RENOWN REGIONAL MEDICAL CENTER

MEDICAL STAFF

RULES & REGULATIONS

March 27, 2019
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RULE 1-1  Relationship between the Bylaws and Rules and Regulations

These Medical Staff Rules and Regulations are intended to be consistent with and complement the Medical Staff Bylaws. In the event that any provision in these Rules and Regulations conflicts with any Medical Staff Bylaw, the Bylaw provision shall control. The most current version of the Medical Staff Bylaws and Rules and Regulations is available electronically on the Renown Health website at www.renown.org/medicalstaffservices. A copy of the latest printed version of Medical Staff Bylaws and Rules & Regulations is available upon request from Medical Staff Services.

RULE 1-2  Medical Staff Organization

A. Departments and Sections.

1. Clinical Organization of the Medical Staff.

The Medical Staff will be organized into clinical Departments to which Members are assigned in accordance with the privileges granted. Departments may, as outlined in this Rule, be divided into Sections to facilitate the efficient management of specialties within a Department. Currently, the Medical Staff is divided into clinical departments, sections and specialties, as listed below. Sections and specialties shall be assigned to and report to the applicable department.

- Department of Anesthesia
  - Pain Management
  - Peri-operative Medicine
  - Certified Registered Nurse Anesthetists (Allied Health) shall be assigned to the Department of Anesthesia
- Department of Emergency Medicine
- Department of Family Medicine
- Department of Medicine
  - Allergy and Immunology
  - Cardiology
  - Critical Care
  - Dentistry
  - Dermatology
  - Endocrinology
  - Gastroenterology
  - Geriatrics
  - Hospice/Palliative Care
  - Hospital Medicine
  - Infectious Disease
  - Internal Medicine
  - Nephrology
  - Neurology
  - Oncology/Hematology
  - Physical Medicine and Rehab/Physiatry
  - Psychiatry
  - Psychology
  - Pulmonology
• Radiation Therapy
• Rheumatology
  ▪ Department of Obstetrics & Gynecology
    • Gynecology
    • Gynecologic Oncology
    • Obstetrics
    • Perinatology/Maternal Fetal Medicine
    • Certified Nurse Midwives (Allied Health) and Physicians’ Assistants (Allied Health) shall be assigned to the Department of Obstetrics & Gynecology
  ▪ Department of Pathology
  ▪ Department of Pediatrics
    • Adolescent Medicine
    • Neonatology
    • Pediatric Cardiology
    • Pediatric Dentistry
    • Pediatric Endocrinology
    • Pediatric Gastroenterology
    • Pediatric Hospitalist
    • Pediatric Infectious Disease
    • Pediatric Intensivists
    • Pediatric Nephrology
    • Pediatric Neurology
    • Pediatric Neurosurgery
    • Pediatric Oncology/Hematology
    • Pediatric Pulmonology
    • Pedodontics
  ▪ Department of Radiology
  ▪ Department of Surgery
    ▪ Cardiothoracic Surgery
    ▪ General Surgery
    ▪ Neurosurgery
    ▪ Orthopaedic Surgery
    ▪ Orthopaedic Trauma Surgery
    ▪ Ophthalmology
    ▪ Oral Surgery
    ▪ Otolaryngology
    ▪ Plastic/Reconstructive Surgery
    ▪ Podiatric Surgery
    ▪ Surgical Oncology
    ▪ Trauma & Critical Care Surgery
    ▪ Urologic Surgery
    ▪ Vascular Surgery


   Upon request of the Residency Committee, a Department or Section shall collaborate with that Committee and the Hospital to delineate the clinical responsibilities and services of medical students, interns, residents and other physicians in training applicable to the clinical services provided by that Department or Section.
RULE 2-1   Physician designation

A. **Admitting Physician** - The member who authorizes the admission order and who is responsible for the completion of the history and physical examination.

B. **Attending Physician** – The member who has oversight over the daily care of the patient.

C. **Discharging Physician** – The member who authorizes the discharge order and who is responsible for completion of the Discharge Summary.

RULE 2-2-A Medical Staff and Privileged Provider Professional Practice Evaluation ("MSPPE")

1. General.
   1.1 MSPPE helps to ensure that the Medical Staff assesses the ongoing professional practice and competence of practitioners, conducting professional practice evaluation, using the results of assessments and evaluations to improve professional competency, practice and the quality of care.

   1.2 MSPPE is conducted through Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

   1.3 MSPPE applies to all privileged providers.

2. **FPPE**.

   2.1 FPPE is performed during a time-limited period, during which time an evaluation of a practitioner is performed to determine the practitioner’s professional performance. Results of FPPE are communicated to appropriate parties, and the evaluation and recommendations are based upon results. Changes are implemented to improve performance.

   2.2 FPPE is used:

   2.2.1 To evaluate privilege-specific competence of practitioners who do not have current documented evidence of competently performing a requested privilege at RRMC. Typically, this occurs when an applicant initially applies for credentials or appointment to the Medical Staff, or when a practitioner requests additional privileges.

   2.2.2 When a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care.

   2.3 Information for FPPE may include, without limitation, chart review, monitoring clinical practice patterns, simulation, proctoring, internal or external review, discussion with others involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

2.4 Possible Indications for FPPE:

   2.4.1 Any single egregious incident or sentinel event;

   2.4.2 When care is determined to be inappropriate or below the standard of care;

   2.4.3 Disruptive behavior;

   2.4.4 Reasons as described in the Medical Staff Bylaws or other Medical Staff governing documents; and

   2.4.5 Non-compliance with the Medical Staff Bylaws or other Medical Staff governing documents.
2.5 Information resulting from FPPE is used to determine whether to continue, limit, or revoke any existing privilege.

3. **OPPE.**

3.1 OPPE helps to identify professional practice trends and issues that impact on quality of care and patient safety. OPPE is conducted on a continuous basis, is used for credentialing purposes, and as appropriate, is reported for peer review purposes.

3.2 Without limitation, criteria used in OPPE may include:
   3.2.1 Review and outcome of operative and other clinical procedures;
   3.2.2 Pattern of blood and pharmaceutical usage;
   3.2.3 Requests for tests and procedures;
   3.2.4 Length of stay patterns;
   3.2.5 Morbidity and mortality data;
   3.2.6 Use of consultants; and
   3.2.7 Other relevant criteria as determined by the Medical Staff.

3.3 Without limitation, information used in OPPE may be acquired by:
   3.3.1 Chart review;
   3.3.2 Direct observation;
   3.3.3 Monitoring of diagnostic and treatment techniques; and
   3.3.4 Discussion with others involved in the care of each patient, including without limitation, consulting physicians, assistants at surgery, and nursing and administrative personnel.

3.4 The type of data to be collected is determined by individual departments and approved by the Medical Staff.

3.5 Information resulting from OPPE is used to determine whether to continue, limit, or revoke any existing privilege.

4. **Confidentiality.**

4.1 Committees which perform and review FPPE and OPPE activities are responsible for evaluating and improving the quality of care rendered by the hospital. Pursuant to federal and Nevada law, these review committees maintain a privilege to refuse to disclose and to prevent any other person from disclosing its proceedings and record and testimony given before it.

4.2 FPPE and OPPE information (“Peer Review Information”) will be maintained as confidential and privileged, in accordance with federal and Nevada law. Peer Review Information will be secured in the Medical Staff Office, and will not be distributed or made available to others, except as authorized or required by law.

**RULE 2-2-B  FPPE/PEER REVIEW PROCESS**

1. **General.**

   1.1 The Medical Staff Peer Review Committee (PRC) is responsible for evaluating and acting on reported concerns regarding privileged practitioners’ (“Provider”) clinical
practice and/or competence and behavior and conduct if it affects patient safety and the quality of care.

1.2 The PRC is accountable to the Medical Executive Committee (MEC). The Committee reports to the MEC on its activities, as appropriate or requested by the MEC. The PRC may recommend corrective action to the Medical Executive Committee (MEC). The PRC reports peer review activities to the MEC and aggregate reports may be provided to the Board through MEC minutes.

2. Reports of Conduct.

2.1 Anyone may report information to the PRC about the conduct, performance or competence of a Provider (“Reported Provider”).

2.2 The Board, MEC, PRC Chair, PRC member, CEO, Chief of Staff (“COS”), CMO, or MSQI Committee may request initiation of a review or investigation. Such request will be submitted in writing, specifying the reason for the request, and summarizing factual information pertaining to the request.

2.3 Reports (“Reports”) may be based on chart review, complaints, direct observation, events, etc.

3. Types of Cases Reviewed.

3.1 Variation from or non-compliance with the Medical Staff Bylaws, Rules and Regulation, hospital/medical staff policies, procedures, federal, state and local laws, regulations and guidelines, etc.

3.2 Competency, complications or adverse Events (i.e. medication errors; procedural complications; unanticipated death; sentinel event; etc.).

