Composed Under Section 8.5.3.2: The affected Applicant or Practitioner is not entitled to appellate review under Rules 8.8 and 8.9 hereof from any action by a hearing committee

composed under Rule 8.5.3.2. The hearing committee report shall be forwarded to the Board for final action. The Board may affirm, reject or modify the action of the hearing committee and itself take any action, whether more or less severe than the action of the hearing committee, it deems warranted by the circumstances.

8.8 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

8.8.1 Request for Appellate Review

The affected Applicant or Practitioner shall have 7 days after receiving a notice of adverse action under Rule 8.7.2 that entitles him to appellate review under Rule 8.7.3.1 to file a written request for appellate review. The request must be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall, in the affected Applicant's or Practitioner's discretion, include requests for:

8.8.1.1 a copy of the hearing committee report and record and all other material, favorable or unfavorable, if not previously forwarded, that was considered in taking the adverse action;

8.8.1.2 the right to submit a written statement pursuant to Rule 8.9.2;

8.8.1.3 the right to make an oral statement pursuant to Rule 8.9.3;

8.8.1.4 consideration of new or additional matters pursuant to Rule 8.9.4.

8.8.2 Waiver

8.8.2.1 An affected Applicant or Practitioner who fails to request an appellate review within the time and manner specified in Rule 8.8.1 shall be deemed to have waived any right to appellate review. Such waiver shall have the same force and effect as provided in Rule 8.4.

8.8.2.2 An affected Applicant or Practitioner who fails to request the right to submit a written statement, or who fails to request the right to make an oral statement shall be deemed to have waived any right to make such request or submit such written statement. Any subsequent request or submission shall not be considered as a part of appellate review.

8.8.2.3 The failure of the affected Applicant or Practitioner to include in his request for appellate review a request for consideration of new or additional matters shall be deemed a waiver of any right he would otherwise have to request the same.

8.8.2.4 The failure of the affected Applicant or Practitioner to submit a written

statement within the time specified herein shall be deemed to be a waiver of any right he may otherwise have had to submit such statement.

8.8.2.5 The failure of the affected Applicant or Practitioner to appear at the time and place designated for oral statements shall be deemed to be a waiver of any right he may otherwise have had to submit such statement.

8.8.3 Notice of Time and Place for Appellate Review

Within 10 days after receipt of a request for appellate review pursuant to Rule 8.8.1, the Chief Executive Officer shall schedule a date for appellate review, including the time and place for oral statements if such have been requested, and the Chief Executive Officer, either by personal delivery or by certified mail, return receipt requested, shall notify the affected Applicant or Practitioner of the same. The date of appellate review shall ordinarily not be less than 25 days, nor more than 45 days, from the date of receipt of the notice of request for appellate review, except that when the Practitioner requesting a review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made. These time periods are merely guidelines and are designed to assist the Chief Executive Officer and the Board in accomplishing their tasks. Consequently, they shall not be deemed to create any right for the affected Applicant or Practitioner to have appellate review scheduled within these precise periods.

8.8.4 Appellate Review Body

The appellate review shall be conducted by the Board or a duly-appointed sub-committee of the Board, together with such other advisory non-voting members as the Board or such sub-committee may designate.

8.9 APPELLATE REVIEW PROCEDURE

8.9.1 Nature of the Proceedings

The appellate review proceedings are a review based upon the hearing record, the hearing committee's report, all subsequent results and actions, the written or oral statements, if any, provided below and any other material that may be presented and accepted under Rule 8.9.4 below. In reaching its decision, the appellate review body is limited to consideration of:

8.9.1.1 whether or not the Staff Bylaws have been followed;

8.9.1.2 whether or not the decision of the hearing committee was based upon substantial evidence of record; and

8.9.1.3 whether or not the hearing committee's decision was a reasonable one in light of the Hospital's duty to the public.

8.9.2 Written Statements

If the Applicant or Practitioner has requested the right to submit a written statement pursuant to Rule 8.8.1.2, he shall have 10 days from the date of his request for appellate review in which to submit to the Chief Executive Officer, either in person or by certified mail, return receipt requested, a written statement detailing the factual and procedural matters with which he disagrees, specifying the particular reasons for such disagreement. In order to assist the appellate review body in its review, the written statement should specifically reference applicable portions of the hearing record. This written statement may cover any matters raised at any step in the procedure to which the appeal is related and legal counsel may assist in its preparation. A similar statement supporting the action of the hearing committee and replying to the statement of the affected Applicant or Practitioner shall be submitted on behalf of the hearing committee within 20 days from the date of receipt of the request for appellate review by the Chief Executive Officer. Such written statements shall be submitted to the appellate review body by the Chief Executive Officer, and the Chief Executive Officer shall provide copies thereof to the affected Applicant or Practitioner or the hearing committee representative, as appropriate.

8.9.3 Oral Statements

If the right to make an oral statement pursuant to Rule 8.8.1.3 has been requested by the affected Applicant or Practitioner, he shall be present at the appellate review proceedings and shall be permitted to speak himself or by his representative against the adverse action. The affected Applicant or Practitioner shall be subject to examination by any member of the appellate review body. The hearing committee shall also be represented by an individual who shall be permitted to speak in favor of the adverse action and who shall answer questions put to him by any member of the appellate review body. Both the affected Applicant or Practitioner and the representative of the hearing committee, in their own discretion, may utilize the services of an attorney-at-law as an advocate at such oral presentations.

8.9.4 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing committee report and not otherwise reflected in the record may be introduced at appellate review only in the discretion of the appellate review body and as the appellate review body deems appropriate, and only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. Failure to request consideration of new or additional matters by the affected Applicant or Practitioner as a part of his request for appellate review shall, pursuant to Rule 8.8.2.3 result in a waiver of his right to make such request.

8.9.5 Presiding Officer

The chairman of the appellate review body shall serve as the presiding officer and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

8.9.6 Presence of Members

A majority of the appellate review body must be present throughout the review and deliberations .

8.9.7 Recesses and Adjournment

The appellate review body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if any, the appellate review shall be closed. The appellate review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

8.9.8 Action Taken

The appellate review body may affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the hearing committee for further review and recommendation within a time period set by the appellate review body. Within a reasonable time following completion of appellate review, the Board shall take action and, if such action is in accordance with the last recommendation of the hearing committee, the Board's action shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

If the decision of the Board is contrary to the final recommendation of the hearing committee, and the matter has not already been considered by the Joint Conference Committee, the Board shall refer the matter to the Joint Conference Committee for further review and recommendation. Recommendations from the Joint Conference Committee should be transmitted to the Board within fifteen (15) days. Should the Board refer a matter to the Joint Conference Committee, the notice to the affected Applicant or Practitioner shall include a statement that a final decision will not be made until the Joint Conference Committee's recommendation has been received. Following receipt of the Joint Conference Committee's recommendation, the Board shall make its final decision which shall be immediately effective and binding and shall not be subject to further hearing or appellate review.

8.9.9 Notice of Final Action

The Chief Executive Officer shall promptly send written notice of the final action of the Board to the affected Applicant or Practitioner either by personal delivery or by certified mail, return receipt requested. Such notice shall include a statement of the basis of the Board's action.

8.10 COMPLETION OF HEARING AND APPELLATE REVIEW PROCESS

The hearing and appellate review process provided herein shall not be deemed to have been concluded until all of the procedural steps provided in this Rule have either been completed or waived.

8.11 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of these Bylaws, no Applicant or Practitioner shall be entitled as a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of an adverse action taken against him.

8.12 BOARD COMMITTEE ACTION

Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act.

8.13 RELEASE

By requesting a hearing or appellate review under this Rule, an Applicant or Practitioner reaffirms his prior agreements to be bound by the provisions of the Staff Bylaws relating to immunity from liability.

8.14 EXCEPTIONS TO HEARING AND APPELLATE REVIEW PROCEDURES

The hearing and appellate review provisions of this Rule Eight do not apply to:

8.14.1 Voluntary Resignation or Failure to Reapply

The expiration or other termination of Appointment or Clinical Privileges due to the Practitioner's voluntary resignation, failure to reapply, or failure to request reinstatement following a leave of absence.

8.14.2 Outpatient Staff

Denial, non-renewal, limitation or termination of Outpatient Staff Appointment and related Clinical Privileges.

8.14.3 Medico administrative Positions

Any automatic termination of Appointment or Clinical Privileges.

8.14.4 Ancillary Service Practitioners

Any automatic termination of Appointment or Clinical Privileges described in Bylaw Article 4.7.1.2 or the assignment, change of assignment, denial of assignment, or denial of a change of assignment to a Staff Category described in Bylaws Article 4.7.1.

8.14.5 Failure to Meet Preliminary Eligibility Requirements

The failure of a person to establish that he meets the preliminary eligibility criteria.

8.14.6 Ineligibility Following Adverse Action

Ineligibility for Appointment or Clinical Privileges.

8.14.7 Temporary Clinical Privileges

Denial, non-renewal, limitation or termination of temporary Clinical Privileges.

8.14.8 Automatic Suspension

Automatic suspension of Clinical Privileges.

8.14.9 Suspension or Restriction of Clinical Privileges During Investigation
Suspension or restriction of Clinical Privileges for up to fourteen (14) days while an investigation is pending.

8.14.10 Interviews
Interviews, including but not limited to Interviews provided for in Rules1.3.3, 1.3.4, 1.5.6, 4.9.10, 7.2.3, and 7.4.4.

8.14.11 Removal from On-call Roster or Other Administrative Actions
Removal from the on-call roster or other administrative action not directly adversely impacting the Practitioner's Appointment or Clinical Privileges.

8.14.12 Other Circumstances
Other circumstances where the hearing and appellate review provisions of Article Eight or Rule 8 do not apply or are limited by the Bylaws or Staff Rules.

8.14.13 Allied Health Professionals
Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the corrective action, hearing or appellate rights provided for in Articles Seven and Eight. Any and all procedural rights for AHPs are set out in Rule 4.910.

RULE NINE: ADMINISTRATIVE PROVISIONS

9.1 INTERPRETATION

9.1.1 Interpretation of these Rules will be the responsibility of the Staff Executive Committee.

9.1.2 In the event said Committee cannot reach a majority decision regarding a point of interpretation, a final decision will rest with the Hospital Board.

9.1.3 These Rules cover many areas of concern to Practitioners in a comprehensive, multi-disciplinary, issue-oriented approach that includes both Practitioners, Hospital employees and independent contractors and others. Accordingly, no reference in these Rules other than one referring directly to a duty, obligation or responsibility of Practitioners, either individually or as a group, shall create any duty, obligation or responsibility for Practitioners, either individually or as a group.

9.1.4 These Rules are in addition to any requirements that may be imposed by Staff Bylaws, Hospital Bylaws, Hospital Rules, Service or Ancillary Service Rules, applicable law or regulation, accreditation requirements or otherwise.

9.1.5 In the event of any conflict between the provisions of these Rules and the provisions of the Staff Bylaws, the terms of the Staff Bylaws shall prevail.

9.2 DEFINED TERMS

Unless stated to the contrary herein, capitalized terms in these Rules shall have the same meaning as defined in the Staff Bylaws.

9.3 COMMITTEES

9.3.1 All committees, standing or special, shall confine their work to the purpose for which they were appointed.

9.3.2 Committees shall not have power of action unless so authorized by the Bylaws or a majority vote of the Staff.

9.3.3 No committee, standing or special, unless specifically granted power of action, shall pass its own rules or regulations, but shall make appropriate recommendation to the Staff Executive Committee for action.

9.3.4 All quality assurance activities will be conducted through organized committees of the Staff.

9.4 NON-DISCRIMINATION IN CARE AND TREATMENT OF PATIENTS

9.4.1 A Practitioner may not ethically refuse to treat a patient whose condition is within the Practitioner's current realm of competence solely because the patient is HIV seropositive or otherwise thought to be HIV-infected. Such patients should not be subjected to discrimination based on fear or prejudice.

9.4.2 Practitioners unable to provide the services required by patients who are, or are thought to be, HIV seropositive, should make referrals to those Practitioners and/or facilities best equipped to provide such services.

9.4.3 It is in the best interest of the patient for the Practitioner to focus on treatment of the disease, rather than on making value judgments about how the disease was contracted.

9.5 ANCILLARY SERVICE RULES

9.5.1 Any rules and regulations of Ancillary Services shall be submitted to the Staff Executive Committee for consideration and approval.

9.5.2 Final approval rests with the Hospital Board.

9.5.3 When properly approved, such rules and regulations shall become a part of these Rules.

9.6 PATIENT CONTACT LIMITS FOR ACTIVE AND CONSULTING STAFF

Pursuant to Bylaws 4.2.1.3 and 4.3.1.3, the following number of patient contacts per calendar year is set as the minimum standard for patient contacts for Active Staff Appointment and the threshold for patient contacts upon which a Practitioner with Consulting Staff Appointment will be required to apply for Active Staff Appointment:

twelve (12) patient contacts per calendar year

"Patient Contacts" means any of the following:

- admission or
- inpatient procedures

9.7 SENTINEL EVENTS AND DISCLOSURE OF UNANTICIPATED OUTCOMES

9.7.1 Policy

Per Hospital policy, all Hospital staff and Medical Staff have the responsibility to report any Sentinel Event and participate in an evaluation, if requested.

A Sentinel Event is defined as an event that has resulted in an unanticipated death or major permanent loss of function, OR

Is one of the following (even if the outcome was not death or major permanent loss of function):

- Suicide
- Infant abduction or discharge to the wrong facility
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part.

9.7.2 Disclosure of Unanticipated Outcomes

The responsible Practitioner or designee should explain the outcome of any treatments or procedures to the patient, family, or legally authorized representative whenever those outcomes differ significantly from the anticipated outcomes, specifically when those outcomes are Sentinel Events.

9.8 HIPAA PRIVACY

The Hospital, together with all Practitioners that provide clinical services at Hospital, constitute an Organized Health Care Arrangement ("OHCA") under the HIPAA Privacy

Regulations. Accordingly, Hospital and the Staff will issue a joint notice of privacy practices, as permitted under the HIPAA Privacy Regulations, and each Practitioner will abide by the terms of this joint notice with respect to Protected Health Information ("PHI"). Practitioner may receive in connection with Practitioner's participation in professional activities of the OHCA. Hospital and Practitioners may share PHI with each other, as necessary to carry out treatment, payment or health care operations functions related to the OHCA.

RULE TEN: ADMISSIONS

10.1 GENERAL GUIDELINES

10.1.1 The Hospital shall accept for care and treatment any patient whose admission to the Hospital is ordered by Practitioner in Good Standing with admitting privileges. No patient will be accepted who is not so admitted.

10.1.2 Subject to these Rules and Hospital Policies, patients may be admitted at any time.

10.1.3 The following types of patients will only be admitted if adequate facilities and personnel are available to isolate the patient:

10.1.3.1 Those having common acute contagious diseases.

10.1.3.2 Those exhibiting violent or suicidal behavior or mental derangement.

10.1.3.3 Those who, in the opinion of the Chief Executive Officer and the Chief of Staff, might endanger the welfare of other patients or seriously affect usual hospital functions.

10.1.4 Admissions and bed assignments are the responsibility of the admitting office.

10.2 ADMISSION PROCEDURE

The procedure each Practitioner shall follow in admitting a patient to the Hospital is as follows:

10.2.1 Contact the admissions office.

10.2.2 Advise the patient or a responsible member of his family to be prepared to submit hospitalization insurance data, social security numbers, and other data upon admission and, in the event that there is no insurance coverage, prepayment in accordance with the Hospital's requirements.

10.2.3 Call in to the appropriate RN or send appropriate admission orders with the

patient.

10.2.4 Initiate the plan of care for the patient.

10.3 INFORMATION TO BE PROVIDED TO PATIENT UPON ADMISSION

10.3.1 It is the general policy of the Hospital to promote patient autonomy with regard to health care decision-making. In that regard, it is the further policy of this Hospital not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed a living will declaration and/or health care proxy.

10.3.2 Upon admission to the Hospital as an inpatient, such patient shall be provided with the following:

10.3.2.1 A statement of the patient's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate living will declarations and/or health care proxies.

10.3.2.2 The written policies of the Hospital respecting the implementation of the patient's rights as set forth in Rule 10.3.1 above.

10.3.2.3 When a patient is admitted on court order, the rights and responsibilities of the patient and the patient's family shall be explained to him. This explanation of the rights and responsibilities of the patient and the patient's family shall be documented in the patient's record.

10.3.3 Documentation of whether the patient has executed an advanced directive shall be included in a prominent part of the patient's current medical record.

10.4 NOTIFICATION UPON ARRIVAL AND/OR TRANSFERS

10.4.1 The admitting Practitioner or his office will be notified when a patient arrives on the floor or when a patient is transferred from one room to another.

10.4.2 Transfer priorities shall be as follows:

10.4.2.1 Emergency Department to appropriate patient bed.
10.4.2.2 From Intensive Care Unit to general care area.

10.4.2.3 Post surgery patients from semi-private to private rooms, when medically necessary.

10.2.2.4 From temporary placement in an appropriate geographic or a clinical service area to the appropriate area for that patient.

10.5 EXAMINATION BY ADMITTING PRACTITIONER

10.5.1 Patients admitted to the Hospital must be seen by the admitting Practitioner, or the Practitioner designated as being on call for the admitting Practitioner, within twenty-four (24) hours of patient's admission.

10.5.2 The emergency department physician does not take the place of the admitting or designated on-call physician for purposes of Rule 10.5.1.

10.5.3 Any Practitioner who admits a patient from his office and who provides signed orders and an admission or observation note indicating that the patient has been examined by the admitting Practitioner shall be considered to have met the requirements of Rule 10.5.1.

10.6 ISOLATION

10.6.1 The Chief of Staff, the Chairman of the Quality Assurance Committee, and the Chief Executive Officer, pursuant to Rule 10.13, or an attending physician Practitioner, may request the isolation of a Hospital patient. When such request is made, the following procedures should be followed:

10.6.1.1 The patient to be isolated shall be moved to an isolation room, if available, after consultation with attending physician.

10.6.1.2 If an isolation room is not available and if the patient is not housed in a private room at the time of isolation then he should be moved to a private room as soon as possible.

10.6.1.3 If no private rooms are available, the other patient in the room must be moved out immediately to any available accommodation. The isolated patient should be moved to a private room as soon as one becomes available.

10.6.2 There shall be a comprehensive list of communicable diseases for which patients must be isolated and for which there are visitation restrictions. The list, and other policies and procedures for isolation, shall conform to the latest edition of the Centers for Disease Control and Prevention, Atlanta, Georgia (CDC) Guidelines.

10.6.3 The Quality Assurance Committee, in carrying out its infection control function, shall have the power to institute any emergency infection control measures it deems appropriate when a danger to patients or personnel is reasonably believed to exist. Should the attending Practitioner feel that a certain policy or procedure

is inappropriate based on the epidemiologic nature of the disease or the mode of transmission of the agent involved, or should there be questionable cases, the attending Practitioner should consult the Chairman of the Committee, an infection control nurse, or epidemiologist for clarification.

10.7 SUICIDAL PATIENTS

10.7.1 For the protection of patients, the Staff, the Hospital and Hospital employees, certain principles are to be met in the care of the potentially suicidal patient:

10.7.1.1 For patients known or suspected to be suicidal, the following steps shall be taken:

10.7.1.1.1 The patient shall be treated on an emergency basis;

10.7.1.1.2 Immediate steps shall be taken to transfer the patient to another institution where suitable facilities are available;

10.7.1.1.3 If admitted, a consult with an appropriate mental health professional is required;

10.7.2 When transfer cannot be effectuated immediately:

10.7.2.1 The patient may be admitted to the Hospital as a temporary measure.

10.7.2.2 The admitting Practitioner shall inform Nursing Services and should encourage that a family member or someone retained by the family be in attendance with the patient at all times.

10.7.2.3 The admitting Practitioner shall authorize nursing personnel to use such reasonable means as to prevent the patient from harming himself.

10.7.2.4 The patient shall be transferred to a psychiatric facility as soon as the medical condition has stabilized.

10.7.3 For patients not considered to present an immediate suicide threat, steps should be taken to refer the patient for appropriate treatment.

