MEDICAL STAFF

RULES & REGULATIONS

Approved by: MGH Board of Directors February 3, 2011

TABLE OF CONTENTS
RULES AND REGULATIONS

I.	**ADMISSIONS**	**1**
II.	**AUTOPSIES**	**1**
III.	**CLINICAL TRIALS**	**1**
IV.	**CONSENT**	**2**
V.	**EMERGENCY SERVICES**	**2**
	A. ER Back up Call Coverage Requirements	
	B. Medical Screening Examinations	
VI.	**MEDICAL RECORDS**	**3**
VII.	**MEDICAL RECORD DELINQUENCY/SUSPENSION/RESIGNATION**	**7**
VIII.	**MEDICAL STAFF COMMITTEES**	**7**
	A. Cancer Committee	
	B. Care Review Committee	
	C. Continuing Medical Education Committee	
	D. Infection Control Oversight Team	
	E. Interdisciplinary Practice Committee	
	F. Laboratory Liaison Committee	
	G. Medical Bioethics Committee	
	H. Patient Record Review Committee	
	I. Pharmacy & Therapeutic Agents Committee	
	J. Quality Improvement Committee	
	K. Trauma Committee	
IX.	**MEDICAL STAFF MEMBERSHIP ISSUES**	**14**
	A. Committee Appointments	
	B. Categories of Membership (Activity Requirements)	
	C. Disaster Plan	
X.	**MEDICAL STAFF POLICIES & PROCEDURES**	**15**
XI.	**ORDERS**	**15**
XII.	**SURGERY**	**16**
XIII.	**CASE MANAGEMENT / CONSULTATION**	**18**
XIV.	**MEDICAL STUDENTS**	**18**

MARIN GENERAL HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS

In accordance with Article XIV, Section I, of the Medical Staff Bylaws, the following rules and regulations are adopted. Rules and Regulations adopted by the Medical Staff in accordance with the Medical Staff Bylaws are binding to all members of the Medical Staff. The collective functions of the medical staff and the independent functions of its individual members shall be accomplished in accordance with applicable state and federal law.

I. ADMISSIONS

A. Except in an emergency, no patient shall be admitted to the hospital unless attended by a member of the medical staff and unless a provisional diagnosis has been stated. All physician (M.D./D.O.) members are considered to hold admitting privileges to such inpatient units as are consistent with their approved specialty privileges, except as noted on their delineation of privileges.

B. Attending Physician

1. Rounding. Unless otherwise specified in Departmental Rules and Regulations, each inpatient shall be seen daily by the attending staff member or by his or her designated alternate. In addition, either the attending member or his or her alternate shall be available on call 24 hours per day to meet the need of the patient. In case of failure to name such associate, the Chief of Staff, should he or she consider it necessary, shall have the authority to request the department chair or division chief to call any appropriate member of the staff to attend the patient.

2. Family Admission: Members of the Medical Staff should not treat themselves or members of their immediate family except for minor short-term problems, or in emergencies until another physician becomes available. Because professional objectivity may be compromised, or patient autonomy impaired, exceptions to this rule may only be made by the Chair of the appropriate Medical Staff Department, or the Chief of Staff.

C. Discharge / Transfer. The attending staff member or designee must inform the patient or their surrogate orally or in writing of any continuing health care requirements upon discharge from the hospital. That physician must also sign a transfer summary report, if applicable, which is to be provided to the patient or their surrogate by the hospital prior to discharge/transfer to another facility.

II. AUTOPSIES

Members of the medical staff are expected to be interested in securing autopsies for non-coroner's cases in appropriate circumstances. No autopsy shall be performed without written consent of the nearest relative or legally authorized agent (see "Permission for Autopsy Procedures Outlined in the Pathology Department Procedure Manual). In all cases, the final decision for the performance of an autopsy should be made after consultation between the attending physician and the pathologist. The attending physician shall be notified by the Pathology Department when and where the autopsy is to be performed. All autopsies shall be performed by the hospital pathologist.

III. CLINICAL TRIALS

Members of the Medical Staff shall provide notice to the MGH Institutional Review Board with written notice of any and all clinical trials to be conducted at Marin General Hospital, any affiliate of Marin General Hospital, or any Sutter Health facility.

IV. CONSENT

A. In all cases of sexual sterilization pursuant to this section, appropriate written consents shall be obtained as required by the laws of the State of California then in effect.

B. No surgical or invasive procedure and no treatment involving unusual risk to the patient (including blood transfusion) shall be performed without both of the following documented in the record:

1. The informed consent of a patient or legally authorized representative. It shall be the responsibility of the operating physician, dentist, or podiatrist to obtain an informed consent. Informed consent shall include at least the following:

(a) An explanation of the procedure, appropriate alternatives and respective benefits;
(b) An explanation of the significant risks, complications, and alternative options. The patient may be informed that he or she has the right to refuse this explanation;
(c) An explanation of the possible consequences of refusing the proposed treatment or procedure.

The physician, dentist, or podiatrist shall document in the medical record that an informed consent has been obtained.

2. The patient's written consent to treatment on an approved hospital form. It shall be the responsibility of the practitioner to provide the admitting nurse (or appropriate nursing personnel on the unit) with a written or verbal order indicating the name of the procedure to be performed.