3.3 Cases forwarded by department or sections.

3.4 Matters related to professionalism, behavior, conduct, or provider wellness.

3.5 Inadequate supervision of a resident/fellow/student.


4.1 A Report will be submitted to the PRC Chair, through the Medical Staff Office (“MSO”). The MSO will provide a copy of the Report to the Chief of Staff (“COS”), Chief Medical Officer (“CMO”) and Chief Executive Officer (“CEO”);

4.2 The PRC Chair will request the Reported Provider’s response to the report (“Response”). Upon receipt of the Response, or if a Response is not received within the requested time period, the PRC Chair may:

   4.2.1 Determine the matter is a non-issue;

   4.2.2 Request additional information from the Provider and/or others. Upon review of received information, the PRC Chair may then determine:

      4.2.2.1 The matter is a non-issue;

      4.2.2.2 To issue a verbal or written warning. The PRC Chair may involve the section and/or Department Chief. A copy of a written warning will be sent to the Department Chief:

      4.2.3 To defer the matter to the Section or Department Chief; or

      4.2.4 To forward the matter to the PRC.
4.3 If the matter is sent to the PRC, the PRC reviews the information and may determine:

4.3.1 The matter is a non-issue;

4.3.2 If the matter is not a non-issue, the PRC may request additional information from the Provider and others, and may interview the Provider and others;

4.3.3 The PRC may:

4.3.3.1 Determine the matter is a non-issue;

4.3.3.2 Defer the matter to the Section or Department Chief;

4.3.3.3 Issue a written warning. The PRC may involve the Section and/or Department Chief. A copy of a written warning will be sent to the Department Chief;

4.3.3.4 Require review by an internal peer reviewer (“Internal Peer Review”). Provider will be notified; or

4.3.3.5 Require review by an external peer review (“External Peer Review”). Provider will be notified.

4.4 Internal Peer Review.

The matter may be sent to the Section or Department Chief for review, or may be reviewed by a member(s) of the PRC. The Internal Peer Review will be completed on a form (approved by the PRC).

4.4.1 If the Internal Peer Review concludes that the standard of care (“SOC”) was met, the matter may be closed and a letter is sent to the Provider. Even if the SOC was met, the PRC may:

4.4.1.1 Issue a written warning. A copy of a written warning will be sent to the Department Chief;

4.4.1.2 Require further review;

4.4.1.3 Forward to MEC, or take other action.

4.4.2 If the Internal Peer Review concludes that the SOC was not met, the matter will be forwarded to the MEC. The COS, CEO and CMO will be notified;

4.4.3 If the Internal Peer Review is inconclusive, the PRC may request an External Peer Review, request another Internal Peer Review, request additional information from the Provider and/or others, forward to the MEC, or initiate other action. The PRC may require written information and/or an in-person appearance.

4.5 External Peer Review.

External peer review may be obtained when those available to perform the review do not have sufficient expertise, or do not feel comfortable performing the review, or have a conflict of interest or bias that would affect the review, or if the PRC believes a second opinion is needed prior to making a recommendation. Upon determining that the matter will be sent to an external reviewer, notification will be made to Legal, who will assist to draft a letter to the external reviewer, bringing the matter under the attorney - client privilege. The COS, CEO and CMO will be notified.
4.5.1 If the External Peer Review concludes that the standard of care ("SOC") was met, the matter is closed and a letter is sent to the Provider. Even if the SOC was met, the PRC may:

4.5.1.1 Issue a written warning. A copy of a written warning will be sent to the Department Chief;

4.5.1.2 Require further review;

4.5.1.3 Forward to MEC, or take other action.

4.5.2 If the External Peer Review concludes that the SOC was not met, the matter will be forwarded to the MEC. The COS, CEO and CMO will be notified.

4.5.3 If the External Peer Review is inconclusive, the PRC may request another review, request additional information, take other action, or forward to the MEC. The PRC may require written information and/or an in-person appearance.

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5. **Flowchart.**
The following chart depicts the general peer review process.

![Flowchart Diagram of RRMC – PR Committee Process]

6. **No Preclusion.**
Nothing in this Rule is intended to preclude the PRC Chair or PRC:

6.1 From involving the Department and/or Section Chief;

6.2 Immediately referring the matter to the MEC; or

6.3 Taking or recommending any other adverse or corrective action, as authorized by
the Medical Staff Bylaws.

7. **Confidentiality**
This Rule describes a process (“Peer Review”) that is confidential and provides certain
immunities to peer review participants, as long as the process is followed. All peer review
documents are confidential. Requests for peer review are delivered in confidential envelopes or
sent by secure email. Emails are not to be forwarded. Each request for peer review states that
the documents may not be shared with any other individual. Completed reviews are collected
by personnel from the Office of Chief of Staff. Agendas for the PRC meetings are numbered
and delivered to those members who have indicated they will be attending the
meeting. Agendas are collected following the meeting. Anyone unable to attend a meeting for
which they have received an agenda must return his/her agenda or call to have it
collected. Members of the PRC and Medical Executive Committee are made aware of the
importance of not discussing these cases with others. Peer review files are secured in the
Office of Chief of Staff.

**RULE 2-3 Proctoring**

A. **Purpose.** The Medical Staff shall require Medical Staff Members and allied health
professional staff to be proctored in order to establish a systematic process of ensuring
that sufficient information is available to confirm the current competency of practitioners in
certain situations. This process, termed Focused Professional Practice Evaluation
(FPPE), will provide the basis for obtaining organization-specific information of current
competence for those providers.

B. **Scope of Proctoring.** For purposes of this policy, FPPE is performed to confirm a
Member’s current competence to perform the clinical privileges granted or maintained by
that Member. Applicants requesting membership but not requesting specific privileges
are not subject to the provisions of this Rule. Such Members do not require FPPE and
may not act as proctors. The decision and process to perform FPPE for current Members
with existing privileges based on trends or patterns of performance identified by OPPE are
outside the scope of this rule (see FPPE rule).

C. **Definitions.**

1. **Practitioner.** For purposes of this Rule, the term “practitioner” refers to any medical
staff member or allied health professional granted clinical privileges.

2. **Proctor.** For purposes of this Rule, the term “proctor” refers to the medical staff
member or designated expert appointed by the Medical Staff to perform FPPE to
evaluate the current competency of the practitioner for some or all general
competencies.

3. **Proctoring.** For purposes of this Rule, the term “proctoring” refers to the process
of obtaining information as a FPPE to confirm the current competence in all general
competencies of a practitioner at the time initial privileges are granted, for specific
privileges if a currently privileged practitioner requests additional privileges, or for
low/no volume providers. Proctoring may be prospective, concurrent, or retrospective.

4. Practitioner FPPE plan. For purposes of this Rule, the term “practitioner FPPE plan” refers to the specific methods and extent of evaluation for a given practitioner recommended by the Department/Section chief and by the Credentials & Privileges Committee and approved by the Medical Executive Committee at the time of recommending approval of the practitioner's privileges.

5. FPPE start date. For purposes of this Rule, the term “FPPE start date” shall mean that date on which a practitioner is granted initial privileges; is granted a new privilege; or at the request of the Medical Executive Committee when proctoring is initiated due to low/no clinical volume at Hospital.

6. FPPE and On-site proctoring. For purposes of this Rule, the term “on-site proctoring” refers to FPPE performed at facilities that are part Renown Health system. The term also refers to the site at which FPPE will be formed. Generally, all FPPE will be performed on-site.

7. Prospective Proctoring. For purposes of this Rule, the term “prospective proctoring” refers to the presentation of cases with planned treatment outlined for review by the proctor.

8. Concurrent Proctoring (Direct Observation). For purposes of this Rule, the term “concurrent proctoring” refers to the real-time observation of a procedure by the proctor. The term also may also be used for real-time observation of the patient's clinical history and physical, and review of treatment orders.

9. Retrospective Proctoring (Chart Review). For purposes of this Rule, the term “retrospective proctoring” refers to a review of case record by the proctor after the case has been completed by the practitioner. The review also may involve interviews of personnel directly involved in the patient's care.

D. Proctoring of Members

1. Situations that require Proctoring.
   a. New Members. All new Members who are requesting clinical privileges at Hospital shall be appointed for a provisional period, during which proctoring shall be completed as a means of determining clinical/technical competence of the applicant prior to advancement to regular active status. All providers requesting privileges are required to be proctored and are placed in an Affiliate status until such time that proctoring has been completed.

   b. Current Members requesting additional privileges. If a current Member seeks additional privileges at any time during a current appointment, then proctoring will be required to determine the clinical/technical competence of the Member to be granted such privileges.

   c. Low Volume Members. If a current Member's clinical activity in the Hospital is not sufficient to evaluate his/her professional competence on an ongoing basis, proctoring may be imposed by the Department/Section Chief with the approval of the Medical Executive Committee.

2. Methods. Proctoring methods are determined by each Department/Section and may include direct observation (both clinical and surgical), review of medical
records (both concurrent and retrospective), and an evaluation of the proctored practitioner’s six general competencies including, but not limited to, interpersonal skills with peers, nursing and ancillary personnel, and hospital administration.

3. **Term.**
   a. The term of proctoring may vary among Departments and Sections as outlined in the applicable Department and Section policies; however, procedures crossing Department/Section lines should have uniform proctoring requirements.
   b. If a sufficient amount of clinical activity has not occurred during the provisional period, the proctoring period may be extended beyond the provisional period as stated in the Medical Staff Bylaws, Rules and Regulations, and Policies upon formal request of the Department/Section Chief and approval by the Credentialing & Privileges Committee.

4. **Responsibilities of Proctored Members.** It is the responsibility of the proctored Member to make every attempt to schedule surgery/procedures in cooperation with the proctor(s), if applicable. The proctored Member shall also inform the proctor(s) of any unusual incident in any way associated with his/her patients.

