

**MEDICAL STAFF RULES AND REGULATIONS**  
**MERCY MEDICAL CENTER, CEDAR RAPIDS, IOWA**

**A. ADMISSION AND DISCHARGE OF THE PATIENT**

- 1) All patients seeking care at the hospital are assigned according to this section.
- 2) A patient may be admitted to the hospital only by those holding admitting privileges. The attending or covering physician shall examine the patient within 24 hours of admission.
- 3) A physician who is a member of the medical staff or has the relevant temporary privileges shall be responsible for the medical care and treatment of each patient in the hospital; for completing the medical record promptly, completely, and accurately; for necessary instructions; and for transmitting reports of the patient to the referring clinician when appropriate. Whenever these responsibilities are transferred to another physician, a note covering the transfer of responsibilities shall be entered in the medical record.
- 4) Whenever a patient is accepted for care, the admitting provider must document that the level of care is appropriate. In the case of an emergency, such documentation shall be recorded as soon as reasonably possible.
- 5) Where no medical staff member is known to provide care to an emergency admission, an admitting clinician is selected for the patient from the appropriate on-call roster or Hospitalist Service.
- 6) All privilege holders must identify a back-up member of the active or associate staff who has appropriate clinical privileges as needed to care for his/her patients in the hospital. This back-up staff member with whom prior coverage arrangements have been made will be called when the primary member is not available to care for his/her patients.

In unusual circumstances for a limited period of time, a clinician may request a waiver of this requirement in accordance with the Medical Staff policy “Back-Up Practitioner Coverage”. Such a waiver may only be granted with the approval of the chair of the appropriate department of the medical staff, and the President of the Medical Staff.

Every staff member providing back-up coverage must recognize and accept back-up responsibility and possess the expertise to provide in-patient care for or appropriately triage, if necessary, a patient presenting with the problems typical of the specialty involved. This assumes some commonality in education and professional experience.

The President of the Medical Staff, or chairperson of the department concerned, or designee, shall have the authority to provide for care in emergency situations by calling an appropriate member of the staff if the practitioner’s back-up is not available. Failure of a clinician to meet these requirements can subject a clinician to corrective action consistent with the Medical Staff Bylaws.

- 7) The admitting clinician shall provide what information he/she has that may be necessary for the protection of the patient from self-harm and the protection of others whenever patients might be a source of danger for any reason.
- 8) For the protection of patients and staff, suicidal patients and potentially violent patients shall be placed in an area where appropriate precautions may be implemented.

- 9) If a question of the validity of admission to or discharge from a critical care unit should arise, that decision is to be made in consultation with the appropriate medical director.
- 10) The appropriate physician shall personally visit or arrange for a qualified covering physician to visit his/her patient in acute care at least once daily.
- 11) The attending clinician is required to maintain progress notes in accordance with Rules and Regulations, Section B, Number 5. These notes must document the need for continued hospitalization.
- 12) The patient shall be discharged only on documented order of the attending clinician. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a report of the incident shall be made in the patient's medical record.

## **B. MEDICAL RECORDS**

- 1) The attending clinician shall be responsible for the preparation of a complete and accurate medical record for each patient using the electronic health record (EHR) selected by the hospital. This record shall include, as appropriate, identification data; chief complaint; personal history; family history, history of present illness; medications; allergies; physical examination; special reports such as consultations, clinical laboratory and radiology services, and other; admitting provisional diagnosis and plan of treatment; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed. Other data may be required based on applicable Medical Staff policy.
- 2) A complete admissions history and physical shall be recorded by a qualified physician and placed in the medical record within twenty-four hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and the physical examination performed within 30 days prior to the patient's admission to the hospital by a qualified clinician, the data from the assessment may be used in the hospital medical record in lieu of the admission history and report of the physical examination. In such instances, an interval admission note that documents the current status of the patient and any changes that may have occurred in the history and physical examination must be recorded in the medical record by a qualified physician prior to surgery and prior to procedures at the time of admission.
- 3) A history and physical examination must be performed by a qualified clinician prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.

When the history and physical examination are not recorded and placed on the medical record before surgery or procedures requiring anesthesia services, the procedure shall be canceled, unless the responsible physician states in writing that such delay would be detrimental to the patient.