10.8 RESPONSIBILITY OF ADMITTING PRACTITIONER

10.8.1 A Practitioner who admits a patient to the Hospital shall be responsible for the ongoing care of the patient until the Practitioner:

10.8.1.1 Permanently transfers the responsibility of the patient's medical care to another

Practitioner by written order in the patient's medical chart and the second Practitioner accepts this responsibility also by written order in the patient's medical record, or,

10.8.1.2 Discharges the patient following a substantial cure, or,

10.8.1.3 Withdraws from the case, notifies the patient, and medical care is accepted by another Practitioner, or,

10.8.1.4 Is discharged by the patient or by the patient's representative, or,

10.8.1.5 Is relieved of patient responsibility by corrective action of the Staff, or,

10.8.1.6 The patient is deceased.

10.8.2 A Practitioner with admitting privileges shall be responsible for:

10.8.2.1 The medical care and treatment of each of his patients in the Hospital,

10.8.2.2 For the prompt completion and accuracy of the medical record,

10.8.2.3 For necessary special instructions,

10.8.2.4 For transmitting reports of the condition of the patient to a referring Practitioner and to relatives of the patient.

10.8.3 Whenever the Practitioner's responsibilities are transferred to another Practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record.

10.9 COVERAGE

10.9.1 Each Practitioner must assure timely, adequate, professional care for his patients in the Hospital, 24 hours per day, 7 days per week, by being available or having available, whenever he must leave town or will be otherwise unavailable, another eligible Practitioner with whom prior arrangements have been made.

10.9.2 Whenever a Practitioner will be out of town or otherwise unavailable, the Practitioner shall notify the Emergency Department in writing the name of the Practitioner or Practitioners who will be assuming responsibility for the care of the patient and also notify the Practitioner’s medical exchange.

10.9.3 In the event an emergency arises and both the attending Practitioner and his designee are unavailable, the Chief of Staff will be notified and will direct another Practitioner to assume immediate care of the patient until the attending

Practitioner or his designee becomes available or the Chief of Staff will assume this responsibility himself.

10.9.4 Each Practitioner who does not reside in the immediate vicinity shall name an Active or Consulting Staff Appointee who resides in the area who may be called to attend his patients in an emergency or until he arrives.

10.10 UNASSIGNED CALL RESPONSIBILITY

10.10.1 The Chief of Staff shall approve and the emergency department shall maintain a list of Practitioners who have the responsibility for unassigned patients who present at the Hospital and require further examination, treatment, or admission to the Hospital.

10.10.2 In the event an unassigned patient requires admission to the Hospital and the patient has requested no particular Practitioner, or if such Practitioner or his designee is unavailable, the Emergency Department physician shall contact the appropriate Practitioner from the unassigned on-call list, and such Practitioner shall assume the care of the patient. However, the Emergency Department physician remains responsible for the patient until the Practitioner arrives at the Hospital or otherwise takes charge of the patient's care.

10.10.3 In the event the on-call Practitioner is unavailable for any reason, the Chief of Staff (or in his absence other Staff officers) will be notified and will obtain the services of another Practitioner to assume immediate care of the patient until the on-call Practitioner becomes available or the Chief of Staff or other Staff officer will assume this responsibility himself.

10.11 SPECIALTY CALL RESPONSIBILITY

10.11.1 The Chief of Staff shall approve and the emergency department shall maintain a list of Practitioners who have responsibility for providing specialty backup services to the Emergency Department physicians and other Practitioners for patients who require further examination or treatment.

10.11.2 In the event a patient requires examination or treatment beyond basic Emergency Department capabilities and the patient has requested no particular Practitioner, or if such Practitioner or his designee is unavailable, the Emergency Department physician shall contact the appropriate Practitioner or Practitioners from the appropriate specialty on-call lists, and each such Practitioner shall provide such services. However, the Emergency Department physician remains responsible for the patient until the Practitioner arrives at the Hospital or otherwise takes charge of his patient's care.

10.11.3 It is recognized that all specialized physician services may not be available at all times; however, if any specialized service is uncovered, alternative contacts (whether at Hospital or at any other hospital) should be specified.

10.11.4 In the event the on-call Practitioner is unavailable for any reason, the Chief of Staff (or in his absence other Staff officers) will be notified and will obtain the services of another Practitioner or arrange for alternate care for the patient. The foregoing provision is not intended to excuse the unavailability of an on-call Practitioner. The On-call Practitioner remains responsible for either providing requested on-call services personally or obtaining another qualified Practitioner to do so and so notifying appropriate Hospital authorities. The on-call Practitioner is also responsible for notifying appropriate Hospital authorities that he will be providing on-call services simultaneously at other hospitals while on-call at Hospital.

10.11.7 When the Emergency Department physician contacts a Practitioner who is on specialty or unassigned call requesting assistance for a patient who is present in the Emergency Department, such on-call Practitioner has a duty to respond that is not negated by his lack of competency or Clinical Privileges. If the Emergency Department physician so requests, the on-call Practitioner must (1) come to the hospital and (2) physically examine the patient. If the on-call Practitioner then determines that he is not competent to perform a needed service, it is his responsibility (1) to stabilize the patient and (2) to either secure the services of a Practitioner who is competent to perform the needed service or to arrange for the transfer of the patient to a hospital where the needed service can be performed.

10.11.8 Requests for consultation made to Practitioners who are on specialty call are further governed by Rule 12, including but not limited to Rule 12.2.3.

10.11.9 The procedure for handling requests for hospital-to-hospital transfers is further governed by Rule 16.3. If a request for a hospital-to-hospital transfer is made to an on-call Practitioner, such on-call Practitioner's duties and responsibilities are not negated by his lack of competency or Clinical Privileges. If the patient is transferred to the hospital, it is the on-call Practitioner's responsibility (1) to come to the hospital and (2) examine the patient. If the on-call Practitioner then determines that he is not competent to perform a needed service, it is his responsibility (1) to stabilize the patient and (2) to either secure the services of a Practitioner who is competent to perform the needed service or to arrange for the transfer of the patient to a hospital where the needed service can be performed.

10.12 SPECIAL PRECAUTIONS

The admitting Practitioner shall be held responsible for giving such information as may be necessary to appropriate personnel to assure the protection of others whenever his patients might be a source of danger from any cause whatsoever.

10.13 RECORDS

10.13.1 Except in emergencies, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated and appropriate legible orders are provided.

10.13.2 In the case of an emergency, such statement shall be recorded within 24 hours of admission.

10.14 PRIORITY

Patients declared emergencies by the attending physician shall take priority over those already scheduled, even to the extent that elective cases may have to be canceled to accommodate emergencies.

10.15 ADMISSION TO SPECIAL CARE UNITS

The criteria for admission to Special Care Units shall be as follows:

10.15.1 Intensive Care Unit (ICU). Any adult or pediatric patient with real or potential life-threatening medical or surgical problems, who is urgently in need of continual observation and/or medical intervention to restore him to a stable condition may be admitted to the ICU by a physician Practitioner with appropriate Clinical Privileges as a direct admission or in-house transfer.

10.15.2 Coronary Care Unit (CCU). Any adult or pediatric patient with real or potential life-threatening medical or surgical problems that are cardiovascular in nature, who is urgently in need of continual observation and/or medical intervention to restore him to a stable condition may be admitted to the CCU by a physician Practitioner with appropriate Clinical Privileges as a direct admission or in-house transfer.

10.15.3 Outpatient Services. Patients whose planned surgical procedures are of short duration, associated with minimal bleeding, minor psychological derangements and minimal to moderate postoperative pain may be considered candidates for admission to the outpatient services unit.

10.15.4 Observation Beds. Observation beds are available to provide short term, non-emergent patient monitoring. Generally, patients who require either additional observation before discharge from outpatient procedures, or observation for the purpose of determining if admission to acute care beds is necessary, are candidates for placement in observation beds.

10.15.5 Any questions regarding admission to or discharge from special care units should be referred to the medical director of the unit (see individual departments' policy

and procedure manuals for admission, length of stay, and discharge criteria).

10.16 CONTINUED HOSPITALIZATION

10.16.1 The attending Practitioner is required to document the need for continued hospitalization after specific periods of stay as identified and approved by the Quality Assurance Committee. This documentation must contain:

10.16.1.1 An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

10.16.1.2 The estimated period of time the patient will need to remain in the Hospital.

10.16.1.3 Plans for post-hospital care.

10.16.1.4 Date and signature of the attending Practitioner.

10.16.2 Upon request of the Quality Assurance Committee, the attending Practitioner must provide written justification of the necessity for continued hospitalization of any patient.

10.16.2.1 The report shall include an estimate of the number of additional days of stay and the reason therefor.

10.16.2.2 This report must be submitted within the time specified by the Quality Assurance Committee in its request.

10.16.2.3 Failure to comply with this policy will be brought to the attention of the committee for action.

10.17 USE OF ASSISTANT SURGEON

10.17.1 An assistant surgeon will assist the primary surgeon in all cases where the primary surgeon determines that the patient's condition and/or the type of surgery to be performed requires assistance and in cases in which an assistant surgeon is mandated by the Surgery Department.

10.17.2 The primary surgeon shall document any such medical necessity in the patient's record.

10.17.3 The assistant surgeon must be appropriately credentialed to perform the procedure in which he is to assist.

10.18 TRANSFER APPROVAL

No patient will be transferred without approval of the attending Practitioner.

RULE ELEVEN: CONSENTS

11.1 CONSENT REQUIRED

Except in emergencies (as set forth in Rule 11.4 below), health care services will not be provided to any person within this facility until express consent has been obtained from the patient or one legally authorized to act on his behalf.

11.2 CONSENT BY PATIENTS

11.2.1 Competent Adults. A competent adult may give, withhold or revoke consent for himself.

11.2.1.1 A competent adult is one who is capable of perceiving all relevant facts related to his condition and proposed treatment so as to make a rational decision based thereon.

11.2.1.2 This right may be limited under certain circumstances, as where the patient is pregnant, or where the patient has dependent minor children.

11.2.1.3 Should either of the circumstances in Rule 11.2.1.2 be present when a competent adult is refusing care, the Chief Executive Officer and legal counsel should be consulted.

11.2.2 Incompetent Adults. An incompetent adult may not give, withhold or revoke consent for himself.

11.2.2.1 An incompetent adult is one who is incapable of perceiving all relevant facts related to his condition and proposed treatment so as to make a rational decision based thereon.

11.2.2.2 Consent to treat an incompetent generally must be obtained from a court appointed guardian, and if there has been no prior adjudication of incompetency, the attending Practitioner should document the basis of his finding in the patient's chart and advise the family of the need to obtain a legal guardian to consent to further treatment.

11.3 CONSENT BY OTHERS

11.3.1 Consent for Incompetent Adults. In certain specific circumstances others are allowed to consent for an incompetent adult, specifically:

11.3.1.1 A person who has been designated as a health care agent in a durable power of attorney for healthcare pursuant to Ark. Code Ann. §20-13-104 (Note that the health care agent has no power in situations involving the withdrawal or withholding of life-sustaining treatment - See Rule 20.8.8 and Rule 20.8.13. Further, the decision of the health care agent takes precedence over the persons named in Rules 11.3.1.2 through 11.3.1.4);

11.3.1.2 An adult for his incompetent adult sibling;

11.3.1.3 A married person for his incompetent spouse; and

11.3.1.4 An adult child for his incompetent mother or father.

11.3.1.5 A person who has been named as a health care proxy by the patient (Although this power only becomes effective when withdrawal or withholding of life-sustaining treatment is involved AND the patient has been determined to be "terminal" or "permanently unconscious" - See Rule 20.8.8 for additional details); and

11.3.1.6 Certain family members who have executed a living will on behalf of the patient Although this power only becomes effective when withdrawal or withholding of life-sustaining treatment is involved AND the patient has been determined to be "terminal" or "permanently unconscious" - See Rule 20.8.13 for additional details).

11.3.2 Consent for Minors. A minor (i.e. any person under the age of 18) may not give, withhold, or revoke consent for himself unless one of the following criteria appears in his chart:

11.3.2.1 The minor is married;

11.3.2.2 The minor has moved out of his parents' home and is no longer receiving support from them;

11.3.2.3 The minor seeks treatment for venereal disease, alcohol or other drug abuse or addiction, pregnancy, or childbirth (not including abortion); or

11.3.2.4 The minor is of sufficient intelligence to understand and appreciate the consequences of the proposed treatment for himself.

11.3.2.5 In cases not covered by Rules 11.3.2.1 through 11.3.2.4 consent must be obtained from either a parent or legal guardian.

11.4 EMERGENCIES

A Practitioner may institute such care and/or treatment that is necessary to maintain life or prevent immediate bodily deterioration, without the patient's express consent if:

11.4.1 The Practitioner has determined and documented in the chart that an emergency exists, (i.e., a situation wherein, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain a consent would reasonably be expected to jeopardize the life, health, or safety of the person affected or would reasonably be expected to result in disfigurement or impaired faculties); and,

11.4.2 The patient is unable, due to his mental or physical condition or age, to give or withhold consent.

11.5 REFUSAL OF CONSENT

11.5.1 All refusals of consent by the patient or one legally authorized to act on his behalf will be documented in the chart.

11.5.2 If an emergency exists as set forth in Rule 11.4 above, the attending Practitioner will immediately notify the Chief Executive Officer who, in consultation with legal counsel, will determine whether it is appropriate to seek judicial action mandating the treatment.

11.6 INFORMED CONSENT

11.6.1 In order for the expressed consent of the patient or his legally authorized representative to be legally binding, the person consenting must be aware of the following facts:

11.6.1.1 The need for the treatment and the likelihood of achieving the stated goals.

11.6.1.2 The nature of the treatment.

11.6.1.3 The risks and consequences ordinarily inherent in the treatment and the risks and consequences ordinarily inherent in the alternative treatment.

11.6.1.4 Any alternatives to the recommended treatment and the risks and consequences ordinarily inherent in the alternative treatment..

11.6.1.5 Any limitations on the confidentiality of information learned from or about the patient.

11.6.2 The Practitioner should supply to the patient the type of information regarding the treatment, procedure or surgery as would customarily have been given to a similarly situated patient (or to others authorized to give consent for such a patient) by other medical care providers with similar training and experience at the time of the treatment, procedure or surgery in the Hospital's locality or in a similar locality.

11.6.3 For all invasive procedures other than the administration of routine medications, the attending Practitioner will document the patient's express consent by completing the special authorization form provided by the Hospital, obtaining the patient's signature thereon and placing it in the patient's chart prior to the treatment unless:

11.6.3.1 The Practitioner determines that full disclosure of the risks involved or the potential consequences would not be in the patient's best interest. In this event, the Practitioner will:

11.6.3.1.1 Document the reasons for nondisclosure in the patient's medical record; and

11.6.3.1.2 Consult with another Practitioner who will note his concurrence in the decision prior to the treatment.

11.6.3.2 The patient expressly waives his right to full disclosure. In this event:

11.6.3.2.1 The patient executes a statement to this effect;

11.6.3.2.2 The Practitioner places the statement in the patient’s chart prior to treatment.

11.7 SURGICAL CONSENT

11.7.1 A specific consent for surgery shall be documented prior to the surgery/procedure to be performed, except in cases of emergency.

11.7.2 Informed consent from the patient or next of kin for any operative procedure shall be obtained by the surgeon Practitioner and documented appropriately.

11.7.3 The consent shall be documented on the form provided by the Hospital, and shall include the date, time and signatures of the patient and witness.

11.7.4 Abbreviations are not acceptable.

RULE TWELVE: CONSULTATIONS

12.1 GENERAL RULES

12.1.1 Consultation (the seeking of information, advice, opinion or the assistance of other qualified individuals) is encouraged in the following situations:

12.1.1.1 The patient is not a good risk for operation or treatment.

12.1.1.2 The diagnosis is obscure.

12.1.1.3 There is doubt as to the best therapeutic measures to be utilized.

12.1.1.4 Probable disorders or complication may arise in a field other than the one in which the attending physician is qualified.

12.1.2 Consultation is required in the following instances:

12.1.2.1 Where the Chief of Staff or Staff Executive Committee believe that there are potential medical/legal implications of the treatment,

12.1.2.2 Where the attending Practitioner is unable to obtain the informed consent of the patient due to his belief that full disclosure of the risks and/or consequences of the procedure is not in the best interest of the patient;

12.1.2.3 Where the Practitioner orders that extraordinary care cease and/or life support systems be removed from an incompetent patient; and,

12.1.2.4 Where attempted suicide or chemical overdose has occurred in which event the consultation shall be with an appropriate mental health professional.

12.2 REQUESTS

12.2.1 A consultation shall be initiated by a documented request from the patient's attending Practitioner for a medical evaluation, written opinion and/or assistance by another physician on the Staff.

12.2.2 The request for consultation must specify the scope of service requested or authority given by the attending Practitioner to the consultant.

12.2.3 The consultant must be well qualified to give an opinion in the field in which his opinion is sought, and he must properly comply with the request for consultation, or notify the patient's attending Practitioner of his inability to do so.

12.2.4 A physician Practitioner with unassigned or specialty call responsibility is subject to providing consultation on request.

12.3 COMPLETION

12.3.1 The consultation shall consist of an examination of the patient and his medical record and the completion of a signed written opinion within 24 hours of the consultation.

12.3.2 When operative procedures are involved (except in emergencies) the consultant shall complete his report prior to surgery.

12.3.3 The written report should be recorded in a consultation form provided by the Hospital and included in the patient's medical record or in a comprehensive progress note in the patient's medical record.

RULE THIRTEEN: CONTINUING EDUCATION

13.1 CONTINUING EDUCATION

Each Practitioner shall obtain the minimum number of continuing education credits every two years as required by the Arkansas State Medical Board and the Practitioner's certifying board. Practitioner will furnish documentation of such hours to the Executive Committee upon its request.

RULE FOURTEEN: CRITICAL CARE UNITS

14.1 INTENSIVE CARE UNIT

14.1.1 Purpose

The Intensive Care Unit is a multi-purpose special care unit receiving medical and surgical patients requiring specialized or intensive care on a 24 hours basis through the use of a highly specialized system of nursing care involving constant electronic surveillance with instant corrective response to emergency situations.

14.1.2 Transfers

14.1.2.1 All transfers to and from the Intensive Care Unit shall be initiated by the attending Practitioner and shall be determined by the patient's condition, mobility status, and rehabilitation potential.

14.1.2.2 In the case of the unit being to capacity and new admissions requested, the matter shall be referred to the Director of the unit who will determine whether or not a new admission should be allowed, and if so, which patient already in the unit should be removed.

14.1.3 Director

14.1.3.1 There will be a Director of the Intensive Care Unit who will be responsible for the unit's clinical operation from a Professional Staff standpoint and to coordinate the activities of the Professional Staff in pursuance of the objectives of the unit.

14.1.3.2 The Director shall have authority to settle basic issues with regard to admissions, discharge, and priority.

14.1.3.3 In the Director's absence, he will designate an Assistant Director who will be responsible.

14.1.4 Treatment

14.1.4.1 Patients admitted to the Intensive Care Unit must be seen by the attending Practitioner or his designee as required by Rule 10.5.1 and at least every twenty-four hours thereafter.

14.1.4.2 If Rule 14.1.4.1 is not adhered to, the Director of the Critical Care Unit should be contacted.

14.2 CORONARY CARE UNIT

14.2.1 Purpose

The Coronary Care Unit is a multi-purpose special care unit receiving medical and surgical patients requiring specialized or intensive care on a 24 hours basis through the use of a highly specialized system of nursing care involving constant electronic surveillance with instant corrective response to emergency situations.

14.2.2 Transfers

14.2.2.1 All transfers to and from the Coronary Care Unit shall be initiated by the attending Practitioner and shall be determined by the patient's condition, mobility status, and rehabilitation potential.

14.2.2.2 In the case of the unit being to capacity and new admissions requested, the matter shall be referred to the Director of the unit who will determine whether or not a new admission should be allowed, and if so, which patient already in the unit should be removed.

14.2.3 Director

14.2.3.1 There will be a Director of the Coronary Care Unit who will be responsible for

the unit's clinical operation from a Professional Staff standpoint and to coordinate the activities of the Professional Staff in pursuance of the objectives of the unit.

14.2.3.2 The Director shall have authority to settle basic issues with regard to admissions, discharge, and priority.

14.2.3.3 In the Director's absence, he will designate an Assistant Director who will be responsible.

14.2.4 Treatment

14.2.4.1 Patients admitted to the Coronary Care Unit must be seen by the attending Practitioner or his designee as required by Rule 10.5.1 and at least every twenty-four hours thereafter.