3. Informed consent for psychotropic medications shall be obtained in accordance with applicable Hospital policy.

V. EMERGENCY SERVICES

A. Active and Courtesy staff members, plus those staff applicants who have been approved for Provisional status by the Credentials Committee, may volunteer to be listed on the emergency department consultation panel for the various specialties. If the list for any specialty is inadequate, in the opinion of the chair of the department or chief of the appropriate division, he or she may require that all active, courtesy and provisional staff members in said department be listed on the emergency department consultation panel for the specialty until the staff members have been subject to such service for 20 years as a member of these staff categories or their equivalents or shall have reached the age of 55, whichever comes first. The consultation panel and the method of its use shall be furnished to the Emergency Department by each Department or Division head.

Any unexcused failure to respond to a call will result in one week's suspension of staff privileges on recommendation of the head of the department.

B. Patients shall be attended by their own physician members of the medical staff. In emergencies patients may be attended by the emergency physician on duty but will be immediately referred thereafter to their own physician.

C. Medical Screening Examinations

All patients in the Emergency Department will be seen and evaluated in the order of severity of their problem, as determined by the Emergency Department staff. No exceptions shall be made. Medical staff members may see patients in the Emergency Department with the understanding that this policy shall apply to their patients as well.

All patients who present to the Hospital and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition, or where applicable, active labor. This medical screening examination may be performed by the following persons:

i. In the Labor and Delivery Unit by a registered nurse who has been determined by the L&D Managing Director to be qualified and experienced in obstetrical nursing and who is required to follow protocols approved by the Medical Staff.

ii. In the case of Psychiatric emergencies by a clinician with LPS (Lanterman-Petri-Short) 5150 authority as designated by the Psychiatric Services Medical Director (inpatient) and who is required to follow protocols approved by the Medical Director.

iii. In the Emergency Department by a licensed Physician Assistant who has been determined by the Medical Staff to be qualified and experienced in emergency care, and who is required to follow protocols approved by the Medical Staff.

iv. In all circumstances in the event the RN or PA performing the screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or active labor, a physician shall be required to examine the patient and make the determination of the existence of an emergency or active labor.

Upon the determination that an emergency medical condition or active labor exists, all available medical treatment within the capability of the Hospital will be provided to the patient to alleviate the emergency, deliver the child or transfer the patient to another hospital in accordance with the Hospital's emergency treatment and transfer policies.

VI. MEDICAL RECORDS

A. Content. The Hospital and attending physician shall be jointly responsible in the area of their respective responsibility for the preparation of a complete, accurate and legible medical record for each patient. This record shall include identification data, a complete history and physical, special reports such as consultation, clinical laboratory, x-ray and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, daily progress notes, final diagnosis, post-discharge continuing health care requirements, condition on discharge, summary or discharge notes, written transfer summary if applicable, and autopsy report.

B. Readmission. In cases of readmission of a patient, all previous medical records shall be available for the use of the attending staff member.

C. Custodian. The Hospital is the custodian of all medical records. A medical record may not be removed except in accordance with a court order, subpoena or statute. Except as otherwise allowed by law, the information contained in the record shall be made available only to persons or agencies to whom the patient has specifically authorized the release.

D. Authentication. All entries placed in the medical record (or called in verbally) by the responsible practitioner shall be promptly authenticated by the responsible practitioner, except as noted in IX.B.

Authentication means to establish authorship by signature or identifiable initials, written, faxed or by computer key or other code after transcription or electronic entry. Authentication is a verification that the entry being authenticated is his/her entry or that he/she is responsible for the entry and that the entry is accurate. For electronically-generated documents that only print the date and time that the practitioner actually reviewed the document, the practitioner must either authenticate, date and time the document itself, or incorporate an acknowledgement that the document was reviewed into another document in the record (such as the H&P, a progress note, etc.).

E. History & Physical

1. Timing: A physician member of the Medical Staff shall be responsible for performing and documenting an adequate history and physical examination on all patients admitted to the hospital no more than thirty (30) days before or within 24 hours after admission. For patients receiving more than minimal sedation, an interval H&P shall also be recorded by the responsible physician immediately prior to the procedure regarding the patient's current condition and any changes since the last H&P. An interval H&P note may be substituted for a patient readmitted within thirty (30) days for the same diagnosis (include a copy of the old H&P).

2. Non-Member Physician Assessment:

(a) A physician may utilize a history and physical performed by a physician not a member of the medical staff, provided the history and physical was performed within the past thirty (30) days. Any MD who does not wish to comply with the requirements of this section must perform his/her own H&P or have another physician perform the admission H&P.

(b) A physician utilizing an H&P performed by a physician not a member of the medical staff must do the following. The responsible physician must:

i. In the case of pre-surgical and pre-procedural H&Ps, review the history and physical examination document and conduct a second assessment immediately prior to the surgery or procedure to confirm the information and findings.
ii. In the case of a non-surgical or procedural admission, review the history and physical examination document within 24 hours of admission;
iii. For all admissions, update any information and findings as necessary (including a summary of the patient's condition, and of the course of care during the interim period) and the current physical/psychosocial status; and
iv. Sign and date the information as an attestation to it being current

3. Nurse Practitioner or Physician Assistant H&P Assessment:

(a) Subject to the Medical Executive Committee's approval in consultation with the Interdisciplinary Practice Committee as appropriate, a Department may establish appropriate

criteria whereby a Nurse Practitioner (NP) or Physician Assistant (PA) may perform an admission H&P. Any such NP or PA must be credentialed for these privileges by MGH and supervised by an Active Staff physician member.