E. **Medical Staff Oversight.** Medical Staff Services will provide the Credentialing & Privileges Committee with information of monitoring compliance with this Rule. The Medical Executive Committee accomplishes this oversight by reviewing the proctoring reports for providers and dealing with any issues or problems involved in implementing this Rule. The appropriate Department/Section Chief shall be responsible for overseeing the proctoring process for all applicants assigned to their clinical areas. The Medical Staff committee(s) involved with Ongoing Professional Practice Evaluation (OPPE) will provide the Medical Executive Committee with data collected for these providers to confirm current competence during the FPPE period.

1. **Proctoring Methods.** Each Department/Section shall be responsible for:
   a. Establishing a minimum number of cases/procedures to be proctored and determining how proctoring will be performed on that service.
   b. Identifying the Medical Staff Members eligible to serve as proctors. Proctors should be qualified and credentialed to perform the procedures being reviewed. The Department/Section Chief automatically shall be assigned as the applicant's proctor unless the Department/Section Chief assigns this responsibility to another member of the Service. The proctor shall charge no fee for this service. If no other Member is qualified or credentialed to serve as a proctor, an outside consultant may be retained and granted temporary membership to serve in a proctoring capacity.

2. **Role of Proctor.** The proctor's role is typically that of an evaluator, not of a consultant. A Member serving as a proctor is an agent of the hospital while assessing and reporting on the competence of another practitioner. The proctor shall receive no compensation directly or indirectly from any patient for this service, and shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any Member who is
subjected to a claim or suit arising from his/her acts or omissions in the role of proctor.

F. Responsibilities of Members Involved in the Proctoring Process.

1. Proctors.
   a. Proctors must be members in good standing of the active medical staff of Hospital and have unrestricted privileges to perform any procedure to be concurrently observed.
   b. Based on the Department/Section Policy requirements for proctoring, the proctor must:
      1. Directly observe the procedure being performed, if required, and complete the appropriate proctoring form.
      2. Retrospectively review the completed medical record following discharge, if required, and complete the appropriate proctoring form.
      3. Ensure the confidentiality of the proctoring results and forms. All proctoring forms must be delivered in a timely manner to Medical Staff Services.
      4. If, at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient, the proctor shall promptly notify the Department/Section chief and may recommend appropriate departmental/section intervention or review.

2. Practitioner Being Proctored. Practitioners being proctored shall:
   a. Notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently.
   b. Provide the proctor with information about the patient's clinical history; pertinent physical findings; pertinent lab and x-ray results; planned course of treatment or management; and direct delivery of any documents that the proctor may request.
   c. Have the prerogative of requesting from the Department/Section Chief a change of proctor if disagreements with the current proctor may affect adversely his or her ability to complete the proctorship satisfactorily.
   d. Inform the proctor of any unusual incidents associated with his/her patients.
   e. Ensure documentation of the satisfactory completion of his/her proctorship, including the completion and delivery of proctor forms. If the proctoring forms are not completed and returned at the end of the 6 months proctoring period, the practitioner may be granted an extension at the request of the Department/Section Chief to the Medical Executive Committee in instances involving proctoring cases that require observation. The Medical Executive Committee also may grant an extension up to three (3) months to allow the proctor additional time to review charts. If the person being proctored has not met the timelines set forth by the Medical Executive Committee, then a privilege suspension shall be imposed due to non-compliance with Medical
Staff requirements. If proctoring still has not been completed at the end of the extended time period, the practitioner may be required to reapply for privileges through the initial application process.

3. **Department/Section Chiefs.** Each Medical Staff Department and Section, through its chief, shall:
   
a. Assign proctors for all new Applicants, Members requesting additional privileges, or low volume Members. The Department or Section Chief may consider proctored assignments completed at another Renown Health-affiliated hospital; however, the Medical Executive Committee has the final authority to accept proctoring completed at such hospital.

b. Establish proctoring guidelines for the Department/Section and review annually.

c. Review all proctoring reports to ensure Member competence.

4. **Medical Executive Committee.** The Medical Executive Committee shall monitor compliance with this Rule. If, at any time during a practitioner's provisional appointment, the Department/Section Chief or Medical Executive Committee determines that the practitioner is not competent to perform specific clinical privileges and his/her continued exercise of those privileges jeopardizes patient safety, the Medical Executive Committee shall review the medical records of patients treated by the practitioner and make a recommendation regarding the appointee's continued appointment and clinical privileges. If necessary, the clinical privileges of the practitioner may be summarily suspended as outlined in the Medical Staff Bylaws.

RULE 3-1 **Physician Proximity**

A. **Members of the Medical Staff.**

1. **Physical Location.** At a minimum, Medical Staff Members shall be physically available within thirty (30) minutes driving time of the Hospital to fulfill their patient care responsibilities under the Medical Staff Bylaws and Rules & Regulations, and applicable Department and Section policies, including, but not limited to, Emergency Room call. For purposes of this Rule, a Member who is at another community hospital located within the Truckee Meadows shall be deemed to be within 30 minutes of Hospital.

2. **Requirement for Responding to Calls for Consultations or Emergency Room Call.** When a Member of the Medical Staff is on Emergency Room call, he or she shall respond to a call or page from the Emergency Room or for in-house consultative services by telephone or in person within thirty (30) minutes of receipt of the call or page. Thereafter, if the Member initially responded by telephone, he or she shall respond in person to the Emergency Room within a reasonable time after being notified by the Emergency Room physician to appear. Telephonically responding to the Emergency Room or physician requesting a consult shall not relieve the Member from his or her obligation to respond in person.

3. **On-Call Physician Taking Simultaneous Call at another Hospital.** When a Member of the Medical Staff is on Emergency Room call, he or she is permitted to be on-call simultaneously at two or more facilities as long as
Hospital knows of such an arrangement in advance. The Member on simultaneous call must have planned back-up in the event that he or she is called while responding to a call from another hospital and is unable to respond to an on-call request from Hospital in a reasonable time as required by section 2, above.

4. On Call Physician Performing Scheduled Procedures or Elective Surgeries. When a Member of the Medical Staff is on Emergency Room call, he or she is permitted to perform scheduled elective procedures and surgeries. However, the Member must have planned back-up in the event that he or she is called while performing the procedure/elective surgery and is unable to respond to the on-call request in a reasonable time as required by section 2, above.

B. Allied Health Professionals. Allied Health Professionals shall be available within 30 minutes of the Hospital to fulfill their responsibilities under the Medical Staff Bylaws and Rules & Regulations, as well as applicable Department and Section policies.

RULE 3-2 PATIENT TYPES AND ADMISSIONS

A. Definitions of Patient Types.

Patients at the Hospital will fall into two (2) general types: inpatient and outpatient. These types are based on the service being provided at Hospital as well as on specific regulatory requirements including, but not limited to, federal and state law and the Medicare Conditions of Participation. These types are defined as follows:

1. “Inpatient” means a patient who has been admitted to a licensed bed in the Hospital for the purpose of receiving inpatient services and with the expectation that the patient will remain over two (2) midnights except for certain defined diagnoses as noted by regulatory authority.

2. “Outpatient” means a patient who has not been admitted to the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

   a. Ambulatory Care Procedure. Ambulatory procedures, including same-day surgeries, angiograms, bronchoscopes, and endoscopies, are generally invasive and require coding and abstracting by HIMS.

   b. Observation. Observation services are those services furnished on the hospital’s premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition in order to determine whether the patient should be admitted as an inpatient or discharged.

   c. Emergency. Emergency services are those services rendered in the Emergency Room or any other area staffed and equipped at all times to provide prompt care for any patient presenting with emergent medical conditions.

   d. Other Outpatient Episodes/Services.
(1) **Clinic Visits:** Encounters during which diagnoses and other related information are provided by the Member who performs the examination or who is overseeing the activities of another clinician.

(2) **Diagnostic and Treatment Services:** Services such as laboratory and radiological studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified physician who is also responsible for providing the patient’s diagnosis and other clinical justification for the test or therapy.

B. **Admission Criteria.**

Only Members of the Medical Staff who have the appropriate privileges to admit patients to the patient types listed in this Rule, as provided by the appropriate laws and the criteria established by the Medical Staff, may admit patients to the Hospital as an inpatient or for acceptance by the Hospital for outpatient hospital registration, including ambulatory care procedures, observation services and emergency services. Any patient admitted to the Hospital shall be under the direct care or supervision of a Member of the Medical Staff.

1. **Provisional Diagnosis Required.** Members must record a provisional diagnosis for the patient at the time of admission. In an emergency, the Member may admit the patient and record the provisional diagnosis as soon as possible thereafter.

2. **Members shall provide relevant and appropriate information to Hospital Staff as may be necessary to enable the Hospital to protect the patient from self-harm and to protect other patients, staff and visitors from possible sources of danger.**

3. **Members shall report all cases of reportable diseases in accordance with applicable laws and Hospital policies.**

C. **Admission of Patients.**

1. **Members with appropriate privileges may admit patients to the Hospital.** A patient’s attending physician shall be responsible for executing all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital’s Policies and Procedures governing admitting and discharging of patients from the Hospital.