14.2.4.2 If Rule 14.2.4.1 is not adhered to, the Director of the Critical Care Unit should be contacted.

RULE FIFTEEN: DISCHARGE

15.1 BY ORDER

15.1.1 Patients shall be discharged only on an order of the attending Practitioner.

15.1.2 It shall be the responsibility of the attending Practitioner to discharge his patients so that patients have adequate time to vacate their rooms by the time specified by Hospital policy.

15.1.3 Should a patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

15.1.4 If, during the course of the patient's admission, the need arises for a patient to leave the Hospital for any reason, a consent for release of liability should be signed.

15.1.5 If the patient leaves the Hospital to go to a physician's office for a procedure, the physician Practitioner should document in the patient's medical record the procedure performed and the reason for taking the patient to the office.

15.1.6 A Practitioner shall not take patients to his office to perform procedures for which the Practitioner is not credentialed to perform within the Hospital.

15.2 BY DEATH

15.2.1 In the event of a death within the Hospital, unless the death is within the jurisdiction of the County Coroner or law enforcement officials, the deceased shall be pronounced dead and the death certificate completed, signed and returned to the funeral director within 48 hours after receipt by the attending Practitioner or, with his approval, by the Practitioner's associate, the Chief of Staff, or the pathologist who performed the autopsy, provided;

15.2.1.1 The individual who signs the certificate has access to the medical history of the deceased patient;

15.2.1.2 The individual who signs the certificate views the deceased at or after death; and

15.2.1.3 Death is due to natural causes.

15.3 DISCHARGE OF OUTPATIENT SURGICAL PATIENTS
Outpatient surgery patients shall be discharged only after meeting approved discharge criteria.

RULE SIXTEEN: EMERGENCY ROOM

16.1 GENERAL RULE

16.1.1 Physician coverage of the Emergency Room shall be provided by qualified physician Practitioners under contract with the Hospital.

16.1.2 The physician Practitioners referred to in Rule 16.1.1 shall provide documentation of bi-annual ACLS training to the Chief Executive Officer, and shall be privileged to provide emergency care within the Hospital if requested on an emergency basis.

16.1.3 All Practitioners and other personnel assigned to the Emergency Room shall receive orientation and training in the reception and care of emergency patients.

16.1.4 Emergency services shall be integrated with other departments of the Hospital.

16.1.5 The policies and procedures governing medical care provided in the emergency service or department shall be established by and shall remain the responsibility of the Staff.

16.1.6 There shall be a Registered Nurse on duty at all times, and professional nursing service available for all patients at all times.

16.1.7 There shall be sufficient Registered Nurses to cover surgical, obstetrical, and emergency services.

16.1.8 An emergency room patient in need of hospitalization or outpatient treatment shall be admitted under the name of his attending Practitioner.

16.1.8.1 If the patient has no attending Practitioner, or if the attending Practitioner is not available, then the patient shall be admitted to the unassigned Practitioner on call.

16.1.9 No patient shall be admitted to the Hospital until a provisional diagnosis has been stated.

16.1.9.1 In case of emergency, the provisional diagnosis will be stated as soon after admission as possible, but will not exceed a period of 24 hours following admission.

16.1.10 The continued ongoing care of a patient hospitalized through the emergency room by the physician Practitioner staffing the emergency room will be continued by the attending Practitioner to whom the patient will be admitted.

16.1.10.1 Patients discharged from the emergency room but in need of additional subsequent care shall be given appropriate instruction for follow up.

16.1.11 The physician Practitioner rendering definitive emergency room care (whether it be the Practitioner staffing the emergency room or the attending Practitioner) shall be responsible for the preparation of a complete emergency room record which shall include a brief history, physical examination, diagnosis, treatment, patient instructions, orders, dispositions, and signature.

16.1.12 All patients presenting at the emergency room will be evaluated, examined, treated, stabilized or transferred pursuant to Rule 16.2.

16.2 PROCEDURES FOR EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

16.2.1 Examination Of Emergency Patients And Obstetrical Patients: Emergency and obstetrical patients shall be examined, stabilized, treated, and/or transferred in the following manner:

16.2.1.1 If an individual Comes To The Emergency Department and a request is made for examination or treatment of a medical condition, a medical screening examination, including ancillary services routinely available to the emergency department, will be provided to determine whether or not an Emergency

Medical Condition exists.

16.2.1.1.1 Such examination and treatment may not be delayed in order to inquire about the individual's method of payment or insurance status.

16.2.1.1.2 For purposes of this section, "comes to the emergency department" includes an individual whose ambulance has reached hospital property.

16.2.1.2 All emergency patients and unassigned obstetrical patients shall be evaluated and assessed by the emergency department.

16.2.1.2.1 Identifying information for all persons presenting to the emergency department shall be entered into a Central Log.

16.2.1.2.2 The Central Log shall also note whether the patient refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

16.2.1.3 If a physician Practitioner is not present and available in the department:

16.2.1.3.1 A Registered Nurse shall preliminarily assess the patient and the assessment shall be completely and adequately documented.

16.2.1.3.2 The Registered Nurse shall contact the physician Practitioner requested by the patient or the physician on call to discuss the assessment findings.

16.2.1.3.3 If the physician Practitioner determines the condition is a first aid case, minor injury or minor illness of a non-emergency nature, orders for treatment may be given per telephone to the Registered Nurse by the physician Practitioner.

16.2.1.3.4 If the physician Practitioner suspects that an Emergency Medical Condition exists, he will come to the Hospital for further examination, treatment, stabilization, or transfer of the patient.

16.2.1.4 If a physician Practitioner is present and available in the department:

16.2.1.4.1 The physician Practitioner shall assess the patient. The assessment shall be completely and adequately documented.

16.2.1.4.2 The physician Practitioner should defer to the patient's wishes to be treated by another Practitioner; however, the original Practitioner remains responsible for the patient until the patient's Practitioner arrives and takes charge of the patient's care.

16.2.1.5 If any physician Practitioner determines that the patient has an Emergency Medical Condition, he shall either:

16.2.1.5.1 Stabilize the Emergency Medical Condition as defined herein, or

16.2.1.5.2 Stabilize and then Transfer the individual to another medical facility in accordance with Rule 16.2.2.

16.2.1.6 Medical care, including diagnostic tests, may only be initiated on the order of a physician Practitioner.

16.2.1.6.1 Such orders should be in writing and signed by the Practitioner.

16.2.1.6.2 Verbal orders should be documented in compliance with Hospital policies and signed by the physician Practitioner in a timely manner.

16.2.1.6.3 Standing orders should be documented in compliance with Hospital policies.

16.2.1.7 If, after an initial examination, a physician Practitioner determines that a patient requires the services of a Practitioner listed by the Hospital on its list of on-call Practitioners, the appropriate on-call Practitioner shall be called.

16.2.1.7.1 If such on-call Practitioner fails or refuses to appear within a reasonable period of time, and the Practitioner orders the Transfer of the patient because the Practitioner determines that without the services of the on-call Practitioner the benefits of Transfer outweigh the risks of Transfer, the name and address of the on-call Practitioner will be reported to the receiving hospital along with the patient's records.

16.2.1.7.2 The Transfer of the patient must be noted in the Central Log, the patient's medical record, and all other appropriate documents.

16.2.1.8 If the patient (or legal representative) refuses the medical examination and treatment described above, the Practitioner will inform the patient (or legal representative) of the risks and benefits to the patient of such examination and treatment.

16.2.1.8.1 All reasonable steps should be taken to secure the patient's written informed consent refusing such examination and treatment.

16.2.1.8.2 Refusal to accept treatment must be noted in the Central Log, the patient's medical record, and all other appropriate documents.

16.2.2 Transfers Of Patients Who Have Not Been Stabilized Or Who Are Pregnant and Having Contractions Will Meet The Following Conditions:

16.2.2.1 No patient who has not been Stabilized or who is pregnant and having contractions may be Transferred unless:

16.2.2.1.1 The patient (or legal representative), after being informed of the Hospital's obligations under Rule 16.2.2 and of the risk of Transfer, in writing requests Transfer to another medical facility; or

16.2.2.1.2 A physician Practitioner signs a certification stating that, based on information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient (and, in the case of labor, to the unborn child) caused by such a Transfer. This certification must also summarize the risks and benefits that the physician Practitioner considered in making his decision.

16.2.2.2 If the patient (or legal representative) refuses to consent to a Transfer described in Rule 16.2.2 below, the physician Practitioner will inform the patient (or legal representative) of the risks and benefits to the patient of such Transfer. Further, all reasonable steps should be taken to secure and document the patient's written informed consent refusing such Transfer.

16.2.2.3 Additionally, no patient who has not been Stabilized or who is pregnant and having contractions may be Transferred to another medical facility unless:

16.2.2.3.1 This Hospital provides medical treatment within its capacity which minimizes the risks to the patient's health (and, in the case of a woman in labor, to the unborn child); and

16.2.2.3.2 It is determined that the receiving facility has available space and qualified personnel for the treatment of the patient; and

16.2.2.3.3 The receiving facility has agreed to accept the Transfer and to provide appropriate medical treatment; and

16.2.2.3.4 A physician has signed a written order authorizing such a Transfer; and

16.2.2.3.5 The above matters are appropriately documented.

16.2.2.4 If the receiving facility has specialized capabilities or facilities that would assist the treatment of the patient, the receiving facility may not refuse the

Transfer unless the receiving facility does not have the Capacity to treat the patient.

16.2.2.5 The receiving facility will be provided with all medical records (or copies thereof) available at the time of Transfer related to the Emergency Medical Condition for which the patient has presented, including all information specified in Rule 16.2.3.

16.2.2.6 Qualified personnel and transportation equipment (including the use of necessary and medically appropriate life support measures during the Transfer) will be provided.

16.2.2.7 Any time a Transfer is contemplated under this Rule 16.2.2, the Shift Supervisor should be notified by the nurse caring for the patient.

16.2.2.7.1 The Shift Supervisor shall confirm that each applicable step of these Procedures has been followed and that all required documentation has been made.

16.2.2.7.2 In the event that one or more requirements are not met, the Shift Supervisor shall notify the responsible physician.

16.2.2.7.3 The Administrator on Call will be consulted as deemed necessary by the Shift Supervisor or physician Practitioner.

16.2.3 Documentation

16.2.3.1 Documentation of Stabilization of a patient before Transfer will include:

16.2.3.1.1 A chronology of the events that have taken place in the case;

16.2.3.1.2 Measures taken or treatment implemented;

16.2.3.1.3 A description of the patient's response to treatment; and

16.2.3.1.4 The results of measures that have been taken to prevent further deterioration.

16.2.3.2 Consent of the receiving facility to accept the patient will be documented in the medical record and will include:

16.2.3.2.1 The patient' name;

16.2.3.2.2 The receiving facility's name;

16.2.3.2.3 The name and position or responsibility of the responsible person or persons at the receiving facility with whom contact was made;

16.2.3.2.3 That the receiving facility has available space and qualified personnel for treatment of the patient;

16.2.3.2.4 That the receiving facility has agreed to accept the Transfer; and

16.2.3.2.5 The date and time of acceptance.

16.2.3.3 The medical record will include documentation of:

16.2.3.3.1 Medical history;

16.2.3.3.2 Records relating to the patient's emergency medical condition;

16.2.3.3.3 Observations of signs or symptoms;

16.2.3.3.4 Preliminary diagnosis;

16.2.3.3.5 Treatment provided;

16.2.3.3.6 Results of any tests;

16.2.3.3.7 Any informed consent or certification required by this rule;

16.2.3.3.8 Any additional information given to the receiving facility;

16.2.3.3.9 The name of the informant at this Hospital. If the receiving hospital is given medical information about the patient by someone other than the person who requests the receiving hospital to accept the patient, both person's names should be documented;

16.2.3.3.10 A record of the medical information that was transmitted;

16.2.3.3.11 The information describing responsibility for the patient during Transfer and transport to the receiving facility; and

16.2.3.3.12 The name and address of any on-call physician Practitioner who has failed or refused to appear within a reasonable time to provide necessary Stabilizing treatment.

16.2.3.4 The physician Practitioner's order to Transfer a patient to another Hospital will

include:

16.2.3.4.1 The destination;

16.2.3.4.2 The name of the physician who will assume medical care responsibility for the patient;

16.2.3.4.3 The type of transportation required;

16.2.3.4.4 The specific category of professional personnel required to accompany the patient; and

16.2.3.4.4 Any equipment, supplies or medication that may be required in transit by the patient with orders covering their use.

16.2.3.5 A refusal of examination and/or treatment pursuant to Rule 16.2.1.8 will be documented and such documentation will include:

16.2.3.5.1 A brief description of the risks and benefits of the examination and treatment to the patient given to the patient or the patient's representative;

16.2.3.5.2 An indication of the patient's or patient representative's informed refusal to consent to the examination or treatment and the stated reasons for such refusal;

16.2.3.5.3 A description of the status or authority of any patient representative; and

16.2.3.5.4 A description of the proposed transfer that was refused by, or on behalf of, the patient.

16.2.3.5.5 A refusal to consent to Transfer pursuant to Rule 16.2.2 will be documented and such documentation will include:

16.2.3.5.5.1 A brief description of the risks and benefits of the recommended Transfer to the patient given to the patient or the patient's representative;

16.2.3.5.5.2 An indication of the patient's or patient representative's informed refusal to consent to the recommended Transfer; and

16.2.3.5.5.3 A description of the status or authority of any patient representative.

16.2.3.5.6 A Transfer request pursuant to Rule 16.2.2.1.1 will be documented and

such documentation will include:

16.2.3.5.6.1 A brief description of the explanation of the Hospital's obligation to provide treatment and of the risks and benefits of Transfer to the patient given to the patient or the patient's representative;

16.2.3.5.6.2 An indication of the patient's or patient representative's informed consent to the Transfer; and

16.2.3.5.6.3 A description of the status or authority of any consenting patient representative.

16.2.3.5.7 A physician Practitioner's certificate pursuant to Rule 16.2.2.1.2 will be documented by a written statement, signed by the physician Practitioner, and made a part of the patient's medical record to the effect that the medical benefits reasonably expected from treatment after Transfer outweigh any risks caused by such Transfer. Such statement will be supplemented with specific references to such anticipated risks and benefits, based on information available at the time.

16.2.3.5.8 All medical and other records related to individuals Transferred to or from the hospital will be maintained for a period of five years from the date of Transfer.

16.2.4 Definitions

16.2.4.1 The term "Capacity" means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual.

16.2.4.2 The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

16.2.4.2.1 Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

16.2.4.2.2 Serious impairment to bodily function; or

16.2.4.2.3 Serious dysfunction of any bodily organ or part.

16.2.4.3 The term "Emergency Medical Condition" also means, with respect to a pregnant woman who is having contractions, that:

16.2.4.3.1 There is inadequate time to effect safe Transfer to another hospital before delivery; or

16.2.4.3.2 A Transfer may pose a threat of health and safety of the patient or the unborn child.

16.2.4.4 The term "to Stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the Transfer of the individual from a facility or, in the case of a pregnant woman, that the patient has delivered (including the placenta).

16.2.4.4.1 A patient will be deemed Stabilized if the treating Practitioner attending to the patient has determined, within reasonable clinical confidence, that the Emergency Medical Condition has been resolved.

16.2.4.4.2 For patients whose Emergency Medical Condition has not been resolved, the determination of whether they are Stable "medically" may occur in one of the following two circumstances:

16.2.4.4.2.1 For purposes of Transferring a patient from one facility to a second facility "Stable for Transfer"; and

16.2.4.4.2.2 For purposes of discharging a patient other than for the purpose of Transfer from one facility to another facility "Stable for Discharge."

16.2.4.4.3 For Transfer between facilities: a patient is Stable for Transfer if the patient is Transferred from one facility to a second facility and the treating Practitioner attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating Practitioner reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.

16.2.4.4.4 If there is a disagreement between the treating Practitioner and an off-site physician (e.g., a physician at the receiving facility or the patient's primary care physician if not physically present at the first facility) about whether a patient is Stable for Transfer, the medical judgment of the treating Practitioner usually takes precedence over that of the off-site physician.

16.2.4.4.5 A patient is considered Stable for Discharge when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonable performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions.

16.2.4.4.6 “Stable for Transfer” or “Stable for Discharge” does not require the final resolution of the emergency medical condition.

16.2.4.5 The term "Transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of a physician employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of a patient who has been declared dead, or leaves the facility without the permission of any such person.

16.2.4.6 The term "Comes To The Emergency Department" means, with respect to an individual requesting examination or treatment, that the individual is on the Hospital property (property includes ambulances owned and operated by the Hospital, even if the ambulance is not on Hospital grounds). An individual in a nonhospital-owned ambulance on Hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital- owned ambulance off Hospital property is not considered to have come to the Hospital's emergency department, even if a member of the ambulance staff contacts the Hospital by telephone or telemetry communications and informs the Hospital that they want to transport the individual to the Hospital for examination and treatment. In such situations, the Hospital may request transport to another facility if it is in formal "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the Hospital's instructions and transports the individual on to Hospital property, the individual is considered to have come to the emergency department.

16.2.5 Transfers from other Facilities. If any hospital personnel or Physician Practitioner has reason to believe that a patient has been received from another facility with an emergency medical condition which has not been stabilized, such person shall report this occurrence immediately to the shift supervisor.

16.2.5.1 All relevant information relating to the condition of the patient shall be recorded.

16.2.5.2 The charge nurse must fully report this occurrence, within twenty-four hours,

to either the Director of Nursing or the Administrator, who shall then evaluate the information and, if warranted, report the possible violation to the Arkansas Health Department.

16.2.5.3 When any doubt exists as to the possibility of a violation, the incident will be reported.

16.3 PROCEDURES FOR ACCEPTING PATIENT TRANSFERS

16.3.1 General Obligation. To the extent that the Hospital has specialized capabilities or facilities, and capacity to provide such services, the Hospital may not refuse to accept from a referring hospital within the United States, an appropriate transfer of an individual who requires such specialized capabilities or facilities.

16.3.2 Other Specialized Capabilities or Facilities. Except as described in Rule 16.3.2, the Hospital is deemed to have specialized capabilities or facilities unless the Practitioner having Specialty Call Responsibility (see Rule 10.11), in conjunction with the Administrator on Call and the Emergency Room Physician, determines otherwise and documents such determination together with relevant facts supporting, within a reasonable period of time following such determination.

16.3.2.1 Such determination to refuse to accept a patient on the basis of a lack of capability shall be reviewed by the Staff Executive Committee.

16.3.3 Capacity. The number of patients that may be occupying a specialized unit, the number of staff on duty, or the amount of equipment on the Hospital's premises do not, in and of themselves, determine the capacity of the Hospital to care for additional patients.

16.3.3.1 If the Hospital generally has accommodated - or can accommodate - additional patients by whatever means (e.g. moving patients to other units, calling in additional staff, borrowing equipment from other facilities, etc.) it does not lack capacity.

16.3.3.2 If there is any doubt regarding capacity, the Practitioner having Specialty Call Responsibility should contact appropriate Hospital personnel prior to accepting the transfer.

16.3.3.3 Any determination that the Hospital lacks capacity to accept a transfer may only be made by the Practitioner having Specialty Call Responsibility (see Rule 10.11 in conjunction with the Administrator on Call and the Emergency Room Physician.

16.3.3.3.1 Such determination together with relevant facts supporting such

determination, shall be documented within a reasonable period of time following such determination.

16.3.3.3.2 Such determination to refuse to accept a patient on the basis of a lack of capacity shall be reviewed by the Staff Executive Committee.

16.3.4 Exceptions. In the event alternative contacts for a specialized service are specified pursuant to Rule 10.11, the alternative contacts so specified should be used.

16.3.4.1 If such alternative contacts are at another hospital, the Emergency Department physician, in conjunction with the Administrator on Call, may make the capability or capacity determinations specified in Rules 16.3.2-16.3.3.

16.3.5 Procedures. All calls seeking referral of a patient to the Hospital will be referred initially to the appropriate Specialty Call Practitioner (See Rule 10.11).

16.3.5.1 The procedures in the event of a refusal to accept such referral on the basis of lack of capability are covered in Rules 16.3.2, 16.3.3, and 16.3.4 above.

16.3.5.2 The procedures in the event of a refusal to accept such referral on the basis of lack of capacity are covered in Rules 16.3.3 and 16.3.4.