All ambulatory surgical patients treated in the facility must have appropriate pre-operative and post-operative evaluations.

- 4) The responsible physician shall countersign any notes recorded by a practitioner who does not have appropriate privileges.
- 5) Pertinent progress notes shall be recorded in a timely fashion sufficient to permit continuity of care and transfer if necessary. Each of the patient's clinical problems shall be clearly identified in the medical record. Progress notes shall be recorded at least daily on all acute care patients.

- 6) Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports should be recorded immediately following surgery for outpatients as well as inpatients, and the report shall be signed promptly by the surgeon and made a part of the patient's medical record. If the complete operative note is not immediately available, a brief summary of the surgical procedure must be completed immediately.
- 7) Consultation reports shall document a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.
- 8) The current obstetrical record shall include a record of prenatal care for the current pregnancy. The prenatal record shall be transferred to the hospital at, or before admission. An interval admission note must include pertinent additions to the history and any subsequent changes in the physical findings.
- 9) All records are the property of the hospital. Records may be accessed according to hospital policy in compliance with state and federal law.
- 10) Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of information concerning the individual patient. All such research projects shall be approved by the appropriate Institutional Review Committee before such records can be studied. Also, subject to the discretion of the CEO or designee, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
- 11) The patient's medical record shall be completed by the attending clinician at the time of discharge, including progress notes, data relevant to the management of the case including pending tests, preliminary diagnosis, discharge summary and necessary validations. When the record has not been completed within 30 days of discharge, it will be considered delinquent.
- 12) The CEO or designee shall notify the practitioner that his or her privileges to admit, consult or perform procedures shall be consider voluntarily relinquished until the records have been completed.

### **C. GENERAL CONDUCT OF CARE**

- 1) A general consent to treatment, authenticated by or on behalf of every patient presenting to the hospital for treatment, must be obtained. Except in emergency situations, informed consent for specific treatment or procedures that entail significant risk must be obtained and documented by the responsible clinician or their designee before the patient is treated in the hospital.
- 2) All orders for treatment shall be entered or verified in the EHR by the ordering clinician. All verbal/telephone/faxed orders shall be signed by the person to whom they are dictated with the name of the clinician providing the order. The order shall be verified by the responsible clinician.
- 3) All previous orders, including DNR, are canceled when patients go to surgery. Patients who will be receiving a general anesthetic will have their oral medications held prior to the procedure as specified in the anesthesia guidelines, unless otherwise specified by the responsible clinician.
- 4) All medications for inclusion in the hospital formulary must be approved by the Medication Management Committee which reports to the Medical Executive Committee.

- 5) Requests for medical, surgical or psychiatric consultation shall be made by the attending clinician to a clinician with relevant privileges.
  - a) The attending clinician shall obtain consultation in the following situations:
    - i) When the patient requires diagnostic testing and/or treatment for which the attending clinician does not have privileges.
    - ii) When required by Medical Staff policy, e.g., to determine the presence of brain death for organ donation purposes.
    - iii) When the patient or his/her legal representative requests a second opinion.
  - b) It is recommended that the attending clinician obtain consultation in the following situations:
    - i) When the diagnosis is obscure after ordinary diagnostic procedures have been completed.
    - ii) When there is uncertainty as to the choice of therapeutic measures to be utilized.

Except in an emergency, the attending clinician shall provide written authorization to permit another clinician to attend or examine his/her patient. Any qualified clinician can be asked to consult within the scope of his/her clinical privileges.

- 6) If a nurse has reasonable doubt or concerns about the care provided to any patient or reasonably believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor/nurse manager. The supervisor/nurse manager shall bring substantiated concerns to the attention of the attending physician. If there is not reasonable resolution, the supervisor/nurse manager shall bring the concern to the chairperson of the appropriate clinical department, or his/her designee, for appropriate action.
- 7) When the patient's need for care requires transfer to another facility, a clinician with admitting privileges in the receiving organization must agree to assume responsibility for the patient's care.
- 8) The transferring clinician is required to follow appropriate state and federal regulations regarding transfers.