2. **The admitting order must specify whether the patient is being admitted as an inpatient or an outpatient (including observation or other outpatient services).**

3. **Changes in patient admission type after the patient is admitted require a new order.** However, absent specific regulatory exception and involvement of the Hospital Utilization Review Committee, a patient admitted as an inpatient cannot be changed to Observation status retroactively.
RULE 3-3 Medical Records

A. Definition.
A medical record consists of medical information in the custody of the Hospital Health Information Management (HIM, or Medical Records) Department that is specific to the patient and pertinent to the patient’s care and treatment. The information contained in the medical record, and any other patient-specific information, shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access.
Medical Staff Members, Hospital staff and others may access patient medical records only if they are involved in the care of the patient, or are engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuits, or some other appropriate authorized activity. This applies regardless of the format in which the records are maintained or stored, i.e., on paper or electronically.

C. Required Elements.
Required elements of the medical record are noted in the hospital HIM policy on medical records.

D. Responsibility and Timeliness. The attending Member is responsible for the timely preparation and completion of the patient’s medical record. All medical record entries must be authenticated within thirty (30) days following the patient’s discharge unless stipulated otherwise in these rules and regulations.

E. Documentation Rules. Except as otherwise stated in these Rules, Members shall comply with the documentation requirements contained herein as follows:
1. Legible. All entries in the medical record must be legible.
2. Authenticated.
   a. Signature. A Member or other practitioner authorized to make an entry in the medical record of a patient must sign the entry either in writing or electronically, and provide his or her printed name and discipline.
   b. Signing Records. Members participating in legal entities in the community who desire to have the privilege of co-signing on records of all patients in whose care they participate with other Members of the same legal entity may do so only after notifying the Hospital in writing. All Members of the legal entity who will participate in co-signing records to authenticate patient treatment will be required to sign the request. These letters shall state that those Members of the entity participating in co-signing of records share equal rights and responsibilities to their patients.
   c. Medical Students. Medical student entries must include the identification of the student’s status and be counter-signed by the supervising Member within twenty-four (24) hours.
   d. Allied Health Professionals. Allied Health Professionals when practicing within their scope of practice and acting under the
supervision of a member of the medical staff, shall have the authority to write orders and progress notes without the co-signature of the attending or supervising physician. Consultations, Operative Reports, Emergency Room Reports, and Histories and Physicals prepared by Allied Health Professionals must be co-signed by the attending physician within twenty-four (24) hours. All Discharge Summaries prepared by Allied Health Professionals must be co-signed by the attending physician within thirty (30) days of discharge. It is noted that a physician may not supervise more than three (3) Allied Health Professionals at any one point in time.

e. Residents and Fellows. Residents and Fellows when practicing within their scope of practice, and as authorized by the Residency Supervisory Committee,[Rule 5.1 Medical Staff Committees refers to Residents, Fellows and Students Committee] and acting under the supervision of a Medical Staff Member, shall have authority to write orders and progress notes without the co-signature of the attending or supervising physician. Consultations, Operative Reports, Emergency Room Reports, and Histories and Physicals prepared by Residents and Fellows must be co-signed by the attending physician within twenty-four (24) hours. All Discharge Summaries prepared by Residents and Fellows must be co-signed by the attending physician within thirty (30) days of discharge.

3. Dated/Timed. All entries must be dated and timed. All documentation of care shall include the time using the 24 hour clock.

4. Abbreviations.

a. When Allowed. During the course of care and treatment of a patient, Members may use abbreviations in all parts of the medical record of a patient, except for Discharge Summaries and Final Summaries.

b. Certain Abbreviations Prohibited.

(1) General Rule. Certain abbreviations have been associated with medication errors and shall not be used. If a Member uses a prohibited abbreviation in a documented order, the order will not be carried out until the Member has been contacted and the order clarified. The prohibited abbreviations are as follows:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Write “International unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d, (daily)</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (x.0 mg)</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>Write (0.X mg)</td>
</tr>
<tr>
<td>MS</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

(2) Exception to General Rule. If, in the judgment of the Hospital staff providing care to the patient (e.g., the
registered nurse, pharmacist, etc.), an order that includes a
prohibited abbreviation is nonetheless clear and complete
and a delay to obtain confirmation from the ordering
Member prior to execution of the order would place the
patient at greater risk, then the order may be carried out;
and the confirmation obtained as soon as possible
thereafter.

(3) Repeated Use of Prohibited Abbreviations. Repeated use
of prohibited abbreviations by a Member is considered a
patient safety issue. Such conduct will be reported in the
Member’s file, should be grounds for disciplinary action by
the Chief of Staff, Department or Section Chief, and will be
considered upon a Member’s application for reappointment.

RULE 3-4 Content of the History and Physical Examination

A. Complete History and Physical Examination
For patients admitted to the hospital or who will be undergoing an outpatient
procedure using anesthesia services, a complete history and physical ("H&P")
must be done. The complete H&P should include:

a. Chief complaint or reason for the admission or procedure;
b. A description of the present illness;
c. Past medical history, including past and present diagnoses, illnesses,
   operations, injuries, treatment, allergies, and health risk factors;
d. An age-appropriate social history;
e. A pertinent family history;
f. A review of systems;
g. Thorough and relevant physical findings including vital signs, heart exam,
   lung exam, and exam of the pertinent body area; and
h. Documentation of medical decision-making including a review of
diagnostic test results; response to prior treatment; assessment, clinical
impression or diagnosis; plan of care; evidence of medical necessity and
appropriateness of diagnostic and/or therapeutic services; counseling
provided, and coordination of care.

B. Focused History and Physical Examination
For patients undergoing an outpatient procedure under moderate sedation, a
focused history and physical may be done in place of a complete H&P. This
focused H&P should include:

1) Chief complaint;
2) History of the present illness including any prior treatment(s) performed;
3) Past medical history including allergies and current medications;
4) Physical examination including vital signs, heart exam, lung exam, and exam of the pertinent body area;

5) Pertinent laboratory or radiologic testing results

6) Assessment; and

7) Plan of care.

RULE 3-5  Physician Orders

A. Orders.

1. General Rule. All orders entered into the patient’s record either electronically or in writing by a practitioner with privileges shall:
   a. contain any necessary information;
   b. be legible and use appropriate terminology;
   c. be signed by the issuing practitioner and reference the Member’s transcription number (if applicable);
   c. be dated and timed; and
   e. follow Rule 3-3(E) (4) regarding the use of abbreviations.

B. Verbal/Telephone Orders.

1. Authentication Required. Verbal orders by Members, including orders given by telephone, will be authenticated by the Member giving the verbal order.

2. When Appropriate. Verbal orders are discouraged and should only be used in situations where any delay in writing the order may cause the patient harm or have an otherwise potentially negative outcome.

3. Protocol. The ordering Member shall allow the receiver of the order to write out the complete order and then read the order back to the Member to ensure the accuracy of the order.

4. Signing of Order. A verbal/telephone order must be authenticated by the prescribing Member or other Member authorized by these Rules and Regulations to sign the order on his or her behalf in a timeframe noted in HIM policy.

RULE 3-6  Consent and Disclosure

A. Informed Consent Required.

The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner’s obligation is to present the medical facts accurately to the patient, or the patient’s surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic
alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient’s authorization or agreement to undergo a specific medical intervention. Documentation of informed consent should be per the guidelines of the hospital’s informed consent policy.

B. Disclosure of Unanticipated Outcomes and Medical Errors.

Notification of any adverse event or occurrence should be done in compliance with Hospital Policy.

RULE 3-7 Medications

A. Compliance with Clinical and Hospital Policies. An order for medication must comply with the Medical Staff-approved clinical policies and procedures, including applicable Hospital policies and procedures, that govern the content of, abbreviations and nomenclature permitted in, medication orders, both generally and for specific types of medications.

B. Medications of Patients Transferred when there is a Change in Status. Upon transfer of the patient to a different status, all medication orders shall be canceled and new orders shall be documented. References to prior medication orders are not acceptable; complete orders for each medication must be documented. If there is a change in Service (e.g. Medicine, Surgery) and/or the Member responsible for the patient, all orders for the patient must be reviewed by the new Service and/or Member, and reaffirmed or discontinued via documented order in the patient's chart.

RULE 3-8 Providing Care, Treatment and Services

A. Daily Care of Patients. The attending physician Member, or appropriate privileged practitioner, must see his or her patients in the Hospital at least daily, or more frequently if required by the patient’s condition or circumstances. A privileged practitioner shall write a progress note on each patient daily that contains sufficient detail to provide a reasonable picture of the patient’s clinical status at the time the physician Member or privileged practitioner rounded and observed the patient. Once a patient clearly meets criteria for transfer and an order for discharge planning is documented, daily visits are no longer required but the physician Member or appropriate privileged practitioner must round on the patient at least twice per week or as required by the patient’s condition or circumstances.

Definition of low acuity: Patient has low complexity with a minimal or limited number of diagnoses or management options, a limited amount of complexity of data to be reviewed, and has a minimal or low risk of significant complication, morbidity, and mortality.

B. Consultations.

1. The Medical Staff, through its Department and Section Chiefs and Medical Directors, shall be responsible for ensuring that Members obtain consultations when appropriate and when requested by the Department or Section Chiefs, Medical Directors, or Chief of Staff. Upon admission, the admitting physician shall request a pediatric hospitalist consult on all patients 18 years old and younger (excluding newborns), admitted to
Renown Medical Center Pediatric Children’s Hospital, Pediatric Floor or Pediatric ICU. Each Department and Section may specify the minimum criteria for requesting a consultation in its policies. In addition, a practitioner shall request a consult in the event that the patient requires a scope of care that is outside the expertise and/or clinical privileges of the attending Member or practitioner, or if uncertainty exists regarding the appropriate course of treatment for a given patient.