16.3.5.3 In the event that a request for transfer is subsequently rescinded, the Specialty Call Practitioner shall contemporaneously document the appropriate facts concerning such request and its subsequent recission.

16.3.5.4 In the event that more than one hour elapses prior to an unrescinded request for transfer being accepted, the Specialty Call Practitioner shall notify the Administrator on call and the Emergency Room Physician to involve them in the decision-making process.

16.3.5.5 In the event that the requested transfer is accepted, the Specialty Call Practitioner shall notify the appropriate Hospital personnel and is responsible for writing appropriate orders.

16.3.6 Continuing Medical Education. Periodically, the Hospital will make available to all physician Practitioners working in the Emergency Department or covering Specialty Call (See Rule 10.11) Continuing Medical Education specific to EMTALA requirements.

RULE SEVENTEEN: IMPAIRED PRACTITIONERS, DISRUPTIVE CONDUCT AND SEXUAL HARASSMENT

17.1 IMPAIRED PRACTITIONERS

17.1.1 Definition

An Impaired Practitioner is one who is unable to practice his profession with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs including alcohol.

17.1.2 Health Assistance and Rehabilitation

17.1.2.1 Purpose. The Hospital and Staff have identified the need to provide Practitioners with an opportunity for assistance in prevention of illness and impairment and for support during rehabilitation of illness or stress prior to those conditions causing actual impairment in the ability to provide Quality Patient Care. A process that provides such opportunity will serve to aid and nurture a Practitioner in retaining his or her ability to function at an appropriate professional level prior to and during periods of illness or stress that do not rise to the level of impairment required for disciplinary action and necessary for the protection of patients. By supporting Practitioners in the retention of professional skills and abilities, this process will enhance continuity of patient care, avoid unnecessary duplication of effort, bolster overall morale within the Staff and adjoining communities, and promote a spirit of cooperation.

17.1.2.2 Education. The Hospital and Staff will provide educational programs for the Staff and other Hospital personnel pertaining to this Policy and the identification, recognition and prevention of conditions of individual Practitioner health that could lead to illness or impairment. Records of such educational programs will be maintained.

17.1.2.3 Identification

17.1.2.3.1 A Practitioner who believes himself to be in need of assistance or supportive rehabilitation in order to prevent illness or impairment or in order to retain the ability to function at an appropriate professional level is encouraged to immediately report to the Chief of Staff, Executive Committee Chairman or their designee his need for assistance and/or support.

17.1.2.3.2 Practitioners and Hospital personnel who believe a Practitioner to be in need of assistance or supportive rehabilitation in order to prevent the Practitioner’s illness or impairment or in order to retain or regain the

Practitioner's ability to function at an appropriate professional level are encouraged to report such need for assistance and/or support to the affected Practitioner either orally or in writing. Such report shall encourage the Practitioner to make a report under Rule 17.1.2.3.1.

17.1.2.3.3 Reports made under Rule 17.1.2.3.1 shall be evaluated for credibility through an informal interview with the Practitioner and other informal interviews as necessary.

17.1.2.3.4 Any actions taken by the Chief of Staff, Executive Committee Chairman or their designee under this Policy shall be considered to be actions of the Executive Committee. The Chief of Staff, Executive Committee Chairman or their designee shall make regular reports to the Executive Committee on the implementation of this Policy.

17.1.2.4 Management

17.1.2.4.1 In accordance with the needs of the Practitioner reported under Rule 17.1.2.3, the Chief of Staff, Executive Committee Chairman or their designee shall assist such Practitioner as follows:

17.1.2.4.1.1 with a referral to an independent Practitioner for assistance with prevention of illness or potential impairment;

17.1.2.4.1.2 with assistance in locating a suitable Practitioner for diagnosis and/or treatment of the conditions of illness or stress potentially leading to impairment;

17.1.2.4.1.3 with assistance in locating a suitable program for supportive rehabilitation under this Policy.

17.1.2.4.2 The Chief of Staff, Executive Committee Chairman or their designee may provide that any Staff Practitioner reported under Rule 17.1.2.3, and such Practitioner's patients, may be monitored as required by the Practitioner's potential illness or impairment until such time as the potential illness or impairment has been abated in a satisfactory manner. In determining the most appropriate method of Practitioner and patient monitoring, patient care interests shall be paramount.

17.1.2.4.3 While this Rule is designed to function outside the Staff disciplinary process, any person working in the Hospital or on its staff who has a reasonable belief that a Practitioner, who appears in the Hospital with the intention of participating directly or indirectly in patient care, seems to be impaired shall immediately report such Practitioner as provided in

Rule 17.1.3.

17.1.2.5 Confidentiality

17.1.2.5.1 Actions taken under this Rule shall be confidential except as:

17.1.2.5.1.1 Provided by law;

17.1.2.5.1.2 Ethical obligation;

17.1.2.5.1.3 When a patient's safety is in immediate jeopardy; or

17.1.2.5.1.4 When necessary to reduce the likelihood of injury or damage to the health or safety of any patient, employee or other person present in the Hospital.

17.1.2.5.2 All requests for confidential information concerning a Practitioner who has been reported under this Rule shall be referred to the Chief Executive Officer.

17.1.2.5.3 In order to effectively implement this Rule, all persons should avoid speculation, conclusion, gossip and any discussion of specific matters reported under this policy with anyone outside those described in this Rule.

17.1.3 Immediate Action

Pursuant to the Rule 7.2.1, the Executive Committee has the authority to summarily suspend the Clinical Privileges of a Practitioner whenever such action must be taken immediately to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient, employee or other person present in the Hospital. Since instances may occur where convening the entire committee may be impractical, and in the interest of time and immediate action, the authority of the Staff Executive Committee to impose summary suspension (subject to subsequent ratification by the Executive Committee) is delegated to any one of the following individuals: the Chief of Staff, the chief of any service, the chairman of any Staff Committee, and the Chief Executive Officer.

In this regard, should any Practitioner appear in the Hospital with the intention of participating directly or indirectly in patient care, and in the opinion of Hospital staff or a fellow Practitioner, the Practitioner appears at that time to be impaired in his capacity to render patient care then the following steps should be taken:

17.1.3.1 The Chief of Staff should be notified and asked to come to the Hospital, meet

with the Practitioner immediately and assess the situation.

17.1.3.2 If in the chief or chairman's opinion any question of impairment through drug or alcohol impairment exists, drug and urine samples should be immediately obtained under direct supervision of the chief or chairman and subsequently evaluated for possible mood-altering substances. If a medical problem is believed to be present, the appropriate evaluation will be requested.

17.1.3.3 Practitioners are required to cooperate with the testing and evaluation described above. Failure to comply shall be grounds for summary suspension and for subsequent termination of Staff Appointment and Clinical Privileges.

17.1.3.4 Based on the chief's or chairman's assessment of the situation, summary suspension pursuant to Rule 7.2.1 may be appropriate.

17.1.4 Report & Investigation

If any individual working in the Hospital or on its staff has a reasonable belief that a Practitioner is an Impaired Practitioner, the following steps should be taken:

17.1.4.1 A report, preferably in writing, should be given to the Chief Executive Officer, any Staff officer, or Staff committee chairman. The report shall include a description of the incident(s) that led to the belief that the Practitioner may be impaired. The report must be factual. The individual making the report does not need to be able to prove the impairment, but must state the facts leading to his belief.

17.1.4.2 After discussing the incident(s) with the individual who filed the report, if any one of the persons named above who receives the report believes there is enough information to warrant an investigation, he shall so advise the Executive Committee.

17.1.4.3 The Executive Committee shall either investigate the matter itself or direct that an investigation be conducted and a report thereof be rendered by:

17.1.4.3.1 A standing committee of the Staff; or

17.1.4.3.1 An outside consultant; or

17.1.4.3.2 Another individual or individuals appropriate under the circumstances.

17.1.4.4 As a part of its investigation, the Executive Committee, in its sole discretion and without triggering any rights under Article Eight of the Staff Bylaws or Rule Eight, may require the Practitioner to undergo a mental and/or physical health assessment by a physician or at a facility selected by the Executive

Committee and under such circumstances (including direct reporting back to the Executive Committee or its designee) as the Executive Committee may establish. Failure or refusal of the affected Practitioner to cooperate with the assessment may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the Executive Committee and shall at a minimum address:

17.1.4.4.1 Whether the Practitioner has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;

17.1.4.4.2 Whether such ability is compromised by reason of illness, the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and

17.1.4.4.3 Whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

17.1.4.5 If, after the investigation, it is found that sufficient evidence exists that the Practitioner is impaired, the Chairman of the Executive Committee shall meet personally with the Practitioner or designate another appropriate individual to do so.

17.1.4.6 The Practitioner should be told that the results of an investigation indicate that he suffers from an impairment that affects his practice. The Practitioner should not be told who filed the report, but may be told of the general nature of the specific incidents contained in the report.

17.1.4.7 Depending upon the severity of the problem, and the nature of impairment, the Executive Committee, subject to appropriate hearing and appellate review procedures, has the following options (which are not to be mutually exclusive):

17.1.4.7.1 Require the Practitioner to undertake a rehabilitation program as a condition of continued Staff Appointment and Clinical Privileges;

17.1.4.7.2 Impose appropriate restrictions on the Practitioner's practice;

17.1.4.7.3 Immediately suspend or restrict the Practitioner's privileges in the Hospital until rehabilitation has been accomplished.

17.1.4.8 The original report and a description of the actions taken by the Executive Committee should be included in the Practitioner's personnel file. If the

investigation reveals not only that no action should be taken on the report but also that there is no merit to the report, the report should be destroyed unless a Federal or state statute or rule or regulation promulgated thereunder requires otherwise. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the Practitioner's personnel file and the Practitioner's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

17.1.4.9 Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy, the matter being confidential except to the extent that disclosure is required by Federal or state law, rule or regulation.

17.1.4.10 In the event of any apparent or actual conflict between Rule 17 and the Staff Bylaws or Rules Seven or Eight, the provisions of the Staff Bylaws and Rules Seven and Eight shall control.

17.1.5 Rehabilitation

If warranted, Hospital and Staff leadership should assist an Impaired Practitioner in locating a suitable rehabilitation program. An Impaired Practitioner shall not be reinstated until it is established, to the Executive Committees satisfaction, that the Practitioner has successfully completed a program in which the Executive Committee has confidence.

17.1.6 Reinstatement

Upon sufficient proof that a Practitioner who has been found to be suffering an impairment has successfully completed such a rehabilitation program, the Executive Committee, in its discretion, should, but need not, consider that Practitioner for reinstatement to the Staff.

17.1.6.1 In considering such a Practitioner for reinstatement, the Executive Committee must consider patient care interests to be paramount.

17.1.6.2 The Executive Committee should obtain at least a letter from the physician director of the rehabilitation program where the Practitioner was treated. The Practitioner must authorize the release of this information. That letter shall state:

17.1.6.2.1 Whether the Practitioner is participating in the program;

17.1.6.2.2 Whether the Practitioner is in compliance with all of the terms of the program;

17.1.6.2.3 Whether the Practitioner attends support group meetings regularly (if appropriate);

17.1.6.2.4 To what extent the Practitioner's behavior and conduct are monitored;

17.1.6.2.5 Whether, in the opinion of those doctors, the Practitioner is rehabilitated;

17.1.6.2.6 Whether an after care program has been recommended to the Practitioner and, if so, a description of the after care program;

17.1.6.2.7 Whether, in his opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and

17.1.6.2.8 Other information relevant to the Practitioner's present ability to render Quality Patient Care to his patients.

17.1.6.3 The Practitioner must inform the Hospital of the name and address of his primary care physician, and must authorize that physician to provide the Hospital with any information regarding his physical or mental condition and treatment. The Hospital has the right to require an opinion from other physician consultants of its choice.

17.1.6.4 From the primary care physician the Hospital needs to know the precise nature of the Practitioner's condition, and the course of treatment as well as the answers to the questions posed above in Rules 17.1.6.2.5 and 17.1.6.2.7.

17.1.6.5 Assuming all of the information received indicates that the Practitioner is rehabilitated and capable of resuming care of patients, the Executive Committee should take the following additional precautions when restoring Clinical Privileges:

17.1.6.5.1 The Practitioner should identify two physician Practitioners who are willing to assume responsibility for the care of the Practitioner's patients in the event of his inability or unavailability to care for and treat his patients.

17.1.6.5.2 The Practitioner should be required to obtain periodic reports (at least quarterly) for the Hospital from his primary physician -- for a period of at least one year -- stating that the Practitioner is continuing treatment or therapy, as appropriate, and that his ability to treat and care for patients in the Hospital is not impaired.

17.1.6.6 The Practitioner's exercise of Clinical Privileges in the Hospital shall be monitored by the Chief of Staff or by a Practitioner appointed by the Chief of

Staff. The nature of that monitoring shall be determined by the Chief of Staff after consultation with the Executive Committee.

17.1.6.7 The Practitioner must agree to submit to alcohol or drug screening test (if relevant to the impairment) on terms prescribed by the Executive Committee.

17.1.6.8 All requests for confidential information concerning a Practitioner who has been determined to be an Impaired Practitioner should be referred to the Chief Executive Officer.

17.2 DISRUPTIVE CONDUCT

17.2.1 Definition

The Staff Bylaws require each Applicant and each Practitioner, at the time Staff Appointment and Clinical Privileges are granted and continuously thereafter, to demonstrate to the satisfaction of the Staff and the Board, a willingness and capability based on current attitude and evidence of past performance:

17.2.1.1 To harmoniously work with and relate to other Practitioners, students, members of other health disciplines, Hospital administration and employees, visitors and the community in general, in the cooperative, professional manner that is essential for maintaining a hospital environment appropriate to Quality Patient Care;

17.2.1.2 To participate equitably in the discharge of Staff responsibilities;

17.2.1.3 To adhere strictly to all applicable ethical standards and principles; and

17.2.1.4 To avoid conduct which reflects adversely on the Applicant or Practitioner's professional fitness.

17.2.2. Disruptive Conduct Prohibited

Disruptive conduct is any activity that disrupts Practitioners, students, members of other health disciplines, Hospital administration and employees and the community in general from maintaining a hospital environment appropriate to Quality Patient Care. Disruptive conduct is prohibited.

17.2.3 Examples

Inappropriate disruptive conduct includes, but is not limited to:

17.2.3.1 Verbal or physical attacks leveled at other Practitioners, Hospital personnel, patients or others that are personal, irrelevant or go beyond the bounds of appropriate professional conduct.

17.2.3.2 Impertinent or inappropriate comments, notes illustrations or other writings made in patient medical records or other documents;

17.2.3.3 Non-constructive criticism such as comments or criticism addressed in such a way as to intimidate, undermine confidence, belittle or imply stupidity or incompetence;

17.2.3.4 Refusal to accept Staff assignments or to participate in committee or departmental affairs except on the Practitioner's terms or to do so in a disruptive manner.

17.2.3.5 Threats of violence or retribution, physical contact with others that is intimidating or threatening;

17.2.2.6 Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

17.2.4 Documentation of Disruptive Conduct

Practitioners, nurses and other hospital employees who observe behavior by a Practitioner which disrupts the smooth operation of the Hospital, or jeopardizes patient care, should document the incident. The report should be submitted to the Chief Executive Officer. That documentation should include:

17.2.4.1 The date and time of the questionable behavior;

17.2.4.2 If the behavior affected or involved a patient in any way, the name of the patient;

17.2.4.3 The circumstances which precipitated the situation;

17.2.4.4 A description of the questionable behavior limited to factual, objective language as much as possible;

17.2.4.5 The consequences, if any, of the disruptive behavior as it relates to patient care or Hospital operations;

17.2.4.6 Record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

17.2.5 Optional Informal Discussion with Practitioner

In an informal attempt to deal with any reported incident, any Staff officer, any chairman of a standing Staff committee, or the Chief Executive Officer, in lieu of, as an alternative to, or as a step preceding a formal request for corrective action under Rule 7.4 may, in his sole discretion, discuss the matter informally with the

Practitioner, emphasizing that the behavior is inappropriate and may subject the Practitioner to more formal action. If such informal discussion is held:

17.2.5.1 The initial approach should be collegial and designated to be helpful to the physician.

17.2.5.2 It should be emphasized that if the behavior continues, more formal action will be taken to stop it.

17.2.5.3 The informal meeting should be documented.

17.2.5.4 A follow-up letter to the Practitioner should state that the Practitioner is required to behave professionally and cooperatively.

17.2.6 Initiation of Formal Investigation by Request for Corrective Action
If any Staff Officer, any chairman of a standing Staff Committee, the Chief Executive Officer, or the Board determines that a single incident or a pattern of disruptive conduct by a Practitioner may warrant corrective action, such person may initiate a formal investigation of the matter by the Staff Executive Committee by making a Request for Corrective Action as described in Rule 7.4. Thereafter the procedures described in Rules Seven and Eight shall apply. Summary suspension pursuant to Rule 7.2 may also be appropriate.

17.3 SEXUAL HARASSMENT

17.3.1 Sexual Harassment Generally
Sexual harassment of any kind is unacceptable and will not be tolerated in the Hospital. It is against the policies of the Hospital for any Practitioner, male or female, to sexually or in any other way, harass another Practitioner, Hospital employee, patient or other person. Sexual or personal harassment is defined as:

17.3.1.1 Sexual advances including fondling, touching, patting, pinching or any other similar physical contact considered unacceptable by another individual;

17.3.1.2 Requests or demands for sexual favors, whether subtle or blatant, or whether in the form of pressure or request for any type of sexual favor accompanied by an implied or stated promise of preferential treatment or negative consequence concerning another person's employment status;

17.3.1.3 Verbal abuse or kidding that is sexually-oriented or personally directed and considered unacceptable by another individual, including comments about bodily appearance where such comments go beyond mere courtesy; "dirty jokes"; any other tasteless, sexually oriented comments, innuendos or actions that offend others; lewd pictures; or any type of conduct that tends to make

employees of one gender "sex objects"; or

17.3.1.4 Engaging in any type of sexually-oriented or personally offensive conduct that would unreasonably interfere with another person's work performance.

17.3.2 Conduct Not Sexual Harassment

Normal, courteous, mutually respectful, pleasant, non-coercive interactions between men and women that are acceptable to both parties are not considered to be sexual or personal harassment.

17.3.3 Reports of Sexual Harassment

17.3.3.1 Complaints of sexual harassment regarding a practitioner, nurse or other hospital employee who observes or who has been the victim of sexual harassment must be made in writing. The complaints should include:

17.3.3.1.1 Date and time of the incident;

17.3.3.1.2 The name of the subject of the harassment;

17.3.3.1.3 A factual, objective description of the conduct;

17.3.3.1.4 The names of other individuals present when the incident occurred; and

17.3.3.1.5 Any action taken, including date, time, place, and name(s) of those intervening.

17.3.3.2 A report of sexual harassment regarding a Hospital employee will be processed in accordance with Hospital personnel policies.

17.3.3.3 A report of sexual harassment regarding a Practitioner that is filed by a Hospital employee should be submitted to the employee's supervisor, who shall forward it to the Chief Executive Officer. The report may be submitted directly to the Chief Executive Officer if the report concerns conduct by the supervisor or conduct that the employee believes is condoned by the supervisor.

17.3.3.4 A report of sexual harassment regarding a Practitioner that is filed by another Practitioner should be submitted directly to the Chief Executive Officer.

17.3.3.5 The Chief Executive Officer should immediately notify the Chief of Staff of the report.

17.3.4 Meeting with Individual Who Filed Report

The Chief Executive Officer should interview the individual who filed the report, and when possible, others who were present when the incident occurred.

17.3.5 Meeting with the Practitioner

17.3.5.1 If, after interviewing the individual who filed the report and others who were present, the Chief Executive Officer determines that the report of sexual harassment is credible, the Chief Executive Officer should schedule a meeting with the Practitioner involved. At that meeting, the Practitioner should be advised of the nature of the complaint(s). The Chief Executive Officer may protect the identity of a complainant if, in the Chief Executive Officer's judgment, that is necessary and appropriate to do so.