#### **D. GENERAL RULES REGARDING SURGICAL CARE**

- 1) Except in emergencies, the history and physical exam, the pre-operative diagnosis and any pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled.
- 2) The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, intra-operative evaluation, and relevant post-anesthetic follow-up.
- 3) Specimens removed at the time of surgery or procedure shall be sent to Pathology in accordance with Medical Staff policy.
- 4) Surgeons and Anesthesiologists shall be available to commence operation at the time scheduled.
- 5) A patient admitted for dental care is a dual responsibility of the dentist/oral and maxillofacial surgeon and a clinician with admitting privileges.

- a) The dentist/oral and maxillofacial surgeon is responsible for:
  - i) A detailed dental history justifying hospital admission.
  - ii) A detailed description of the examination of the oral cavity and pre-operative diagnosis.
  - iii) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist/oral and maxillofacial surgeon should clearly state the number of teeth and fragments removed. Tissue, including teeth and fragments shall be sent to the hospital pathologist for examination in accordance with Medical Staff policy.
  - iv) Progress notes as are pertinent to the oral condition.
  - v) Requesting laboratory and radiology procedures pertinent to the condition.
- b) The admitting clinician is responsible for:
  - i) The medical history pertinent to the patient's general health.
  - ii) A physical examination to determine the patient's condition prior to anesthesia and surgery.
  - iii) Supervision of the patient's general health status while hospitalized.
- 6) The discharge of the patient shall be on written order of the dentist/oral and maxillofacial surgeon.
- 7) A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a clinician with admitting privileges.
  - a) The podiatrist is responsible for:
    - i) A detailed podiatric history justifying hospital admission.
    - ii) A detailed description of the podiatric examination and a pre-operative diagnosis.
    - iii) A complete operative report describing the findings and technique.
    - iv) Progress notes as are pertinent to the podiatric condition.
    - v) Requesting laboratory and radiology procedures pertinent to the condition.
- 8) The physician is responsible for:
  - a) The discharge of the patient shall be on written order of the podiatrist.

#### **E. EMERGENCY SERVICES**

- 1) A patient presenting to the hospital with a possible emergent condition shall have an appropriate medical screening examination to determine if an emergency medical condition exists. This will be performed in accordance with the hospital's policies and procedures. Such examination will be performed by a health care provider with appropriate privileges. Examination of patients with obstetrical concerns will be performed by a physician with appropriate privileges, or a qualified nurse in consultation with a physician.

#### **F. INVESTIGATIONAL DRUGS**

- 1) An "Investigational Drug" for the purpose of this rule shall refer to all drugs which have not been approved by the Federal Food and Drug Administration. A physician wishing to administer, or have administered, an investigational drug to a patient in the hospital must:

- a) have the investigational study approved by the Institutional Review Committee,
  - b) secure a written consent from the patient or the patient's representative, and
  - c) write an order for the medication.
- 2) If the principal investigator is not the attending practitioner, the attending practitioner must concur with the order. The principal investigator or designee shall provide all necessary information to pharmacy and the nursing staff prior to administration of the drug(s) and certify on the patient chart that such a release has been obtained when his/her orders the administration of the drug.
  - 3) Members of the nursing and house staff will not be allowed to administer such drugs until adequate information concerning the drug is made available, including pharmacology, toxicology, monitoring parameters and treatment of adverse reactions.

### **G. AUTOPSY**

- 1) It shall be the duty of all clinicians to consider the need for an autopsy as appropriate, such as in cases of unanticipated and/or unexplained death, unknown diagnosis or death following dental, medical, or surgical diagnostic procedures and/or therapies. In all deaths, except as required by state law, an autopsy may be performed only with written consent, signed in accordance with state law. All autopsies shall be performed by a pathologist with autopsy privileges. Provisional anatomical diagnoses shall be recorded on the medical record within seventy-two hours, and the complete report shall be made a part of the record within two months.

### **H. MEDICAL STAFF ORGANIZATION**

#### 1) ORGANIZATION OF CLINICAL DEPARTMENTS

May divide into a specialty section where there at least 3 members of that specialty.

May request that a specialty section with 8 or more members be designated by the MEC as a separate clinical department of the Medical Staff with representation on the Medical Executive Committee.

Once formed, must maintain at least 5 members to be represented on the MEC as a separate clinical department. A department whose number of members is less than 5 will relinquish its status on the MEC as a separate clinical department effective at the beginning of the next Medical Staff year.