(b) A physician may utilize an H&P performed by such an NP or PA under specific conditions listed below, provided the H&P was performed within the past thirty (30) days. Any physician who does not wish to comply with the requirements of this section must perform his/her own H&P or have another physician perform the admission H&P.

The responsible physician must:

1. In the case of pre-surgical and pre-procedural H&Ps, review the history and physical examination document and conduct a second assessment immediately prior to the surgery or procedure to confirm the information and findings.
2. In the case of a non-surgical or procedural admission, review the history and physical examination document within 24 hours of admission;
3. For all admissions, update any information and findings as necessary (including a summary of the patient's condition, and of the course of care during the interim period) and the current physical/psychosocial status; and
4. Sign and date the information as an attestation to it being current.

c) Quality Assurance: Any omissions or deficiencies in such H&Ps should be reported to the supervising physician and monitored through Medical Staff peer review and quality assurance programs.

(d) A Pre-operative risk assessment will be determined by a physician (not by a NP or PA), prior to the surgery or procedure.

4. Content of H&P.

A complete H&P must include 8 elements: chief complaint, history of present illness, past medical/surgical history including allergies, a list of medications including dosages when available, family and social history, an inventory of systems, physical examination, and a diagnosis with a plan of care. For major diagnostic and therapeutic interventions, or for ambulatory surgery requiring admission for less than 24 hours, an abbreviated H&P may include only those elements relevant to the surgical or invasive procedure to be performed, but at a minimum must include a chief complaint, history of present illness, medication and allergy list, physical examination and diagnosis with a plan of care.

A pediatric admission H&P shall also ordinarily include 4 more elements: developmental age, daily activities, immunization status, and family/guardian's expectations and involvement in assessment, treatment and continuous care. Psychiatric and psychological examination of patients shall be performed in compliance with Department of Psychiatry rules.

.

5. Format of H&P

Any patient who will be admitted to inpatient status and who will be undergoing a surgical or invasive procedure OR whose hospital stay is anticipated to be more than 24 hours duration must have a dictated or typed/printer-generated history and physical. This requirement does not apply to the admission of healthy obstetric patients admitted for delivery or the corresponding admission of their healthy newborns.

For patients anticipated to stay less than 24 hours, legible handwritten documents or documents generated from a physician's outpatient electronic health record are acceptable as long as they include the required documentation relevant to the surgical or invasive procedure being performed.

F. Emergency H&P Except in cases of life-threatening emergency, surgery shall not commence without a physician's, NP's or PA's history and physical examination on the patient's chart. In emergency cases, the practitioner will write a brief note indicating the emergent nature of and indications for the procedure to be done.

G. Performance of H&P by Doctor of Podiatric Medicine. A member of the Medical Staff who is a doctor of podiatric medicine and has been licensed by the California Board of Podiatric Medicine may perform and document a history and physical examination for all podiatry patients admitted to the hospital for care, as well as for all podiatry patients undergoing podiatric surgical procedures on an outpatient basis.

H. Dental Patient. If a patient is not competent to provide a patient history, but has an H&P on file from an MD/DO who has not been granted staff privileges, the patient's H&P from the non-MGH staff MD/DO will be reviewed and the patient's physical status and readiness for general anesthesia assessed by the anesthesiologist. The anesthesiologist will perform and record a physical exam the day of surgery.

I. Operative Report. All operations performed shall be fully described by the operating surgeon, dentist, or podiatrist on the patient's medical record, or dictated immediately following the procedure. The report shall contain the findings, the technical procedures used, the specimens removed, estimated blood loss, the postoperative diagnosis, and the name of the primary surgeon and any assistants. Because the operative report is not placed in the medical record immediately after surgery, an operative progress note is to be entered into the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient. The full operative report must be dictated within 24 hours after surgery.

J. Discharge/Completion.

Patients shall be discharged only on order of a responsible physician. At the time of discharge, the responsible physician shall see that the record is complete insofar as is reasonably possible and, when possible, shall record the final diagnosis and sign the record. A list of current medications including doses and timing shall be provided to the patient at discharge. Within 7 days after discharge, a discharge summary shall be written or dictated by the responsible physician or practitioner. The medical record shall be complete within 14 days following discharge of the patient.

1. The discharge summary shall briefly recapitulate the significant findings and events of the patient's hospitalization, which includes the reason for hospitalization, final diagnosis, significant findings, procedures performed and care, treatment and services provided, the patient's condition at discharge, allergies, and information provided to the patient and family, as appropriate, as required by hospital policy.

2. A final progress/discharge note may be substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48 hour stay, including normal newborns and uncomplicated obstetric deliveries. If the patient was hospitalized for less than forty-eight (48) hours for minor ailments, the abbreviated clinical resume format may be used. The note must clearly summarize the hospital course and include relevant discharge instructions.