17.3.5.2 The Practitioner should be given an opportunity to respond to the allegations.

17.3.5.3 If, at the conclusion of this meeting, it is believed that the alleged misconduct did, in fact, occur:

17.3.5.3.1 The Practitioner must be informed that the conduct is inappropriate will not be tolerated by the Hospital;

17.3.5.3.2 It must be made clear that the offending behavior must cease and, if appropriate, an apology must be offered to the individuals involved; and

17.3.5.3.3 Further incidents of a similar nature will result in formal Staff disciplinary action.

17.3.5.3.4 The meeting shall be documented.

17.3.6 Initiation of Formal Investigation by Request for Corrective Action

Without regard to whether the actions described in Rules 17.3.3, 17.3.4, and 17.3.5 above have been taken, if any Staff Officer, any chairman of a standing Staff Committee, the Chief Executive Officer, or the Board determines that a single incident or a pattern of disruptive sexual harassment conduct by a Practitioner may warrant corrective action, such person may initiate a formal investigation of the matter by the Staff Executive Committee by making a Request for Corrective Action as described in Rule 7.4. Thereafter the procedures described in Article Seven of the Staff Bylaws shall apply. Summary suspension pursuant to Rule 7.2 may be appropriate.

RULE EIGHTEEN: MEDICAL RECORDS

18.1 GENERAL RULE

Although the Hospital may provide clerical/secretarial assistance to Practitioners with respect to Medical Records, the responsibility for preparation and completion of the medical record rests solely with the Practitioner providing care to the patient, and no record shall be considered complete until authenticated by the Practitioner's signature. All entrees are written or, in the case of dictation, transcribed and inserted in the medical record, and all clinical entries in the patient's medical record shall be current, complete, accurate, legible, pertinent, accurately timed, dated and authenticated.

18.2 SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when they have been approved by the Quality Assurance Committee.

18.2.1 An official record of approved abbreviations shall be kept on file in the Medical Records Department and at the nurse’s stations.

18.2.2 Each abbreviation or symbol may have only one meaning.

18.2.3 The abbreviations list is reviewed annually and revised as needed.

18.2.4 Symbols and abbreviations are not used in obtaining informed consent.

18.2.5 Abbreviations not included in the official record may not be used.

18.3 SIGNATURE STAMPS

Signature stamps are prohibited.

18.4 STANDING ORDERS

A Practitioner's standing orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record or shall be appended to the medical record and shall be timed, dated and signed by the Practitioner.

18.5 ELECTRONIC OR COMPUTER GENERATED SIGNATURES

Practitioners are authorized to authenticate patient records using electronic or computer generated signatures according to policies and procedures adopted by the Staff and Governing Board.

18.5.1 Practitioners are assigned unique identifiers generated through a confidential code.

18.5.2 Penalties for inappropriate use of the identifier are incorporated in the policies.

18.5.3 A Practitioner must certify in writing (with statement to be retained in the offices

of the Chief Executive Officer) that he is the only person authorized to use the security code.

18.5.4 The hospital will periodically monitor the use of identifiers as described in the policy.

18.6 NECESSARY INFORMATION

Each patient's medical record shall include the following:

18.6.1 Identification data, including name, face sheet, sex, marital status, address, date of birth, name of legally authorized representative, and if receiving mental health services, the patient's legal status;

18.6.2 The date and time of admission(s) and discharge(s);

18.6.3 The name and address of the patient's nearest relative (or responsible party) and that person's occupation;

18.6.4 Name, address, and telephone number of an emergency contact;

18.6.5 The patient's medical record number;

18.6.6 A statement, signed by the patient or his guardian, authorizing medical care and treatment of the patient by any physician authorized to provide medical care and treatment at the Hospital;

18.6.7 Chief complaint/reason(s) for admission or treatment;

18.6.8 The record and findings of the assessment of the patient's physical, psychological, and social status;

18.6.9 A summary of psychological needs, as appropriate to the age of the patient;

18.6.10 With regard to child and adolescent services, evaluation of the patient's developmental age;

18.6.11 A current plan for provision of care, initiated on admission and indicating patient care required, how it is to be accomplished, and the methods, approaches, goals, and modifications necessary to ensure best results for the patient;

18.6.12 Goal of treatment and treatment plan;

18.6.13 Whether or not the patient has executed an advance directive;

18.6.14 Detailed history of present illness;

18.6.15 Past medical history;

18.6.16 Emergency care provided prior to time of arrival with time and means of arrival;

18.6.17 Immunization status;

18.6.18 Allergies, specifically to medication or other chemicals

18.6.19 Family, marital and social history;

18.6.20 Review of systems;

18.6.21 Complete physical examination, including a record of blood pressure, pulse and respirations;

18.6.22 Statement of conclusions and impressions drawn from the Health and Physical Evaluation;

18.6.23 Admission, principal, comorbid and complication diagnosis;

18.6.24 Diagnostic and therapeutic orders;

18.6.25 Medical or surgical treatment;

18.6.26 Operative or other invasive procedure reports;

18.6.27 Special treatment procedures (See hospital policy for required documentation);

18.6.28 Reassessment, when necessary;

18.6.29 Physicians' progress notes, nurses notes, and entries by other authorized individuals;

18.6.30 Pathological findings;

18.6.31 TNM cancer staging form (as appropriate) completed by the attending physician or surgeon;

18.6.32 Evidence of appropriate informed consent;

18.6.33 Evidence of known advance directives;

18.6.34 Clinical observations;

18.6.35 Appropriate documentation of use of restraints;

18.6.36 Diagnostic and therapeutic procedures and tests performed and the results, including where applicable, laboratory and x-ray reports, consultation reports, operative reports, pathology reports, and autopsy reports;

18.6.37 Response to care provided;

18.6.38 Consultation Reports;

18.6.39 Record of donation and receipt of transplants or implants;

18.6.40 Every medication ordered for, prescribed for, or dispensed to any patient and the dosage of and, if any, adverse reaction to the medication;

18.6.41 Referrals/communications to external or internal care providers or community agencies;

18.6.42 Final diagnosis (including allergies, complications, hospital acquired infections, untoward reactions to drugs and/or anesthesia agents identified during current hospitalization);

18.6.43 Autopsy, when performed;

18.6.44 Discharge instructions;

18.6.45 Documentation of patient leaving AMA;

18.6.46 Any referrals/communications made to external or internal care providers and to community agencies;

18.6.47 A discharge summary, except as provided in Rule 18.13.6, where a final progress will be acceptable;

18.6.48 Assessment of care provided;

18.6.49 Signature of the attending Practitioner;

18.7 OPERATIVE PROCEDURES

The record of any patient undergoing operative or other invasive procedure and/or anesthesia shall include, in addition to other requirements set out in Rule 18.6, the following:

18.7.1 Preoperative diagnosis;

18.7.2 Postoperative diagnosis;

18.7.3 Detailed account of findings at surgery;

18.7.4 An accurate description of the specimen removed;

18.7.5 Details of the surgical procedure, including use of drains or other devices;

18.7.6 Estimated blood loss during the surgical procedure;

18.7.7 Accounting of all sponges and instruments;

18.7.8 Condition of patient at time of discharge from surgical suite;

18.7.9 Any undue complications which occurred during surgery;

18.7.10 Name of primary surgeon and any assistants;

18.7.11 Date and time of the surgical procedure performed;

18.7.12 When the history and physical examination (or an update note as required by Rule 18.11.4) has not been written or transcribed and placed in the patient's chart before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending Physician states in writing in the progress notes that such delay would be detrimental to the patient;

18.7.13 The attending Practitioner shall time, date and sign the preoperative note and any orders or pre-anesthesia notations which have been recorded by a member of the nursing staff or a CRNA;

18.7.14 Operative reports shall be dictated immediately following surgery for outpatients as well as inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record.

18.7.14.1 Any Practitioner who has not dictated an operative report twenty-four (24) hours following the day of the operation shall be automatically suspended from surgical privileges except for any inpatients who are already scheduled for surgery.

18.7.14.2 The medical record department will be assigned the duty of notifying the Practitioner of any such delinquent records.

18.7.15 In addition to a dictated operative report the Practitioner shall note in writing in the medical record, any information concerning the surgery or the patient's condition which might be pertinent to the patient's care during the interval between the surgery and the completion of the transcription of the operative report and its insertion into the medical record. Such postoperative documentation shall include, but not be limited to, the following:

18.7.15.1 Patient's vital signs;
18.7.15.2 Patient's level of consciousness;
18.7.15.3 Medications (including intravenous fluids);
18.7.15.4 Blood and blood components administered; and
18.7.15.5 Any unusual event or complications, including blood transfusion reactions and management of any such events or complications.

18.8 EMERGENCY CARE

When a patient is given emergency care, the patient's record shall include, in addition to the information required by Rule 18.6, the following:

18.8.1 Time and means of arrival;

18.8.2 Emergency care given the patient prior to arrival;

18.8.3 Condition of patient on discharge or transfer;

18.8.4 The patient's leaving against medical advice, if appropriate;

18.8.5 Conclusions at termination of treatment, including final disposition, patient's condition at discharge, and any instructions for follow-up care.

18.9 LABOR AND DELIVERY

Labor and delivery records shall include, in addition to other requirements in Rule 18.6 for medical records, the following to be completed within 24 hours of delivery:

18.9.1 Record of previous obstetric history and prenatal care including blood serology and RH-factor determination.

18.9.2 A history, physical and obstetrical examination report upon admission describing condition of mother and fetus.

18.9.3 Complete description of the progress of labor and delivery and if applicable, the reasons for induction and any operative procedures.

18.9.4 Full report of condition of infant to include Apgar score and/or blood gases and pH, while applicable, physical exam immediately following delivery.

18.9.5 Records of anesthesia, analgesia and medications given in the course of labor and delivery.

18.9.6 Records of fetal heart rate and vital signs.

18.9.7 Signed report of consultants when such services have been obtained.

18.9.8 Names of assistants present during delivery.

18.9.9 Progress notes including description of involution of uterus, type of lochia, condition of breast and nipples, and report of infant following delivery.

18.10 NEWBORNS

Newborn medical records shall include, in addition to other requirements in Rule 18.6 for medical records, the following:

18.10.1 Date and time of birth, birth weight and length, period of gestation, sex.

18.10.2 Parents' names and addresses.

18.10.3 Type of identification placed on infant in delivery room.

18.10.4 Type of delivery, whether caesarian or vaginal.

18.10.5 Whether anesthesia was given to mother, and if so, what type and amount.

18.10.6 Physical examination including any abnormalities noted.

18.10.7 Description of complications of pregnancy or delivery including premature rupture of membranes, condition at birth including color, quality of cry, method and duration of resuscitation.

18.10.8 Record of prophylactic installation of medication into each eye at delivery.

18.10.9 Use of Oxygen during neonatal period.

18.10.10 Progress notes including temperature, weight and feeding charts, number, consistency and color of stools, frequency of urination, condition of eyes and skin, and mode of neurological behavior.

18.10.11 Consent for circumcision (if applicable).

18.10.12 Discharge summary, including any instructions given to the child’s mother.

18.10.13 A copy of the birth certificate.

18.10.14 Results from phenylketonuria, congenital hypothyroidism and galactosemia tests.

18.11 MEDICAL HISTORY AND PHYSICAL

18.11.1 A complete medical history and physical shall be dictated within 24 hours of admission. This should include:

18.11.1.1 The chief complaint;

18.11.1.2 Details of the present illness;

18.11.1.3 Relevant past, social and family histories;

18.11.1.4 All pertinent findings resulting from an assessment of all the systems of the body;

18.11.1.5 Provisional diagnosis;

18.11.1.6 Patient's current medical problems;

18.11.1.7 Known allergies;

18.11.1.8 All known significant diagnoses;

18.11.1.9 Condition of the patient;

18.11.1.10 Previous procedures;

18.11.1.11 Medications and dosages;

18.11.1.12 Assessment of mental status;

18.11.1.13 Any medication reactions; and

18.11.1.14 Existing comorbid conditions.

18.11.2 The Hospital will not accept histories and physicals from physicians who do not have Appointment and Clinical Privileges.

18.11.3 When a complete history and physical has been obtained within thirty (30) days prior to an admission, such as in the office of a physician Practitioner, a durable, legible copy may be placed in the patient's Hospital medical record together with

an interval admission note that includes the reason for the admission, additions to the history, and subsequent changes in the physical findings.

18.11.4 When a complete history and physical has been obtained more than seven (7) but within thirty (30) days prior to admission, a durable, legible copy may be placed in the patient's Hospital medical record if all of the following are done:

18.11.4.1 An appropriate assessment, which should include a physical examination of the patient to update any components of the patient's current medical status that have changed since the history and physical or to address any areas where more current data is needed, is completed within seven (7) days prior to admission or dictated within twenty-four (24) hours of admission, but prior to surgery or a procedure requiring anesthesia services, confirming that the necessity for the procedure or care is still present and the history and physical are still current; and

18.11.4.2 The Practitioner completes an updated note, addressing the patient's current status and/or changes in the patient's status, regardless of whether there were any changes in the patient's status, within seven (7) days prior to or dictated within twenty-four (24) hours after admission and such update note is on or attached to the history and physical; and

18.11.4.3 The history and physical, including all updates and assessments, is included in the medical record within twenty-four (24) hours after admission.

18.11.5 There must be a complete history and physical in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement to that effect and an admission note in the chart by the Practitioner who admitted the patient.

18.11.6 An outpatient who receives anesthesia will have a documented history and physical examination just as if the patient were admitted to the hospital as an inpatient. The extent of documentation required in the physical examination is to be reflective of the type of anesthesia planned and/or given.

18.11.6.1 For patients receiving a topical, local, or regional block, the physical examination shall include:

18.11.6.1.1 Assessment of mental status; and

18.11.6.1.2 Examination specific to the proposed procedure.

18.11.6.2 For patients receiving IV sedation, the physical examination shall include:

18.11.6.2.1 Assessment of mental status;

18.11.6.2.1 Examination specific to the proposed procedure; and

18.11.6.2.1 Examination of the heart and lungs by auscultation.

18.11.6.3 For patients receiving general, spinal, or epidural anesthesia, the physical examination shall include:

18.11.6.3.1 Assessment of mental status;

18.11.6.3.2 Examination specific to the proposed procedure;

18.11.6.3.3 Examination of the heart and lungs by auscultation; and

18.11.6.3.4 Assessment and written statement about the patient's general condition.

18.11.6.4 For outpatient procedures not requiring the assistance of an anesthetist, the appropriate record may be dictated or may be a handwritten record, such as the emergency room sheet. This H&P should be comprised of the following information as a minimum:

18.11.6.4.1 Why the patient is having the procedure;

18.11.6.4.2 What kind of symptoms the patient has;

18.11.6.4.3 A signed consent to perform the procedure; and

18.11.6.4.4 Patient's current medical problems.

18.12 PROVISIONAL DIAGNOSIS

A provisional diagnosis (reason for admission) will be recorded by the admitting physician at the time admission orders are given and reflect his evaluation of the patient's condition upon admission.

18.13 PROGRESS NOTES AND DISCHARGE SUMMARIES

18.13.1 The first item on the patient's progress note sheet, to be entered at the time of admission by the attending Practitioner, shall be a short admission note containing pertinent information concerning the patient's chief complaint, reason for admission, vital signs, physical findings and proposed diagnostic or treatment procedures.

18.13.2 The attending Physician Practitioner (or the Physician Practitioner covering for

the attending Physician Practitioner) shall round on each patient daily and shall enter or countersign a progress note. All progress notes shall be recorded at the time of observation, should be directly related to the patient's clinical problems and should be correlated with specific orders in light of the results of tests and treatment.

18.13.3 If possible, at the time of discharge of all patients a final diagnoses and final medications shall be recorded in full, either in the final progress note or discharge orders, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner. A discharge summary shall be dictated in a timely manner.

18.13.4 The discharge instruction sheet should include any instructions to the patient and/or family. When pre-printed instructions are given to the patient or family, the record shall so indicate. A sample of the instruction sheet in use at the time will be on file in the medical record department.

18.13.5 Except as provided in Rule 18.13.6, a discharge summary shall be documented in all medical records by the attending physician Practitioner. The discharge summary shall recapitulate the reason for hospitalization, significant findings, procedures performed, treatment rendered, the events of the hospitalization, the patient's condition on discharge and instructions to the patient and family, if any. The final diagnosis shall be stated in the discharge summary.

18.13.6 For cases involving minor treatments of less than 48 hours duration, or normal newborn infants and uncomplicated obstetrical deliveries, a final progress note will be acceptable. Such final progress note, which may be handwritten, should document the patient's disposition, diagnosis, condition at discharge, discharge instructions, and required follow-up care.

18.14 CONSULTATIONS

18.14.1 All consultations shall be requested in writing, after which the consulting Practitioner shall add the written or dictated report of his findings together with his recommendations. The consultation sheet shall become a part of the medical record. The procedure for requesting consultations is delineated in Section 12.2 of these Rules.

18.14.2 When operative procedures are involved, the consultation record, except in emergency cases, shall be recorded prior to surgery.

18.14.3 Required consultations are delineated in Rule 12.1.2.

18.14.4 Any qualified Practitioner with clinical privileges in this hospital may be called

for consultation within his area of expertise.

18.15 PATHOLOGY REPORTS

18.15.1 If a frozen section report will not be available within an hour due to the absence of the pathologist or any other reason, the attending Practitioner will make the necessary arrangements for taking the frozen section.

18.15.2 The specimens removed during surgical procedures will ordinarily be sent to Pathology for evaluation.

18.15.2.1 Specimens shall be properly labeled, packaged as designated, and identified as to patient and source in the Operating Room or suite at the time of removal.

18.15.2.2 Each specimen must be accompanied by pertinent clinical information and, to the degree known, the pre-operative and post-operative diagnoses.

18.15.2.3 Receipt by the Laboratory of surgically removed specimens for examination shall be documented, and the identity of the specimens/patient shall be assured throughout the processing and storage.

18.15.3 Every specimen sent to the Laboratory shall be examined by the Pathology Department. Certain type specimens are specifically exempt from routine submission to the pathologists for examination (see below), but may be submitted at the discretion of the surgeon if examination is deemed necessary. IF THE SPECIMENS ARE NOT SUBMITTED FOR THE PATHOLOGIST'S EXAMINATION, THEY MUST BE APPROPRIATELY DESCRIBED AS TO NUMBER, SIZE, CONFIGURATION, COLOR, ETC., IN THE OPERATIVE SUMMARY AND DISPOSITION OF THE SPECIMEN ADEQUATELY DOCUMENTED.

18.15.4 The following specimens are specifically exempt from routine submission to the pathologist for examination. THESE EXCEPTIONS ARE MADE ONLY WHEN THE QUALITY OF CARE WILL NOT BE COMPROMISED BY THE EXCEPTION, WHEN ANOTHER SUITABLE MEANS OF VERIFICATION OF THE REMOVAL HAS BEEN ROUTINELY EMPLOYED, AND WHEN THERE IS AN AUTHENTICATED OPERATIVE OR OTHER OFFICIAL REPORT THAT DOCUMENTS THE REMOVAL.

18.15.4.1 Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliances, portion of rib removed only to enhance operative exposure (except when the examination of the bone marrow may assist in the evaluation of the patient's condition),

foreign body [except when tissue is excised around foreign body, or the foreign body, such as a bullet, should be retained for medical-legal reasons iris tissue and routine scar removal (except in cases of patients whose scars are the result of previous cancer surgery).

18.15.4.2 Orthopedic appliances that are to be retained for medical-legal reasons should be properly labeled and placed in secured storage in the Surgery area.

18.15.4.3 Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

18.15.4.4 Traumatically injured members that have been amputated and for which examination for any medical or legal reasons is not deemed necessary.

18.15.4.5 Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

18.15.4.6 Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a new born infant, leftover veins used for grafting, and varicose veins.

18.15.4.7 Grossly normal placentas from healthy full term viable infants that have been removed in the course of operative and nonoperative obstetrics.

18.15.4.8 Deciduous teeth, provided the number, including fragments, is recorded in the medical record.

18.15.4.9 Kidney and urinary bladder stones may be exempt if chemical analysis is requested by the surgeon and report of such an analysis is to become a part of the patient's chart. If chemical analysis is not to be requested, the stone must be submitted to the pathologist for documentation.

18.15.4.10 Gallstones, provided that the number, size, shape, color, etc., are documented by the pathologist prior to being returned to the clinician.

18.15.4.11 Redundant skin removed for cosmetic reasons.

18.15.4.12 Vaginal wall mucosa from anterior and/or posterior repairs, when no hysterectomy is performed.

18.15.4.13 Joint tissue removed through arthroscope in a "piecemeal" fashion which destroys anatomy (unless needs for microbiologic culture or if

histopathologic evaluation is requested by the surgeon).