2. **Timeframe of Consultation.** Members requesting consultations may record the request as an order but must verbally communicate with the consultant to clarify and confirm the request. Routine consultations will be completed within twenty-four (24) hours. If the consult is more urgent, this will be communicated to the consulting physician at the time the consult is requested. If it is mutually acceptable to the ordering practitioner and the consultant, an Allied Health Professional that works with the consultant may perform the initial consultation which the consultant must cosign within twenty-four (24) hours.

3. **Timing of Consultation Notes.** Within twenty-four (24) hours of performing a patient consultation, a privileged practitioner shall prepare documented (or otherwise recorded) notes of the consultation that contain the findings made by the practitioner through interviewing the patient, review of the patient’s medical record, examination of the patient, and a diagnosis and recommendations for care and treatment. The practitioner shall include in such notes the date of the request of consultation and the date on which the consultation occurred. The notes shall be contained in the patient medical record. If the consultation note is not immediately available to the requesting practitioner, the consultant shall note in the chart their recommendations regarding the care of the patient.

4. **Readmitted Patients.** Physicians consulting on patients and continuing to participate in their care and treatment upon readmission shall not be required to provide another formal report of consultation, but will, instead, be required to provide an update note for the medical record, following the same guidelines as imposed for the use of interval notes.

C. **Sedation/Anesthesia Assessments.**

1. **Pre-Anesthesia Assessment.** Prior to administering deep sedation or anesthesia to a patient, an Anesthesiologist must complete a pre-anesthesia evaluation that includes:

   a. **History:**

      (1) Medical History performed by a physician with a review of systems (specific to cardiovascular disease);

      (2) Any adverse or allergic drug reactions with anesthesia or sedation;

      (3) Level of consciousness;

      (4) NPO status;

      (5) Airway assessment; and
(6) ASA classification.

b. Physical Assessment:
   (1) Prior to induction, updated vital signs and oxygen saturation;
   (2) Physiological monitoring is measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room record;
   (3) Brief description of the planned procedure(s);
   (4) Planned anesthesia type, including risks, benefits, and alternatives; and
   (5) Re-evaluation must be done immediately prior to moderate or deep sedation use and before anesthesia induction.

2. Post-Anesthesia Assessment. The practitioner who administered the anesthesia must write a post-anesthesia follow-up report within 48 hours after completion of surgery. The report should:
   a. Be recorded on the Anesthesia Assessment Form; and
   b. Specifically document the CMS mandated criteria for a post-anesthesia assessment along with any intra-operative or postoperative anesthesia complications.

3. Pre-sedation Assessment.
   All patients undergoing moderate sedation will have an airway assessment prior to the initiation of moderate sedation.

D. Operative Care of Patients.
1. Immediate Progress Note after Surgery. A Member shall write a brief operative note in the progress notes immediately following inpatient or outpatient surgery before the patient leaves the surgery suite or recovery area when the operative report is not immediately available prior to transfer to the next level of care. The documented note must include the following elements:
   a. name of primary surgeon and any assistants;
   b. post-operative diagnosis;
   c. procedure performed;
   d. estimated blood loss;
   e. findings of the procedure;
   f. specimens removed, if any; and
   g. any complications.

2. Post-Operative Report. An operative report must be dictated for transcription within 24 hours after surgery. The report should contain the following:
   a. Pre-operative diagnosis;
b. Post-operative diagnosis;
c. Operations performed;
d. Names of principal surgeon, assistant surgeons and a description of their tasks;
e. Type of anesthesia administered;
f. Intra-operative findings;
g. Description of the procedures performed;
h. Intra-operative complications, if any; and
i. Specimens removed, if any; and
j. Any prosthetic devises, grafts, tissues, transplants, or devices implanted.

E. Off-Service Notes.
When an attending physician signs off of a case, he or she shall enter a documented order that clearly identifies the new attending physician. Off-service notes are encouraged in those cases when an attending physician appropriately is transferring care of the patient to another Member due to the complexity of the case or a prolonged length of stay.

F. Termination of Physician-Patient Relationship.
In the event that the physician-patient relationship is terminated for any reason (by the physician Member or the patient), the Member shall use his or her best reasonable efforts to assist the patient in obtaining a new physician qualified to provide the care required by the patient.

RULE 3-9 Coordination of Care and Treatment of Patients
A. Discharge.
1. Order Required. Patients shall be discharged only on the order of the responsible attending physician Member or Allied Health Practitioner. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible attending physician Member or Allied Health Practitioner shall communicate all appropriate medical information to any practitioner and/or any agency, entity or institution to which a patient is referred following discharge from the hospital.

2. Patient Leaving Hospital AMA. If a patient leaves the Hospital against medical advice, the attending physician Member or other practitioner shall document the patient’s decision in the medical record.

3. Discharge Summary.
   a. When Required. For patients who have been in the Hospital for a period of more than 48 hours, the attending physician Member or other practitioner shall dictate or write a patient discharge summary within 48 hours of discharge. For uncomplicated patients who have been in the Hospital for less than 48 hours, the attending physician Member or other practitioner shall dictate or write a discharge note.
Newborn patients with no clinical problems do not require a discharge summary regardless of length of stay.

b. **Form and Contents of the Discharge Summary.**

   (1) The discharge summary can be handwritten, entered or dictated for transcription.

   (2) The content of the discharge summary should be consistent with the rest of the record and include:

   (a) Admitting date and reason for hospitalization;

   (b) Discharge date;

   (c) Final diagnoses;

   (d) Succinct summary of significant findings, treatment provided and patient outcome;

   (e) Documentation of all procedures performed during current hospitalization and complications (if any);

   (f) Condition of patient upon discharge and to where the patient is discharged; and

   (g) Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential.

c. **Completion of the Discharge Summary**

   The discharge summary must be completed, including all signatures, within thirty (30) days after the patient is discharged.

B. **Patient Death.** In the event of a patient’s death, the patient shall be pronounced dead by a qualified Member of the Medical Staff or by two registered nurses in accordance with Hospital policy. Reporting of deaths to the Washoe County Coroner’s Office will comply with hospital policy and state law.

C. **Progress Notes.** Members and other privileged practitioners shall write progress notes in the medical record that are adequate to reflect the continuing course of the case and include references to pertinent test results and diagnostic findings, as well as any new problems encountered during the course of the patient’s admission to the Hospital. Progress notes will be completed prior to discharge of the patient.

D. **Emergency Dept.** Emergency Department reports are required on all patients seen in the Emergency Department by a member of the Medical Staff within 24 hours of the patients visit.

**RULE 3-10 Emergency Room Coverage**

A. **Duty of Medical Staff Members.**

   1. **Obligation of Members.** Members of the Medical Staff shall provide coverage to the Emergency Room ("ER") of the Hospital. Members also are required to respond to requests for in-house consultative services when they are scheduled to provide ER coverage. This obligation requires Members providing ER coverage, at a minimum, to:
a. Respond to any call without regard to any individual’s race, color, age, creed, sex, national origin, ancestry, marital status, sexual orientation, disability, financial status or participation in any private or governmental payor program, except to the extent that such circumstance is medically significant to the provision of appropriate medical care to that individual.

b. Assist in the diagnosis and treatment of the patient, and when the patient's condition so warrants, accept continuing primary responsibility for the patient's care, including admission to the hospital and/or subsequent outpatient care.

c. Assist in the decision to and arrangement for transfer in concurrence with the Emergency Room physician when the patient's condition so warrants and in accordance with applicable federal and state laws, Hospital transfer policies and procedures, and these Bylaws and Rules & Regulations.

d. Respond to the Emergency Room in a timely manner, telephonically within thirty (30) minutes and physically in a timely manner as determined by the emergency department provider. Members are expected to assume responsibility for a patient in a time frame appropriate for the patient's medical condition. If unable to do so, the Member must inform the ER of his or her back-up physician. If a Member does not have a back-up available, or the critical patient's stay in the ER is prolonged and/or necessary stabilizing treatment is delayed because of physician issues, the ER physician will notify the appropriate Department or Section Chief of the situation. The Department or Section Chief will be responsible for arranging appropriate and prompt care for the patient.

2. Responsibilities of Department and Section Chiefs. Department and Section Chiefs shall ensure that adequate coverage is provided in all cases when there are seven (7) or more Members eligible for call in the department/section. When there are less than seven (7) Members in the department/section, the Chair will submit a proposed call schedule to the MEC and Board.

B. Assignment to Schedule.

1. Written Schedule Required. Members of a Department or Section will be assigned to cover the ER according to a written schedule.

2. Allocation of Emergency Room Coverage. Department and Section Chiefs will allocate ER coverage equally between the Department or Section members eligible and/or required to provide such coverage. If a Member requests additional time on the coverage schedule, the Department or Section Chief may allocate such time to the Member if appropriate.
3. **Coverage in Extreme Emergency Situations.** In cases of extreme emergency, an Emergency Room physician may obtain the services of any Member, regardless of Medical Staff category, who is immediately available to cope with the situation. Such Member shall provide whatever medication or treatment is deemed necessary by that physician, given the urgency of the situation.

4. **Multiple Specialties Available.** When two or more specialties maintain core privileges in a required specialty, including, but not limited to, hand call or facial fracture call, and an ER patient requires the services provided by those specialties, then the Emergency Room Physician ("ERP") may contact a Member on call in either specialty to cover the patient. The Member called must see the patient or obtain coverage from a Member in the other on call specialty.