3. A summary (preferably dictated) shall be provided for all patients who die while in the hospital or who are transferred from the hospital, regardless of length of stay.

4. Discharge Summary by NP/PA/CNM reviewed within 24 hours:

   Subject to the Medical Executive Committee's approval in consultation with the IDP Committee as appropriate, a Department may establish appropriate criteria whereby a Nurse Practitioner (NP) or Physician Assistant (PA) or Certified Nurse Midwife (CNM) may dictate or write a discharge summary. Any such NP or PA or CNM must be credentialed for these privileges by MGH, and supervised by an Active Staff physician member. A responsible physician is still responsible to write an order for the patient's discharge. A responsible physician shall review, authenticate and countersign the discharge summary promptly after it is written or dictated by the responsible practitioner.

   However, for routine obstetrical admissions (not requiring physician management), a CNM may write the discharge order and authenticate the discharge summary without physician countersignature, if the CNM has privileges to independently manage cases and the physician has not managed the patient.

K. Completion/Filing. No medical record shall be filed until it is complete except on order of the Patient Record Review Committee.

VII. MEDICAL RECORD DELINQUENCY/SUSPENSION

Once each week the responsible staff member will be sent a letter concerning their incomplete records. A medical staff member will be suspended when a medical record becomes delinquent if the medical staff member has not attempted to complete his/her medical records during the prior 14 days by either a) visiting the Health Information Management Dept. to complete all available records, or b) attending a department/section meeting to which the physician's incomplete records have been delivered (to complete all available records). Suspension will not be assigned if a medical staff member is unable to complete records due to prolonged illness or vacation – the HIM Dept. should be given written notification of such an illness or vacation when applicable.

Any applicant or staff member who is hereby suspended for more than sixty (60) calendar days during a twelve month period shall be deemed to have voluntarily resigned their Medical Staff membership and privileges. This resignation shall be automatic. This resignation will result in the physician being required to reapply to the Medical Staff, pay the standard application fee, and complete all incomplete/delinquent charts prior the processing of the application.

The responsibility for control of delinquent medical records shall be delegated to the Medical Executive Committee or its designated body.

VIII. MEDICAL STAFF COMMITTEES

In accordance with Article 11.3-2(f), it is a duty of the Medical Executive Committee to evaluate the medical care rendered to all patients in the hospital. The Medical Executive Committee has transferred data collection responsibilities in the areas of care review, infection control, and medical records from standing Medical Staff Committees to subcommittees and teams who are required to report their activities to the Medical Executive Committee on at least a bi-annual basis. The results of

their activities are intended to supplement, not replace, the quality assessment and peer review responsibilities of the medical staff and their findings are considered confidential.

A. **Cancer Committee**

1. COMPOSITION: The Cancer Committee shall be a multidisciplinary committee designed to function according to the recommendations of the Commission on Cancer of the American College of Surgeons. It shall include representatives from surgery, medical oncology, internal medicine, psychiatry, urology, gynecology, diagnostic and radiation oncology, pathology and family practice. The Committee must also include the Cancer Liaison Physician, the cancer registrar and representatives from hospital administration, nursing, social services, and quality management. It may also include representatives from pharmacy, nutrition, clergy, and rehabilitation. The Chair and the physician members shall serve a three year term of membership. They may serve up to three consecutive terms.

2. DUTIES: The committee shall be concerned with the entire spectrum of care for all cancer patients admitted to the hospital and is responsible for planning, initiating, stimulating, and assessing all cancer-related activities. Its functions will be to:

(1) Organize, publicize, implement and evaluate regular educational and consultative cancer conferences that are multidisciplinary, hospital-wide and patient oriented;
(2) Ensure that educational programs, conferences, and other clinical activities include all major cancer sites;
(3) Ensure that consultative services in the major disciplines are available to all cancer patients;
(4) Monitor and evaluate the quality of patient care, either directly, or by review of audit data. Plan and implement a minimum of two patient care evaluation studies annually, one to include survival data (outcome) and, if available, comparison data;
(5) Encourage the development of screening and early detection programs;
(6) Ensure that cancer rehabilitation services are available and utilized;
(7) Encourage the development of a support care system for all patients with cancer.

3. MEETINGS: The committee will as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

B. **Care Review Committee:** The Care Review Committee is a subcommittee of the Medical Executive Committee composed of at least two officers of the Medical Staff one of whom shall serve as Committee Chair, at least two representatives from the Quality Management Department, the Senior Vice-President/Medical Director, a representative from the Medical Staff Services office, and any other additional Medical Staff or hospital staff required to fulfill its responsibilities.

This subcommittee shall recommend actions to the Medical Executive Committee and Hospital administration for maintaining optimum quality of care within the hospital and assist Medical Staff leadership in fulfilling peer review activities within their specialty area. These may include mechanisms to:

(i) set priorities for action on problem correction.

(ii) refer priority problems for assessment and corrective action to appropriate Departments or Divisions.

(iii) perform such other tasks necessary generally to integrate the quality assessment, risk management and utilization review functions of the Medical Staff.