18.15.4.14 Spinal Lamina.

18.15.4.15 Skull removed in cases of immediate depressed skull fracture.

18.15.4.16 Skin, fat, and subcutaneous tissue removed in face-lift, neck-lift, abdomina plasty, suction lipectomy, etc.

18.15.4.17 Cartilage and bone from submucous resection and/or rhinoplasty.

18.15.4.18 Intrauterine contraceptive devices.

18.15.4.19 Esophageal foreign bodies (coins, pins, food, etc.)

18.15.4.20 Bunion tissue.

18.16 SPONGE AND NEEDLE COUNTS

The count form for sponges and needle and instrument count must be placed in the medical record of all surgical patients.

18.17 POST ANESTHESIA NOTE

18.17.1 Post anesthesia medical record information should be documented in the medical record within forty-eight (48) hours of the anesthesia and should include the level of consciousness of the patient on entering and leaving the recovery area, the status of infusions, the status of all tubes, drains and catheters, vital signs, presence or absence of anesthesia-related complications, and date and time of the post anesthesia visit.

18.17.2 All anesthesia personnel are encouraged to make pertinent post anesthesia entries in the medical records of patients to whom they have administered anesthesia. When the post anesthetic visit and record entry by anesthesia personnel are not feasible because of early patient release from the Hospital, the Practitioner who discharges the patient shall be responsible for meeting these requirements.

18.18 RESPIRATORY THERAPY

Pertinent clinical evaluations of the results of respiratory therapy must be placed in the patient's medical record on a timely basis and authenticated by the responsible physician.

18.19 PHYSICAL THERAPY

Authentication of the results of physical therapy may be done at the conclusion of the patient's stay.

18.20 DELINQUENT RECORDS

Any chart on an in-house patient shall be considered as delinquent when:

18.20.1 An Admission Note, or History and Physical has not been dictated within 24 hours of admission.

18.20.2 An Operative Record has not been dictated within 24 hours of the procedure.

18.20.3 A written note of pertinent aspects of a surgical procedure and the patient's condition is not entered into the chart immediately following surgery.

18.20.4 Progress Notes have not been recorded as required by the Utilization Review Plan. Progress Notes shall be written:

18.20.4.1 Daily for patients in CCU or ICU and patients with more severe circumstances as previously noted.

18.20.4.2 At least once in every 48 hours for all other patients.

18.20.5 The Attending Practitioner will be notified of the delinquency by the Director of Medical Records, and unless the delinquency is corrected in a timely manner after notification, he will be subject to corrective action as prescribed in the Staff Bylaws.

18.21 AUTOMATIC SUSPENSION

18.21.1 A patient's medical record must be completed within thirty (30) days after the patient is discharged from the hospital.

18.21.2 If a patient's record remains incomplete 15 days after the patient's discharge, the Practitioner responsible for said record will be notified and given seven (7) days to complete such delinquent records. If the records continue to be incomplete at the end of such seven (7) day period, the Practitioner will be so notified and given an additional seven (7) days to complete such delinquent records. Upon expiration of the second seven (7) day period without such records being completed the Practitioner will be automatically suspended for delinquent records pursuant to Rule 7.3.1 effective upon notification by phone by Medical Records personnel.

18.21.3 An automatic suspension of admitting privileges for failure to complete medical records will include the following restrictions:

18.21.3.1 The suspended Practitioner may not admit patients to the Hospital;

18.21.3.2 May not admit a patient under another physician's name and take over the

treatment of the patient after admission;

18.21.3.3 May not take emergency room call; and

18.21.3.4 May not perform surgery.

18.21.4 The suspended Practitioner will be allowed to continue the treatment of patients he may have in the Hospital at the time.

18.21.5 Repeated automatic suspensions after warning for failure to complete medical records within the time periods set out herein may subject the Practitioner involved to further corrective action, including possible termination of Appointment and all Clinical Privileges.

18.21.5.1 After a third suspension within any twelve (12) month period, the Practitioner is asked to appear before the Executive Committee for a discussion regarding the problems leading to the suspensions.

18.21.5.2 A fourth suspension within any twelve (12) month period constitutes voluntary resignation from the Staff and is not subject to any hearings or appeals.

18.21.6 Any Practitioner whose Appointment and Clinical Privileges have been terminated for repeated violations will be reinstated only if:

18.21.6.1 All delinquent medical records have been completed;

18.21.6.2 Reapplication is made for Appointment and Clinical Privileges, including a new delineation of Clinical Privileges requested;

18.21.6.3 Application for reinstatement is approved via regular channels as set forth in the Staff Bylaws.

18.21.7 Practitioners who plan to be out of town should inform the medical records director prior to leaving so that records can be brought up to date.

18.21.8 In the event of death or disability of the attending Practitioner, the Quality Assurance Committee shall complete the medical record insofar as possible or shall authorize the record to be filed incomplete.

18.22 RELEASE OF RECORDS

18.22.1 All medical records are the property of the Hospital and may not be removed from the Hospital's jurisdiction and safekeeping absent a valid court order or subpoena.

18.22.2 Medical records shall not be released to the patient until the patient has been formally discharged by his attending Practitioner since any prior release would involve incomplete records.

18.22.3 Medical records shall not be released to the patient or any other party except upon presentation to the hospital of a signed authorization from the patient or his legal representative containing the following information:

18.22.3.1 The name of the institution requesting the records;

18.22.3.2 The name of the person to whom the disclosure is to be made;

18.22.3.3 The name of the patient;

18.22.3.4 The purpose or need for disclosure;

18.22.3.5 The extent or nature of information sought;

18.22.3.6 A statement that the "consent is subject to revocation at any time;"

18.22.3.7 The date on which the authorization automatically expires;
18.22.3.8 The date the authorization was signed;

18.22.3.9 The patient's signature;

18.22.4 Upon receipt of the aforementioned authorization, the Hospital shall not release any medical records directly to the patient (as opposed to a third party at the patient's direction) until it has contacted the attending Practitioner and determined if there are any bona fide medical reasons not to release the records.

18.22.4.1 If no such bonafide medical reasons exists, the medical records can be released immediately upon verification of this fact.

18.22.4.2 If the Practitioner indicates that a problem of this nature does exist, the patient will be so advised and instructed to seek a conference with the attending Practitioner in an attempt to resolve the problem.

18.22.4.3 If the Practitioner fails to respond within seventy-two hours that bona fide medical reasons exist not to release the medical records, the medical records department, in its discretion, may release the records.

18.22.5 Access to all medical records of all patients shall be afforded to Practitioners for bona fide study and research consistent with preserving the confidentiality of

personal information concerning the individual patients.

18.22.5.1 All such projects shall be approved by the Staff Executive Committee or the Institutional Review Board before records can be studied.

18.22.5.2 Subject to the discretion of the Chief Executive Officer, former Practitioners may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

RULE NINETEEN: ORDERS

19.1 GENERAL RULES

19.1.1 Medical care may be given to patients in the Hospital only by or on the order of a Practitioner who has been granted appropriate Clinical Privileges.

19.1.2 Orders shall be specific, legible, and complete, and Hospital personnel have the right and obligation to question any order that is illegible, ambiguous or incomplete.

19.1.3 Under appropriate circumstances, nursing personnel have the right and obligation to question the orders for a particular patient or the need for consultation. All inquiries concerning an order or patient care should first be directed to the responsible Practitioner. However, in the event that said Practitioner is unavailable or his explanation is unsatisfactory, further inquiry should be directed through the following channels (with additional contact with the Practitioner, if possible) until a resolution is obtained:

19.1.3.1 the nursing supervisor, who may refer the matter to

19.1.3.2 the Chief Nursing Officer, who may refer the matter to the Chief Executive Officer, who may refer the matter to
.

19.1.3.3 the Chief of Staff.

19.1.4 The resolution and the means by which it was obtained should be documented in an objective, concise and factual manner.

19.1.5 Except as specified herein, all orders for treatment shall be in writing, signed, dated, and timed before being carried out.

19.1.6 Orders which are considered illegible or improperly written will not be carried out

until rewritten.

19.1.7 The use of "renew", "repeat", and "continue orders" are not acceptable.

19.1.8 Drugs used shall be listed in the formulary of the Hospital.

19.1.8.1 Exceptions to this list shall be well justified and approved by the Quality Assurance Committee.

19.1.8.2 All drugs and medications administered to patients shall be those approved in the latest edition of national formulary, American Hospital Formulary Service of AMA Drug Evaluations.

19.1.8.3 The Hospital pharmacist shall have the authority to dispense drugs according to their generic names though a proprietary name is specified.

19.1.8.4 Practitioners who do not desire generic drugs should write on their order "no replacements."

19.1.8.5 Drugs for bona fide clinical investigations may be exceptions provided the prescription of such drugs is first approved by the Executive Committee and is subsequently used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of the Federal Drug Administration.

19.2 VERBAL AND TELEPHONIC ORDERS

Verbal and telephonic orders are acceptable provided the following steps are taken:

19.2.1 The order is dictated to a registered nurse, LPN or scribe in accordance with applicable laws and regulations. Pharmacists may receive orders for medications. Other professionals may receive orders for patient treatments pertinent to their field when nursing personnel are not available to coordinate services.

19.2.2 The ordering Practitioner is identified;

19.2.3 The person receiving the order is identified by name and title;

19.2.4 When the order is dictated, it is then read back by person receiving it to the ordering Practitioner for correction;

19.2.5 The order is properly transcribed by the person receiving the order in the patient's medical record and signed by such person in the name of the ordering Practitioner per the name of the person receiving the order (first initial, last name and title); and

19.2.6 The ordering Practitioner shall authenticate all verbal orders and telephonic medication orders within seventy-two (72) hours and all other verbal and telephonic orders within ninety-six (96) hours.

19.3 TELEFAXED AND ELECTRONIC ORDERS

Telefaxed orders may be placed directly in the chart and are considered the same as an original order for all purposes. Electronic orders via approved computer services will likewise be placed directly in the chart and are considered the same as an original order for all purposes.

19.4 STANDING ORDERS

Standing orders are those affecting all patients treated in a specific service (e.g., all obstetrical patients or all newborns).

19.4.1 Standing orders shall be those formulated by an individual Practitioner and specifically approved by the Quality Assurance Committee.

19.4.2 Standing orders shall be transcribed on the Practitioner's order form in the patient's medical record and shall be initiated by nursing personnel unless, in the professional opinion of the nurse in charge, the patient's condition appears to require the Practitioner's confirmation of the order.

19.5 AUTOMATIC CESSATION

19.5.1 All orders for the following classification of medications shall be automatically discontinued after the following time periods:

19.5.1.1 DEA Schedule II drugs	4 days
19.5.1.1 DEA Schedule III, IV, & V drugs	10 days
19.5.1.1 Anticoagulants	10 days
19.5.1.1 Antibiotics	10 days
19.5.1.1 Oxytoxics	10 days
19.5.1.1 Cortisone products	10 days

19.5.2 A daily report will be generated by the pharmacy and used by nursing to notify Practitioners of any medications that will be discontinued 48 hours prior to their discontinuation. A reminder to reorder will be stamped on the patient’s order sheet.

19.5.3 Exceptions to the foregoing automatic cessation are as follows:

19.5.3.1 The order indicates an exact number of doses to be administered.

19.5.3.2 An exact period of time for the medication is specified.

19.5.3.3 The attending Practitioner reorders the medication.

19.5.3.4 The attending Practitioner specified "Automatic 3 day stop order does not apply."

19.5.4 All patients transferred electively from the Critical Care Units should have all orders reviewed and rewritten by the attending Practitioner.

19.5.5 All previous orders are canceled when patients go to surgery.

19.6 MEDICATIONS BROUGHT FROM HOME

19.6.1 Any medications brought to the hospital by the patient or obtained in any other manner outside of the Hospital pharmacy will not be administered to that patient unless specifically ordered and so directed by the attending Practitioner in writing in the medical records, the medication is sent to the Hospital pharmacy for identification purposes and dispensed as prescribed, and the administration of such medication is thereafter approved by Hospital administration.

19.6.2 If it is discovered that the patient retains in his possession after admission any prescribed or unprescribed drugs or medications, this fact will be brought to the attention of the attending Practitioner for his authorization or denial.

19.7 OXYTOXIC DRUGS

Oxytoxic drugs may be administered for induction or augmentation of labor without the presence of the Practitioner as long as the Practitioner or another Practitioner qualified to manage any complications is immediately available.

19.8 RADIOLOGY SERVICES

Formal interpretation of x-rays and other imaging modalities taken in this hospital shall be performed by a radiologist. The Staff shall designate the paramedical personnel who will be permitted to administer diagnostic agents and which diagnostic agents they shall be permitted to administer. A list will be kept in the administrative office and the radiology department.

19.9 RAPE PROCEDURES

For the proper care and procedures to be followed for victims of suspected rape or sexual abuse, consult the Emergency Room Policy and Procedure Manual.

19.10 ORDERS BY OUTPATIENT STAFF

19.10.1 For the purposes of Bylaw 4.4.2.1, and to further define the Prerogatives of

Practitioners with Outpatient Staff Appointment, "routine" is defined as those tests that are part of day-to-day evaluations and treatments for patients who do not require inpatient stays and those tests that are relatively low risk of untoward effects on the patient. Tests and treatments that are not "routine" require referral to a Practitioner with Active or Consulting Staff Appointment and appropriate Clinical Privileges.

19.10.2 The following specific tests and treatments are considered to be "routine":

Diagnostic Imaging

X-ray routine
CT scan
MRI scan
Venous Doppler
Mammogram
Intravenous pyelogram
Arthrogram
Bone density tests
Upper GI series
Lower GI series
Barium swallow
Other non-invasive digestive tract x-ray

Nuclear Medicine

Thyroid scan and radioisotope functions
Cardiovascular and hematopoietic scans
Bone scans
Renal scans
Cerebral scans
Hepatobiliary scans
Labeled white cell scans
Cerebral perfusion cans

Ultrasound

Abdominal
Pelvic (including OB)
Small parts (thyroid, scrotal, etc.)
Venous
Carotid
Transcranial

Laboratory

Routine labs
Chemistries
Bacteriology
Parasitology
Virology
Serology
Surgical specimens
Cytological specimens

Cardiovascular

Electrocardiogram
Cardiac ultrasound
Holter monitor
Carotid doppler
Non-invasive vascular studies

Respiratory Studies

Blood gasses
Respiratory function studies
Pulse oximetry
Instruction in metered dose inhalers
Vital capacity determination

Neurological Tests

Electroencephalogram
Electromyogram
Evoked response (sensory, auditory, visual)
Nerve conduction

Therapy and Consultations

Occupational therapy
Speech therapy
Physical therapy
Range of motion test
Dietary consult
Social service consult
Case coordination
Respiratory therapy

Diabetes education
Cardiac rehab
Pulmonary rehab
Nicotine abuse education
Other non-operative measurements, examinations, and education

RULE TWENTY: TERMINAL PATIENTS

20.1 PURPOSE

The purpose of these rules and regulations is to set forth a course of conduct to be followed by the Staff in the care and treatment of terminal patients. Different actions are required for different patients under different circumstances. Rules 20.2, 20.5, 20.6, and 20.7 cover circumstances where the patient is dead. Specifically, Rule 20.6 details medical standards for circulatory and respiratory death and Rule 20.7 details requirements for brain death. Rule 20.8 covers the use of living wills and health care proxies. Rule 20.10 covers withdrawal of life support and Rule 20.09 covers the use of DNR orders. Rule 20.11 covers conflicts resolution.

20.2 THE DEAD PATIENT

20.2.1 An individual is dead who has sustained either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem.

20.2.2 A determination of death must be made in accordance with accepted medical standards.

20.2.3 When the patient is dead as defined by the aforementioned criteria, the attending Practitioner, or the emergency room physician at the request of the attending Practitioner, shall pronounce the patient dead and document the factors leading to his pronouncement in the patient's chart. He shall then remove all life support equipment from the patient, and notify the family of the patient's death.

20.3 THE COMPETENT PATIENT

20.3.1 A competent patient is a person who is:

20.3.1.1 an adult (18 years of age or older) or an emancipated minor; and

20.3.1.2 conscious; and

20.3.1.3 able to understand the nature and severity of the illness, injury or medical condition; and

20.3.1.4 able to understand the nature, risks and consequences of any proposed medical treatment and alternatives; and

20.3.1.5 able to make informed choices regarding medical treatment.

20.3.2 When a Practitioner's order is dependent on a determination of competency, the Practitioner shall document the factors leading to the determination that the patient is competent at the time, and that the patient has been provided with any relevant facts concerning his treatment. Any such determination requires a second opinion whereby a consulting Practitioner confirms and documents both the patient's competency, including the applicability of each of the five factors listed above, and the express desire of the patient regarding his medical care.

20.3.3 If a competent patient refuses medical treatment and/or requests that extraordinary care and/or life support systems be withheld or withdrawn, the Practitioner shall consult with Administration and Hospital counsel regarding such action. [See Rule 20.9 (for withholding) and Rule 20.10 (for withdrawing care.)] (The right to refuse life-saving treatment of an otherwise competent patient who is pregnant or who has minor children depending upon him for financial or legal support may not be absolute.)

20.4 THE INCOMPETENT PATIENT

20.4.1 An incompetent patient is one who fails to meet the criteria in either Rule 20.2 or 20.3 above.

20.4.2 If there is a living will or health care proxy for the incompetent patient, the Practitioner shall consult with Administration and Hospital counsel regarding carrying out the instructions embodied in the living will or health care proxy. (See Rule 20.8.)

20.4.3 If there is no living will but the attending Practitioner deems it medically advisable to withdraw or withhold life-prolonging medical treatment, life support systems or nutrition and hydration from such incompetent patient, the Practitioner shall consult with Administration and Hospital counsel regarding such action. [See Rule 20.9 (for withholding care), Rule 20.10 (for withdrawing care) and Rule 20.8.12 (for withdrawing or withholding nutrition and hydration)]

20.5 ACCEPTED MEDICAL STANDARDS FOR DEATH

20.5.1 "An individual who has sustained either:

20.5.1.1 irreversible cessation of circulatory and respiratory functions; or

20.5.1.2 irreversible cessation of all functions of the entire brain, including the brainstem, is dead." Ark. Code Ann. § 20-17-101.

20.5.2 An individual presenting the findings in either Rule 20.6 (cardiopulmonary) or Rule 20.7 (neurologic) is dead. In either section, a diagnosis of death requires that both cessation of functions, as set forth in Rule 20.6.4, and irreversibility, as set forth in Rule 20.6.5, be demonstrated and appropriately documented in the patient's chart.

20.6 POLICY ON CIRCULATORY AND RESPIRATORY DEATH

It is the policy of this Hospital to preserve and enhance human life and to provide medical care to all patients in accord with prudent medical practices. The purpose of this policy is to establish the criteria and procedures for all determinations of death in the irreversible absence of all circulatory and respiratory function.

20.6.1 A patient who has sustained "irreversible cessation of circulatory and respiratory functions is dead." Ark. Code Ann. § 20-17-101(a).

20.6.2 A determination of circulatory and respiratory death at this hospital "shall be made in accordance with accepted medical standards." Ark. Code Ann. § 20-17-101(b).

20.6.3 Determination of circulatory and respiratory death will be made in accordance with the following criteria:

20.6.4 Cessation of Circulatory and Respiratory Functions. An individual with irreversible cessation of circulatory and respiratory functions is dead.

20.6.4.1 Cessation is recognized by an appropriate clinical examination. Clinical examination will disclose at least the absence of responsiveness, heartbeat and respiratory effort. Medical circumstances may require the use of confirmatory tests, such as an ECG.

20.6.5 Irreversibility of Circulatory and Respiratory Functions. Irreversibility of recognized functions by persistent cessation of functions during an appropriate period of observation and/or trial or therapy.

20.6.6 In clinical situations where death is expected, where the course has been gradual, and where irregular agonal respiration or heartbeat finally ceases, the period of observation following the cessation may be only the few minutes required to complete the examination.

20.6.7 If resuscitation is not undertaken and ventricular fibrillation and standstill develop in a monitored patient, the required period of observation thereafter may be as short as a few minutes.

20.6.8 When a possible death is unobserved, unexpected, or sudden, the examination may need to be more detailed and repeated over a longer period, while appropriate resuscitative effort is maintained as a test of cardiovascular responsiveness.