5. **Exemption from Emergency Department Call.** A physician may request exemption from emergency department call coverage. The request will be granted if the physician meets one (1) of the criteria noted below:

   a. Age fifty-five (55) with ten (10) years continuous ED call coverage, or

   b. Age sixty (60) with ten (10) years of total service in ED call coverage.

C. **Failure to Fulfill Emergency Department Coverage Obligations.**

   If a Member scheduled to provide ER coverage fails to respond to the Emergency Room Physician after multiple attempts, then the ERP immediately will contact the scheduled Member's Section Chair followed by the Department Chief or, if said Chief is unavailable, the Chief of Staff. If the Department or Section Chief is contacted, he or she will notify the Chief of Staff promptly of such contact. The Chief of Staff will take immediate corrective action against the scheduled Member, in the following sequence:

   1. **First Instance.** In the first instance of a Member failing to fulfill his or her ER coverage obligations, the Chief of Staff will direct the Department or Section Chief to send a written warning to the Member.

   2. **Second Instance.** If the Member fails to fulfill his or her ER coverage obligations for a second time within a 12 month period, the Chief of Staff will send a letter to the Member requesting that the Member prepare and submit a written request for a plan of action to eliminate further instances of failing to fulfill his or her ER coverage obligations. If appropriate, the Member also will be referred to the Physician Aid Committee of the Nevada State Medical Association for intervention or assistance.

   3. **Third Instance.** If the Member fails to fulfill his or her ER coverage obligations for a third time within 12 months of the second instance, the Member will be subject to disciplinary action as noted in Part II of the Medical Staff Bylaws.
RULE 3-11  Private Patients in the Emergency Room

A. Emergent Patients. Members will assume the responsibility for care of their own patients who present in the Emergency Room with an emergency medical condition, provided that delays in the arrival of a private physician do not in any way compromise the care of the patient.

B. Non-Emergent Patients. A Member’s private patient who presents in the Emergency Room for care in a situation not involving an emergency medical condition, as that term is defined by federal and state law, is, and will continue to be, the responsibility of the Member and not the responsibility of the Emergency Room physician. If the patient lists a Member as his or her private physician, that Member will be contacted as soon as possible after the patient has presented in the Emergency Room.

RULE 3-12  Blood Services

Practitioners shall follow the blood utilization policies of Renown Regional Medical Center.

RULE 3-13  Autopsies

A. When Performed. An autopsy may be performed only if required by the Washoe County Coroner or other authorized government official, or upon the written request of an authorized individual as provided by law.

B. Performance of Autopsy. All autopsies shall be performed by pathologists who are qualified Members of the Medical Staff. The post-mortem report should be made part of the medical record within a reasonable time. Autopsy reports should be completed within 60 working days for uncomplicated cases.

RULE 3-14  Suicidal Patients

For the protection of patients, the Medical, Nursing and Hospital Staffs, and the Hospital, the following standards shall be met for a patient determined to be potentially suicidal:

1. The attending physician Member or other practitioner shall obtain a psychiatric consultation as soon as possible after a patient has made a suicide attempt or if the Member or practitioner reasonably believes that the patient reasonably may attempt suicide.

2. Prior to the consultation, the practitioner in charge of providing the patient’s care should evaluate the type of immediate medical care required by the patient and write the appropriate orders to obtain the care necessary to stabilize the patient medically.

3. If a patient’s medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician Member is encouraged to seek appropriate information and/or consultation for the patient.

RULE 3-15  Use of Restraints and Seclusion to Protect Patients and Others
A patient may be restrained or secluded for either behavioral or medical-surgical purposes only if necessary to improve the patient’s wellbeing and/or to protect the safety of other patients. Members of the Medical Staff shall follow applicable law and the Hospital’s clinical interdisciplinary policy regarding use of restraints.

RULE 3-16 Member Objection to Withholding/Withdrawing Life-Sustaining Treatment.

If a Member of the Medical Staff is unwilling or unable to honor a Hospital patient’s advance directive to withhold or withdraw life-sustaining treatment, as provided in Nevada Revised Statute 449.628, the Member and/or Hospital will take all reasonable steps to transfer the patient to a Member who will honor the patient’s advance directive. Under no circumstances will a patient be abandoned or put in a situation where care is compromised or not provided as a result of a Member’s conscientious objection to a patient’s advance directive.

RULE 3-17 Organ and Tissue Donation

Members of the Medical Staff shall follow applicable law and the Hospital’s clinical interdisciplinary policy regarding organ and tissue donations.

RULE 3-18 Tissue Specimens

All tissue specimens removed during an operation that are clinically relevant to the indication for the procedure or subsequent therapy shall be read by a Medical Staff member with privileges to read specimens at the Hospital, who shall make such examination as he or she may consider necessary to arrive at a tissue diagnosis. The pathologist’s signed report shall be made a part of the patient’s medical record.

RULE 3-19 Treatment of Family Members and Self

A. AMA Guideline. Members of the Medical Staff should not act as a physician to themselves or their immediate family members (first degree relatives, spouse, and children) unless no viable alternative treatment options exist in the Northern Nevada region.

1. Any procedure requiring written informed consent in any setting;
2. Any procedure that might be life-threatening or that uses life-threatening modalities as part of the treatment (e.g., cancer chemotherapy);

3.

4. Any hospital-based treatment (inpatient or outpatient).

B. Rule for Members Treating Family Members

1. If a Medical Staff Member desires to act as physician to a family member in any Hospital facility, the Member first must notify the Chief of Staff to review the situation prior to the initiation of the diagnostic/therapeutic plan, or as soon thereafter as such notification reasonably may be made, and attest to:
   a. the necessity of the plan/procedure;
b. the lack of viable treatment alternatives in the Northern Nevada region; and

c. the provision of informed consent by the patient that addresses the patient’s understanding of the risks of:

(1) Coercion;

(2) Conflict of interest;

(3) The complexities that might arise in the event that the patient experiences a bad outcome; and

(4) An awareness of the issues surrounding reimbursement and insurance fraud.

2. The Member should consult with the Bioethics Committee as soon as reasonably practicable.

3. The Chief of Staff may review the case at the conclusion of the treatment episode to assure that appropriate technical and professional standards have been met.

RULE 4-1 Contacting Physicians at Home in a Disaster

A. Need to Contact Physicians at Home. In the event of a phone company or answering service breakdown, Nursing Services may need to contact Medical Staff Members at home to ensure communication between the Hospital and Members of the Medical Staff is available.

B. Protocol. Upon notification of a service breakdown, the Director of Medical Staff Services (“Director”) will be notified of the need to access the home numbers of members. The Director, Administrator on Call, or the Senior Emergency Department Physician will direct the Shift Coordinator or Security Personnel to a sealed envelope containing the home numbers of all Members. The sealed envelope will be kept in the front of the Medical Staff Services Department Safety Handbook and in the HEICS box and will be updated quarterly. This envelope will be sealed. If a member of the Hospital staff opens the envelope without appropriate authorization, the Hospital will take appropriate action in accordance with its policies and procedures. After being utilized, the list will be returned to Medical Staff Services Department to be updated and placed in a new sealed envelope.

C. Guidelines for acceptable circumstances to access:

1. Phone company trunk failure or answering service problems, e.g., power failures; phone failures; computer failures; inability to contact the answering service; or inability for the answering service to function.

2. Officially declared disasters.

3. Circumstances requiring implementation of disaster protocols.

RULE 4-2 Occurrence Reports

A. Process.
1. An occurrence report regarding a Member, Allied Health Professional, or other practitioner, including a resident, will be forwarded from the quality department to the Chief of Staff.

2. The individual who is the subject of the report will be notified and allowed to review, but not copy, the occurrence report with any identifying information on the reporter redacted.

3. The Chief of Staff may:
   a. Refer the matter to the Member’s Department or Section Chief, with a request for a timely written response;
   b. If appropriate, the Chief of Staff may contact the individual who submitted the occurrence report to determine whether the issue that gave rise to the incident report has been resolved or improved;
   c. Request a written response from the Member or
   d. If a resident or fellow is involved, the matter will be forward and deferred to the appropriate residency program director.

B. Action.
   The Chief of Staff may exercise the following options:
   1. No Action (insignificant event).
   2. Referral the matter for Medical Staff Peer Review.
   3. Refer the matter for Investigation.
   4. Any other action allowed by the Medical Staff Bylaws or Rules and Regulations.

If the occurrence report involves a resident, and the residency program director will provide the Chief of Staff with the resident's response.

C. Documentation of Action Taken. Any action taken as the result of an occurrence report will be maintained in the individual’s quality assessment file. All actions taken at the Department level will be reviewed by the Medical Staff Quality Improvement Committee and assessed for a system problem. The Medical Staff Quality Improvement Committee reserves the right to make recommendations back to the Department or Section Chief if the Committee is not satisfied with the actions of the Department.

RULE 4-3 Confidentiality of Medical Staff Records

A. Applicability. As provided in Article XI of the Medical Staff Bylaws, all records maintained by or on behalf of the Medical Staff, including the records and minutes of all meetings of Medical Staff committees, Departments, Sections and the credentials and peer review files for Members, Allied Health Practitioners, and other practitioners, shall remain confidential and privileged to the extent allowed by law.