The Care Review Committee shall meet as often as necessary to conduct its business. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee as required.

C. <u>Continuing Medical Education Committee</u>

1 COMPOSITION.

The CME Committee shall consist of not less than three (3) Members of the Active staff selected on a basis that will ensure insofar as feasible, representation of primary care clinical specialties, additional interested representatives of clinical Departments, if any, and staff representatives from the quality assurance program and the CME office.

2 DUTIES. The CME Committee shall:

a. review, evaluate and oversee provision of continuing medical education ("CME") that meets all customary requirements, provides practical information which can be applied to the current and future practice of medicine, and is appropriate to the scope of services provided by physicians.

b. review and approve CME activities based upon both educational needs and demonstrated compliance with the essential areas and elements as well as the standards for commercial support, which are established by the California Medical Association.

c. oversee and provide sponsorship that represents an endorsement of the educational activity's ability to meet the CMA requirements as outlined in our policies and procedures (i.e. speaker's ability to meet the identified need, accomplish the desired objectives, etc).

d. work together with the CME Office to take the necessary steps in an attempt to ensure the quality, scientific integrity, and balance of each presentation.

e. perform an annual review of program goals, budget and accomplishments

f. comply with all ACCME and CMA accreditation recommendations.

3. MEETINGS. The Committee shall meet as often as necessary at the call of its Chair. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

D. **<u>Infection Control Committee</u>**: The Infection Control Committee shall consist of at least one Medical Staff epidemiologist, an internist and a surgeon, the employee health nurse, a bacteriologist/ microbiologist, the Infection Control Specialist, a nurse, a representative from administration, and other representatives as needed from relevant hospital services.

The duties of the Committee include:

(a) overseeing a hospital-wide infection control program intended to protect patients, healthcare personnel, and visitors from transmission of infection within the hospital environment and monitoring the effectiveness of the program.

(b) implementing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities.

(c) implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques and educating staff in current infection prevention methods.

(d) developing written policies defining special indications for isolation requirements and reviewing departmental infection control policies and procedures.

(e) acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, departments and other committees.

(f) reviewing sensitivities of organisms specific to the facility.

(g) investigating potential outbreaks and taking appropriate preventive action.

The Committee shall meet at least quarterly and shall submit reports of its activities and recommendations to the Medical Executive Committee.

E. **Committee on Interdisciplinary Practice**: The Interdisciplinary Practice Subcommittee shall be composed of representatives from the Active Medical Staff and nursing, at least one of whom shall be the senior administrative nurse or designee, representing administration. The medical staff and nursing members shall be equal in number and appointed by the Chief of Staff and senior administrative nurse respectively. In addition, representatives of the various allied health professions should serve as consultants on an as-needed basis, and, if available, shall be included in the committee proceedings when an application from a member of the specialty is being considered. The Chair of the Credentials Committee will act as Chair. All appointed members (physician and nursing) shall be empowered with voting privileges. Motions for approval of standardized procedures will be carried by a majority vote of the physicians and a majority vote of the nurses rather than a simple majority of those present.

The Interdisciplinary Practice Committee shall

a) evaluate and make recommendations regarding

i) the need for and appropriateness of the performance of in-hospital services by allied health practitioners, as well as any applicable terms and conditions thereon;

ii) the minimum standards of training, education, character, competence, and overall fitness of AHPs eligible to apply for the opportunity to perform in-hospital services;

iii) the credentialing, monitoring, and evaluation of the performance of allied health professionals practicing in the Hospital

iv) the professional responsibilities of AHPs who have been determined eligible to perform in-hospital services.

b) review and recommend policies and procedures for each standardized procedure; and

c) review and recommend approval of standardized procedures on a tri-annual basis.

d) identify nursing functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business & Professions Code; and
e) perform any other required functions specified in Article 70706 of California Title 22 that are applicable to nursing staff at this Hospital.

The Interdisciplinary Practice Committee shall meet as frequently as necessary to perform its duties but not less than annually.

F. **Laboratory Liaison Committee** The Laboratory Liaison Committee shall consist of at least four members of the Medical Staff including the Pathologist Medical Director of Laboratory Services and hospital staff from the following areas: clinical laboratory administration, nursing management, quality management, information systems, general acute care, critical care, emergency medicine, and other additional Medical Staff or hospital staff required to fulfill its responsibilities.

This Committee is responsible for reviewing the quality improvement activities of the Clinical Laboratory on an ongoing basis. This committee shall review the effectiveness of the monitoring, evaluation, and problem-solving activities of the laboratory service including blood utilization and tissue review.

This Committee shall meet as often as necessary to conduct its business, but no less than four times a year. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee as required by them.

G. **Medical Bioethics Committee**

1. COMPOSITION: The Medical Bioethics Committee shall consist of physicians and such other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Board of Directors, although a majority and the committee Chair shall be physician members of the Medical Staff.

2. DUTIES: The Medical Bioethics Committee may participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on bioethical matters.

3. MEETINGS: The committee shall meet as often as necessary at the call of its Chair, but at least annually. It shall maintain a record of its activities and report to the Medical Executive Committee.