20.6.9 Diagnosis in individuals who are first observed with rigor mortis or putrefaction may require only the observation period necessary to establish that fact.

20.6.10 When the patient is dead as defined by the aforementioned criteria, the attending Practitioner, or the emergency room physician at the request of the attending Practitioner, shall pronounce the patient dead and document the factors leading to his pronouncement in the patient's chart and shall then notify the family of the patient's death.

20.7 POLICY ON BRAIN DEATH

It is the policy of this hospital to preserve and enhance human life and to provide medical care to all patients in accord with current prudent medical practices. The purpose of this policy is to establish the criteria and procedures for the determination of death in the irreversible absence of all brain functions.

20.7.1 A patient who has sustained "irreversible cessation of all functions of the entire brain, including the brainstem, is (legally) dead." Ark. Code Ann. § 20-17-101(a).

20.7.2 A determination of brain death at this hospital "shall be made in accordance with accepted medical standards." Ark. Code Ann. § 20-17-101(b).

20.7.3 Determination of brain death shall be made in accordance with the following criteria:

20.7.3.1 The functions of the entire brain, including the brainstem, that are relevant to the diagnosis are those that are clinically ascertainable. Where indicated, the clinical diagnosis is subject to confirmation by laboratory tests as described below. It must be determined that both cerebral and brainstem functions are absent. Testing for apnea must also be done. Consultation with a Practitioner experienced in this diagnosis is advisable.

20.7.3.2 Cerebral Functions. Coma or unresponsiveness must be present. This means that there is no cerebral motor response to pain in all extremities (nail bed pressure and supraorbital pressure). Medical circumstances may require the use of confirmatory studies such as EEG or blood flow study.

20.7.3.3 Brain Stem Functions. Reliable testing of brainstem reflexes requires a perceptive and experienced physician using adequate stimuli as follows:

20.7.3.3.1 Pupils: (a) No response to bright light (b) Size: midposition (4mm) to dilated (9mm);

20.7.3.3.2 Ocular movement: (a) No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent) (b) No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side);

20.7.3.3.3 Facial sensation and facial motor response :(a)No corneal reflex to touch with a throat swab (b) No jaw reflex (c) No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint

20.7.3.3.4 Pharyngeal and tracheal reflexes: (a) No response after stimulation of the posterior pharynx with tongue blade (b) No cough response to bronchial suctioning

20.7.3.3.5 When these reflexes cannot be adequately assessed, confirmatory tests are recommended.

20.7.3.4 Apnea Testing. Apnea testing should be performed as follows:

20.7.3.4.1 Prerequisites:

20.7.3.4.1.1 Core temperature >36.5°C or 97°F;

20.7.3.4.1.2 Systolic blood pressure >90 mm Hg;

20.7.3.4.1.3 Euvolemia. *Option*: positive fluid balance in the previous 6 hours;

20.7.3.4.1.4 Normal Pco2. *Option*: arterial Pco2 >40 mm Hg;

20.7.3.4.1.5 Normal Po2. *Option*: preoxygenation to obtain arterial Po2 >200 mm Hg;

20.7.3.4.1.6 Connect a pulse oximeter and disconnect the ventilator;

20.7.3.4.1.7 Deliver 100% O2, 6 1/min, into the trachea. *Option*: place a cannula at the level of the carina;

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

20.7.3.4.1.9 Measure arterial Po2, Pco2, and pH after approximately 8 minutes and reconnect the ventilator;

20.7.3.4.1.10 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);

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

20.7.3.4.1.12 Connect the ventilator if, during testing, the systolic blood pressure becomes <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.

20.7.3.5 Irreversibility of Cessation. The irreversibility of the cessation of brain functions will be established when all of the following are present:

20.7.3.5.1 The cause of coma is established and is sufficient to account for the loss of brain functions. Most difficulties with the determination of death on the basis of neurologic criteria have resulted from inadequate attention to this basic diagnostic prerequisite. In addition to careful clinical observations, other than clinical observations compatible with the diagnosis of brain death (see Rule 20.7.3.6 below), confirmatory laboratory tests (see Rule 20.7.3.7 below) may be conducted.

20.7.3.5.2 The possibility of recovery of any brain function is excluded. The most important reversible conditions are sedation, hypothermia, neuromuscular blockade, and shock. Complicating condition (see Rule 20.7.3.8.1) should be ruled out. A determination that blood flow to the brain is absent can be used to demonstrate a sufficient and irreversible condition.

20.7.3.5.3 The cessation of all brain functions persist for an appropriate period of observation and/or trial of therapy. Even when coma is known to have started at an earlier time, the absence of all brain functions must be established by an experienced Practitioner at the initiation of the observation period. The duration of observation periods is a matter of clinical judgment, and some physicians recommend shorter or longer

periods than those given here.

20.7.3.5.4 Except for patient with drug intoxication, hypothermia, young age, or shock, medical centers with substantial experience in diagnosing death neurologically report no cases of brain functions returning following a six hour cessation, documented by clinical examination and confirmatory laboratory test. In the absence of confirmatory tests, a period of observation of at least twelve hours is recommended when an irreversible condition is well established.

20.7.3.5.5 For anoxic brain damage where the extent of damage is more difficult to ascertain, or where the patient is five years of age or less, observation for twenty-four (24) hours is generally desirable. In anoxic injury, the observation period may be reduced if a test shows cessation of cerebral blood flow or if an EEG shows electrocerebral silence in an adult patient without drug intoxication, hypothermia, or shock.

20.7.3.5.6 Complete cessation of circulation to the normothermic adult brain for more than ten minutes is incompatible with survival of brain tissue. Documentation of this circulatory failure is therefore evidence of death of the entire brain.

20.7.3.6 Clinical Observations Compatible With the Diagnosis of Brain Death. The following manifestations are occasionally seen and should not be misinterpreted as evidence for brainstem function:

20.7.3.6.1 Spontaneous movements of limbs other than pathologic flexion or extension response;

20.7.3.6.2 Respiratory-like movements (shoulder elevation and adduction, back arching, intercostal expansion without significant tidal volumes);

20.7.3.6.3 Sweating, blushing, tachycardia;

20.7.3.6.4 Normal blood pressure without pharmacologic support or sudden increases in blood pressure;

20.7.3.6.5 Absence of diabetes insipidus;

20.7.3.6.6 Deep tendon reflexes; superficial abdominal reflexes; triple flexion response;

20.7.3.6.7 Babinski reflex.

20.7.3.7 Confirmatory Laboratory Tests. A confirmatory test is not mandatory but is desirable in patients in whom specific components of clinical testing cannot be reliably performed or evaluated. It should be emphasized that any of the suggested confirmatory tests may produce similar results in patients with catastrophic brain damage who do not (yet) fulfill the clinical criteria of brain death. The following confirmatory test findings are listed in the order of the most sensitive test first. Consensus criteria are identified by individual tests.

20.7.3.7.1 Conventional Angiography. No intracerebral filling at the level of the carotid bifurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.

20.7.3.7.2 Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16 channel EEG instruments.

20.7.3.7.3 Transcranial Doppler ultrasonography.

20.7.3.7.3.1 Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.

20.7.3.7.3.2 Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.

20.7.3.7.4 Technetium-99m hexamethylpropyleneamineoxime brain scan. No uptake of isotope in brain parenchyma ("hollow skull phenomenon").

20.7.3.7.5 Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

20.7.3.8 Complicating Conditions

20.7.3.8.1 Drug and Metabolic Intoxication

20.7.3.8.1.1 Drug intoxication is the most serious problem in the determination of death, especially when multiple drugs are used. If, in addition, alcohol has been ingested, the synergistic effect between alcohol and such drugs must be considered, and blood alcohol levels should

be obtained. Recent general anesthesia, metabolic encephalopathies, and encephalomeningitides may also influence the brain injured patient's response during evaluation for potential brain death. Cessation of brain functions caused by the sedative and anesthetic drugs, such as barbiturates, benzodiazephines, meprobamate, methaqualone, and trichloroethylene, may be completely reversible even though they produce clinical cessation of brain functions and electrocerebral silence. In cases where there is any likelihood of sedative presence, toxicology screening for all likely drugs is required. If exogenous intoxication is found, death may not be declared until the intoxicant is metabolized or intracranial circulation is tested and found to have ceased.

20.7.3.8.1.2 Total paralysis may cause unresponsiveness, areflexia, and apnea that closely simulates death. Exposure to drugs such as neuromuscular blocking agents or aminoglycoside antibiotics, and diseases like myasthenia gravis are usually apparent by careful review of the history. Prolonged paralysis after use of succinylcholine chloride and related drugs requires evaluation for pseudo-cholinesterase deficiency. If there is any question, low-dose atropine stimulation, electromyogram, peripheral nerve stimulation, confirmatory laboratory tests (see Rule 20.7.3.7) or extended observation, as indicated, will make the diagnosis clear.

20.7.3.8.1.3 In drug-induced coma, EEG activity may return or persist while the patient remains unresponsive, and therefore, the EEG may be an important evaluation along with extended observation. If the EEG shows electrocerebral silence, short latency auditory or somatosensory evoked potentials may be used to test brainstem functions, since these potentials are unlikely to be effected by drugs. Drugs known to be associated with an isoelectric EEG include barbiturates, methoqualone, diazepam, mecloqualone, meprobamote, and trichloroethylene. Blood levels of all such agents must be below toxic levels before a determination of brain death can be completed.

20.7.3.8.1.4 Some severe illnesses (i.e., hepatic encephalopathy, hyperosmolar coma, and preterminal uremia) can cause deep coma. Before irreversible cessation of brain functions can be determined, metabolic abnormalities should be considered and, if possible, corrected. Confirmatory tests of circulation or EEG may be necessary.

20.7.3.8.2 Hypothermia. Criteria for reliable recognition of death are not available

in the presence of hypothermia (below 32.2 degrees centigrade core temperature). The variables of cerebral circulation in hypothermic patients are not sufficiently well studied to know whether tests of absent or diminished circulation are confirmatory. Hypothermia can mimic brain death by ordinary clinical criteria and can protect against neurologic damage due to hypoxia. Further complications arise since hypothermia also usually precedes and follows death. If these complicating factors make it unclear whether an individual is alive, the only available measure to resolve the issue is to restore normothermia. Hypothermia is not a common cause of difficulty in the determination of death.

20.7.3.8.3 Children. The brains of infants and young children have increased resistance to damage and may recover substantial functions even after exhibiting unresponsiveness on neurological examination for longer periods than do adults. Physicians should be particularly cautious in applying neurologic criteria to determine death in children younger than five years.

20.7.3.8.4 Shock. Physicians should also be particularly cautious in applying neurologic criteria to determine death in patients in shock because the reduction in cerebral circulation can render clinical examination and laboratory tests unreliable.

20.7.3.8.5 Other Pitfalls in the Diagnosis of Brain Death. The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made with certainty on clinical grounds alone. Confirmatory tests are recommended.

20.7.3.8.5.1 Severe facial trauma;

20.7.3.8.5.2 Preexisting pupillary abnormalities;

20.7.3.8.5.3 In addition to the drugs listed in Rule 20.7.3.8.1, the presence of tricyclic antidepressants, antiepileptic drugs and chemotherapeutic agent;

20.7.3.8.5.4 Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2.

20.7.3.9 Procedures

20.7.3.9.1 If the above criteria are met and there is no evidence of continuing brain activity, the patient may be declared dead. Such declaration must be made by two physicians on the Staff, at least one of whom should be the Practitioner primarily responsible for the patient's care. Neither of the physicians involved may have any responsibility for any contemplated

transplantation of any of the patient's organs. The patient evaluation form for diagnosis of brain death must be completed and signed by both Practitioners and filed in the patient's medical record.

20.7.3.9.2 The following must be documented in the patient's chart:

20.7.3.9.2.1 Etiology and irreversibility of condition;

20.7.3.9.2.2 Absence of brainstem reflexes;

20.7.3.9.2.3 Absence of motor response to pain;

20.7.3.9.2.4 Absence of respiration with Pco2>60 mm Hg;

20.7.3.9.2.5 Justification for confirmatory test and result of confirmatory test;

20.7.3.9.2.6 Repeat neurologic examination.

20.7.3.9.3 Brain death declaration is the formal pronouncement of death and the time documented for this declaration is the time of patient death to be used for all legal matters, including the death certificate issued by the hospital.

20.7.3.9.4 The pronouncement of death is by law a medical act. Therefore, consent is not required, nor is it to be requested from the patient's next-of-kin. However, the patient's family must be given full information concerning the brain death determination process by the attending Practitioner prior to and at all stages during the process.

20.7.3.9.5 In cases where the Coroner has jurisdiction, his permission is not required for the brain death determination process or termination of medical therapy. However, in all such cases where the Coroner has jurisdiction, the Coroner's office will be immediately notified of the death and the Coroner's authorization must be obtained for removal of organs.

20.7.3.9.6 When organs are to be removed from brain dead patients, a declaration of brain death must be made prior to their removal. Removal of organs must be authorized by the next-of-kin unless the deceased patient had executed a valid organ donation agreement during his lifetime. Life-support measures will be continued until the organs have been removed. Procedures for identifying, notifying, obtaining informed consent, and referring potential organ and tissue donors to procurement agencies will conform to law.

20.7.3.9.7 All Hospital rules, policies and procedures concerning matters relevant to any deceased patient (i.e., permission for autopsy, Coroner's jurisdiction, etc.) apply equally to brain dead patients after a declaration of brain death has been made and all medical therapy or life-support devices have been discontinued.

20.7.3.9.8 Under special circumstances (such as organ donation), the declaration of death may be signed several hours after the completion of the diagnostic criteria. The most common occasion when such a delay might occur is when an operation to remove organs for donation is scheduled for the morning following the diagnostic evaluation. In such cases, certification of death must be completed before transfer to the operating room for organ removal.

20.8 LIVING WILLS AND HEALTH CARE PROXIES

Arkansas law, specifically Ark. Code Ann. § 20-17-201 et seq., codifies the Arkansas Rights of the Terminally Ill and Permanently Unconscious Act, and provides a mechanism whereby patients may express in writing their desires concerning the withdrawal or withholding of medical or surgical care in the future should they be unable to make such a determination for themselves. Due to increased publicity in this area, the use of "living will" declarations has become more common in the hospital setting. Under a “living will,” a patient may issue either or both an “advance directive” (giving instructions as to his care) and/or designate a “health care proxy” (a person to make medical decisions in the event the patient is unable to do so). The advance directive and health care proxy is only applicable when the patient is a qualified patient (See Rule 20.8.5) and when the requirements of Rule 20.8.10 have been met. They must also be contrasted with the durable power of attorney for healthcare (See Rule 11.3.1.1).

20.8.1 Execution. It is the policy of the Hospital to assist patients and their families with regard to the execution of living will declarations. To that end, upon request, patients and/or their families will be furnished with sample living will declaration forms. Hospital personnel and Practitioners, while assisting patients or their families in the execution of living will declarations, should be careful not to provide legal advice or counsel. Arkansas law requires that a living will declaration be executed only by a person who has reached the age of eighteen (18) and who is of sound mind. The living will declaration also must be witnessed by two individuals. Except in extraordinary circumstances, it is the policy of the Hospital that Hospital personnel and Staff Appointees not witness such a living will declaration.

20.8.2 Maintenance of Living Will Registry. The Hospital maintains a living will registry in which patients or prospective patients may file copies of their living will declaration. As a regular part of the admission procedure, the living will registry should be checked for each patient and the existence of a living will in the registry

should be duly noted in the patient's medical record. Upon admission to the Hospital, a copy of the living will which is located in the registry, or a copy of any living will provided to the Hospital or attending Practitioner by the patient, shall be made a part of the patient's medical record. Should the Hospital or attending Practitioner be unwilling to comply with the living will declaration, the patient should be promptly advised.

20.8.3 Competent Patients. So long as a patient is competent (See Rule 20.3), a living will declaration is inoperative.

20.8.4 Revocation of a Living Will Declaration. A living will declaration may be revoked at any time and in any manner by the patient, without regard to the patient's mental or physical condition. Such a revocation is effective upon its communication to the attending Practitioner or Hospital personnel by the patient or by a witness to the revocation. The attending Practitioner and/or Hospital personnel shall make the revocation a part of the patient's medical record.

20.8.5 Qualified Patient. A qualified patient is a patient eighteen (18) or more years of age who has executed a living will declaration or appointed a health care proxy and who has been determined by the attending Practitioner in consultation with another Practitioner who has examined the patient, to be in a terminal condition or in a permanently unconscious state.

20.8.6 Terminal Condition. Terminal condition means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending Practitioner, result in death within a relatively short period of time.

20.8.7 Permanently Unconscious. Permanently unconscious means a lasting condition, indefinitely without change in which thought, feeling, sensations and awareness of self are absent.

20.8.8 Health Care Proxy. A health care proxy is a person eighteen (18) years of age or older appointed by a qualified patient as attorney-in-fact to make health care decisions (including the withholding or withdrawal of life-sustaining treatment) if a qualified patient, in the opinion of the attending Practitioner, is permanently unconscious, incompetent or otherwise mentally or physically incapable of communication. Note: Such health care proxy should NOT be confused with a durable power of attorney for healthcare (See Rule 11.3.1.1).

20.8.9 Contents of Declaration. It is important for the attending Practitioner and health care personnel to note specifically what a patient's living will declaration declares. There are several possibilities which can be used singly or in conjunction with each other:

20.8.9.1 The declaration may direct removal of life-sustaining treatment (i.e. any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or to maintain the patient in a state of permanent unconsciousness) if the patient has an incurable or irreversible condition that will cause his death within a relatively short period of time.

20.8.9.2 The declaration may authorize the withholding or withdrawing of life-sustaining treatments that are no longer necessary for comfort or to alleviate pain if the patient becomes permanently unconscious.

20.8.9.3 The declaration may appoint a health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

20.8.10 When Declaration Becomes Operative. A declaration becomes operative when:

20.8.10.1 It is communicated to the attending Practitioner; and

20.8.10.2 The declarant is determined by the attending Practitioner and another Practitioner in consultation to be in a terminal condition (or permanently unconscious) and no longer able to make decisions regarding administration of life-sustaining treatment. When the declaration becomes operative, the attending Practitioner and other health care providers must act in accordance with its provisions or take all reasonable steps to transfer care of the patient to another Practitioner or health care provider.

20.8.11 Medical Record Documentation. Upon determining that a patient is in a terminal condition or is permanently unconscious, the attending Practitioner who has knowledge of the existence of a declaration shall record this determination and the terms of the patient's declaration in the patient's medical record.

20.8.12 Withdrawal or Withholding of Nutrition and Hydration. Arkansas' living will statute states that it does not affect the responsibility of the attending Practitioner or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort, care, or alleviation of pain. Thus, the withholding or withdrawing of nutrition and hydration is a medical and ethical decision.

20.8.12.1 The AMA Council on Ethical and Judicial Affairs issued a current opinion entitled "Withholding or Withdrawing Life-Sustaining Medical Treatment" which states the following:

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the

patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decision maker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decision maker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decision maker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decision makers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decision makers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process: (1) there is no available family member willing to be the patient's surrogate decision maker, (2) there is a dispute among family members and there is no decision maker designated in an advance directive, (3) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent, and (4) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision making is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decision maker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interest analysis.

20.8.12.2 If the attending Practitioner deems it medically advisable to withdraw or withhold nutrition and hydration, he shall do the following:

20.8.12.2.1 In the patient's progress notes the Practitioner shall document that the patient's condition is (1) incurable, (2) terminal, (3) irreversible (there is no known treatment which will lead to remission or cure of the patient's condition), and (4) that the burdens of the nutrition and hydration outweigh their benefit;

20.8.12.2.2 The Practitioner shall request an independent consultation from another Practitioner who shall likewise document in the patient's chart those factors enumerated in paragraph (a) above.

20.8.12.2.3 The Practitioner shall obtain the concurrence of the persons responsible for the patient's care to the withdrawal or withholding of the nutrition and hydration and shall document such concurrence in the patient's chart prior to the order becoming effective.

20.8.12.2.4 Once the above factors have been documented in the progress notes, the attending Practitioner shall then write an order in the patient's chart to withdraw or withhold nutrition and hydration. This order is an exception to any rule permitting telephone or oral orders.