Where a recognized specialty section falls below 3 members, it will automatically relinquish its specialty designation at the beginning of the next Medical Staff year.

#### 2) COMMITTEE MEMBERS AND CHAIRS

Every committee chair, and all department members are Medical Staff members, except as provided in these bylaws. Committee chairs must communicate with the MEC on all matters requiring MEC oversight. Committees must communicate with Medical Staff members in a timely fashion regarding committee business, and will respond to committee members' suggestions, complaints, requests and concerns.

Committee members and chairs are appointed by the President of the Medical Staff, based on expertise in the issues within the committee's purview and appropriate representation, subject to approval by the MEC. Committee members serve the term appointed unless they resign or are removed as permitted under these bylaws. All committee members shall act in good faith to carry out their committee responsibilities.

Medical Staff members of Multi-Disciplinary committees are appointed by the President of the Medical Staff, subject to the approval of the MEC. Governing Body members of these committees are appointed by the Chairperson of the Governing Body. Administrative members of these committees are appointed by the CEO.

### 3) CREDENTIALS COMMITTEE

The Credentials Committee shall consist of at least five members including the Vice President and Secretary/Treasurer of the Medical Staff as well as at least three Past Presidents of the Medical Staff. The current President of the Medical Staff serves as an ex-officio member without vote. The CMO may attend the meeting and, when present, serve as an ex officio member without vote. The chairperson of the committee will be selected from one of the Past Presidents.

The Credentials Committee shall meet as necessary to conduct business and shall maintain a permanent record of its proceedings and actions. Attendance of at least 50% of voting members shall constitute a quorum for decision-making purposes.

The Credentials Committee's report to the MEC on its actions and recommendations is included in the regular MEC report to the Governing Body.

The duties of the Credentials Committee include:

- i) Review the credentials of all applicants and to make recommendations to the MEC for membership and delineation of clinical privileges in compliance with these bylaws. Where relevant, the review shall include specific consideration of the recommendations of the department chair in which such applicant requests privileges;
- ii) Periodically review all current information available regarding the current clinical competence of Medical Staff members previously granted clinical privileges. This review will assist the Credentials Committee in making recommendations affecting clinical privileges, reappointment to the Medical Staff, and the assignment of members and practitioners to the clinical departments as provided in these bylaws;
- iii) Review information referred by the President of the Medical Staff or from the MEC or other Medical Staff committees;
- iv) Promulgate, review and recommend to the MEC policies and procedures related to the credentialing process; and
- v) Review and recommend criteria for clinical privileges.

### 4) BYLAWS, RULES AND REGULATIONS COMMITTEE

The Bylaws, Rules and Regulations Committee shall consist of six members of the active Medical Staff.

This committee shall review the bylaws, rules and regulations and all rules and regulations and policies of the Medical Staff and of each department and section at least annually and as needed to determine that they are complete, current and not in conflict with one another.

The committee, with the assistance of outside, independent Medical Staff legal counsel when necessary, shall assist in the interpretation of these bylaws, rules, and regulations and recommend changes, as necessary, to the MEC.

The bylaws committee annually reviews Medical Staff forms and any proposed changes to them, which may include the application, leave of absence form and the additional privileges application, to determine that the forms remain current and continue to reflect the Medical Staff governance documents.

#### 5) MEDICAL STAFF WELLNESS COMMITTEE

A chemical dependence, mental or physical illness or other impairment may affect a Medical Staff member's ability to practice with reasonable skill and safety to patients and staff. The Medical Staff Wellness Committee exists to provide a non-punitive approach to assist Medical Staff with matters of individual physical and mental health and to proactively maintain a healthy Medical Staff. However, if at any time it is determined that a member is unable to safely perform the Privileges he or she has been granted, or if it is determined that the member's behavior or actions so warrant, the matter shall be forwarded for appropriate correction action under these bylaws. The Wellness Committee seeks to maintain the ability of all members and practitioners to practice with reasonable skill and safety not limited by physical or mental disorders or disabilities.

The committee receives reports from any source regarding possible impairment of a member, including self-referrals, and screens out specious or inappropriate reports.

As appropriate, the committee refers members to medical, psychological or surgical specialists, or other sources, for evaluation and treatment of condition affecting the member's ability to safely practice.