H. **Patient Record Review Committee:**

The Patient Record Review Committee shall consist of at least three (3) members of the medical staff with representatives from nursing, clinical services, quality management, medical records, pharmacy, administration, and physical therapy. Additional members may be appointed from time to time to assist the committee in addressing specific issues. The Committee shall be chaired by a physician appointed by the Chief of Staff.

Issues impacting directly on physician practice or which require an amendment to the Medial Staff Bylaws, Rules and Regulations shall require approval of a majority of physician members. In all other issues, all members shall have equal vote.

The Patient Record Review Committee is responsible for the review and evaluation of medical records, or a representative sample, to determine if the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

To fulfill this responsibility the Committee shall:

a) review patient records on at least a quarterly basis to assess whether they are complete, timely, and accurate;
b) identify opportunities for improvement of any aspect of the patient medical record process and recommend amendments to hospital and medical staff rules and regulations, policies and procedures, support systems, staffing, etc., to facilitate change;
c) act as an educational resource for hospital and medical staff on regulatory agency requirements and accreditation standards and guidelines.

The Patient Record Review Committee shall meet at least quarterly, keep a record of its activities and report to the Medical Executive Committee as requested.

I. **Pharmacy & Therapeutics Committee**

1. COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least five representatives from the Medical Staff, and a single voting representative from each of the following: the pharmaceutical service, the nursing service and hospital administration.

2. DUTIES: The Committee's duties shall include:

   (a) assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage.
   (b) advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs.
   (c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
   (d) periodically developing and reviewing a formulary or drug list for use in the hospital.
   (e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital.
   (f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
   (g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.
   (h) reviewing untoward drug reactions.

3. MEETINGS: The committee shall meet as often as necessary but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

J. **Performance Improvement Committee of the Medical Staff**

Purpose It shall be a joint committee of the Medical Staff and Hospital Leadership with the direct oversight of organizational performance. The goal of improving organizational performance is to identify and monitor processes and activities that continually improve the quality of care and services to our patients.

(1) Functions

a. Prioritization and selection of housewide projects
b. Quarterly evaluation of projects for improvement and feasibility
c. Evaluation and recommendation of required functions at Multidisciplinary Practice Committees
d. Oversight of patient safety and projects approved by Multidisciplinary Practice Committees
e. Evaluation and recommendation of Hospital Dashboard
f. Evaluation and recommendation of ORYX indicators
g. Evaluation of the necessity and appropriate utilization of hospital services
h. Development and review of annual PI Plan and the Utilization Management Plan

(2) **Responsibilities:** The committee shall meet and report as follows:

a. Monthly meetings with reporting calendar
b. Monthly executive summary to MEC
c. Monthly executive summary to Directors Group
d. Quarterly (or as needed) summary to Medical Policy Committee
e. PI presentations to all above groups for increased awareness and education

Membership. The membership shall include:

- Vice Chief of Staff (Chairperson)
- Director Quality Management Services (Co-Chair)
- Vice President Medical Affairs
- Chief Nursing Officer
- Assistant Administrator, Ancillary and Support Services
- Vice President Finance or designee
- Medical Staff Members at Large (2)
- Ad Hoc Members shall include Director of Information Systems

3. **Meetings**

The committee shall meet as often as necessary but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

K. **Trauma Committee**

1. **Membership.** The membership shall consist of the following persons:

a) Trauma Medical Director
b) A Trauma Surgeon from Marin General Hospital
c) Medical Director of the Emergency Department at Marin General Hospital or designee
d) Physician specialists, to include an Orthopedic Surgeon, a Neurosurgeon, an Intensivist / Pulmonologist, a Plastic Surgeon, a Pediatrician, an Obstetrician, and a Radiologist
e) Trauma Program Director

f) Administrator for the Trauma Program will be an ex officio member without vote.
g) Ad Hoc Membership: Other hospital department representatives, as determined by the committee chair.
h) The Trauma Medical Director will recommend appointments to the Chief of Staff for a term of two (2) years.
i) Attendance Requirement. All physicians participating in the Trauma Service are required to attend 50% of the yearly meetings.
j) Committee Chair. The committee will be chaired by the Medical Director of the Trauma Service or his/her designee and be facilitated by the Trauma Program Director.

2. **Duties**. The Trauma Services Committee shall*:*

a) Conduct a multidisciplinary review of both process & outcomes of trauma care, as well as pre-hospital care review.
b) Oversee the Trauma Education Plan for physicians, hospital staff and the community.
c) Oversee and validate the Trauma Registry Data Base
d) Review at regular intervals the Trauma Quality indictors defined by the American College of Surgeons.
e) The Chair or his/her designee will represent the Trauma Service to the local EMS Agency, and other Trauma Committees at the State level.
f) Develop and recommend to the Chiefs of Staff and administration, policies and procedures to ensure that services meet all requirement of the Marin County Trauma Plan.

3. **Meetings**

a) Frequency. The committee shall meet as often as necessary at the direction of its Chairman, but no less than six (6) times per calendar year.
b) Reports. The Committee shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee at least semiannually.

IX. MEDICAL STAFF MEMBERSHIP ISSUES:

A. Committee Appointments:

Appointments to committees ordinarily will be made for a period of two years. A committee chairman may not serve consecutive terms for more than four years, unless an exception is made by vote of the Medical Executive committee or department, as appropriate.