20.8.12.3 If any of the four criteria above are lacking, Hospital personnel shall continue to provide nutrition and hydration until all such criteria are met or the attending Practitioner, in consultation with Administration, has obtained a court order authorizing the withdrawal and/or withholding of nutrition and hydration.

20.8.13 Execution of a Living Will Declaration for Another

20.8.13.1 Ark. Code Ann. § 20-17-214 provides, in certain circumstances where the patient is a minor, or where the patient is an adult who has executed no valid living will declaration nor designated a health care proxy, that a living will declaration may be executed on behalf of the patient by the first of the following individuals or category of individuals who exists and who is reasonably available for consultation:

20.8.13.1.1 A legal guardian of the patient, if one has been appointed;

20.8.13.1.2 In the case of an unmarried patient under the age of eighteen (18), the parents of the patient;

20.8.13.1.3 The patient's spouse;

20.8.13.1.4 The patient's adult child, or if there is more than one (1), then a majority of the patient's adult children participating in the decision;

20.8.13.1.5 The parents of a patient over the age of eighteen (18);

20.8.13.1.6 The patient's adult sibling, or if there is more than one (1), then a majority of the patient's adult sibling participating in the decision;

20.8.13.1.7 A person standing in loco parentis to the patient; or

20.8.13.1.8 A majority of the patient's adult heirs at law who participate in the decision.

20.8.13.2 Due to the extraordinary circumstances involved in surrogate decision making, the Practitioner should consult with the Chief Executive Officer and Hospital legal counsel regarding any such surrogate declaration.

20.9 DO NOT RESUSCITATE ORDERS

It is the general policy of this Hospital that efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest ("CPR"). Orders not to initiate resuscitation ("DNR" orders) are appropriate only when a competent patient refuses such treatment or when circumstances indicate that administration of CPR would be futile or not in accord with the desires or best interests of the patient.

20.9.1 Competent Patients. Practitioners should discuss with appropriate competent patients (See Rule 20.3) the possibility of cardiac and respiratory arrest. Patients who are at risk of cardiac or respiratory failure should be encouraged to express, in advance, their preferences concerning the use of CPR. These discussions should

include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. In addition, subsequent discussions are desirable, on a periodic basis, to allow for changes in the patient's circumstances or in available treatment alternatives which may alter the patient's preferences. The circumstances which led to the Practitioner's determination of the patient's competency and a general discussion of the Practitioner's discussion with the patient should be documented in the patient's chart. Additionally, should the patient elect to decline CPR, the patient should be encouraged to execute a living will and/or health care proxy to this effect.

20.9.2 Incompetent Patients

20.9.2.1 If an incompetent patient has previously executed a living will, and if the requirements of Rule 20.8 have been met (particularly Rules 20.8.5, 20.8.6, 20.8.7, 20.8.10), the Practitioner should appropriately document these facts in the patient's chart.

20.9.2.2 If an incompetent patient has previously executed a health care proxy, and if the requirements of Rule 20.8 have been met, decisions concerning CPR may be made on behalf of the patient by the proxy and should be appropriately documented in the patient's chart.

20.9.2.3 If no health care proxy has been appointed by the patient, the Practitioner should consult with the patient's family concerning the previously expressed wishes of the patient, or if such preferences are unknown, in accordance with the patient's best interests. The Practitioner should encourage the execution of a healthcare proxy. (See Rule 20.8.13) A registered nurse, chaplain or social worker will be available to assist the Practitioner and family in this process.

20.9.3 Practitioner's Ethical Obligations. The Practitioner has an ethical obligation to honor the resuscitation preferences expressed by the patient or the patient's proxy. The Practitioner should not permit his personal value judgments about the quality of life to obstruct the implementation of the patient's or proxy's preferences regarding the use of CPR. However, if in the judgement of the treating Practitioner, CPR would be futile, the treating Practitioner may enter a DNR order in the patient's chart. Where there is adequate time to do so, the Practitioner must first inform the patient, or the incompetent patient's proxy, of the content of the DNR order, as well as the basis for its implementation. The Practitioner should also be prepared to discuss appropriate alternatives, such as obtaining a second opinion or arranging for transfer of care to another Practitioner.

20.9.4 Futility Defined. Resuscitative efforts should be considered futile if they cannot be expected either to restore cardiac or respiratory function to the patient or to

achieve the expressed goals of the informed patient.

20.9.5 Applicability of DNR Orders

20.9.5.1 DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and do not influence other therapeutic interventions that may be appropriate for the patient.

20.9.5.2 Further, DNR orders should be reviewed periodically for continued appropriateness, and this further review should be documented in the patient's chart.

20.9.6 Documentation of DNR Orders

20.9.6.1 Prior to the order being written, the Practitioner must make a progress note including the information outlined below:

20.9.6.1.1 Patient's competency;

20.9.6.1.2 Diagnosis;

20.9.6.1.3 Prognosis, stating the irreversibility of the medical condition;

20.9.6.1.4 Patient's wishes, proxy decision or family decision, and the date and times of relevant discussions;

20.9.6.1.5 Recommendations of consultations and treatment team;

20.9.6.1.6 Any clarification or other information that the Practitioner may have;

20.9.6.1.7 Any organ donation information;

20.9.6.1.8 On repeated admissions, the Practitioner may write "no change in physical condition" and continue the DNR status; and

20.9.6.1.9 Clear guidelines to nursing staff and others as to specific resuscitative efforts described in Rule 20.9.6.3 that are to be withheld.

20.9.6.2 All DNR orders a patient should be in writing and signed by the attending Practitioner.

20.9.6.2.1 Telephone orders are acceptable only if a progress note addressing the information described above is documented by the Practitioner in the patient's records. Telephone orders must be received by a Registered Nurse and witnessed by another licensed nurse.

20.9.6.2.2 The DNR order and progress notes (written and signed by the attending Practitioner) may be faxed to the appropriate nursing unit.

20.9.6.3 A DNR order includes withholding any or all of the following:

20.9.6.3.1 Defibrillation;

20.9.6.3.2 Use of emergency and/or cardiac life support (ACLS) drugs;

20.9.6.3.3 Cardiopulmonary Resuscitation;

20.9.6.3.4 Intubation; and

20.9.6.3.5 Mechanical Ventilation.

20.9.6.4 Any modification of the above must be clearly defined in the Practitioner order. Orders such as “Slow Code”, “Chemical Code” and/or “Partial Code” will not be accepted. The Practitioner who writes such orders will be called for clarification.

20.9.6.5 DNR orders written prior to surgery must be renewed post-op.

20.9.7 Implementation of DNR Orders

20.9.7.1 A copy of any living will or health care proxy should be made a part of the patient's chart;

20.9.7.2 The Quality Assessment and Improvement Committee will conduct post-care internal review of DNR orders (or selected samples thereof);

20.9.7.3 The Ethics Committee will be available to advise and consult the attending Practitioner, if requested; and

20.9.7.4 Any changes in the patient's competency or medical condition will be reported to the Practitioner.

20.10 ORDERS WITHDRAWING LIFE SUPPORT

It is the general policy of this Hospital that efforts should be made to preserve, protect and defend a patient’s life and safety. However, this does not require treatment to be continued that is futile or to which certain competent patients refuse. Orders withdrawing life support ("WLS" orders) are appropriate only when a competent patient refuses continuation of such treatment or when circumstances indicate that administration of life support would be futile or not in accord with the desires or best interests of the patient.

20.10.1 Competent Patients. Practitioners should discuss with appropriate competent patients (See Rule 20.3) the possibility of being artificially maintained on life support. Patients who are at risk should be encouraged to express, in advance, their preferences concerning the use of artificial life support. These discussions should include a description of the procedures encompassed by artificial life support and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. In addition, subsequent discussions are desirable, on a periodic basis, to allow for changes in the patient's circumstances or in available treatment alternatives which may alter the patient's preferences. The circumstances which led to the Practitioner's determination of the patient's competency and a general discussion of the Practitioner's discussion with the patient should be documented in the patient's chart. Additionally, should the patient elect to decline artificial life support under certain future circumstances, the patient should be encouraged to execute a living will and/or health care proxy to this effect.

20.10.2 Incompetent Patients

20.10.2.1 If an incompetent patient has previously executed a living will, and if the requirements of Rule 20.8 have been met (particularly Rules 20.8.5, 20.8.6, 20.8.7, 20.8.10), the Practitioner should appropriately document these facts in the patient's chart.

20.10.2.2 If an incompetent patient has previously executed a health care proxy, and if the requirements of Rule 20.8 have been met, decisions concerning CPR may be made on behalf of the patient by the proxy and should be appropriately documented in the patient's chart.

20.10.2.3 If no health care proxy has been appointed by the patient, the Practitioner should consult with the patient's family concerning the previously expressed wishes of the patient, or if such preferences are unknown, in accordance with the patient's best interests. The Practitioner should encourage the execution of a healthcare proxy. (See Rule 20.813) A registered nurse, chaplain or social worker will be available to assist the Practitioner and family in this process.

20.10.3 Practitioner's Ethical Obligations. The Practitioner has an ethical obligation to honor the preferences expressed by the patient or the patient's proxy. The Practitioner should not permit his personal value judgments about the quality of life to obstruct the implementation of the patient's or proxy's preferences regarding the continued use of life support. However, if in the judgement of the treating Practitioner, continued artificial life support would be futile, the treating Practitioner may enter a WLS order in the patient's chart. The Practitioner should first inform the patient, or the incompetent patient's proxy, of the content of the

WLS order, as well as the basis for its implementation. The Practitioner should also be prepared to discuss appropriate alternatives, such as obtaining a second opinion or arranging for transfer of care to another Practitioner.

20.10.4 Futility Defined. Life support efforts should be considered futile if they only serve to prolong the process of dying or to maintain the patient in a condition of permanent unconsciousness.

20.10.5 Applicability of WLS Orders

20.10.5.1 WLS orders only preclude continuation of artificial life support and do not influence other therapeutic interventions that may be appropriate for the patient.

20.10.5.2 WLS orders should be reviewed periodically for continued appropriateness, and this further review should be documented in the patient's chart.

20.10.6 Documentation of WLS Orders

20.10.6.1 Prior to the order being written, the Practitioner must make a progress note including the information outlined below:

20.10.6.1.1 Patient's competency;

20.10.6.1.2 Diagnosis;

20.10.6.1.3 Prognosis, stating the irreversibility of the medical condition;

20.10.6.1.4 Patient's wishes, proxy decision or family decision, and the date and times of relevant discussions;

20.10.6.1.5 Recommendations of consultations and treatment team;

20.10.6.1.6 Any clarification or other information that the Practitioner may have;

20.10.6.1.7 Any organ donation information; and

20.10.6.1.8 Clear guidelines to nursing staff and others as to specific artificial life support efforts described in Rule 20.10.6.3 below that are to be withdrawn.

20.10.6.2 All WLS orders a patient should be in writing and signed by the attending Practitioner.

20.10.6.2.1 Telephone orders are acceptable only if a progress note addressing the information described above is documented by the Practitioner in the patient's records. Telephone orders must be received by a Registered Nurse and witnessed by another licensed nurse.

20.10.6.2.2 The WLS order and progress notes (written and signed by the attending Practitioner) may be faxed to the appropriate nursing unit.

20.10.6.3 A WLS order may include withdrawing any or all of the following:

20.10.6.3.1 Mechanical Ventilation;

20.10.6.3.2 Intubation; and

20.10.6.3.3 Nutrition and hydration. (See Rule 20.8.12)

20.10.7 Implementation of WLS Orders

20.10.7.1 A copy of any living will or health care proxy should be made a part of the patient's chart;

20.10.7.2 The Quality Assessment and Improvement Committee will conduct internal review of WLS orders and be available to advise and consult the attending Practitioner, if requested; and

20.10.7.3 Any changes in the patient's competency or medical condition will be reported to the Practitioner.

20.11 RESOLVING CONFLICTS

20.11.1 If a competent patient or the duly appointed health care proxy of an incompetent patient has clearly refused to consent to extraordinary care, this refusal should be honored unless the attending Practitioner is personally opposed to the withdrawing or withholding, in which event transfer to another Practitioner should be arranged.

20.11.2 However, if no health care proxy has been duly appointed and if there is a conflict between the wish of the next-of-kin of an incompetent or unconscious patient and the Practitioner concerning withdrawing or withholding of extraordinary care, the extraordinary care should be continued until the dispute is resolved by appointment of a health care proxy, transfer of the patient to another Practitioner or judicial decision.

RULE TWENTY-ONE: AUTOPSIES

21.1 AUTOPSIES GENERALLY

Autopsies performed on patients who have been admitted to the Hospital are a professional service provided for consultive purposes to Practitioners. The Pathology Ancillary Service may refuse an autopsy request that it deems inappropriate or that does not meet autopsy guidelines. Specifically, the Pathology Ancillary Service may refuse autopsies that it deems would be more appropriately performed by a forensic pathologist (such as any death resulting wholly or in part from massive trauma, gunshot wound, casualty, homicide, poisoning, suicide, criminal abortion, rape, therapeutic misadventure, drowning, sudden i nfant death syndrome, or death of a suspicious or unusual nature).

21.2 SITUATIONS WHERE AUTOPSIES SHOULD BE ATTEMPTED

The attending Practitioner shall attempt to secure an autopsy in the following situations:

21.2.1 Deaths in which an autopsy may help explain unknown and unanticipated medical complications to the attending physician;

21.2.2 All deaths in which the cause of death is not known with certainty on clinical grounds;

21.2.3 Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide reassurance to them regarding the same;

21.2.4 Unexpected or unexplained deaths occurring during or within 48 hours of any dental, medical (including radiology), or surgical diagnostic procedures or therapies;

21.2.5 Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards;

21.2.6 Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;

21.2.7 Natural deaths that are subject to, but waived by, a forensic medical jurisdiction such as:

21.2.7.1 Persons dead on arrival to the Hospital;

21.2.7.2 Deaths occurring in the Hospital within 24 hours of admission; and

21.2.7.3 Deaths in which the patient sustained or apparently sustained an injury while hospitalized.

21.2.8 Deaths resulting from high-risk infectious and contagious diseases;

21.2.9 All obstetric deaths, including deaths incidental to delivery and within seven days

of delivery;

21.2.10 All neonatal and pediatric deaths;

21.2.11 Deaths of patients of any age where it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplanted organs; and

21.2.12 Deaths known or suspected to have resulted from environmental or occupational hazards;

21.2.13 Deaths within 48 hours of admission after receiving outpatient treatment.

21.2.14 Deaths related to medically inheritable conditions (for the purpose of genetic counseling).

21.3 EXCEPTIONS

Autopsies need not be attempted when:

21.3.1 There are massive trauma or gunshot wounds where the cause of death is apparent; and

21.3.4 The case must be referred to the Arkansas Medical Examiner.

21.4 AUTOPSY CONSULTATIONS

The Practitioner performing the autopsy shall consult with the deceased's attending Practitioner to determine the scope of the autopsy. Use of limited autopsies to answer specific questions is encouraged when appropriate.

21.5 HAZARDOUS AUTOPSIES

Hazardous infectious disease deaths will be evaluated on a case-by-case basis.

21.5.1 Autopsies on cases involving diseases such as AIDS or Hepatitis B are strongly discouraged. If, after consultation between the attending Practitioner and the Pathology Department, an autopsy is felt necessary, then a limited autopsy will be used whenever possible to answer specific questions posed by the attending Practitioner.

21.5.2 Autopsies on infectious disease deaths where the infectious disease agent is difficult or impossible to eradicate (such as the prion of Creutzfeldt-Jakob Disease) shall be referred to appropriate research centers.

21.6 AUTOPSY PERMISSION

Procedures for obtaining permission for an autopsy shall be as follows:

21.6.1 Permission must be obtained from the deceased's next of kin.

21.6.1.1 Permission shall be in the form of a written, signed authorization.

21.6.1.2 Efforts to obtain permission to perform an autopsy for deaths that meet the screening criteria and for which the next of kin refuses to grant permission should be documented in the medical record.

21.6.2 The authorization shall be documented in the deceased's medical record before an autopsy is performed.

21.7 AUTOPSY DOCUMENTATION

21.7.1 The Practitioner responsible for performing the autopsy shall indicate in the deceased's medical record the time and date on which the autopsy will be performed. This indication shall be placed in the deceased's medical record no later than 48 hours before the autopsy is to be performed.

21.7.2 A provisional anatomical diagnosis shall be made a part of the deceased's medical record within 72 hours of the conclusion of the autopsy.

21.7.3 Upon receipt of autopsy results or other information that would change the information in the cause-of-death section of the death certificate from that originally reported, the Practitioner who certified the death certificate shall immediately file a supplemental report of cause of death with the Arkansas Division of Vital Records in order to amend the record.

21.7.4 A complete protocol of the autopsy findings shall be made a part of the deceased's medical record within 60 days of the conclusion of the autopsy.

21.7.5 A duplicate copy of the autopsy report shall be maintained in the laboratory autopsy file.

21.7.6 Autopsy services shall be provided under the supervision of a board certified pathologist.

21.7.7 Autopsy findings should be incorporated in the Quality Assurance and Continuing Education programs.

RULE TWENTY-TWO: PHYSICIANS IN TRAINING (RESIDENTS)

22.1 SUPERVISION

All patients being followed by physicians in training shall be supervised by a physician

Practitioner in accordance with the schedule of services.

22.2 EDUCATION

All Practitioners are urged to take an active part in the education of residents, interns, medical students, nurses and other medical personnel. The Executive Committee is the committee responsible for professional graduate education. An annual report from the supervising physician Practitioners will be provided to the Executive Committee in a form prescribed by the Executive Committee.

22.3 NO APPOINTMENT OR CLINICAL PRIVILEGES

Physicians in training shall not hold Appointment or Clinical Privileges to the Staff. They shall only be permitted to attend to patients who have been admitted by a physician Practitioner on the Professional Staff to whom the physician in training has been assigned by their program director. Physicians in training are permitted to participate in emergency medical care in accordance to the system established by the Staff.

22.4 SUPERVISION

Except in an emergency, physicians in training will not participate in the care of any hospitalized patient without supervision by an attending physician Practitioner. Such physician Practitioner shall be ultimately responsible for the care of the patients and for the supervision of the patient care rendered by the physician-in-training designee to the case. The attending physician Practitioner's participation shall be appropriately documented.

22.5 RESPONSIBILITIES

Responsibilities of physicians in training shall include the following:

22.5.1 Attending hospital patients subject to the requirements and limitations set out in this Rule.

22.5.2 Rendering care to hospital patients at a generally recognized level of quality and efficiency established and consistent with their level of advancement and competence.

22.5.3 Being responsible to and working under the supervision of attending physician Practitioners.

22.5.4 Being responsible and accountable to the training program director.

22.5.5 Participating in emergency medical care in accordance with the system established by the Hospital.

RULE TWENTY-THREE: MODERATE SEDATION

23.1 DEFINITION

Moderate Sedation is a medically controlled, minimally depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously respond appropriately to physical stimulation and/or verbal command. Such sedation is indicated for short term therapeutic, diagnostic or surgical procedures.

23.1.1 Moderate Sedation may be administered at Hospital by the following individuals only:

23.1.1.1 Physician Practitioner privileged for Moderate Sedation
23.1.1.2 Anesthesiologist Practitioner
23.1.1.3 The following Allied Health Professionals: Certified Registered Nurse Anesthetist (CRNA) and RNs with demonstrated competency in administration and monitoring patients receiving moderate sedation in the presence of a physician meeting the above criteria.

23.2 PRE-SEDATION REQUIREMENTS

Prior to any sedation procedure, each of the following requirements must be met:

23.2.1 Appropriate Physician documentation to include a current History and Physical (according to TJC standards), ASA classification, signed consent and NPO status.

23.2.2 Patient informed consent must be obtained.

23.3 PRIVILEGING CRITERIA

23.3.1 An Applicant must have a working knowledge of the Moderate Sedation policy and documentation requirements.

23.3.2 An Applicant must have knowledge of the Anesthesia classification system, Pharmacology of drugs administered, airway management, principles of pulse oximetry and management of untoward sequella of the procedure and agents used.

Approved by the Medical Staff Executive Committee on December 14, 2015.

Chief of Staff

Approved by the Hospital Board on December 28, 2015.

Secretary, Hospital Board

RULES

OF THE MEDICAL STAFF

OF

MAGNOLIA REGIONAL MEDICAL CENTER