B. Location of Records. All Medical Staff records shall be maintained in Medical Staff Services. Additional quality improvement records are secured in Quality Services, Utilization Management, Trauma Services and Emergency Services. These records will be kept in locked file cabinets or in a secure electronic format under the direction of the Department head of these areas.

C. Access to Records. All requests under this section for Medical Staff records shall be made to the Medical Staff Services Director, who shall allow access to the records as provided in this Rule. Unless otherwise stated, a person permitted access under this Rule shall be given a reasonable opportunity to inspect the records and make notes, but may not remove or make copies of records. Those individuals may only review information they provided, filled out on our behalf or
they were a part of the committee/department at the time of the information they wish to review.

1. **Access for Official Hospital or Medical Staff Functions.** Medical Staff officers, Department and Section Chiefs, Members of the Board of Governors, the Medical Staff Services staff, the CEO, or his or her designated representative, and the CMO shall have access to Medical Staff records to the extent necessary to perform official functions as follows:
   
a. Medical Staff Officers shall have access to all Medical Staff records.
   
b. Medical Staff Department and Section Chiefs shall have access to all Medical Staff records pertaining to the activities of their respective sections.
   
c. Consultants (who may or may not be Members of the Medical Staff) reviewing a practitioner's performance at the request of a Medical Staff committee or section shall have access to the credentials and peer review files of the practitioner being reviewed and any other pertinent Medical Staff committee records.
   
d. The CEO (or designated representatives); the CMO and the Chief of Staff shall have access to all Medical Staff records.

2. **General Access by Practitioners to Medical Staff Records.**
   
a. **Credentialing and Peer Review Files.** A practitioner shall have the right to copies of any document in his or her own credentialing and peer review files that he/she submitted or filled out on behalf of Renown, (i.e., his or her application, reapplication, privileges list, or correspondence from him or her) or that were addressed directly to the practitioner. A practitioner shall not be allowed access to any further information in his or her credentialing and quality file without a subpoena or on advice of Renown legal counsel.
   
b. **Medical Staff Committee Files.** A practitioner shall be allowed access to Medical Staff committee files (to include committee minutes) only if, they are a member of the committee or were at the time of the minutes or following a written request by the practitioner that is approved by the Medical Executive Committee and the Board of Governors, for good cause or as directed by Renown legal counsel.

3. **Access by Outside Persons or Organizations.**
   
a. **Credentialing Or Peer Review At Other Hospitals.**
      
(1) **Routine Requests for Information.** If a practitioner has not encountered disciplinary or peer review problems or been denied privileges at the Hospital, the CEO, the CMO or Chief of Staff may release information contained in the practitioner's credentials and peer review file in response to a request from another hospital or its medical staff. Such requests must include notification that the practitioner is a member of that hospital's medical staff, exercises privileges at that hospital, or is an applicant for medical staff membership or privileges. Disclosure shall be limited to the information requested and express written consent by the practitioner must be received.
      
(2) **Non-Routine Requests for Information.** If a practitioner has encountered disciplinary or peer review problems or been denied privileges at the Hospital, then no information shall
be released until a copy of a signed release, deemed satisfactory by legal counsel, has been received from the requesting institution. Additionally, all responses to such requests shall be reviewed and approved by the Chief of Staff, who may consult with legal counsel.

b. Other Requests. All other requests by persons or organizations outside the Hospital for information contained in Medical Staff records shall be forwarded to the Chief of Staff and the Director of Medical Staff Services.

D. Subpoenas. All subpoenas of Medical Staff records shall be referred to the CEO or his or her designee, who shall consult the Chief of Staff, the CMO, Renown legal counsel and the Director of Medical Staff Services.

RULE 4-4 Practitioner Health Issues

A. Applicability. The Medical Staff shall provide assistance to any Member who is referred, by himself/herself or another person, for assistance with an individual health issue on a confidential, non-punitive basis if the conduct of the Member is not subject to Section 4.7 of the Bylaws.

B. Assistance Provided. The Medical Staff shall provide education about practitioner health issues, address the prevention of physical, psychiatric, or emotional illness, and facilitate the confidential diagnosis, treatment and rehabilitation of such illnesses. The Medical Staff may use resources provided by the Nevada Health Professionals Assistance Foundation, which administers the Nevada State Board of Medical Examiners’ Diversion Program. The goal of such assistance is rehabilitation, rather than discipline, to aid a Member in retaining and regaining optimal professional functioning that is consistent with the protection of patients.

C. Method of Requesting Assistance. A request for assistance shall be directed to the Chief of Staff, who will assess the situation using whatever data is available and discuss the issue with the Member in question. If an individual other than the Member allegedly requiring assistance makes the request for assistance, the Chief of Staff shall evaluate the credibility of the alleged claim through reasonable efforts. If the Chief of Staff determines that the matter is credible, he or she may involve the Member’s Department Chief and/or Section Chief, other Medical Staff officers, and other Medical Staff Members whose duties are relevant to the issues.

D. Confidentiality. At all times throughout the process, the Chief of Staff shall ensure that the confidentiality of the referral and any other action taken throughout the process is maintained, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

E. Appropriate Action.

1. Action per Bylaws Section 4.7(E). The Chief of Staff may take such action as determined to be reasonably sufficient to address the Member’s health issue, as those actions are detailed in Section 4.7(E) of the Bylaws.

2. Other Action. If the Medical Staff takes action other than that specified in Section 4.7(E) of the Bylaws, the Member must enter into a written contract with the Medical Staff that specifies the action to be taken and requirements for compliance by the Member. The types of action that may be taken include any or all of the following:

a. Rehabilitation Program. The Member may be required to enter into a recognized rehabilitation program. A Member may be allowed to take a voluntary leave of absence to enter such a rehabilitation program, which shall not be reported to the National Practitioner
Data Bank. The Member may return from such a leave of absence upon successful completion of the rehabilitation program, as verified in writing by the rehabilitation program director. The Member also must have a written aftercare rehabilitation program, a copy of which shall be provided to the Medical Staff.

b. Mentorship. The Member will be assigned a mentor from the Associate or Active Staff to assist in monitoring the Member and the safety of his or her patients.

c. Random Drug Testing. The Member may be required to submit to random drug and alcohol testing for a specified period of time. The Member bears the expense for all such testing. The Chief of Staff may refer the Member to the Nevada Health Professionals Assistance Foundation for monitoring at the sole cost of the Member. In the event that any random blood or urine test for drugs or alcohol is positive without a legitimate reason, then the Member immediately shall resign from the Medical Staff.

RULE 5-1 ORGANIZATION AND FUNCTIONS MANUAL

Section 1. Organization and Functions of the Staff

The medical staff shall be organized as a departmentalized staff including the departments of anesthesiology, emergency medicine, family medicine, medicine, obstetrics and gynecology, pathology, pediatrics, radiology and surgery. A Department Chief shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.1 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Department Chief, hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

1.2 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, is responsible for the following activities:

1.2.1 Governance, direction, coordination, and action:

a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from Departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;
d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

1.2.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:
   i. Medical assessment and treatment of patients;
   ii. Use of medications;
   iii. Use of blood and blood components;
   iv. Operative and other procedures;
   v. Education of patients and families;
   vi. Accurate, timely, and legible completion of patients’ medical records to include the quality of medical histories and physical examinations;
   vii. Appropriateness of clinical practice patterns;
   viii. Significant departures from established pattern of clinical performance;
   ix. Use of developed criteria for autopsies;
x. Sentinel event data;
xii. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient; and
xiii. Findings of the assessment process relevant to individual performance.

Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.2.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the medical staff’s and administration’s approach to and methods of performance improvement;
b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
d. Participate as requested in the hospital’s patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.2.4 Credentials review (see Part III: Credentials Procedures Manual)

1.2.5 Information Management

a. Review and evaluate medical records to determine that they:
   i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and
   ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.
b. Develop, review, enforce, and maintain surveillance over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

   Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.2.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.
1.2.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.2.8 Bylaws review

a. Conduct periodic review of the medical staff bylaw, rules, regulations, and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations, and policies.

1.2.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.2.10 Infection Control Oversight

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:
   i. Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;
   ii. Review of prevalence and incidence studies, as appropriate; and
   iii. Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biennially.

1.2.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by The Joint Commission;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to The Joint Commission Patient Care Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:
   i. Prescribing/ordering of medications;
   ii. Preparing and dispensing of medications;
   iii. Administering medications; and
   iv. Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.2.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;
b. Establish programs for educating practitioners and staff to prevent substance
dependence and recognize impairment;

c. Notify the impaired practitioner’s Department Chief and the MEC whenever
the impaired practitioner’s actions could endanger patients. The existence of
the Practitioner Health Committee does not alter the primary responsibility of
the Department Chief] for clinical performance within that chair’s Department;

d. Create opportunities for referral (including self-referral) while maintaining
confidentiality to the greatest extent possible; and

e. Report to the MEC all practitioners providing unsafe treatment so that the
practitioner can be monitored until his/her rehabilitation is complete and
periodically thereafter. The hospital shall not reinstate a practitioner until it is
established that the practitioner has successfully completed a rehabilitation
program in which the hospital has confidence.

1.2.13 Utilization Management

a. Study recommendations from medical staff members, quality assessment
coordinators and others to identify problems in utilization and the review
program;

b. Monitor the effectiveness of the review program and perform retrospective
review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate
Department or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer
the data to medical staff peer review committees for their review and action;

and

f. Develop, with the aid of legal counsel, policies to guide the director of
utilization management, medical staff, and administration in matters of
privileged communication and legal release of information.