B. Categories of Membership:

Active staff members will be expected to maintain a minimum of four admissions, outpatient procedures, or consultations per year or be regularly involved in medical staff activities as defined by the Medical Staff, except Active members of the Department of Psychiatry who will be expected to maintain a minimum of four admissions, outpatient procedures, or consultations per year or be regularly involved in medical staff functions as determined by the Medical Staff. Active staff members who neither meet annual patient contact numbers nor are regularly involved in medical staff activities as defined by the Medical Staff shall be transferred to Courtesy Staff.

Each Courtesy staff member will be limited to twelve patient admissions or related contacts in every one year period except courtesy members of the Department of Psychiatry will be limited to three admissions or related privileges per year. Courtesy staff members who exceed the

specified patient contact limits will be transferred to Active staff and assume all rights and responsibilities required of that Medical Staff category. This provision may be waived by the Medical Executive Committee for good cause.

Consulting staff members who meet Bylaws criteria for their staff category shall not be required to maintain a minimum number of patient contacts as long as adequate documentation of current clinical competence is available from those institutions at which Active or Associate staff membership is held.

Inactive Designation: Medical staff members who, at the time of reappointment application submission, have had no activity (i.e. admissions, consultations, outpatient surgeries, etc.) in the period being evaluated shall have the "inactive" designation applied to their membership. This designation will not appear on any roster or be referenced in any correspondence with other healthcare organizations, but will be retained as an internal reference. Staff members designated as inactive will be advised, provided with an opportunity to challenge, and informed regarding impact of continued lack of patient contact on their membership and privileges. Medical staff members who continue to be inactive through the next two year period of their affiliation will be advised that due to their inactivity their privileges and membership will be allowed to expire at the end of their current reappointment period. If at any time in this four year cycle the member is able to document activity, the inactive designation will be dropped.

TRANSFER OF INACTIVE STAFF MEMBERS

After four consecutive years in which a member of the medical staff fails to care for any patients in this hospital, that member shall be deemed to have voluntarily resigned his/her membership, and the term of appointment shall expire as described in the Medical Staff Rules. Such a resignation shall not be subject to procedural rights otherwise set forth in the Bylaws as there is no medical disciplinary action implied by membership expiration based upon inactivity.

C. **Disaster Plan**:

Members of the medical staff shall accept assignments to posts in accordance with the hospital or community disaster plan and shall be provided with information necessary to their participation in this plan.

X. MEDICAL STAFF POLICIES AND PROCEDURES

Policies and procedures shall be developed as necessary to implement more specifically the general principles found within the Medical Staff Bylaws and Rules and Regulations. The policies and procedures may be adopted, amended or repealed by majority vote of the Medical Executive Committee. Such policies and procedures shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or other policies.

XI. ORDERS

A. Standing Orders and medical policies for all nursing units shall be prepared by appropriate committees for approval by the Medical Executive Committee. Changes in these orders shall require the same procedure.

B. All orders shall be written or typed and signed, dated, and timed. Verbal orders shall be signed by the recipient to whom dictated, with the name of the practitioner per his or her own name. The

practitioner is permitted to dictate drug orders only to a registered nurse, licensed vocational nurse, pharmacist, respiratory therapist, or physician assistant. Other verbal orders may be dictated to other authorized staff as pertinent to the scope of their licensure. Verbal orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

All verbal orders shall be authenticated by the responsible practitioner or the attending physician within 48 hours. All verbal orders and entries in the chart must be authenticated in a timely manner, and dated and timed.

C. Drugs used shall be those listed in the United States Pharmacopeia, National Formulary, and other drugs approved by the Pharmacy Committee. As far as possible, the use of proprietary names shall be avoided and standard generic names employed.

D. Legibility. Prescribers must adhere to the order writing standards established by the Pharmacy and Therapeutics Committee. If two people cannot read a hand-written order, it is determined to be illegible. Any practitioner may be required to take a handwriting course at their own expense if s/he is sent more than 3 letters in one year concerning illegibility, as a patient safety issue.

E. Restraints: Medical Staff members are expected to comply with Hospital policies on restraints. Medical staff members shall co-sign, date, and time, verbal restraint orders within 24 hours.

XII. SURGERY

A. Except in cases of emergency, surgery shall not commence without the following: 1) a current, appropriate history and physical examination written on the patient's chart, 2) a duly signed informed consent for surgery, and, 3) unless waived by the surgeon and anesthesiologist, all laboratory requirements in effect at the time.

In emergency cases, the practitioner will write a brief note indicating the emergent nature of and indications for the procedure to be done. All laboratory requirements must be waived by the surgeon and the anesthesiologist. Emergency surgery is defined as life threatening or those procedures in which failure to initiate surgery within one hour will likely result in irreparable harm to the patient. [Full definition in Surgical Services policy and procedure].