The committee assists members with post-evaluation and treatment monitoring. Referrals, monitoring and all member-related activity by the committee and its members is confidential.

When needed, confidential reports to the MEC are provided that offer information limited to the ability of the member or practitioner to function in a safe and competent manner. Should a member or practitioner fail to comply with treatment plans and monitoring or otherwise jeopardize patient safety, the committee refers the member or practitioner to the MEC for corrective action.

The committee organizes staff-wide education about professional impairment issues.

The Committee will consist of at least 3 members as follows; 1 (one) Administrator from the Medical Center; 2 (two) other members of the Medical Staff with 5 or more years of service on the Medical Staff. Consideration should be made that one of the Medical Staff members have experience in behavioral health and/or substance abuse evaluation and treatment. The term of service will be determined by the MEC. No medical staff member of the Wellness Committee shall serve on other Peer Review or Quality Committees in the Hospital during the time they are serving on the Wellness Committee.

#### 6) JOINT CONFERENCE COMMITTEE

The committee is the forum in which the Medical Staff and Governing Body resolves any disputes and may accept requests to resolve differences between or among other Medical Staff and/or hospital leaders. The Joint Conference Committee is comprised of the non-conflicted Medical Staff members and an equal number of Governing Body who are neither Medical Staff members nor hospital employees. The Joint Conference Committee may review proposed strategic plans before they are implemented and may request additional

information from administration prior to final approval by the Governing Body. The committee may request additional information from throughout the hospital community to assist in the resolution of disputes. Either the MEC or the Governing Body can refer plans and disputes to the Joint Conference Committee. The Joint Conference Committee fulfills other responsibilities set forth in these bylaws. The recommendations of the Joint Conference Committee shall be submitted for review and recommendation by the MEC at its next meeting or within thirty (30) days, whichever is sooner, and at such MEC meeting the MEC shall review and provide a recommendation to the Governing Body for final action.

## **I. MEMBERS' CONFLICTS OF INTERESTS**

- 1) Medical Staff officers and department chairs, Medical Staff members appointed to chair committees, or serve on the Governing Body, and other members as described herein, shall disclose potential conflicts of interest. Membership and privileges are not affected by any conflict of interest or the declaration of any potential conflict of interest. Exercise of certain Medical Staff obligations and prerogatives may be affected by these conflict-of-interest requirements.
  - a) Members Subject to Disclosure Requirement
    - i) Members must disclose conflicts of interest if:
      - they are asked to serve as proctors or reviewers;
      - they are appointed to chair committees, including but not limited to hearing committees;
      - they are elected to be a Medical Staff officer.
- 2) All applicable Medical Staff members shall file a conflict-of-interest report with the Medical Staff office. The President of the Medical Staff and Chief Medical Officer (CMO) shall review all reports. The Medical Staff Office shall maintain a copy of the conflict-of-interest disclosure report. The information is shared only with those who need the information. Failure to disclose a conflict of interest upon reasonable request will automatically disqualify the member from the position creating the conflict of interest.
  - a) Disclosing Financial Information

Members' financial interests are unrelated to qualifying for and maintaining Medical Staff membership and privileges. However, financial interests could be an issue when the member serves as a peer reviewer, a proctor, in Medical Staff leadership and on committees or on the Governing Body. Those financial interests that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the financial interests are or could be involved, including:

    - i) Hospital contracts, employment, lease, ownership interest, joint venture, or other financial relationship with the hospital or hospital system or any management company operating the hospital.
    - ii) Employment, partnership or other economic affiliation with individuals or entities involved in the subject matter of the review or other Medical Staff activity.
    - iii) Grants, academic affiliation, research support.
    - iv) Significant interest in hospital vendors, suppliers, manufacturers, or donors.
    - v) Competitive or collaborative relationships.
    - vi) Economic competitors.
    - vii) Any relationship that is affected by the outcome of a peer review, medical equipment selection or other decision.
  - b) Disclosing Personal Information
    - i) Members' personal affiliations and relationships are unrelated to qualifying for and maintaining Medical Staff membership and privileges. Personal relationships interests could be an issue when the member serves as a peer reviewer, in Medical Staff leadership and on committees or on the

Governing Body. Those personal relationships that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the interests are or could be involved, including:

- Employment, partnership or other economic affiliation
  - Family relationship/Friendship
  - Enmity or serious hostility
- 3) Because of the potential adverse ramification of overly broad dissemination, any personal or financial information disclosed is shared only as needed and used solely for the purpose of resolving conflicts of interest.
  - 4) Procedure to be followed at meetings involving Medical Staff leaders when actual or potential conflicts of interest have been disclosed by a member and the potential conflict may impact the activities of the meeting:
    - a) Whenever a body, such as a Medical Staff committee, is considering a transaction or arrangement with an organization or individual which could result in a conflict of interest for the affected member, the affected member must disclose a conflict of interest.
    - b) If there is a conflict of interest, the chair shall direct the affected member to leave the meeting during discussion of the matter that gives rise to the potential conflict of interest. If directed to leave, the affected member may make a statement or answer questions on the matter before leaving.
    - c) The affected member shall not vote on the matter giving rise to the potential conflict unless permitted to vote by the body.
    - d) If a member of the Medical Staff may receive a financial gain in a transaction or arrangement which such member is in a position to evaluate and approve, the following should be observed in addition to the provisions described above:
      - The body may appoint a non-interested person or committee to evaluate alternatives to the proposed transaction.
      - The affected member will not be present for discussion or vote regarding the transaction.
  - 5) Minutes of meetings when a conflict of interest is present shall reflect the following:
    - a) A list of members present, and voting or abstaining.
    - b) If a member disclosed a potential conflict of interest.
    - c) That the issue of a conflict of interest was discussed and whether the members determined a conflict of interest existed.
    - d) If alternatives were proposed.
    - e) Whether a final decision or recommended action was made.
  - 6) Retention period  
Conflict of interest documents will be retained in the Medical Staff office for 7 years.

## **J. PROFESSIONAL PRACTICE INVESTIGATION PROCESS**

- 1) Whenever the professional conduct of any member or practitioner with clinical privileges is considered to be detrimental to patient safety; lower than the acceptable professional standards of the Medical Staff; or contrary to the Medical Staff bylaws and/or rules and regulations, a request for review of professional practice may be made.
  - a) A request for review of professional practice of any Medical Staff member may be made in writing to the President of the Medical Staff, relevant department chair, or the CMO. Upon receipt of such request, the

affected department chair and CMO will jointly review the request to determine if the complaint is credible and requires further evaluation.

- b) If the complaint is found to raise legitimate concerns as to the professional conduct or competency of the Medical Staff member or practitioner, it will be referred to the Peer Review Committee for review and Investigation. The CMO or the Peer Review Committee may determine that an external review is appropriate.
- c) The Peer Review Committee, subject to the conflict-of-interest rules in these bylaws, shall consist of at least three (3) members of the Medical Staff and should consist of a representation from a variety of specialties. Other members of the Medical Staff may be called to participate in a consultative role.
- d) The types of cases reviewed by the Peer Review Committee may include, but are not limited to:
  - i) Surgical and/or procedure complications
  - ii) Improper use of medications/blood products.
  - iii) Medical and/or surgical incident reports requiring additional input.
  - iv) Significant deviations from professional practice norms monitored by quality improvement indicators as identified by department chairs.
  - v) Cases referred by the MEC.
- e) Within thirty (30) days of receiving a written request for formal review, the Peer Review Committee will:
  - i) Formally conduct its review – the affected member or practitioner is encouraged early in the review to assist the committee in its deliberations and promote a mutual sharing of information.
  - ii) Complete its review within 30 days. However, the committee may extend the review process if needed, but the extension should not exceed an additional 30 days unless there are circumstances warranting a longer extension.
  - iii) The Peer Review Committee will determine if:
    - (1) A significant quality of care issue exists.
    - (2) A quality-of-care concern is present, but creates little or no risk of patient harm.
    - (3) A quality-of-care concern has contributed to, or creates a material risk of patient harm.
  - iv) Where the Peer Review Committee identifies a specific quality of care issue, it may recommend one or more of the following:
    - (1) Additional training or proctoring.
    - (2) Requirement for consultation.
    - (3) Formal period of review (FPPE).
    - (4) Formal letter of reprimand.
    - (5) Letter of education.
    - (6) Suspension, reduction, or termination of clinical privilege(s) or membership.
    - (7) Any other such action as determined appropriate.
- f) Upon completion of its review the Peer Review Committee will submit a written report of its findings and recommendations to the MEC.
- g) The MEC shall review the matter within thirty (30) days following the receipt of the report, or at its next scheduled meeting following receipt of the report. However, the MEC may extend the review process if needed, but the extension should not exceed an additional 30 days unless there are circumstances warranting a longer extension. In reviewing the matter, and prior to taking action, the MEC may, at its discretion, permit the affected member or practitioner to appear before the MEC. Such appearance is not mandatory, does not constitute a hearing, and shall be preliminary in nature. None of the procedural rules provided in these bylaws with respect to hearing shall apply.