Section 2. General language governing committees

The following shall be the standing committees of the medical staff: Medical Executive,
Credentials & Privileges, Medical Staff Quality Improvement, Bylaws, Nominating, and
Residents, Fellows and Students. A committee shall meet as often as necessary to fulfill
its responsibilities. It shall maintain a permanent record of its proceedings and actions and
shall report its findings and recommendations ultimately to the MEC. The Chief of Staff
may appoint additional ad hoc committees for specific purposes. Ad hoc committees will
cease to meet when they have accomplished their appointed purpose or on a date set by
the Chief of Staff when establishing the committee. The Chief of Staff and the CEO, or
their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the Chief of Staff or by
action of the MEC for failure to remain a member of the medical staff in good standing or
for failure to adequately participate in the activities of the committee. Any vacancy in any
committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.1 MEC
Description of the MEC is in Part I: Governance; Section 6.2.

2.2 Credentials & Privileges Committee
Description of the Credentials & Privileges Committee is in Part III: Credentials Procedures Manual; Section 1.

2.3 Medical Staff Quality Improvement (MSQI) Committee
a. Composition: The medical staff quality committee is noted in the MSQI charter.
b. Responsibilities: The committee shall be responsible for those functions described in sections 1.2.3 a-d above

2.4 Bylaws Committee
a. Composition: The Committee will consist of at least five (5) Members of the Active Staff including the Immediate Past Chief of Staff and the present Chief of Staff. The Chairman will be the Secretary of the Medical Staff, if possible.
b. Responsibilities: The committee shall be responsible for those functions described in section 1.2.8 above.

2.5 Nominating Committee
a. Composition: The Nominating Committee is comprised of five Active Staff Members appointed by the Chief of Staff, the Immediate Past Chief of Staff and the CMO. The Immediate Past Chief of Staff shall chair the Committee.
b. Responsibilities: The committee shall provide an annual slate of nominees for the elected medical staff positions.

2.6 Residents, Fellows and Students Committee
a. Compositions: The Committee will consist of the Residency Directors and at least three (3) Members of the Active Staff, as well as representatives from Administration and Nursing Administration.
b. Responsibilities: The Residents, Fellows and Students Committee will be responsible for the review of training practices that impact the quality of care at Hospital. These issues include, but are not limited to, the supervision of residents, fellows and students and their interface with private Medical Staff in the delivery of care, assuring that each participant in a professional graduate education program is supervised in his/her patient care responsibilities by an LIP(s) who has been granted clinical privileges through the Medical Staff process.
2.7 Utilization Management Committee (hospital committee)
   a. Composition: The utilization management committee shall consist of at least two (2) members of the medical staff. The CEO shall appoint the hospital representatives to the committee.
   b. Responsibilities: This committee shall be responsible for the functions described in section 1.2.13 above.

2.8 Peer Review Committee
   a. Composition: The Peer Review Committee shall consist of at least three (3) members of the medical staff appointed by the Chief of Staff.
   b. Responsibilities: The committee shall be responsible for the activities of the Peer Review Process as defined in the Rules and Regulations above.

2.9 Cancer Committee
   a. Composition: Members of the Committee will include representatives from the Active Staff in the following specialties: Surgery, Medical Oncology, Radiation Oncology, Pathology, Radiology, Urology, Gastroenterology, Pulmonology, General Surgery and Gynecology Oncologic Surgery. Additionally the ACOS Physician Liaison must be a member of this committee. Multidisciplinary staff from the cancer registry, social services, quality services, nursing, pharmacy and administration will also be available to facilitate communication between the hospital and medical staff.
   b. Responsibilities: The cancer committee will concern itself with the entire spectrum of care for cancer patient admitted to the hospital.

2.10 Practitioner Wellness and Health Committee
   a. Composition: Members of the committee will be appointed by the Chief of Staff. Members should not hold any discipline related position (e.g. member of the MEC or Peer Review Committee), with the exception of the committee chair who may serve on the MEC. A good faith effort will be made to appoint a psychiatrist or behavioral health practitioner.
   b. Responsibilities: Assist in the medical staffs’ obligation to protect patients, medical staff members, and other from harm by providing education about practitioner health, address prevention of physical cognitive, psychiatric or emotional illness; facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition, including without limitation, professional impairment that might be caused by drugs, alcohol, mental, physical, or aging problems, or disruptive behavior. The committee will help facilitate rehabilitation rather than discipline, by assisting practitioners to retain and regain optimal professional functioning that is consistent with protection of patients. The Chair of the Wellness Committee will recuse himself/herself from any disciplinary proceedings. For complete Committee details see the Renown Regional Medical Center Practitioner Wellness and Health Committee Policy and Procedure.
Section 3. Confidentiality of Information

3.1 Confidentiality of Documents
   a. To the fullest extent permitted by law, the following shall be kept confidential:
      i. Information submitted, collected, or prepared by any representative of this
         or any other healthcare facility or organization or medical staff for the
         purposes of assessing, reviewing, evaluating, monitoring, or improving the
         quality and efficiency of healthcare provided;
      ii. Evaluations of current clinical competence and qualifications for staff
         appointment/affiliation and/or clinical privileges or specified services;
         Contributions to teaching or clinical research; or
      iii. Determinations that healthcare services were indicated or performed in
         compliance with an applicable standard of care.
   
   This information will not be disseminated to anyone other than a representative of the hospital or
   to other healthcare facilities or organizations of health professionals engaged in official,
   authorized activities for which the information is needed. Such confidentiality shall also extend to
   information provided by third parties. Each practitioner expressly acknowledges that violations of
   confidentiality provided here are grounds for immediate and permanent revocation of staff
   appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

   No representative of this healthcare organization shall be liable to a practitioner for damages or
   other relief for any decision, opinion, action, statement, or recommendation made within the scope
   of his/her duties as an official representative of the hospital or medical staff. No representative of
   this healthcare organization shall be liable for providing information, opinion, counsel, or services
   to a representative or to any healthcare facility or organization of health professionals concerning
   said practitioner. The immunity protections afforded in these bylaws are in addition to those
   prescribed by applicable state and federal law.

3.3 Covered Activities
   (1) The confidentiality and immunity provided by this article apply to all
       information or disclosures performed or made in connection with this or any
       other healthcare facility’s or organization’s activities concerning, but not
       limited to:
       a Applications for appointment/affiliation, clinical privileges, or specified
          services;
       b Periodic reappraisals for renewed appointments/affiliations, clinical
          privileges, or specified services;
       c Corrective or disciplinary actions;
       d Hearings and appellate reviews;
       e Quality assessment and performance improvement/peer review activities;
       f Utilization review and improvement activities;
       g Claims reviews;
       h Risk management and liability prevention activities; and
Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases
When requested by the Chief of Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest
A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

Section 4: Secure Communication
All members of the medical staff will have and use HIPPA compliant and Renown approved email and texting applications to communicate electronically HIPPA protected patient information or information related to quality improvement programs and/or peer review.
Appendix A  Conflict of Interest disclosure

1. Do you or a Family Member have a Business Relationship, or have a Financial Interest in any entity that has a Business Relationship (including employment) with Renown Health?

☐ No  ☐ Yes

If Yes, please provide the name of Family Member, your relationship and the nature of the Financial Interest and/or Business Relationship(s):

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

2. Do you or a Family Member have any Financial Relationship with any business that provides any healthcare services to Renown?

☐ No  ☐ Yes

If Yes, please explain:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Acknowledgement

I hereby certify that I have read the Renown Conflict of Interest Policy ("Policy") and the applicable section(s) of the Medical Staff Bylaws, Rules and Regulations and agree to comply with this Policy and make all required disclosures. I agree to immediately (within 30 days) disclose, in writing, any potential Conflict of Interest that may develop before the completion of my next Annual Disclosure Statement.

I further certify that the information contained on this form is true and correct to the best of my knowledge and I have made reasonable efforts to assure that accurate and complete information has been provided.

Signature: ____________________________

Print Name: __________________________

Date: _____________________________

Renown Health Conflict of Interest Disclosure Form  Revised November 16, 2017
MODEL MEDICAL STAFF CODE OF CONDUCT

To encourage a culture of safety and quality, organized medical staffs are encouraged to adopt a Code of Conduct as part of their medical staff bylaws. The medical staff bylaws, of which this Code of Conduct is a part, shall be the exclusive means for review and disciplining medical staff members for inappropriate or disruptive behavior.

I. APPLICABLE DEFINITIONS:

“Appropriate behavior” means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

“Disruptive behavior” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

“Harassment” means conduct toward others based on their race, religion, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

“Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

“Medical staff member” means physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

II. TYPES OF CONDUCT

A. APPROPRIATE BEHAVIOR
Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings (i.e., comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct, referral to the Health and Wellbeing Committee, economic sanctions, or the filing of an action before a state or federal agency);
- Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

B. INAPPROPRIATE BEHAVIOR

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their
families; nurses, physicians, hospital personnel and/or the hospital.

C. DISRUPTIVE BEHAVIOR
Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed at any one in the hospital including physicians, nurses, other medical staff members, or any hospital employee, administrator or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment; and,
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

D. INTERVENTIONS
Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the physician’s disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff’s Health and Wellbeing Committee (or equivalent committee).

END OF MEDICAL STAFF RULES AND REGULATIONS