B. All tissues removed at an operation shall be sent to the hospital pathologist, who shall make such examination as he may consider necessary to arrive at a diagnosis. The following exceptions are permitted at the discretion of the surgeon who must verify the removal in his operative report: (a) ribs removed only to enhance operative exposure; (b) newborn foreskin; (c) placenta; (d) cataract; (e) teeth; (f) foreign bodies; (g) orthopedic hardware; (h) tissue removed in the treatment of deformity rather than disease. Exceptions are defined in approved Dept. of Pathology Policies, pursuant to program flexibility granted by the Dept. of Health Services, in compliance with Title 22, Section 70223.g.

C. In cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient.

D. The head of a department or division may intervene in any emergency situation indicating a change in treatment; the circumstances shall be reported to the executive committee of the department or division.

XIII. CASE MANAGEMENT / CONSULTATION

A. **Responsibility and Transfer of Responsibilities**. The responsibility of care always remains with the attending physician or their designated oncall alternate, except in an emergency if he/she is unavailable. Whenever the attending transfers such responsibilities to another Staff member, he/she shall enter a note on the order sheet in the medical record transferring responsibility, stating the date and time of transfer.

B. **Consultation**.

a. General. The good conduct of medical practice includes the proper and timely use of consultation. Judgement as to the seriousness of the illness and the proper diagnosis and treatment rests with the physician responsible for overall medical care. The Department Chairman has oversight authority for assuring that consultants are called as needed. A physician to physician contact shall occur when requesting consultation.

b. Indications. The attending physician is responsible for requesting a consultation when indicated. Except in an emergency, consultation should be considered in cases which according to the judgment of the attending physician, additional skills and clinical advice or review might be beneficial to the treatment of the patient; including, without limitation, all cases in which:

(i) a patient is not a good risk for an operation or treatment,
(ii) the diagnosis is obscure after ordinary diagnostic procedures have been completed,
(iii) there is a question as to the choice of therapeutic measures to be used,
(iv) the specific skills of other practitioners may be needed because of the unusual complexity of the patient's problem,
(v) the patient exhibits severe psychiatric symptoms,
(vi) such consultation is requested by the patient or family,
(vii) the patient has a problem beyond the scope of privileges granted to the practitioner,
(viii) such consultation is required by Hospital, Medical Staff or Department Rules.

c. Completeness. Consultation includes examination of the patient and the medical record. The attending physician is responsible for supplying the consultant with all available and relevant information and the reason for the consultation. The consultant shall enter a signed, written opinion in the medical record. When a consultation precedes an operative procedure, the consultation shall be recorded before the operation, except in emergencies. The attending physician may obtain a consultation by a non-staff member, who has requested and who has been granted temporary privileges.

XIV. MEDICAL STUDENTS, RESIDENTS OR FELLOWS

UCSF Medical Students, or other formally approved residents or fellows, may function in patient care roles pursuant to the provisions of written affiliation arrangements approved by the hospital and the Medical Staff. Professional liability insurance for medical students, residents and fellows will be provided by the primary training institution. All medical students, residents and fellows will wear their hospital's ACGME program identification badges.

A. **Medical Students.** They may write orders, examine patients and participate in care of patients only under the direct supervision of a qualified Medical Staff member who is a fully licensed physician and has a UCSF Clinical Faculty appointment. All such orders must be countersigned by the supervising physician before being carried out. Medical student entries in the medical record shall be edited and amended as necessary by the preceptor.

Medical Students will be permitted to function clinically only in accordance with written training protocols developed by the responsible preceptor and/or the training institution, and as approved by the affected Department. Trainees may participate in deliveries and assist at procedures only under the direct supervision of the preceptor/attending physician. Trainees are not to replace any regular member of the operative team. Medical Students' responsibilities and functions are to be delineated by each Department. Ultimate responsibility for all patient care rests with the attending physician.

A. Residents or Fellows. Upon the written recommendation of any Department or Division, the Medical Executive Committee shall consider establishment of clinical rotations accredited by the Accreditation Council on Graduate Medical Education (ACGME) to further patient care and educational objectives. There must be a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in any residency or fellowship program. This applies to participants in formally constituted onsite participating facility program(s) with direct involvement in carrying out patient care responsibilities. Requests for non-ACGME accredited programs or their participants will not be considered. A written letter of agreement between the primary site and MGH shall be required prior to commencing any clinical rotation.

The ACGME accredited primary site professional graduate education committee(s) and the MGH medical staff members and Department Chairs responsible for overseeing such participants will regularly communicate about the safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. The primary site professional graduate education committee(s) and the governing body will periodically communicate about the educational needs and performance of the participants in the program.

This section applies only to graduate medical education programs accredited by the ACGME that are in compliance with that entity's requirements; the primary site organization should be able to demonstrate compliance with any residency review committee citations related to the ACGME standards, and to promptly notify the MGH Medical Staff should their program accreditation status change.

EFFECTIVE WITH APPROVAL OF THE BOARD OF DIRECTORS: February, 2011
END
Reviewed 8/03 (renumbered); February, March, May, July 2004, December, 2004; December, 2005, December, 2006, October, 2007, May, 2009; January, 2010; January 2011.

Medical Staff Rules -- Approval Page

ADOPTED by the MGH Medical Staff on

December 10, 2010

____
Chief of Staff

APPROVED by the MGH Board of Directors on

February 3, 2011

____
Chairman