- h) Upon completion of its review, the MEC will:
- 1) Accept, modify or reject the recommendation of the Peer Review Committee
  - 2) Within 5 days after concluding its review, notify the CEO and the affected member or practitioner of all findings and recommendations made by the MEC, and whether any of the recommendations are for Adverse Action giving rise to a member's right to request a hearing.

## **K. PERSONAL CONDUCT**

### 1) APPROPRIATE PERSONAL CONDUCT

The following kinds of conduct by members and practitioners are not restricted by these bylaws:

- i) Advocating for patients.
- ii) Input that is meant to improve care.
- iii) Engaging in legitimate professional business enterprises.

### 2) ACTIONABLE PERSONAL CONDUCT

Deviations from patient care standards and violations of Medical Staff bylaws, rules and regulations are addressed through the Peer Review and Corrective Action provisions of these bylaws. An individual's conduct, apart from his or her interaction with his or her patients, can be subject to corrective action if it undermines the Medical Staff culture of safety to promote quality patient care.

Conduct that undermines the culture of safety includes:

- a) Harassment on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation.
- b) Verbal, written, visual or physical abuse, directed against another Medical Staff member, house staff, hospital employee, contractor or volunteer, or patient.

Such conduct by members and practitioners is actionable under these bylaws.

### 3) PERSONAL CONDUCT INVESTIGATION PROCESS

Members of the Hospital staff are encouraged to directly discuss with practitioners or members of the Medical Staff, when appropriate, issues of personal conduct that fall below standards established by the Medical Staff.

- a) Complaints or reports about the conduct of administrative personnel, nurses, and other non-Medical Staff health professionals, shall be made to the office of Human Resources.
- b) Where there is a reasonable concern that a practitioner's or member's conduct is below the standards set forth in these bylaws, a written report should be submitted to the CMO, and may include the following information:
  - Name of practitioner or Medical Staff member;
  - Date and time of the conduct in question;
  - Actions affecting a specific patient;
  - Contributing circumstances that may have precipitated the incident
  - Objective description of the conduct in question;
  - Names of others who witnessed the behavior;

- Adverse clinical consequences, or impact on patient care, hospital staff, or operations;
  - Actions taken by staff or other practitioners or members of the Medical Staff in response to the situation, to include the date, time, place, and actions undertaken; and
  - Name and signature of the individual reporting the behavior.
- c) The CMO, or designee, will investigate the report, in consultation with the relevant department chair and Medical Staff president as necessary. The inquiry may include interviews with individuals reporting, or named in the report, and review all information deemed appropriate to the inquiry.
- d) The CMO, after inquiry, may determine that the report is not founded within the context of this policy. The CMO may dismiss the report on these grounds.
- e) Informal Action
- i) Single Incident
- If the report reflects a single, isolated confirmed incident of conduct not meeting appropriate standards under these bylaws, the CMO or designee will discuss the situation with the member or practitioner and/or may decide that the single incident is so significant that it warrants further action.
  - Discussions during an initial intervention are meant to be collegial and helpful to the member or practitioner and the Hospital.
  - The CMO or designee will provide the member or practitioner with a copy of the Medical Staff bylaws as they pertain to the standards of personal conduct and inform the member or practitioner that the Governing Body requires compliance.
- ii) Significant Single Incident; Repeated Pattern of Departure from Personal Conduct Standards. For a single confirmed incident which the CMO determines is so significant that it warrants further action, or for repeated pattern of substandard conduct, the CMO and the President of the Medical Staff or designee(s) will proceed as follows:
- Consult with the relevant department chair as needed.
  - Meet with the member or practitioner to provide him/her the opportunity to explain the conduct or activities in question, and emphasize to the member or practitioner that they must conform their personal conduct to meet the standards mandated by the Medical Staff bylaws. Any failure to meet these standards is not acceptable, and can be the basis for formal corrective action, and potential loss of Medical Staff membership or clinical privileges, either of which may require formal reporting to the NPDB and the Iowa Board of Medicine.
  - The MEC and CEO will be notified of the recurring conduct falling below established standards.
  - All meetings shall be documented in writing in the member or practitioner's file.
  - A follow-up letter will be sent to the member or practitioner stating the problem and notifying the member or practitioner that he or she is required to conduct themselves professionally and cooperatively.
  - The affected Medical Staff member or practitioner may, at his or her discretion, reply in writing to the CMO to respond to issues listed in the follow-up letter. This response will remain a part of the member or practitioner's record.
  - The CMO or the president of the Medical Staff may request that the member or practitioner's conduct be reviewed by the MEC.
  - The CMO or the President of the Medical Staff may, at any time, initiate formal corrective action in accord with the Medical Staff Bylaws and applicable policies.

- Summary suspension, as provided in the Medical Staff Bylaws, may be appropriate if the affected Medical Staff member or practitioner represents an immediate risk of harm to patients or others in the hospital.
- f) Formal Action
- i) Any officer of the Medical Staff, chairperson of a clinical department, chairperson of any standing committee of the Medical Staff, the CEO or designee, or the Governing Body in accord with these Medical Staff bylaws may, upon presenting a reasonable basis for action, request an invitation for corrective action at any time.
  - ii) The action of the MEC upon receiving a request for corrective action may be one or more of the following, or other action as appropriate:
    - Determine that no action is warranted.
    - Issue a warning, a letter of admonition, or a reprimand.
    - Recommend terms of probation or a requirement for consultation.
    - Recommend a reduction, suspension, or revocation of clinical privileges.
    - Recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained.
    - Recommend that the member's Medical Staff membership be suspended or revoked.
    - Referral to the Medical Staff Wellness Committee.
- g) Medical Staff members and practitioners are entitled to hearing and appeals rights as described in these bylaws if Adverse Action is recommended.

#### **L. CREDENTIALS FILES**

- 1) Should the hospital be closed, the Governing Body will arrange for the credentials files and other Medical Staff records to be placed with an appropriate custodian for a minimum of two years after closure, during which time the records will be maintained as confidential but the members will be permitted access. At least thirty days in advance of closure of the hospital, the CEO notifies all Medical Staff members of the arrangements for storage and appropriate access.
- 2) Access to Medical Staff credentials files is limited to those identified here, under the circumstances identified here.
  - a) Only those Medical Staff leaders and administrative personnel carrying out peer review and other Medical Staff operations have access to credentials files, and only as needed to fulfill their legitimate duties.
- 3) Medical Staff members are granted access to their own credential's files upon written request, with the exception of letters of reference, but only for review in the Medical Staff office, at a time convenient to the member and the Medical Staff office supervisor or designee, in whose presence the member's review will take place. The member may receive a copy of only those documents provided by or addressed personally to the member. The member may request in writing that the MEC either correct or amend information in the member's credentials file. Information supporting the request should be included. The member is notified promptly, in writing, of the decision of the MEC.
- 4) In the event of an action or proposed action against a member, applicant, or holder of clinical privileges, access to that member's credentials file is governed by the hearing procedures established in the Medical Staff bylaws.

- 5) No patient survey or customer satisfaction information is placed in credentials files or used in credentialing unless it has been reviewed by the appropriate committee or department and determined to serve to document the member's qualifications for Medical Staff membership and/or clinical privileges.
- 6) Any person may provide information to the Medical Staff about the conduct, performance or competence of its members or applicants. When information is provided, the relevant department chair and/or President of the Medical Staff shall review the information and decide:
  - a) That the information is unreliable and should not be placed in the file;
  - b) To notify the member of any information by a written summary and offer him or her the opportunity to respond before it is placed into his or her file; or
  - c) To place the information in the file at the discretion of the relevant department chair and/or President of the Medical Staff, along with a notation if a request has been made to the MEC to initiate corrective action against the member as outlined in these bylaws.